PARTNERS FOR HEALTH

Your 2019 Eligibility & Enrollment Guide

Local Government Employees

Tennessee State Group Insurance Program

If you need help…

Contact your agency benefits coordinator. He/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 or 615.741.3590 — M-F, 8-4:30	tn.gov/partnersforhealth
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	855.288.7936 — 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 Use and Employee Assistance Program	Optum	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	ActiveHealth Management	888.741.3390 — M-F, 8-8	http://go.activehealth.com/wellnesstn
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
Vision Insurance	Davis Vision	800.208.6404 — M-F, 7-10; Sat, 8-3; Sun, 11-3 Basic Client Code: 8155 Expanded Client Code: 8156	davisvision.com/stateofTN

Online resources…

Visit the ParTNers for Health website at https://www.tn.gov/partnersforhealth. It has information about all the benefits described in this guide. It also has frequently asked questions, definitions of insurance terms and videos. Enrollment forms and handbooks referenced in this guide are located on our website or you can get copies from your agency benefits coordinator.

The ParTNers for Health website also includes a "Help" button, or live-chat feature, that is operational during normal business hours.

In Zendesk at https://benefitssupport.tn.gov/hc/en-us, you can search the help center, find articles or submit questions. To access Zendesk, you can also click the "Questions?" button on the website.

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Authorization No. 317375, October 2018.
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INTRODUCTION

Overview

This guide will help you understand your insurance options and the coverage rules for local government employees. There is a separate guide for retirement insurance.

Benefits Administration (BA) within the Department of Finance and Administration manages the State Group Insurance Program. The local government plan is available to local government agencies and eligible quasi-governmental organizations that choose to participate.

If you are eligible, you may enroll in health coverage. Dental and vision insurance 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 resources office. He/she is available to answer benefits questions and can provide you with forms and insurance booklets.

You can also find information like brochures and handbooks, plan documents, summaries of benefits and coverage and sample certificates of coverage on the Benefits Administration website, https://www.tn.gov/partnersforhealth.

Authority

The Local Government Insurance Committee determines the premiums, benefits package, funding method, administrative procedures, eligibility provisions, and rules relating to the Local Government Plan. You will be given written notice of changes.

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 8-27-704(a)
- All other individuals cited in state statute, approved as an exception by the Local Government Insurance Committee or defined as full-time employees for health insurance purposes by federal law

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.

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 Local Government 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
- 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 insurance 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 insurance. However, if you are married to an employee who is also a member of the state, local education or local government plan, you can each enroll in employee only coverage if you are not covering dependent children. If you have children, one of you can choose employee only and the other can choose employee + child(ren). Then you can each choose your own benefit option and carrier.

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 cancelled 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 and for each covered month thereafter.

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 and each 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 (BA) service center to request an address change or email address change. You will be required to provide your social security number or Edison ID, date of birth, previous address and confirm authorization of the change before BA can update your information. **It is your responsibility to keep your address, phone number and email address current with your employer.**

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 insurance or voluntary dental and vision insurance, if offered by your agency. You can also make changes to your existing coverage, like transferring between health, dental and vision options and cancelling 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 cancelling coverage in this guide.

Cancelling Coverage

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

- You lose eligibility for the State Group Insurance Program (e.g., changing from full-time to part-time)
- You experience 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 cancelled 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.

Divorce — If you request to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 34-4-106 and the requirement that you provide notice of termination of health insurance to your covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. As the employee, it is your responsibility to make sure that any request to terminate your dependent spouse is consistent with those legal requirements.

Cancelling coverage in the middle of the plan year — You may only cancel coverage for yourself and/or your dependents in the middle of the plan year if you lose eligibility or you experience an event that results in you/your dependents 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, divorce, legal separation, annulment
- Birth, adoption/placement for adoption
- Death of spouse, dependent
- New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependents)
- Entitlement to Medicare, Medicaid or TRICARE
- Court decree or order
- Open enrollment
- Change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)
- Marketplace enrollment

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)

If dental coverage is offered by your agency and you have enrolled in the Prepaid dental option, you may request to cancel that coverage if there is no participating general dentist within a 40-mile radius of your home address.

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 insurance 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 and Accountability Act (HIPAA) is a federal law. It allows you to enroll in a group health plan due to certain life events.

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's 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 cancelled and COBRA eligibility will not apply.

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any voluntary coverages. You may reinstate coverage when you return to work. If cancelled 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.

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 insurance under a federal law known as COBRA. This law allows employees and dependents whose insurance would end to continue the same benefits for specific periods of time. 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

BA will send a COBRA packet 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 BA.

Continuing Coverage at Retirement

There are separate eligibility guides for retirement insurance. The Guide to Continuing Insurance at Retirement for Local Government is available on the ParTNers for Health website under "Publications" at https://www.tn.gov/partnersforhealth.

Coverage for Dependents in the Event of Your Death

If you die while actively employed, your covered dependents will be offered continuation of whatever medical, dental and vision elections are in effect for them on the date of your death. Your surviving dependent(s) should contact Benefits Administration to confirm what type of coverage continuation they are eligible for.

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

If you are a member of the Tennessee Consolidated Retirement System (TCRS), election of a monthly pension benefit from the TCRS is required for insurance continuation. Your covered dependents do not have to be the pension beneficiaries, but election of a lump sum pension payout by either you or your designated pension beneficiary, will forfeit continuation of retiree insurance for your surviving dependents. Premiums for continued coverage of your eligible surviving dependents will be deducted from your monthly TCRS pension check if a covered dependent is your designated pension beneficiary. Covered surviving dependents must submit insurance premiums directly to Benefits Administration if your TCRS pension check is insufficient to cover the premiums or if your designated pension beneficiary is someone other than a dependent covered on your insurance at the time of your death.

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

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

- If you are eligible for continuation of coverage as a retiree at time of death, your dependents may elect COBRA or RETIREE continuation of dental and/or vision elections in effect for them on the date of your death; or

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

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

If You Are Covered Under COBRA

Your covered dependents will get up to six months of health insurance 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.

Basic Features of the Health Options

	PPOs (PREMIER, STANDARD, LIMITED)	LOCAL CDHP/HSA
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 CDHP	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 CDHP	Higher than the PPOs
PHYSICIAN OFFICE VISITS — includes specialists and behavioral health and substance use 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	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
HEALTH SAVINGS ACCOUNT	None	Your contributions are tax free/tax deductible

AVAILABLE BENEFITS

Health Insurance

You have a choice of four health insurance options:

- Premier Preferred Provider Organization (PPO)
- Standard PPO
- Limited PPO
- Local Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA)

You also have a choice of three insurance carrier networks:

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

With each health insurance option, you can see any doctor you want. However, each carrier network has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. 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 health insurance option:

- Provides the **same comprehensive health insurance coverage** (although medical policies for specific services may vary between carriers)
- Includes in-person and state-sponsored Telehealth medical services
- 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 Local 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 Local 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, except for in-network preventive care and certain maintenance drugs, 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

Health Savings Account

If you enroll in the Local CDHP/HSA, 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. For example, you could take the money you save in premiums for this plan versus a PPO and put it in your HSA. 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 $3,500 for individuals and $7,000 for families in 2019.
- At age 55 and older, you can make an additional $1,000/year contribution ($4,500 for individuals or $8,000 for families).

Restrictions

You cannot enroll in the Local CDHP/HSA if you are enrolled in another plan, including a PPO, your spouse's plan or any government plan (e.g., Medicare A and/or B, Medicaid , TRICARE, Social Security benefits), or if you have received care from an Veterans Affairs (VA) facility or the Indian Health Services (IHS) within the past three months.

Generally, members eligible to receive care at any VA facility cannot enroll in the Local CDHP because a HSA is automatically opened for them. Individuals are not eligible to make HSA contributions for any month if they receive medical benefits from the VA at any time during the previous three months. However, members may be eligible if the following applies:

-Member did not receive any care from a VA facility for three months, or

-The member only receives care from a VA facility for a service-connected disability (and it must be a disability).

Go to IRS.gov for HSA eligibility information.

You cannot have a HSA if you or your spouse are enrolled in a flexible spending account (FSA) or a HRA. Instead, if you have one available, you can enroll in a limited purpose FSA for dental or vision costs.

Pharmacy

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines the out-of-pocket prescription costs. Specialty drugs must be filled through a Specialty Network Pharmacy and can only be filled every 30 days.

There are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price for these certain medications, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication. The maintenance tier list includes certain medications for high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).

Eligible members will be able to receive certain low-dose statins in-network at zero cost share. These medications are primarily used to treat high cholesterol. No high dose or brand statins are included.

Any and all compound medications (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound medications require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Members won't have to pay for some specific medications used to treat opioid dependency.

2019 Monthly Premiums for Health

ALL REGIONS						
	LEVEL 1		LEVEL 2		LEVEL 3	
	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
PREMIER PPO						
Employee Only	$662	$702	$740	$780	$804	$844
Employee + Child(ren)	$1,027	$1,067	$1,146	$1,186	$1,246	$1,286
Employee + Spouse	$1,424	$1,504	$1,590	$1,670	$1,729	$1,809
Employee + Spouse + Child(ren)	$1,789	$1,869	$1,997	$2,077	$2,172	$2,252
STANDARD PPO						
Employee Only	$620	$660	$693	$733	$753	$793
Employee + Child(ren)	$962	$1,002	$1,074	$1,114	$1,168	$1,208
Employee + Spouse	$1,334	$1,414	$1,489	$1,569	$1,620	$1,700
Employee + Spouse + Child(ren)	$1,676	$1,756	$1,871	$1,951	$2,034	$2,114
LIMITED PPO						
Employee Only	$481	$521	$538	$578	$585	$625
Employee + Child(ren)	$747	$787	$834	$874	$907	$947
Employee + Spouse	$1,036	$1,116	$1,157	$1,237	$1,258	$1,338
Employee + Spouse + Child(ren)	$1,302	$1,382	$1,452	$1,532	$1,580	$1,660
LOCAL CDHP/HSA						
Employee Only	$434	$474	$483	$523	$525	$565
Employee + Child(ren)	$671	$711	$750	$790	$815	$855
Employee + Spouse	$931	$1,011	$1,039	$1,119	$1,130	$1,210
Employee + Spouse + Child(ren)	$1,170	$1,250	$1,306	$1,386	$1,420	$1,500

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.

2019 Benefit Comparison

PPO services in this table ARE NOT subject to a deductible. Local CDHP/HSA services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications.

Note: This grid is available in a one-page, easy-to-use format at this link on the Benefits Administration website: https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/benefit_grid_2019_le_lg.pdf

HEALTHCARE OPTION	PREMIER PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OFFICE VISITS				
• Well-baby, well-child visits as recommended • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended • Annual hearing and non-refractive vision screening • Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No charge	$45 copay	No charge	$50 copay
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA				
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed 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 • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45 copay	$70 copay	$50 copay	$75 copay
Behavioral Health and Substance Use [2] • Including virtual visits	$25 copay	$45 copay	$30 copay	$50 copay
Telehealth (approved carrier programs only)	$15 copay	N/A	$15 copay	N/A
Allergy Injection Without an Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Chiropractic • 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
Convenience Clinic	$25 copay	$45 copay	$30 copay	$50 copay
Urgent Care Facility	$45 copay	$70 copay	$50 copay	$75 copay
Emergency Room Visit	$150 copay		$175 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

LIMITED PPO		LOCAL CDHP/HSA	
IN-NETWORK [1]	OUT-OF-NETWORK [1]	IN-NETWORK [1]	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
$15 copay	N/A	30% coinsurance	N/A
100% covered	100% covered up to MAC	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
$35 copay	$55 copay	30% coinsurance	50% coinsurance
$55 copay	$80 copay	30% coinsurance	50% coinsurance
$200 copay		30% 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

See footnotes on page 17.

Note

Generally, the higher the health plan premium, the less you'll pay out-of-pocket for your healthcare services. The lower the health plan premium, the more you'll pay out-of-pocket for your healthcare services.

Members who enroll in the Local CDHP/HSA can put savings from the lower premium into their HSA account to help pay out-of-pocket costs.

Using Edison ESS

Edison is the State of Tennessee's Enterprise Resource Planning (ERP) system. When using Employee Self Service (ESS) in Edison to add/make changes to benefits, Internet Explorer 11 is the preferred browser. You may not be able to enroll if you use another browser, mobile device or a tablet.

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.

2019 Benefit Comparison, continued

PPO services in this table ARE subject to a deductible unless noted with a [5]. Local CDHP/HSA services in this table ARE subject to a deductible with the exception of in-network preventive care.

Note: This grid is available in a one-page, easy-to-use format at this link on the Benefits Administration website: https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/benefit_grid_2019_le_lg.pdf

	PREMIER PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OUTPATIENT FACILITIES				
• Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No charge	40% coinsurance	No charge	40% coinsurance
OTHER SERVICES				
Hospital/Facility Services [4] • Inpatient care; outpatient surgery • Inpatient behavioral health and substance use [2]	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 and skilled nursing facility [4]; outpatient • Outpatient IN-NETWORK physical, occupational and speech therapy [5]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging) [5]	10% coinsurance		20% coinsurance	
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
All reading, Interpretation and Results [5]	10% coinsurance		20% coinsurance	
Ambulance (air and ground)	10% coinsurance		20% coinsurance	
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
Also Covered	Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered subject to applicable deductible and 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
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT TOWARD THE OUT-OF-POCKET MAXIMUM				
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

LIMITED PPO		LOCAL CDHP/HSA	
IN-NETWORK [1]	OUT-OF-NETWORK [1]	IN-NETWORK [1]	OUT-OF-NETWORK [1]
No charge	50% coinsurance	No charge	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	50% coinsurance
30% coinsurance		30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	
30% coinsurance		30% coinsurance	
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
See separate sections in the Member Handbook for details.			
$1,800	$3,600	$2,000	$4,000
$2,500	$4,800	$4,000	$8,000
$2,800	$5,500	$4,000	$8,000
$3,600	$7,200	$4,000	$8,000
$6,800	$10,400	$5,000	$8,000
$13,600	$20,800	$10,000	$16,000
$13,600	$20,800	$10,000	$16,000
$13,600	$20,800	$10,000	$16,000

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 (MAC) 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 Local CDHP Plan, the deductible and out-of-pocket maximum amount can be met by one or more persons, but must be met in full before it is considered satisfied for the family. No one family member may contribute more than $7,900 to the in-network family out-of-pocket maximum total. See the "Out of Pocket Maximums" section in the Member Handbook for more details. For Local CDHP Plan, coinsurance is after deductible is met unless otherwise noted.

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

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management, and Applied Behavior Analysis.

[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.

[5] For PPO Plans, the deductible DOES NOT apply. For Local CDHP, the deductible DOES apply as required.

Dental Insurance

You and your dependents are eligible for voluntary dental coverage, if offered by your employing agency. You must pay 100 percent of the premium if you elect this coverage. Two dental insurance 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 a select number of dentists in Cigna Dental HMO (DHMO)
- Copays for dental treatments, including adult and child orthodontia for up to 24 months
- No claim forms
- Referrals to specialists are required
- Preexisting conditions are covered if they are listed in the Patient Charge Schedule, unless treatment starts before coverage begins
- 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 and major dental care. Coinsurance for basic, major, orthodontic and out-of-network covered services
- You or your dentist will file claims for covered services
- Referrals to specialists are **not** required
- 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 Dental

	CIGNA PREPAID PLAN	METLIFE DPPO PLAN
ACTIVE MEMBERS		
Employee Only	$13.44	$23.64
Employee + Child(ren)	$27.91	$54.36
Employee + Spouse	$23.83	$44.72
Employee + Spouse + Child(ren)	$32.76	$87.50

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.

	CIGNA PREPAID OPTION		METLIFE DPPO OPTION	
COVERED SERVICES	**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 Permanent teeth	$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	$200 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 equal or less than 24 months. Then, full charge.[6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	$3,360 copay ($140 x 24 months) for treatment fee only. Then, member pays full charge after initial 24 months. [6]		$1,250 [5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

MAC—Maximum Allowable Charge is the lesser of the amount charged by the dentist or the maximum payment amount that in-network dentists have agreed to accept in full for the dental service. When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network 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 six-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

Voluntary vision coverage is available to you and your dependents, if offered by your agency. You must pay 100 percent of the premium for this coverage. Two options are available: a Basic plan and an Expanded plan. Both plans offer:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglass lenses or contact lenses once every calendar year
- 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 Davis Vision. You will receive the maximum benefit when visiting a provider in their 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/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.

Davis Vision offers some value-added services which include:

- Zero copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location
- Free pair of eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Expanded Plan
- Free pair of "Fashion Selection" eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Basic Plan
- Free pair of frames at Visionworks retail locations
- 40% discount off retail under the in-network Expanded Plan and 30% discount off retail under the in-network Basic Plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations
- 20% discount off retail cost of an additional pair of conventional or disposable contact lenses under the in-network Expanded Plan
- One year warranty for breakage of most eyeglasses
- 30% to 60% off the cost of brand name hearing aids through EPIC Hearing Healthcare

Monthly Premiums for Vision

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	$3.07	$5.56
Employee + Child(ren)	$6.13	$11.12
Employee + Spouse	$5.82	$10.57
Employee + Spouse + Child(ren)	$9.01	$16.35

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 discounts represent the cost the carrier will cover.

	BASIC PLAN	EXPANDED PLAN
Routine Eye Exam	$0 copay	$10 copay
Retinal Imaging Benefit	$39 copay	$39 copay
Frames	$55 allowance; 20% discount off balance above the allowance	$150 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass)		
• Single	$0 copay	$0 copay
• Bifocal, trifocal, lenticular	$0 copay	$0 copay
• Standard progressive Lens	$55 allowance; 20% off balance over $55; not to exceed $65 out-of-pocket	$50 copay
• Premium progressive Lens	$55 allowance; 20% off balance over $55; not to exceed $105 out-of-pocket	$50-140 copay [1]
Eyeglass Lens Options (upgrades)	20% discount off all options with out-of-pocket not to exceed amount shown below	
• Anti-reflective	Up to $40	$40 copay
• Polycarbonate	Adults $35; Children $0	Adults $30; Children $0
• Photochromic	Up to $70	20% off retail price; not to exceed $70 out-of-pocket
• Scratch resistance coating	$0	$0 copay
• UV coating	Up to $15	$10 copay
• Tints	Up to $15	$15 copay
• Polarized	Up to $75	20% off retail; not to exceed $75 out-of-pocket
• Premium anti-reflective	Up to $55	$40-69 copay [1]
• Scratch protection plan: single vision/multifocal lenses	$20 copay/$40 copay	$20 copay/$40 copay
• All other eyeglass lens options		20% discount
Exam for Contact Lenses (fitting and evaluation)	20% discount off retail price	$50-60 copay
Contact Lenses [2]		
• Elective Conventional or disposable	$55 allowance; 20% off balance over $55	$140 allowance; 20% off balance over $140
• Medically necessary [3]	$155 allowance; 20% off balance over $155	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	$35 allowance	up to $50 allowance
• Frames	up to $55 allowance (frames and lenses combined)	up to $75 allowance
• Eyeglass lenses		
• Single vision		up to $35 allowance
• Lined bifocal		up to $55 allowance
• Lined trifocal		up to $70 allowance
• Elective contacts (conventional or disposable)	$30 allowance	up to $55 allowance
• Medically necessary contacts [3]	$80 allowance	up to $200 allowance
• Lens options-UV, polycarbonate, photochromic/ transitions plastic		up to $10 allowance
Frequency		
• Eye exam	once every calendar year per person	once every calendar year per person
• Eyeglass lenses and contacts	once every calendar year per person	once every calendar year per person
• Frames	once every two calendar years per person	once every two calendar years per person

[1] Copays for premium progressive lens and premium anti-reflective coating 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

Your Employee Assistance Program (EAP) is administered by Optum. It is available to all members enrolled in medical insurance and their benefits-eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

Master's level specialists are available around the clock to assist with stress, legal, financial, mediation and work/life services. They can even help you find a network provider, a plumber who works nights, find services for your elderly parents, theater tickets, all-night pharmacies and so much more.

Optum knows you are busy, and they want to provide you with information when you need it. All you have to do is call 855.Here4TN (855.437.3486).

Here4TN Behavioral Health & Substance Use Services

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Behavioral health benefits are only available to those enrolled in medical insurance. Your enrolled dependents can use these benefits too.

Optum is your behavioral healthcare vendor. To receive maximum benefit coverage, participants must use a network provider. For assistance finding a provider, call 855.Here4TN (855.437.3486).

In addition to office visits, this benefit includes virtual visits. What does that mean? You can meet with a provider through private, secure video conferencing. Virtual visits allows you to get the care you need sooner and in the privacy of your home. The cost for virtual visits is the same as an office visit. To get started, go to Here4TN.com, scroll down, select provider search, and click on virtual visits to find a provider licensed in Tennessee, or call 855.Here4TN (855.437.3486) for assistance. Learn more about your behavioral health benefit by visiting Here4TN.com.

ParTNers for Health Wellness Program

In 2019, two voluntary wellness programs will be offered to enrolled local government employees, spouses and adult dependents. Note: members must meet certain criteria to qualify for these programs:

Disease management: ActiveHealth Management is your new wellness program vendor. There are programs available for members with chronic diseases that include asthma, diabetes, coronary artery disease (CAD), congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) to better manage your chronic condition. If you qualify for any of these programs, ActiveHealth will contact you about enrolling in telephonic or group coaching. You will also have access to ActiveHealth Management's website and mobile app which includes a variety of educational resources and tools such as a health assessment as well as a health education library with videos and articles. You are encouraged but not required to participate. For more information, go to http://go.activehealth.com/wellnesstn.

Diabetes Prevention Program: Classes for those who are pre-diabetic. Members must pre-qualify for this program.

For more information about who is eligible and how to access these two programs, visit the ParTNers for Health website, under Other Benefits and Wellness.

In addition to these programs, you will have access to ActiveHealth Management's website and mobile app which includes a variety of educational resources and tools.

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program. 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.

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 expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law 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. 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) 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, you will be notified 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.

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/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 agency benefits coordinator and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he/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 agency benefits coordinator. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from you.

Financial losses due to fraud, waste or abuse have a direct effect on you as a plan member. When claims are paid or benefits are provided to a person who is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your 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/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 agency 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 use 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 use 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

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 1-866-576-0029.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697

If you speak a language other than English, help in your language is available for free.

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-576-0029 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው

ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

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

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

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

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

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

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

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

The Notice of Privacy Practice

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

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practice is located on the Benefits Administration website at https://www.tn.gov/partnersforhealth. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

Prescription Drug Coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. By law, we are required to inform plan members of this coverage yearly. You can find a copy of the required notice regarding your options on the Benefits Administration website.

If you are actively employed or a pre-65 retiree enrolled in health coverage, you have pharmacy benefits. You do not need to enroll in Medicare prescription drug coverage regardless of your age. Once your retiree group health coverage terminates due to becoming Medicare eligible you may want to enroll in Medicare prescription drug coverage if you need pharmacy benefits.

Summary of Benefits and Coverage

As required by law, the State of Tennessee Group Health Plan has created a Summary of Benefits and Coverage (SBC). The SBC describes your 2019 health coverage options. You can view it online at https://www.tn.gov/partnersforhealth/summary-of-benefits-and-coverage.html or request that we send you a paper copy free of charge. To ask for a paper copy, call Benefits Administration at 855.809.0071.

Plan Document

The information contained in this guide provides a detailed overview of the benefits available to you through the State of Tennessee. More information is contained within the formal plan documents. If there is any discrepancy between the information in this guide and the formal plan documents, the plan documents will govern in all cases. You can find a copy on the Benefits Administration website at https://www.tn.gov/partnersforhealth/publications.html.

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at https://www.tn.gov/partnersforhealth/publications.html, including, but not limited to, the plan document, brochure and handbook for The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare), brochures and handbooks for medical, pharmacy, dental and vision.

Notes

STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
19TH FLOOR, 312 ROSA L. PARKS AVENUE • WILLIAM R. SNODGRASS TENNESSEE TOWER
NASHVILLE, TENNESSEE 37243-1102