PARTNERS
FOR HEALTH

State Group
Insurance Program

2017 Eligibility and Enrollment Guide

Local Government Employees

Rev. 3-22-17

If you need help…

Contact your agency benefits coordinator. He or she has received special training in our insurance programs. For additional information about a specific benefit or program, refer to the chart below.

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 — M-F, 8-4:30	tn.gov/finance partnersforhealthtn.gov Email: benefits.administration@tn.gov
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	PayFlex	855.288.7345 — M-F, 7-7 Sat, 9-2	stateoftn.payflexdirect.com
Pharmacy Benefits	CVS/caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Abuse and Employee Assistance Program	Optum	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness and Nurse Advice Line	Healthways	888.741.3390 — M-F, 8-8	partnersforhealthtn.gov (wellness tab)
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	mybenefits.metlife.com/ StateOfTennessee
Vision Insurance	EyeMed Vision Care	855.779.5046 — M-Sat, 7:30-10 Sun, 10-7	eyemedvisioncare.com/stoftn
Long-Term Care Insurance	MedAmerica	866.615.5824 — M-F, 8:30-6	ltc-tn.com

Enrollment forms and handbooks…

All enrollment forms and handbooks referenced in this guide are located on our website at **tn.gov/finance** or you can get a copy from your agency benefits coordinator.

Online resources…

Visit the ParTNers for Health website at partnersforhealthtn.gov. Our ParTNers for Health website has information about all the benefits described in this guide—plus definitions of insurance terms that may be unfamiliar and answers to common questions from members. The website is updated often with new information.

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INTRODUCTION

Overview

This guide is to help you understand your insurance options. Read the information in this guide and make sure you know the rules.

Benefits Administration within the Department of Finance and Administration manages the group insurance program. Three separate groups receive benefits. The State Plan includes employees of state government and higher education. The Local Education Plan is available to local K-12 school systems. The Local Government Plan is available to local government agencies that choose to participate.

If you are eligible, you may enroll in health coverage. Dental, vision and long-term care coverages are also available, if offered by your agency.

For More Information

Your agency benefits coordinator is your primary contact. This person is usually located in your human resource office. He or she is available to answer benefit questions and can provide you with forms and insurance booklets.

You can also find information that explains benefit details on the Benefits Administration website. This includes brochures and handbooks for health, pharmacy, dental, vision and long-term care. Plan documents and summaries of benefits and coverage are also available.

Authority

The Local Government Insurance Committee sets benefits and premiums. The Committee is authorized to (1) add, change or end any coverage offered through the state group insurance program, (2) change or discontinue benefits, (3) set premiums and (4) change the rules for eligibility at any time, for any reason.

Local Government Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- One member appointed by the Tennessee Municipal League
- One member appointed by the Tennessee County Services Association

Certain state and federal laws and regulations, which may be amended or the subject of court rulings, apply to the group insurance program. These laws, regulations and court rulings shall control over any inconsistent language in this guide.

ELIGIBILITY AND ENROLLMENT

Employee Eligibility

The following employees are eligible to enroll in coverage:

- 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 8-27-207(i)
- 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

Employees NOT Eligible to Participate in the Plan

Individuals who do not meet the employee eligibility rules outlined above, are ineligible UNLESS they otherwise meet the definition of an eligible employee under applicable state or federal laws or by approval of the Local Government Insurance Committee. As an example, the following individuals are normally ineligible but might qualify for coverage if they meet the federal definition of a full-time employee under the Patient Protection and Affordable Care Act.

- Individuals performing services on a contract basis

Dependent Eligibility

If you enroll in health, vision or dental coverage, you may also enroll your eligible dependents. You do not have to be enrolled in long-term care to enroll your eligible dependents.

The following dependents are eligible for coverage:

- 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
- Children for whom the plan has qualified medical child support orders

All dependents must be listed by name during enrollment. Proof of the dependent's eligibility is also required. Refer to the dependent definitions and required documents chart for the types of proof you must provide. A dependent can only be covered once within the same plan, but can be covered under two separate plans (state, local education or local government). Dependent children are eligible for coverage through the last day of the month of their 26th birthday.

Children who are mentally or physically disabled and not able to earn a living may continue 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.

A newly hired employee can choose coverage for his/her spouse as a dependent when that spouse is an eligible employee who declined coverage when first eligible. 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.

Individuals Not Eligible for Coverage as a Dependent

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse (with the exception of long-term care)
- Foster children
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

Enrollment and Effective Date of Coverage

As a new employee, your eligibility date is either your hire date or the last day of your agency's probationary period (if your agency applies a probationary period to insurance coverage). You must complete enrollment within 31 days after your eligibility date. Coverage starts on the first day of the month after your hire date or the first day of the month following the end of your probationary period (if your agency applies a probationary period to insurance coverage).

If you are a part-time employee who has completed one full calendar month of employment and you gain full-time status, your coverage will start the first day of the month after gaining full-time status. Application must be made within 31 calendar days of the date of the status change, but you should submit your enrollment request as soon as possible to avoid the possibility of double premium deductions.

You must be in a positive pay status on the day your coverage begins. 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 under the special enrollment provisions during the year. Refer to the special enrollment provisions section of this guide for more information.

Positive Pay Status – Being paid even if you are not actually performing the normal duties of your job. This is related to any type of approved leave with pay.

A dependent's coverage starts on the same date as yours unless newly acquired. Application to add a newly acquired dependent must be submitted within 60 days of the acquire date. Family coverage based on enrolling newly acquired dependent children due to birth, adoption or legal custody must begin on the first day of the month in which the event occurred and the children shall be eligible for coverage on the date they were acquired. Coverage for an adopted child begins when the child has been adopted or has been placed for adoption. If enrolled in single coverage and adding a newly acquired spouse, you may choose to begin family coverage on the first day of the month in which your spouse was acquired or the first day of the following month. Depending on the date you choose, your newly acquired spouse will be covered beginning with the acquire date (date of marriage) or the first day of the following month.

An insurance card 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 (Tier)

There are four premium levels for health, dental and vision coverage to choose from depending on the size of your family.

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

Family Coverage – Coverage other than employee only is considered family coverage.

If you enroll as a family in the second, third or fourth premium level, all of you must enroll in the same health, dental and vision options. 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.

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 benefit coordinator can explain when your premium will be taken from your paycheck.

The plan permits a 30-day deferral of premium. If the premium is not paid at the end of that deferral period, coverage will be canceled back to the date you last paid a premium. There is no provision for restoring your coverage.

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

Adding New Dependents

Enrollment must be completed within 60 days of the date a dependent is acquired. The "acquire date" is the date of birth, marriage, or, in case of adoption, when a child is adopted or placed for adoption. Premium changes start on the first day of the month in which the dependent was acquired or, the first of the next month, depending on the coverage start date.

An employee's child named under a qualified medical support order must be added within 40 days of the court order.

If adding dependents while on single coverage, you must request the correct family coverage tier for the month the dependent was acquired so claims are paid for that month. This change is retroactive and you must pay the premium for the entire month the dependent is insured.

To add a dependent more than 60 days after the acquire date, the following rules apply based on the type of coverage you currently have.

If you have single coverage

- The new dependent can enroll if they have a qualifying event under the special enrollment provisions or during the annual enrollment period.

If you have family coverage

- The new dependent can enroll if they have a qualifying event under the special enrollment provisions or during the annual enrollment period.

- The new dependent can also enroll if the level of family coverage you had on the date the dependent was acquired was sufficient to include that dependent without requiring a premium increase. You must have maintained that same level of family coverage without a break. The dependent's coverage start date may go back to the acquire date in this case.

More information is provided under the special enrollment provisions section of this guide.

Updating Personal Information

You can update personal information, such as home address, in Edison or by contacting your agency benefits coordinator. You can also call the Benefits Administration service center to request an address change. You will be required to provide the last four digits of your social security number, Edison ID, date of birth, previous address and confirm authorization of the change before our office can update your information. **It is your responsibility to keep your address and phone number current with your employer.**

Annual Enrollment Period

During the fall of each year, benefit information is mailed to you. Review this information carefully to make the best decisions for you and your family members. The enrollment period gives you another chance to enroll in health coverage or voluntary dental and vision coverage, if offered by your agency. You can also make changes to your existing coverage, like transferring between health, dental and vision options and canceling coverage. Changes you request start the following January 1.

Benefit enrollments remain in effect for a full plan year (January 1 through December 31). **You may not cancel coverage outside of the enrollment period unless eligibility is lost or there is a qualifying change or event.** For more information, see the section on canceling coverage in this guide.

Canceling 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 a special qualifying event, family status change or other qualifying event as approved by Benefits Administration

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 canceled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for adopted children ends when the legal obligation ends. Insurance continued for a disabled dependent child ends when he/she is no longer disabled or at the end of the 31-day period after any requested proof is not given.

For a divorce or legal separation, you cannot remove your spouse unless your spouse or the court gives permission until occurrence of one of the following:

- The final divorce decree is entered
- The order of legal separation is entered
- The petition is dismissed
- The parties reach agreement
- The court modifies or dissolves the injunction against making changes to insurance

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 that results in you becoming newly eligible for coverage under another plan. There are no exceptions. You have 60 days from the date that you and/or your dependents become newly eligible for other coverage to turn in an application and proof to your agency benefits coordinator. The required proof is shown on the application. Events that might result in becoming newly eligible for coverage elsewhere are:

- Marriage
- Adoption/placement for adoption
- New employment (self or dependents)
- Return from unpaid leave
- Entitlement to Medicare, Medicaid or TRICARE
- Birth
- Divorce or legal separation
- Court decree or order
- Open enrollment
- Change in place of residence or work out of the national service area (i.e., move out of the U.S.)
- Change from part-time to full-time employment (spouse or dependents)

Once your application and required proof are received, the coverage end date will be either:

- The last day of the month before the eligibility date of other coverage
- The last day of the month that the event occurred
- The last day of the month that documentation is submitted (to cancel prepaid dental)

Transferring Between Plans

Members eligible for coverage under more than one state-sponsored plan may transfer between the state, local education and local government plans. You may apply for a transfer during the plan's designated enrollment period with an effective date of January 1 of the following year. In no case may you transfer to another state-sponsored plan and remain on your current plan as the head of contract.

If You Don't Apply When First Eligible

If you do not enroll in health coverage when you are first eligible, you must wait for the annual enrollment period. You can also apply during the year through special enrollment due to certain life events.

Special Enrollment Provisions

The Health Insurance Portability Accountability Act (HIPAA) is a federal law. It allows you to enroll in a group health plan due to certain life events. The state group insurance program will only consider special enrollment requests for health, dental and vision coverage.

An employee experiencing one of the events below may enroll in employee only or family coverage. Previously eligible dependents (those who were not enrolled when initially eligible and are otherwise still eligible) may also be enrolled.

- A new dependent spouse is acquired through marriage
- A new dependent newborn is acquired through birth
- A new dependent is acquired through adoption or legal custody

You must make the request within 60 days of acquiring the new dependent. You must also submit proof, as listed on the enrollment application, to show:

- The date of the birth
- The date of placement for adoption
- The date of marriage

The above events are ONLY subject to special enrollment IF you want to use the event to enroll yourself or you already have coverage and want to add other previously eligible dependents at the same time as the new dependent. If you already have coverage and only want to add a newly acquired dependent, this is treated as a regular enrollment change.

Options for coverage start dates due to the events above are:

- Day on which the event occurred if enrollment is due to birth, adoption or placement for adoption
- Day on which the event occurred or the first day of the next month if enrollment is due to marriage

Other events allow enrollment based on a loss of coverage under another plan:

- Death of a spouse or ex-spouse
- Divorce
- Legal separation
- Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause)
- Termination of spouse or ex-spouse's employment
- Employer ends total premium support to the spouse's, ex-spouse's or dependent's insurance coverage (not partial)
- Spouse's or ex-spouse's work hours reduced
- Spouse maintaining coverage where lifetime maximum has been met
- Loss of TennCare (does not include loss due to non-payment of premiums)

Applications for the above events must be made within 60 days of the loss of the insurance coverage.

You must submit proof as required during enrollment to show ALL of the following:

- A qualifying event has occurred
- You and/or your dependents were covered under another group health plan at the time of the event
- You and/or your dependents may not continue coverage under the other plan

If enrolling due to loss of coverage under another plan, options for coverage start dates are:

- The day after the loss of other coverage, or
- The first day of the month following loss of other coverage

Important Reminders

- If enrolling dependents who qualify under the special enrollment provisions, you may choose to change to another carrier or health option, if eligible
- If you or your dependents had 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 a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION OF EMPLOYMENT

Extended Periods of Leave

Family and Medical Leave Act (FMLA)

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. Cancelation 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 canceled 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. You may reinstate coverage when you return to work. If canceled for nonpayment, you must wait for the next annual enrollment period to re-enroll, unless you have a qualifying event under the special enrollment provisions during the year.

To Reinstate Coverage After You Return

You must submit an application to your agency benefits coordinator within 31 days of your return to work. You must enroll in the same health option you had before. If you do not enroll within 31 days of your return to work, you must wait for the next annual enrollment period to re-enroll unless you have a qualifying event under the special enrollment provisions during the year. Coverage goes into effect the first of the next month after you return to work.

If you and your spouse are both insured with the state group insurance program, you can be covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract. To transfer coverage, submit an enrollment application to suspend your coverage. Your spouse should submit an enrollment application to add you as a dependent. Benefits Administration must be contacted to assist with this change and to transfer deductibles and out-of-pocket expenses.

Reinstatement for Military Personnel Returning from Active Service

An employee who returns to work after active military duty may reinstate coverage on the earliest of the following:

- The first day of the month, which includes the date discharged from active duty
- The first of the month following the date of discharge from active duty
- The date returning to active payroll
- The first of the month following return to the employer's active payroll

If restored before returning to the employer's active payroll, you must pay 100 percent of the total premium. In all instances, you must pay the entire premium for the month.

Reinstatement of coverage is not automatic. Military personnel must re-apply within 90 days from the end of leave.

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.

In the event that 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 transfer to your spouse's contract as a dependent. Application must be made within one full calendar month of your termination of employment.

Continuing Coverage through COBRA

You may be able to continue health, dental and/or vision coverage 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. Persons may continue health, dental or vision insurance if:

- Coverage is lost due to a qualifying event (refer to the COBRA brochure on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

Benefits Administration will send a COBRA packet to you. It will be sent to the address on file within 7-10 days after your coverage ends. 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 Benefits Administration.

Continuing Coverage at Retirement

Members whose first employment with the participating agency began prior to July 1, 2015, who meet the eligibility rules may continue health insurance at retirement for themselves and covered dependents until eligible for Medicare. For service retirement, a minimum of ten years employment is required. To continue coverage as a retiree, you must submit an application within one full calendar month of the date active coverage ends. A member cannot have retiree coverage and keep active coverage as an employee in the same plan. After the one full calendar month period, eligible retirees may only continue coverage if qualified for a special enrollment provision or through COBRA. Information on eligibility requirements can be found in the guide to continuing insurance at retirement, available on the Benefits Administration website. Employees whose first employment with local government began on or after July 1, 2015, will not be eligible to continue insurance coverage at retirement.

One way to save money to pay for healthcare expenses when you retire is to enroll in the HealthSavings CDHP, which includes a tax-free health savings account (HSA). Please see the available benefits section for details.

Coverage for Dependents in the Event of Your Death

If You Are an Active Employee

Your covered dependents will get six months of health coverage at no cost. After that, they may continue health coverage under COBRA for a maximum of 36 months as long as they remain eligible. If your spouse will be receiving your TCRS retirement benefit, he or she may be eligible to continue insurance as a retiree in lieu of COBRA. The surviving spouse should contact the agency benefits coordinator or Benefits Administration to confirm eligibility. Dental and vision insurance will terminate at the end of the month of the death of the employee. However, continuation of dental and vision coverage through COBRA will be available.

If You Are a Covered Retiree

Your covered dependents will get up to six months of health coverage at no cost. Dependents may apply to continue to be covered as long as they continue to meet eligibility rules.

If You Are Covered Under COBRA

Your covered dependents will get up to six months of health coverage at no cost. After that, they may continue health coverage under COBRA if they remain eligible. Coverage may be continued under COBRA for a maximum of 36 months.

AVAILABLE BENEFITS

Health Insurance

You have a choice of four health insurance options:

- Partnership Preferred Provider Organization (PPO) (with or without the Partnership Promise)
- Standard PPO
- Limited PPO
- Local HealthSavings Consumer-driven Health Plan (CDHP)

You also have a choice of three insurance carrier networks:

- BueCross BlueShield Network S
- Cigna LocalPlus Network
- Cigna Open Access Plus Network (monthly surcharge applies)

With each healthcare option, you can see any doctor you want. However, each carrier has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. These providers make up a network. You can visit any doctor or facility that is in the network. These providers have agreed to take lower fees for their services. The cost is higher when using out-of-network providers.

Each healthcare option:

- Provides the **same comprehensive health insurance coverage**
- Offers the **same provider networks**
- Covers **in-network preventive care** (like annual well visits and routine screenings) **at no cost to you**
- Covers **maintenance** prescription drugs without having to first meet a deductible
- Has a deductible
- Has out-of-pocket maximums to limit your costs

There are some differences between the PPOs and the CDHP.

With the PPOs

- You pay a higher monthly premium but have a lower deductible
- You pay fixed copays for doctor office visits and prescription drugs without first having to meet your deductible

With the CDHP

- You pay a lower monthly premium but have a higher deductible
- You pay the full discounted network cost for **ALL** healthcare expenses, including pharmacy, until you meet your deductible
- You have a tax free health savings account (HSA) which can be used to cover your qualified medical expenses, including your deductible

Partnership Promise

The Partnership PPO rewards you with lower costs when you agree to complete simple steps for better health. These steps are called the Partnership Promise. By enrolling in the Partnership PPO and agreeing to the promise, you will be rewarded by paying $50 to $100 less in monthly premiums compared to the No Partnership Promise PPO.

By agreeing to the Partnership Promise, you (and your covered spouse, if applicable) are making a specific commitment to do the following steps within 120 days of the day your insurance coverage begins:

- Complete the online Healthways Well-Being Assessment (WBA)
- Get a biometric screening at a worksite location or from your doctor (you can use screening results from a doctor's visit within the last 12 months)

Note: to access the WBA and physician screening form, visit partnersforhealthtn.gov and click on the Partnership Promise link for more information.

The Partnership Promise is an annual commitment. When you sign the enrollment application or enroll through Edison employee self-service (ESS) you are agreeing to fulfill the Partnership Promise steps each year. You will not be required to sign a new promise each year. You and all eligible family members must enroll in the same healthcare option. Your covered spouse, if applicable, must also agree to the Partnership Promise. Children are not required to complete the steps.

Should you or your spouse fail to complete the requirements, you are not eligible for the Partnership Promise PPO discounted premium in 2018.

Health Savings Account

If you enroll in the Local HealthSavings CDHP, a health savings account (HSA) will be set up for you. You can contribute pre-tax money to your HSA through payroll deduction to cover your qualified medical expenses, including your deductible, if payroll deduction is offered by your agency. The HSA is managed by PayFlex, a company selected and contracted by the state.

Benefits of a HSA

- The money you save in the HSA (both yours and any employer contributions) rolls over each year and collects interest. You don't lose it at the end of the year.
- You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses.
- The money is yours! You take your HSA with you if you leave or retire.
- The HSA offers a triple tax advantage on money in your account:
  1. Both employee and employer contributions (if offered) are **tax free**
  2. Withdrawals for qualified medical expenses are **tax free**
  3. 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 health insurance plan (like vision and dental expenses, hearing aids, contact lens supplies, acupuncture and more) with a great tax advantage.
- It serves as another retirement savings account option. Money in your account can be used tax free for health expenses even after you retire. And, when you turn 65, it can be used for non-medical expenses. But non-medical expenses will be taxed.

Contribution Limits

- IRS guidelines allow total tax-free annual contributions up to $3,400 for individuals and $6,750 for families in 2017.
- At age 55 and older, you can make an additional $1,000/year contribution ($4,400 for individuals or $7,750 for families).

Restrictions

You cannot enroll in the HealthSavings CDHP if you are enrolled in another plan, your spouse's plan, or any government plan (e.g., Medicare A and/or B, Medicaid).

If you are eligible for VA medical benefits and did not receive benefits during the preceding three months, you can enroll in and make contributions to your HSA. If you receive VA benefits in the future, then you are NOT entitled to contribute to your account for another three months. However, if your veteran's hospital care or medical service was for a service-connected disability, you may contribute to your HSA. Veterans are responsible for determining their eligibility. Restrictions may apply. Go to IRS.gov to learn more.

Basic Features of the Health Options

	PPOs (PARTNERSHIP, STANDARD, LIMITED)	HEALTHSAVINGS CDHP
COVERED SERVICES	Each option covers the same set of services	
PREVENTIVE CARE — routine screenings and preventive care	Covered at 100% (no deductible)	
EMPLOYEE CONTRIBUTION — premium	Higher than the HealthSavings Plan	Lower than the PPOs
DEDUCTIBLE — the dollar amount of covered services you must pay each calendar year before the plan begins reimbursement	Lower than the HealthSavings Plan	Higher than the PPOs
PHYSICIAN OFFICE VISITS — includes specialists and behavioral health and substance abuse services	You pay fixed copays without having to first meet your deductible	You pay the discounted network cost until the deductible is met, then you pay coinsurance
NON OFFICE VISIT MEDICAL SERVICES — hospital, surgical, therapy, ambulance, advanced x-rays	You pay the discounted network cost until the deductible is met, then you pay coinsurance	
PRESCRIPTION DRUGS	You pay fixed copays without having to first meet your deductible, with the exception of the Limited PPO which has a separate pharmacy deductible	You pay for the medication at the discounted network cost until your deductible is met — then you pay coinsurance until you meet the out-of-pocket maximum
OUT-OF-POCKET MAXIMUM — The most you pay for covered services; once you reach the out-of-pocket maximum, the plan pays 100%	Higher than the HealthSavings Plan	Lower than the PPOs
HEALTH SAVINGS ACCOUNT	None	Your contributions are tax free/tax deductible

2017 Monthly Premiums for Active Employees

ALL REGIONS						
	LEVEL 1		LEVEL 2		LEVEL 3	
	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & IGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
PARTNERSHIP PROMISE PPO						
Employee Only	$618	$658	$695	$735	$754	$794
Employee + Child(ren)	$958	$998	$1,076	$1,116	$1,169	$1,209
Employee + Spouse	$1,329	$1,409	$1,493	$1,573	$1,621	$1,701
Employee + Spouse + Child(ren)	$1,669	$1,749	$1,875	$1,955	$2,035	$2,115
NO PARTNERSHIP PROMISE PPO						
Employee Only	$668	$708	$745	$785	$804	$844
Employee + Child(ren)	$1,008	$1,048	$1,126	$1,166	$1,219	$1,259
Employee + Spouse	$1,429	$1,509	$1,593	$1,673	$1,721	$1,801
Employee + Spouse + Child(ren)	$1,769	$1,849	$1,975	$2,055	$2,135	$2,215
STANDARD PPO						
Employee Only	$625	$665	$702	$742	$762	$802
Employee + Child(ren)	$968	$1,008	$1,088	$1,128	$1,181	$1,221
Employee + Spouse	$1,343	$1,423	$1,508	$1,588	$1,637	$1,717
Employee + Spouse + Child(ren)	$1,686	$1,766	$1,894	$1,974	$2,056	$2,136
LIMITED PPO						
Employee Only	$426	$466	$479	$519	$520	$560
Employee + Child(ren)	$661	$701	$742	$782	$805	$845
Employee + Spouse	$916	$996	$1,029	$1,109	$1,117	$1,197
Employee + Spouse + Child(ren)	$1,150	$1,230	$1,292	$1,372	$1,403	$1,483
HEALTHSAVINGS CDHP						
Employee Only	$384	$424	$431	$471	$468	$508
Employee + Child(ren)	$595	$635	$668	$708	$725	$765
Employee + Spouse	$825	$905	$926	$1,006	$1,005	$1,085
Employee + Spouse + Child(ren)	$1,035	$1,115	$1,163	$1,243	$1,262	$1,342

The premium amounts shown reflect the **total monthly premium.** The different premium levels are based on the demographics of your agency. Please see your agency benefits coordinator for your monthly deduction, your employer's contribution or if you are unsure as to which premium level applies to you.

Member Cost at a Glance — In-Network Comparison

The examples below are based on the Level 1 Premium Tier

EMPLOYEE ONLY	PARTNERSHIP PPO		STANDARD PPO		LIMITED PPO		HEALTHSAVINGS CDHP	
Deductible	$500		$1,000		$1,600*		$2,000	
Out-of-Pocket Maximum (medical and pharmacy)	$3,600		$4,000		$6,600		$3,500	
Medical Coinsurance	10%		20%		30%		30%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	$668	$708	$625	$665	$426	$466	$384	$424
PARTNERSHIP PROMISE DISCOUNT	- $50 premium discount =		None		None		None	
	$618	$658						

EMPLOYEE + CHILD(REN)	PARTNERSHIP PPO		STANDARD PPO		LIMITED PPO		HEALTHSAVINGS CDHP	
Deductible	$750		$1,500		$2,200*		$4,000	
Out-of-Pocket Maximum (medical and pharmacy)	$5,400		$6,000		$13,200		$7,000	
Medical Coinsurance	10%		20%		30%		30%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	$1,008	$1,048	$968	$1,008	$661	$701	$595	$635
PARTNERSHIP PROMISE DISCOUNT	- $50 premium discount =		None		None		None	
	$958	$998						

EMPLOYEE + SPOUSE	PARTNERSHIP PPO		STANDARD PPO		LIMITED PPO		HEALTHSAVINGS CDHP	
Deductible	$1,000		$2,000		$2,500*		$4,000	
Out-of-Pocket Maximum (medical and pharmacy)	$7,200		$8,000		$13,200		$7,000	
Medical Coinsurance	10%		20%		30%		30%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	$1,429	$1,509	$1,343	$1,423	$916	$996	$825	$905
PARTNERSHIP PROMISE DISCOUNT	-$100 premium discount=		None		None		None	
	$1,329	$1,409						

EMPLOYEE + SPOUSE + CHILD(REN)	PARTNERSHIP PPO		STANDARD PPO		LIMITED PPO		HEALTHSAVINGS CDHP	
Deductible	$1,250		$2,500		$3,200*		$4,000	
Out-of-Pocket Maximum (medical and pharmacy)	$9,000		$10,000		$13,200		$7,000	
Medical Coinsurance	10%		20%		30%		30%	
Monthly Premium	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
	$1,769	$1,849	$1,686	$1,766	$1,150	$1,230	$1,035	$1,115
PARTNERSHIP PROMISE DISCOUNT	-$100 premium discount=		None		None		None	
	$1,669	$1,749						

* In the Limited PPO, there is a separate deductible for pharmacy of $100 per member

2017 Benefit Comparison

PPO services in this table ARE NOT subject to a deductible and costs DO APPLY to the annual out-of-pocket maximum. CDHP services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. Costs DO APPLY to the annual out-of-pocket maximum.

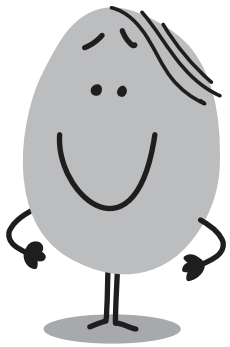
HEALTHCARE OPTION AND ACTUARIAL VALUE	PARTNERSHIP PPO 83.9%		STANDARD PPO 78.2%	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OFFICE VISITS				
• Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No charge	$45 copay	No charge	$50 copay
OUTPATIENT SERVICES				
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25 copay	$45 copay	$30 copay	$50 copay
Specialist Office Visit • Including surgery in office setting	$45 copay	$70 copay	$50 copay	$75 copay
Behavioral Health and Substance Abuse [2]	$25 copay	$45 copay	$30 copay	$50 copay
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	10% coinsurance		20% coinsurance	
All Reading, Interpretation and Results	10% coinsurance		20% coinsurance	
Telehealth	$15 copay	N/A	$15 copay	N/A
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Allergy Injection with Office Visit	$25 copay primary; $45 copay specialist	$45 copay primary; $70 copay specialist	$30 copay primary; $50 copay specialist	$50 copay primary; $75 copay specialist
Chiropractors • Limit of 50 visits per year	Visits 1-20: $25 copay Visits 21-50: $45 copay	Visits 1-20: $45 copay Visits 21-50: $70 copay	Visits 1-20: $30 copay Visits 21-50: $50 copay	Visits 1-20: $50 copay Visits 21-50: $75 copay
PHARMACY				
30-Day Supply	$7 copay generic; $40 copay preferred brand; $90 copay non-preferred	copay plus amount exceeding MAC	$14 copay generic; $50 copay preferred brand; $100 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 copay generic; $80 copay preferred brand; $180 copay non-preferred	N/A - no network	$28 copay generic; $100 copay preferred brand; $200 copay non-preferred	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 copay generic; $40 copay preferred brand; $160 copay non-preferred	N/A - no network	$14 copay generic; $50 copay preferred brand; $180 copay non-preferred	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10% coinsurance; min $50; max $150	N/A - no network	10% coinsurance; min $50; max $150	N/A - no network
CONVENIENCE CLINIC AND URGENT CARE				
Convenience Clinic	$25 copay	$45 copay	$30 copay	$50 copay
Urgent Care Facility	$45 copay	$70 copay	$50 copay	$75 copay
EMERGENCY ROOM				
Emergency Room Visit	$150 copay (services subject to coinsurance may be extra)		$175 copay (services subject to coinsurance may be extra)	

LIMITED PPO 71.1%		LOCAL HEALTHSAVINGS CDHP 70.9%	
IN-NETWORK	OUT-OF-NETWORK [1]	IN-NETWORK	OUT-OF-NETWORK [1]
No charge	$50 copay	No charge	50% coinsurance
$35 copay	$55 copay	30% coinsurance	50% coinsurance
$55 copay	$80 copay	30% coinsurance	50% coinsurance
$35 copay	$55 copay	30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	
$15 copay	N/A	30% coinsurance	N/A
100% covered	100% covered up to MAC	30% coinsurance	50% coinsurance
$35 copay primary; $55 copay specialist	$55 copay primary; $80 copay specialist	30% coinsurance	50% coinsurance
Visits 1-20: $35 copay Visits 21-50: $55 copay	Visits 1-20: $55 copay Visits 21-50: $80 copay	30% coinsurance	50% coinsurance
$14 copay generic; $60 copay preferred brand; $110 copay non-preferred	copay plus amount exceeding MAC	30% coinsurance	50% coinsurance plus amount exceeding MAC
$28 copay generic; $120 copay preferred brand; $220 copay non-preferred	N/A - no network	30% coinsurance	N/A - no network
$14 copay generic; $60 copay preferred brand; $200 copay non-preferred	N/A - no network	20% coinsurance without first having to meet deductible	N/A - no network
10% coinsurance; min $50; max $150	N/A - no network	30% coinsurance	N/A - no network
$35 copay	$55 copay	30% coinsurance	50% coinsurance
$55 copay	$80 copay	30% coinsurance	50% coinsurance
$200 copay (services subject to coinsurance may be extra)		30% coinsurance	

What is actuarial value?

Insurance plans have actuarial value — on average for plan members as a whole, a percentage of total costs for covered benefits that a plan will pay for. (Members pay the rest through copays, deductibles and coinsurance.) The higher the percentage or actuarial value, the more the plan pays on average for the group.

HEALTHCARE OPTION	ACTUARIAL VALUE
Partnership PPO	83.9%
Standard PPO	78.2%
Limited PPO	71.1%
Local HealthSavings CDHP	70.9%



ALEX, your confidential, online benefits expert, can help you compare your options based on your own situation.

Visit ALEX on **partnersforhealthtn.gov.** He will ask you a series of questions that may help you choose your plan.

All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

	PARTNERSHIP PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Hospital/Facility Services • Inpatient care; outpatient surgery [4] • Inpatient behavioral health and substance abuse [2] [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care [4] • Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient [4]; outpatient • Skilled nursing facility [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance	
Hospice Care [4] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
DEDUCTIBLE				
Employee Only	$500	$1,000	$1,000	$2,000
Employee + Child(ren)	$750	$1,500	$1,500	$3,000
Employee + Spouse	$1,000	$2,000	$2,000	$4,000
Employee + Spouse + Child(ren)	$1,250	$2,500	$2,500	$5,000
separate pharmacy deductible applies	N/A		N/A	
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED				
Employee Only	$3,600	$4,000	$4,000	$4,500
Employee + Child(ren)	$5,400	$6,000	$6,000	$6,750
Employee + Spouse	$7,200	$8,000	$8,000	$9,000
Employee + Spouse + Child(ren)	$9,000	$10,000	$10,000	$11,250
PARTNERSHIP PROMISE DISCOUNT				
For individuals who agree to complete the Partnership Promise	premium discount (reflected in premium chart): $50 for employee only and employee+child(ren) coverage; $100 for employee+spouse and employee+spouse+child(ren) coverage		N/A	

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted. **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 Plans,** the out-of-pocket maximum amount can be met by one or more persons.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a service from an in-network provider. 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.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization (PA) is required.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization (PA) required. When using out-of-network providers, benefits for 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. (For DME, PA only applies to more expensive items.)

LIMITED PPO		LOCAL HEALTHSAVINGS CDHP	
IN-NETWORK	OUT-OF-NETWORK [1]	IN-NETWORK	OUT-OF-NETWORK [1]
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	
100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (after the deductible has been met)	
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance for oral surgeons	50% coinsurance for oral surgeons	30% coinsurance for oral surgeons	50% coinsurance for oral surgeons
30% coinsurance non-contracted providers (i.e., dentists, orthodontists)		30% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
N/A - no network	50% coinsurance	N/A - no network	50% coinsurance
$1,600	$3,000	$2,000	$4,000
$2,200	$4,000	$4,000	$8,000
$2,500	$4,600	$4,000	$8,000
$3,200	$6,000	$4,000	$8,000
$100 per member		N/A	
$6,600	$10,000	$3,500	$5,000
$13,200	$20,000	$7,000	$10,000
$13,200	$20,000	$7,000	$10,000
$13,200	$20,000	$7,000	$10,000
N/A		N/A	

Using Edison ESS

When you use ESS in Edison to enroll in your benefits, Internet Explorer 11 is your best choice. You may not be able to enroll in your benefits if you use the Chrome browser or any mobile devices. Although not recommended, other browsers might work. All of your information may not be on the enrollment screens, which could mean that you are not enrolled in your choices. If these issues cannot be resolved, you will need to use the recommended browser.

Passwords

If you are using the Edison system for the first time or are having trouble logging in, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps or call the Benefits Administration service center.

Note: The names of three health insurance options are shortened in Edison. Please check the chart below before making your selection.

HEALTH INSURANCE OPTION NAME	NAME AS IT APPEARS IN EDISON
Partnership Promise PPO	Partners Promise
No Partnership Promise PPO	No Partners Promise
HealthSavings CDHP	Local CDHP

Dental Insurance

You and your dependents are eligible for dental coverage, if offered by your employing agency. You must pay 100 percent of the premium if you elect this coverage. Two options are available—a prepaid plan and a dental preferred provider organization (DPPO) plan.

In the prepaid plan, you must select from a specific group of dentists. Under the DPPO plan, you may visit the dentist of your choice; however, members get maximum savings when visiting a network provider. Both dental options have specific rules for benefits such as exams and major procedures, and have a four-tier premium structure just like health insurance.

You can enroll in dental coverage as a new employee or during the annual enrollment period. You may also enroll if you have a special qualifying event. You do not have to be enrolled in health coverage to be eligible for dental insurance.

Prepaid Plan (Cigna)

- Must select and use a general dentist from the prepaid dental plan list for each covered family member — the network is Cigna Dental Care (HMO)
- Services at predetermined copayments
- No claim forms
- Preexisting conditions are covered
- No maximum benefit levels
- No deductibles
- No charge for oral exams, routine semiannual cleanings, most x-rays and fluoride treatments; however, an office visit copay will apply

DPPO Plan (MetLife)

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider — the network is PDP
- $1,500 calendar year benefit maximum per person
- Deductible applies for basic, major and out-of-network dental care
- You or your dentist will file claims for covered services
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount
- Some services require waiting periods of up to one year and limitations and exclusions apply
- Lifetime benefit maximum of $1,250 for orthodontia

Monthly Premiums for Active Members

	PREPAID PLAN	DPPO PLAN
Employee Only	$12.99	$22.37
Employee + Child(ren)	$26.97	$51.44
Employee + Spouse	$23.02	$42.32
Employee + Spouse + Child(ren)	$31.65	$82.80

Dental Insurance Benefits at a Glance

Here is a comparison of deductibles, copays and your share of coinsurance under the dental options. Costs represent what the member pays.

COVERED SERVICES	CIGNA PREPAID OPTION		METLIFE DPPO OPTION	
	GENERAL DENTIST	SPECIALIST DENTIST	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	none		$25 single; $75 family, per policy year [1]	$100 single; $300 family, per policy year [1]
Annual Maximum Benefit	none		$1,500 per person, per policy year	
Pre-existing Conditions	covered		some exclusions	
Office Visit	$10 copay [2]		no charge	20% of MAC
Periodic Oral Evaluation	no charge		no charge	20% of MAC
Routine Cleaning – Adult	no charge		no charge	20% of MAC
Routine Cleaning – Child	no charge	$15 copay	no charge	20% of MAC
X-ray — Intraoral, Complete Series	no charge	$5 copay	no charge	20% of MAC
Amalgam (silver) Filling — 2 Surfaces Permanent	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$125 copay	$600 copay	20% of MAC	40% of MAC
Major Restorations — Crowns (porcelain fused to high noble metal)	$275 copay, plus lab fees [3]		50% of MAC [4]	
Extraction of Erupted Tooth (minor oral surgery)	$15 copay	$70 copay	20% of MAC	40% of MAC
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	$100 copay	$120 copay	50% of MAC	
Dentures — Complete Upper	$310 copay, plus lab fees [3]		50% of MAC [4]	
Orthodontics	$140 monthly copay for treatment [6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	$3,360 treatment fee only [6]		$1,250 [5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

MAC—Maximum Allowable Charge (maximum amount of charge agreed to by dentist)

The benefits listed are a sample of the most frequently utilized dental treatments. Refer to vendor materials for complete information on coverage, limitations and exclusions.

[1] Does not apply to diagnostic and preventive benefits such as periodic oral evaluation, cleaning and x-ray.

[2] A charge may apply for a missed appointment when the member does not cancel at least 24 hours prior to the scheduled appointment.

[3] Members are responsible for additional lab fees for these services.

[4] A 6-month waiting period applies.

[5] The orthodontics lifetime maximum is for a dependent member enrolled in the state group dental insurance program even if the member has been covered under different employing agencies.

[6] Additional copays apply for specific orthodontic procedures. Orthodontic treatment after a member's effective date will not be covered under the Cigna plan if it began prior to the member's effective date.

Vision Insurance

Vision coverage is available to local government employees and dependents, if offered by your agency. You must pay 100 percent of the premium if you elect this coverage. Two options are available — a basic plan and an expanded plan. Both plans offer the same services, including:

- Annual routine eye exam
- Frames
- Eyeglass lenses
- Contact lenses
- Discount on LASIK/Refractive surgery

What you pay for services depends on the plan you choose. With the basic plan, you pay a discounted rate or the plan pays a fixed-dollar allowance for services and materials. The expanded plan provides services with a combination of copays, allowances and discounted rates. See the benefit chart on the following page to compare benefits in both plans. The basic and expanded plans are both administered by EyeMed Vision Care. You will receive the maximum benefit when visiting a provider in their **Select network.** However, out-of-network benefits are also available.

General Limitations and Exclusions

The following services are not covered under the vision plan:

- Treatment of injury or illness covered by workers' compensation or employer's liability laws
- Cosmetic surgery and procedures
- Services received without cost from any federal, state or local agency
- Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility
- Services by a vision provider beyond the scope of his or her license
- Vision services for which the patient incurs no charge
- Vision services where charges exceed the amount that would be collected if no vision coverage existed

Note: If you receive vision services and materials that exceed the covered benefit, you will be responsible for paying the difference for the actual services and materials you receive.

Additional Discounts

- 40 percent off on additional pairs of eyeglasses at any network location, after the vision benefit has been used
- 15 percent off conventional contact lenses after the benefit has been used
- 20 percent off non-covered items such as lens cleaner, accessories and non-prescription sunglasses

Monthly Premiums for Active Members

	BASIC	EXPANDED
Employee Only	$3.35	$5.86
Employee + Child(ren)	$6.69	$11.72
Employee + Spouse	$6.35	$11.14
Employee + Spouse + Child(ren)	$9.83	$17.23

Vision Insurance Benefits at a Glance

Here is a comparison of discounts, copays and allowed amounts under the vision options. Copays represent what the member pays. Allowance and percentage discount represent the cost the carrier will cover.

	BASIC PLAN	EXPANDED PLAN
Routine Eye Exam	$0 copay	$10 copay
Retinal Imaging Benefit	none	up to $39 copay
Frames	$50 allowance; 20% discount off balance above the allowance	$115 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass) • Single, bifocal, trifocal, lenticular • Standard progressive Lens • Premium progressive Lens	$50 allowance; 20% off balance over $50	 $15 copay $55 copay discount on no-line bifocals [1] $55+(20% off retail price-$120 allowance) for other [1]
Eyeglass Lens Options (upgrades) • Anti-reflective • Polycarbonate • Photochromic • Scratch resistance coating • UV coating • Tints • Polarized • Premium anti-reflective • All other eyeglass lens options	20% discount off all options	maximum copayments: $45 copay $30 copay; $0 for children 18 and under discount applied $15 copay $10 copay $25 copay 20% off retail price discount applied 20% discount
Exam for Contact Lenses (fitting and evaluation)	15% discount off retail price	up to $60 copay
Contact Lenses [2] • Elective • Conventional • Disposable • Medically necessary [3]	 $50 allowance; 15% off balance over $50 $50 allowance $150 allowance	 $130 allowance; 15% off balance over $130 $130 allowance covered at 100%
LASIK/Refractive Surgery (for select providers)	15% discount off retail price or 5% off promotional price	15% discount off retail price or 5% off promotional price
Out-of-Network Benefits • All eye exams • Frames • Eyeglass lenses • Single vision • Lined bifocal • Lined trifocal • Elective contacts (conventional or disposable) • Medically necessary contacts [3] • Lens options-UV, polycarbonate, photochromic/ transitions plastic	 up to $30 allowance up to $50 allowance (frames and lenses combined) $25 allowance $75 allowance	 up to $45 allowance up to $70 allowance up to $30 allowance up to $50 allowance up to $65 allowance up to $50 allowance up to $100 allowance up to $5 allowance
Frequency • Eye exam • Eyeglass lenses and contacts • Frames	 once every calendar year per person once every calendar year per person once every two calendar years per person	 once every calendar year per person once every calendar year per person once every two calendar years per person

[1] Copays for premium progressive lens are subject to change
[2] Instead of eyeglass lenses
[3] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

Employee Assistance Program

The Employee Assistance Program (EAP) is a no cost, confidential support tool that helps you, and those around you, deal with personal issues and situations. Seeking help is not a weakness. The goal is that after you make the decision to ask for help, you will find the program both easy to access and helpful. Sooner or later, all of us will encounter a personal problem of some kind. The EAP can help provide support and resources for:

- Family and relationship
- Anxiety and depresseion
- Dealing with addiction
- Legal and financial
- Child and elder care
- Workplace conflicts
- Grief and loss
- Work/life balance

The EAP offers seminars on various topics of interest at locations across the state. Visit the website for more information.

All services are confidential. Obtain prior authorization as required. Services can be easily accessed by calling Optum Health — available 24 hours a day, 365 days a year. You may participate in EAP services on work time with your supervisor's approval.

You and your eligible dependents may get up to five counseling sessions per episode at no cost to you. If you need assistance beyond the EAP, you will be referred to your insurance carrier's behavioral health and substance abuse benefits. The program is available to all local government employees enrolled in a state sponsored health plan. Dependents of local government members may get EAP services even if the dependents are not enrolled in health coverage.

ParTNers for Health Wellness Program

The ParTNers for Health Wellness Program is free to all members, their eligible spouses and dependents.

24/7 Nurse Advice Line

The nurse advice line gives you medical information and support, 24/7, at no cost to you. Whether you have questions about a new diagnosis or you aren't sure about an urgent situation, the nurse advice line is there when you need it. Call day or night to talk to a nurse about:

- The closest hospital or after-hours clinic
- Understanding what your doctor told you
- Your symptoms or questions about medications

Working with a Health Coach

Coaching offers you professional support to create and meet goals for better health. Calls are private and scheduled when it is convenient for you. For more information about working with a coach, see the frequently asked questions section of the ParTNers for Health website.

Healthways Well-Being Connect

Well-Being Connect provides you with online tools and resources like healthy recipes, meal plans and exercise trackers. Choose from a variety of online health improvement focus areas and keep track of your progress to reach your personal goals. Registration is easy. Simply go to partnersforhealthtn.gov, click on the "My Wellness Login" button and follow the registration instructions.

Healthways Well-Being Assessment (WBA)

The online Well-Being Assessment (WBA) is a questionnaire that summarizes your overall health and offers steps you can take for better health. By completing the confidential online assessment, you will learn more about how your lifestyle habits affect your overall well-being. Once you complete the assessment, you will view your results and create your personal well-being plan, which will help you set goals and focus on areas where you can make improvements. Visit the wellness program page on the ParTNers for Health website for more information.

Weekly Health Tips by Email

Don't forget to sign up for free weekly health tips by email. Visit the Partners for Health website and click the "Weekly Health Tips" link to sign up. You will get a short email with each week's healthy living tip.

Wellness and Fitness Center Discounts

Additional wellness and fitness center discounts are available through the ParTNers for Health Wellness Program and Employee Assistance Program (EAP) services. Our carriers BlueCross BlueShield and Cigna also offer fitness and other discounts for health insurance plan members.

Long-term Care Insurance

Long-term care insurance is available to local government participants, if your agency chooses to participate. Qualified employees, their eligible dependents (spouse and children ages 18 through 25), retirees, parents and parents-in-law are eligible to enroll in long-term care coverage. This insurance covers certain services required by individuals who are no longer able to care for themselves without the assistance of others. Natural aging, a serious illness or an accident may bring on this need.

Services covered include nursing home care, assisted living, home health care, home care and adult day care. Benefits are available through different options based on a daily benefit amount ($100, $150 or $200) for either a three-year or five-year coverage period. The benefits are also available with or without inflation protection.

When your agency first chooses to offer this benefit, active employees can enroll in coverage on a guaranteed issue basis (no medical underwriting) during the initial offering period. If your agency already offers this benefit, as a new employee, you have 90 days to enroll and have guaranteed issue of coverage. You may sign-up for coverage by completing the enrollment form enclosed in the enrollment kit, over the phone by speaking with customer service or online via the insurance carrier's website. Your spouse, eligible dependent children, parents and parents-in-law may also apply for coverage; however, they must provide information about their health status and will be subject to medical underwriting review for approval to enroll. After the initial guaranteed issue period, you may still apply for coverage, but will also be subject to the same medical underwriting review for approval to enroll.

You must pay 100 percent of the premium if you choose this coverage. Premiums are based on age at the time of enrollment. So the younger you are when you apply, the lower your monthly premium will be. You may choose to have the premium taken from your payroll check, or may opt for a direct bill arrangement with the carrier. Direct billing or payment by bank draft can be set up on a quarterly, semi-annual or annual basis.

OTHER INFORMATION

Coordination of Benefits

If you are covered under more than one insurance plan, the plans will coordinate benefits together and pay up to 100 percent of the eligible charges. At no time should payments exceed 100 percent 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 or her employer, that coverage would be primary for your spouse and secondary for you.

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. This is necessary because it is not uncommon for other coverage information to change. This helps ensure accurate claims payment. In addition to sending a letter, the carriers may also attempt to gather this information when members call in. 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 office. 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 the plan has already paid for, 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 those persons 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 benefits coordinator and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he or she cannot be covered even if you are under court order to continue to provide coverage.

If there is any kind of error in your coverage or an error affecting the amount of your premium, you must notify your 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 healthcare. It is estimated that between 3–14 percent 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 (EOB) 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 or 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 experience a problem relating to the plan policies or the services provided, there are established internal and external procedures to help you resolve your complaint. 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. Other appeal questions may be directed to the Benefits Administration appeals coordinator at 615.741.4517 or 866.576.0029.

Administrative Appeals

To file an appeal about an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues or timely filing issues) contact your agency benefits coordinator and explain your request. The benefits coordinator will forward your request to Benefits Administration for review and response.

Benefit Appeals

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

Different insurance companies manage approvals and payments related to your medical, behavioral health, substance abuse and pharmacy benefits. To avoid delays in the processing of your appeal, make sure that you direct your request to the correct company. You have insurance cards for medical and pharmacy. You can find member service numbers for medical, behavioral health and substance abuse on your medical card. Your pharmacy card will have the member service number for pharmacy.

Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), call the toll-free member service number on your insurance card. You may file a formal request for an appeal or member grievance by completing a 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.

Pursuing Further Action

In cases where internal and external appeal procedures have been completed, decision letters will notify you of the option to pursue further action through litigation.

LEGAL NOTICES

Information in this Guide

This guide does not give every detail of the state-sponsored plans. The Plan Document is the legal publication that defines eligibility, enrollment, benefits and administrative rules. If information in this guide conflicts with the Plan Document, the Plan Document will control. Your department or facility (benefits section) has a copy or you can obtain a copy from the Benefits Administration website.

The information contained in this guide is accurate at the time of printing. The Insurance Committees may change the plans at their discretion. Changes to federal and/or state laws may also impact the plans. You will be given written notice of changes. The benefits described in this guide cannot be changed by any oral statements.

Discrimination

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 866.576.0029 or 615.741.4517.

Member Privacy

The state group insurance program considers your protected health information (PHI) private and confidential. In accordance with the federal Health Insurance Portability and Accountability Act (HIPAA), policies and procedures are in place to protect such information against unlawful use and disclosure. PHI is individually identifiable health information. This includes demographics such as age, address, e-mail address and relates to your past, present or future physical or mental health condition. We are required by law to make sure your PHI is kept private.

When necessary, your PHI may be used and disclosed for treatment, payment and healthcare operations. For example, your PHI may be used or disclosed, including, but not limited to:

- In order to provide, coordinate or manage your healthcare
- To pay claims for services which are covered under your health insurance
- In the course of the operation of the state group insurance program to determine eligibility, establish enrollment, collect or refund premiums and conduct quality assessments and improvement activities
- To coordinate and manage your care, contact healthcare providers with information about your treatment alternatives
- Conduct or arrange for medical review, auditing functions, fraud and abuse detection, program compliance, appeals, right of recovery and reimbursement/subrogation efforts, review of health plan costs, business management and administrative activities
- To contact you with information about your treatment or to provide information on health-related benefits and services that may be of interest to you

To obtain a copy of the privacy notice describing, in greater detail, the practices concerning use and disclosure of your health information, visit the Benefits Administration website or you may obtain a copy from your agency benefits coordinator.

Medicare Part D

Medicare eligible retirees have access to a Medicare supplement plan. The supplemental plan does not include pharmacy benefits and retirees should enroll in a Medicare Part D plan for prescription drug benefits. For further information, refer to the notice of creditable coverage which is available on the Medicare supplement page of the Benefits Administration website.

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program available to all employees eligible for health insurance coverage. 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 Partnership Promise/wellness program, you will be asked to complete a voluntary Well-Being Assessment or "WBA" 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 will also be asked to complete a biometric screening, which will include a sample of your blood to determine blood sugar and cholesterol levels, blood pressure, height, weight and BMI. You are not required to complete the WBA or to participate in the biometric screening or other medical examinations.

However, employees who choose to participate in the wellness program will receive lower monthly premiums or state funds contributed to their HSA for agreeing to the Partnership Promise. Although you are not required to complete the WBA, participate in the biometric screening or health coaching, only employees who do so will receive lower cost monthly premiums or state HSA funds.

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 WBA 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, and may also be used to offer you services through the wellness program, such as health coaching. 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 may 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 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. Anyone who receives your information for purposes 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 healthcare professionals) and their vendor partners (case managers with the medical and behavioral health vendors and the biometric screening vendor) in order 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 precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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.

TERMS AND DEFINITIONS

Acquire Date
The acquire date is the date that establishes a relationship between you and your dependents, such as date of marriage for a spouse, date of birth for a natural child or date of legal obligation if you are appointed as a guardian.

Balance Billing
If you get treated by out-of-network providers, you can be subject to balance billing by the out-of-network provider. This is the process of billing a patient for the difference between the provider's charges and the amount that the provider will be reimbursed from the patient's insurance plan. For example, let's say that a doctor typically charges $100 for a certain service. An in-network doctor has agreed to provide the same service for a reduced rate of $75 and he or she writes off the rest of the charge. An out-of-network provider has not agreed to any reduced rates as he or she does not have a contract with the carrier and will bill the entire charge of $100. However, the insurance carrier will not reimburse more than $75 for the service which means that you may owe the out-of-network provider the additional $25.

Claims
Claims are the bills received by the plan after a member obtains medical services.

Coinsurance
Coinsurance is the percentage of a dollar amount that you pay for certain services. Unlike a fixed copay, coinsurance varies, depending on the total charge for a service.

Consumer-Driven Health Plan (CDHP)
A consumer-driven health plan (CDHP) is a type of medical insurance or plan that typically has a higher deductible and lower monthly premiums. Typically, you take responsibility for covering minor or routine healthcare expenses until your deductible is met. Once you meet your deductible, coinsurance applies.

Copay
A copay is a flat dollar amount that you pay for certain services like office visits and prescriptions.

Deductible
A fixed dollar amount you must pay each year before the plan pays for services that require coinsurance.

Drug List
The drug list is a list of covered drugs. The listing includes generic and preferred brand drugs covered by the plan. This list is often called a formulary.

Drug Tiers
The drugs covered by the state's pharmacy benefit are grouped into three tiers — generic, preferred brand and non-preferred brand. Each tier has a different payment amount.

Fully Insured Plan
Under a fully insured plan, an insurance company, rather than a group sponsor (like the state) pays all claims. The sponsor pays a premium to the insurance company. The state's dental, long-term care and vision plans are fully insured.

Generic Drug (Tier One)
A generic drug (also called tier one) is a Food and Drug Administration (FDA) approved copy of a brand name drug. A generic medicine is equal to the brand name product in safety, effectiveness, quality and performance. You pay the least when you fill a prescription with a generic drug.

Guaranteed Issue
Guaranteed issue means that you cannot be denied coverage and do not have to answer questions about your health history as long as you enroll within a certain amount of time.

Head of Contract
The head of contract is an employee who works for a participating employer group and enrolls in coverage during the initial eligibility timeframe. Two married employees who both work for participating employer groups could each be the head of their own contract or one could be the head of contract and the other a covered dependent spouse.

Health Insurance Portability and Accountability Act (HIPAA)
The Health Insurance Portability and Accountability Act (HIPAA) is legislation that protects health insurance coverage for persons who lose or change jobs and establishes a privacy rule and national standards for protecting personal health information. HIPAA means your personal health information can't be shared without your consent and protects your privacy.

In-Network Care
In-network care is provided by a network provider. Costs for in-network care are usually less expensive than out-of-network care as a result of special agreements between insurance carriers and providers.

Maximum Allowable Charge (MAC)
The maximum allowable charge (MAC) is the most that a plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay the difference between the MAC and the actual charge.

Meeting Your Deductible
Meeting your deductible means you have reached your annual deductible. This is the amount you pay each year before the plan pays for services that require coinsurance.

Network
A network is a group of doctors, hospitals and other healthcare providers contracted with a health insurance carrier to provide services to plan members for set fees.

Non-Preferred Brand Drug (Tier Three)
A non-preferred brand drug (also called tier three) belongs to the most expensive group of drugs. You will pay the most if your prescription is filled with a non-preferred brand.

Out-of-Network Care
Out-of-network care refers to health care services from a provider who is not contracted with your insurance carrier. Costs for out-of-network care are usually more than for in-network care. The benefits paid are usually based on the maximum allowed by the plan. When out-of-network charges are higher than the maximum allowed, the member pays the difference.

Out-of-Pocket Maximum
An out-of-pocket maximum is the most you will pay for services in any given year. The out-of-pocket maximum does not include premiums. Once you reach your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year. There are separate maximums for in-network and out-of-network services. A separate out-of-pocket maximum applies to in-network pharmacy in the standard and partnership options.

Preferred Brand Drug (Tier Two)
A preferred brand drug (also called tier two) belongs to a group of drugs that cost more than generics but less than non-preferred brands.

Preferred Provider Organization (PPO)
A PPO gives plan participants direct access to a network of doctors and facilities that charge pre-negotiated (and typically discounted) fees for the services they provide to members. Plan participants may self-refer to any doctor or specialist in the network. The benefit level covered through the plan typically depends on whether the member visits an in-network or out-of-network provider when seeking care.

Premium
The amount you pay each month for your coverage, regardless of whether or not you receive health services. What you pay depends on where you work (state, higher education, local education or local government) and the benefit option you select.

Preventive Care
Preventive care refers to services or tests that help identify health risks. For example, preventive care includes screening mammograms and colonoscopies as well as regular blood pressure checks. In many cases, preventive care helps a patient avoid a serious or even life-threatening disease.

Primary Care Physician
Primary care physician (also known as PCP) refers to your regular medical doctor. This is the doctor you see most often. A PCP can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician's assistants and nurse midwives (licensed healthcare facility only) may also be considered primary-type providers when working under the supervision of a primary care physician.

Self-Insured Plan
Under a self-insured plan, a group sponsor (like the State) or employer, rather than an insurance company, is financially responsible for paying the plan's expenses, including claims and plan administration costs. The state's health insurance plans are self-insured.

Special Enrollment Provision
A rule that allows persons to request enrollment beyond the initial eligibility period due to certain life events.

Special Qualifying Event
A personal change in status, such as divorce or termination of spouse or ex-spouse's employment, which may allow persons to change benefit elections.

The Plan
In the broadest sense of the word, Plan is the applicable State of Tennessee Comprehensive Medical and Hospitalization Program. Plan may also refer to specific group plans within the larger comprehensive plan, such as the State Plan, the Local Education Plan or the Local Government Plan.

STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
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