PARTNERS FOR HEALTH

Your 2021 Eligibility & Enrollment Guide

Local Government Employees

Tennessee State Group Insurance Program | **Revised 01/21**

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	Optum Bank	866.600.4984 — 24/7	optumbank.com/Tennessee
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. 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 green "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 blue "Questions?" button on the website.

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TABLE OF CONTENTS

If viewing online, you can hover over linked topics and click to go to that page.

TN Department of Finance and Administration,
Authorization No. 317375, October 2019.
This public document was promulgated at a cost of $0.01 per copy.

INTRODUCTION

Benefits Administration within the Department of Finance and Administration manages the State Group Insurance Program. ParTNers For Health is the official logo and website name for Benefits Administration.

The Local Government Plan is available to local government agencies and eligible quasi-governmental organizations that choose to participate. This guide explains insurance options and the coverage rules for local government employees participating in the Local Government Plan. There is a separate guide for continuing insurance at retirement.

If you are eligible for the Local Government Plan, you may enroll in health coverage. Dental and vision insurance are also available, if offered by your agency.

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

Employees

Eligible

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

NOT Eligible

Individuals who do not meet the employee eligibility rules outlined above, are ineligible UNLESS 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

Dependents

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

Eligible

- Your spouse (legally married); individual agencies may deny eligibility to the spouses of employees who are eligible for group health insurance through the spouse's employer
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian
- Children for whom the plan has qualified medical child support orders

All dependents must be listed by name on the enrollment change application in part 7. You are also required to provide a valid Social Security number for a dependent (if they have one). Other required information includes date of birth, relationship, gender and acquire date.

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑
			❑ M ❑ F			❑	❑	❑

* The acquire date is the date of marriage, birth, adoption or guardianship.
Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2).

❑ A separate sheet with more dependents is attached

Proof of the dependent's eligibility is also required. Refer to the dependent definitions and required documents chart below and at tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf for the types of proof you must provide.

Not Eligible

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

DEPENDENT ELIGIBILITY

Definitions and Required Documents

PARTNERS FOR HEALTH

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	You will need to provide a document proving marital relationship **AND** one document from the additional documents list below:
		Proof of Marital Relationship • Government issued marriage certificate or license • Naturalization papers indicating marital status
		Additional Documents • Bank Statement issued within the last six months with both names; **or** • Mortgage Statement issued within the last six months with both names; **or** • Residential Lease Agreement within the current terms with both names; **or** • Credit Card Statement issued within the last six months with both names; **or** • Property Tax Statement issued within the last 12 months with both names; **or** • The first page of most recent Federal Tax Return filed showing "married filing jointly" or "married filing separately" with the name of the spouse provided thereon, submit page 1 of the return with the income figures blacked out
		If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility
Natural (biological) child under age 26	A natural (biological) child	The child's birth certificate; **or**
		Certificate of Report of Birth (DS-1350); **or**
		Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); **or**
		Certification of Birth Abroad (FS-545)
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	Final court order granting adoption; **or**
		International adoption papers from country of adoption; **or**
		Court order placing child in custody of member for purpose of adoption
Child for whom the participant is legal guardian	A child for whom the participant is the legal guardian	Court order making member a guardian of another and stating the length of the guardianship
Stepchild under age 26	A stepchild	Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse, or documents determined by BA to be the legal equivalent
Child for whom the plan has received a qualified medical child support order	A child who is named as an alternate recipient with respect to the participant under a qualified medical child support order (QMCSO)	Court documents signed by a judge; **or**
		Medical support orders issued by a state agency
Disabled dependent	A dependent of any age (who falls under one of the categories previously listed) and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26 and while covered under a state-sponsored plan.	Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday. The insurance carrier will review the form, make a determination, and provide BA with documentation once a determination has been made. If approved for incapacity, the child will continue the same coverage.

Never send original documents. Please mark out or black out any social security numbers and any personal financial information on the copies of your documents BEFORE you return them.

Revised 07/20

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.

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 30 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 then gain full-time status, your coverage will start the first day of the month after gaining full-time status. Newly eligible employees must submit an Enrollment Change Application within 30 calendar days of the date of the status change, but you should make the request as soon as possible to avoid the possibility of double premium payroll deductions.

You must be in a positive pay status (i.e., any type of approved leave with pay) 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 your normal work duties. 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. The application to add a newly acquired dependent (tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2020.pdf) 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. You may choose the same or different levels for health, dental and vision.

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

Family Coverage – Is any coverage level other than "Employee Only."

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

Edison Employee Self Service (ESS) Instructions

You will need to log in to Edison at https://hub.edison.tn.gov/psp/paprd/EMPLOYEE/EMPL/h/?tab=PAPP_GUEST to enroll. Instructions for enrolling are available at tn.gov/partnersforhealth. Click on the For New Employees tile and then look under Resources for Higher Ed, Local Ed & Local Gov Employee Self Service (ESS) Instructions.

If you have trouble logging in to Edison, go to the Edison home page and instead of clicking on the red Portal Login button, click on the First Time Login/New Hire blue button. It will take you to a page where you can verify your identity and receive your Access ID. Local Government employees can call the Benefits Administration Service Center at 1-800-253-9981 or 615-741-3590.

Premium Payment

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

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

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

Adding New Dependents

Enrollment must be completed within 60 days of the date a dependent is acquired (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2020.pdf). 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 Employee Only 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 on page 8 of this guide.

Updating Personal Information

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

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

Annual Enrollment Period

During the fall of each year, benefit information is mailed to you and provided in detail on our Partners for Health website at tn.gov/partnersforhealth. Review this information carefully to make the best decisions for you and your family members. The 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 below.

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 30-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 (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1047_2020.pdf). 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

- Annual enrollment
- Change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)
- Marketplace enrollment (Marketplace enrollments are those offered under the Patient Protection and Affordable Care Act (PPACA)

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 25-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 or loss of eligibility under another plan. The State Group Insurance Program will consider special enrollment requests for health, dental and vision insurance 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 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 (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2020.pdf). 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
- Loss of coverage due to exhausting lifetime benefit maximum
- 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 you are 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
- If you are applying to enroll due to a loss of eligibility, please be aware that voluntary actions resulting in a loss of coverage, i.e., voluntary cancellation of coverage or cancellation due to failure to pay premiums, do not constitute a loss of eligibility. The same is true for cancelling, waiving or declining coverage during another plan's enrollment period if such election occurs outside of the annual enrollment period for the State of Tennessee Group Insurance Program.

Loss of eligibility does not include termination of coverage for cause.

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION

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. Cancellation due to failure to pay premiums does not apply to FMLA.

Leave Without Pay — Health Insurance Continued

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

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any voluntary coverages. 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 30 days of your return to work. You must enroll in the same health option you had before. If you do not enroll within 30 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 you a COBRA packet to the address on file within 7-10 days after receiving notification of your coverage ending. Make sure your correct home address is on file with your agency benefits coordinator. You have 60 days from the date coverage ends or the date of the COBRA notice, whichever is later, to return your application to Benefits Administration. Coverage will be restored immediately if premiums are sent with the application. If you do not receive a letter within 30 days after your insurance ends, you should contact BA.

Continuing Coverage at Retirement

Please note that your agency must have opted in to offering the continuation of coverage on the retirement group health plan in addition to other eligibility criteria. There are separate eligibility guides for retirement insurance. The Guide to Continuing Insurance at Retirement for Local Government is available on the ParTNers for Health website under "Publications" at 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 State health, dental and vision insurance they have 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 coverage under COBRA for a maximum of 36 months, as long as they remain eligible. Instead of COBRA, your eligible dependents may continue coverage through retiree group health 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 is one of the required criteria to continue insurance for your covered dependents if you die. Your covered dependents do not have to be the pension beneficiaries, but if either you or your designated pension beneficiary elected to take a lump sum pension payout, this will result in your surviving dependents losing the right to continue retiree health insurance coverage even if the other eligibility criteria are met.

If eligible, premiums for continued coverage of your eligible surviving dependents will be deducted from your monthly TCRS pension check if a covered dependent is your 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 have up to a total of 36 months of COBRA, provided they continue to meet the eligibility requirements.

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. There are two narrow networks, BlueCross BlueShield Network S and Cigna LocalPlus, which exclude some providers to keep premiums and rate increases low. There is also one broad network, Cigna Open Access Plus (OAP), for maximum choice.

- BlueCross BlueShield (BCBST) Network S
- Cigna LocalPlus Network
- Cigna Open Access Plus Network is a broad network with the most providers in Tennessee. OAP gives you access to more providers than the other networks but this broad choice costs more.

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 in-network providers have agreed to take lower fees for their services. The cost is higher when using out-of-network providers.

2021 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	$698	$738	$780	$820	$848	$888
Employee + Child(ren)	$1,083	$1,123	$1,208	$1,248	$1,314	$1,354
Employee + Spouse	$1,501	$1,581	$1,677	$1,757	$1,823	$1,903
Employee + Spouse + Child(ren)	$1,886	$1,966	$2,106	$2,186	$2,290	$2,370
STANDARD PPO						
Employee Only	$654	$694	$731	$771	$794	$834
Employee + Child(ren)	$1,014	$1,054	$1,132	$1,172	$1,232	$1,272
Employee + Spouse	$1,407	$1,487	$1,570	$1,650	$1,708	$1,788
Employee + Spouse + Child(ren)	$1,767	$1,847	$1,973	$2,053	$2,145	$2,225
LIMITED PPO						
Employee Only	$507	$547	$567	$607	$617	$657
Employee + Child(ren)	$788	$828	$879	$919	$956	$996
Employee + Spouse	$1,092	$1,172	$1,220	$1,300	$1,326	$1,406
Employee + Spouse + Child(ren)	$1,373	$1,453	$1,531	$1,611	$1,666	$1,746
LOCAL CDHP/HSA						
Employee Only	$458	$498	$509	$549	$554	$594
Employee + Child(ren)	$708	$748	$791	$831	$859	$899
Employee + Spouse	$982	$1,062	$1,096	$1,176	$1,191	$1,271
Employee + Spouse + Child(ren)	$1,234	$1,314	$1,377	$1,457	$1,497	$1,577

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.

Network providers and facilities can and do change. Benefits Administration cannot guarantee that all providers and hospitals that are in a network when you enroll will stay in that network. A provider or hospital leaving a network is not a qualifying event and does not allow you to make changes.

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 Telehealth medical services through PhysicanNow or MDLive programs sponsored by BCBST and Cigna
- 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 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, a 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 Optum Bank, 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 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 $3,600 for individuals and $7,200 for families in 2021.
- At age 55 and older, you can make an additional $1,000/year contribution.

Your full HSA contribution is not available upfront at the beginning of the year or after you enroll. Your pledged amount is taken out of each paycheck each pay period. You may only spend the money that is available in your HSA at the time of service or care.

Local CDHP/HSA Restrictions

You cannot enroll 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 any Veterans Affairs (VA) facility or the Indian Health Services (IHS) within the past three months. Generally, members receiving free 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 they did not receive any care from a VA facility for three months, or member only receives care from a VA facility for a service-connected disability (it must be a disability). Go to https://www.irs.gov/irb/2004-33_IRB/ar08.html for HSA eligibility information.

HSA and FSA Restrictions

You cannot enroll in the Local CDHP/HSA if either you or your spouse have a medical flexible spending account (FSA) or health reimbursement account (HRA) at either employer. But if your employer offers one, you can have a limited purpose FSA (L-FSA) for vision or dental expenses along with your HSA.

Pharmacy

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines out-of-pocket prescription costs. Specialty drugs must be filled at 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. The maintenance tier list includes certain medications: high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD), diabetes (oral medications, insulins, needles, test strips and lancets) and some osteoporosis medications.

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.

2021 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 in-network preventive care and 90-day supply maintenance medications. In the table, $ = your copayment amount; % = your coinsurance; and 100% covered or No charge = you pay $0 in-network. See footnotes on page 19.

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_2021_le_lg_final.pdf

HEALTHCARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs	
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	No charge	$50
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	$45	$30	$50
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	$70	$50	$75
Behavioral Health and Substance Use [2] • Including virtual visits	$25	$45	$30	$50
Telehealth (approved carrier programs only)	$15	N/A	$15	N/A
Allergy Injection Without an Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Chiropractic and Acupuncture • Limit of 50 visits of each per year	Visits 1-20: $25 Visits 21-50: $45	Visits 1-20: $45 Visits 21-50: $70	Visits 1-20: $30 Visits 21-50: $50	Visits 1-20: $50 Visits 21-50: $75
Convenience Clinic	$25	$45	$30	$50
Urgent Care Facility	$45	$70	$50	$75
Emergency Room Visit	$150		$175	
PHARMACY				
30-Day Supply	$7 generic; $40 preferred brand; $90 non-preferred	copay plus amount exceeding MAC	$14 generic; $50 preferred brand; $100 non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 generic; $80 preferred brand; $180 non-preferred	N/A - no network	$28 generic; $100 preferred brand; $200 non-preferred	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 generic; $40 preferred brand; $160 non-preferred	N/A - no network	$14 generic; $50 preferred brand; $180 non-preferred	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10%; min $50; max $150	N/A - no network	10%; min $50; max $150	N/A - no network

LIMITED PPO Member Costs		LOCAL CDHP/HSA Member Costs	
IN-NETWORK [1]	OUT-OF-NETWORK [1]	IN-NETWORK [1]	OUT-OF-NETWORK [1]
No charge	$50	No charge	50%
$35	$55	30%	50%
$55	$80	30%	50%
$35	$55	30%	50%
$15	N/A	30%	N/A
100% covered	100% covered up to MAC	30%	50%
Visits 1-20: $35 Visits 21-50: $55	Visits 1-20: $55 Visits 21-50: $80	30%	50%
$35	$55	30%	50%
$55	$80	30%	50%
$200		30%	
$14 generic; $60 preferred brand; $110 non-preferred	copay plus amount exceeding MAC	30%	50% plus amount exceeding MAC
$28 generic; $120 preferred brand; $220 non-preferred	N/A - no network	30%	N/A - no network
$14 generic; $60 preferred brand; $200 non-preferred	N/A - no network	20% without first having to meet deductible	N/A - no network
10%; min $50; max $150	N/A - no network	30%	N/A - no network

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 have trouble logging in to Edison, go to the Edison home page and click on the Retrieve Access ID button if you have logged in before and don't remember your Access ID, or click the First Time Login / New Hire link if you have never logged in before. If you know your Access ID but need to reset your password, click the red Employee Portal Login button, enter your Access ID, and click Continue. Then click the link that says Forgot your Password? You can also view helpful troubleshooting videos on the Partners for Health website at https://www.tn.gov/partnersforhealth/videos.html.

Local Government employees can call the Benefits Administration Service Center at 800.253.9981 or 615.741.3590.

2021 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. In the table, % = your coinsurance. See footnotes on page 19.

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_2021_le_lg_final.pdf

HEALTHCARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs	
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 [5]	40%	No charge [5]	40%
OTHER SERVICES				
Hospital/Facility Services [4] • Inpatient care; outpatient surgery • Inpatient behavioral health and substance use [2] [6]	10%	40%	20%	40%
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10%	40%	20%	40%
Home Care [4] • Home health; home infusion therapy	10%	40%	20%	40%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4]; outpatient • Outpatient IN-NETWORK physical, occupational and speech therapy [5]	10%	40%	20%	40%
X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging) [5]	10%		20%	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10%	40%	20%	40%
All Reading, Interpretation and Results [5]	10%		20%	
Ambulance (air and ground)	10%		20%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10%	40%	20%	40%
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 Member Costs		LOCAL CDHP/HSA Member Costs	
IN-NETWORK [1]	OUT-OF-NETWORK [1]	IN-NETWORK [1]	OUT-OF-NETWORK [1]
No charge [5]	50%	No charge	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%		30%	50%
30%	50%	30%	50%
30%		30%	
30%		30%	
30%	50%	30%	50%
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 $8,550 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 behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[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), depression and osteoporosis medications.

[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.

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

Basic Features of the Health Options

IN-NETWORK	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 Local 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 Local 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

Dental Insurance

You and your dependents are eligible for voluntary dental coverage, if offered by your employing agency. Two different dental plans are offered. You pay the full monthly premium. 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.

2021 Monthly Premiums for Dental

	CIGNA PREPAID PLAN	METLIFE DPPO PLAN
ACTIVE MEMBERS		
Employee Only	$13.84	$23.64
Employee + Child(ren)	$28.75	$54.36
Employee + Spouse	$24.54	$44.72
Employee + Spouse + Child(ren)	$33.74	$87.50

Prepaid Plan (Cigna)

- Must select and use a network general dentist (NGD) from the prepaid dental plan list for each covered family member — the network is a select number of dentists in Cigna Dental HMO (DHMO). You may select a network pediatric dentist as the NGD for your dependent child under age 13. At age 13, you must switch the child to a NGD or pay the full charge from the pediatric dentist. The list of providers for the state may be found by visiting the website, https://www.cigna.com/sites/stateoftn/.
- Copays for dental treatments, including adult and child orthodontia for up to 24 months
- An office visit fee copay applies per patient, per office visit, and is in addition to any other applicable patient charges
- No claim forms
- Preexisting conditions are covered if they are listed in the patient charge schedule, unless treatment starts before coverage begins
- Certain limitations and exclusions apply. Please refer to the patient charge schedule and the Cigna dental certificate (https://www.tn.gov/partnersforhealth/publications/publications.html) for additional details
- Referrals to specialists are required
- 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 applies
- Orthodontic treatment is not covered if the treatment plan began prior to the member's effective date of coverage with Cigna. The completion of crowns, bridges, dentures or root canal treatment already in progress on the member's effective date of coverage is also not covered.

DPPO Plan (MetLife)

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider. The list of network providers in the MetLife DPPO network for the state may be found by visiting the website, https://www.metlife.com/stateoftn/.
- $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
- Pre-treatment estimates are recommended for more expensive services
- Benefits for covered services are paid at the lesser of dentist charge, maximum allowable charge or alternate benefit amount
- Some services require waiting periods of six months and up to one year, and certain limitations and exclusions apply
- Lifetime benefit maximum of $1,250 for orthodontia

NOTE: A complete description of the benefits, provisions, conditions, limitations and exclusions for both the MetLife and Cigna dental plans will be included in their respective Certificate of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. These documents may be reviewed at https://www.tn.gov/partnersforhealth/publications/publications.html.

Dental Insurance Benefits at a Glance

The benefits listed below are a sample of the most frequently utilized dental treatments. For a complete list of copays for the Cigna Prepaid option, please refer to the patient charge schedule. Review the Cigna certificate of coverage for complete details on benefits, limitations and exclusions. Both documents are at cigna.com/stateoftn.

MAC or maximum allowable charge is the highest dollar amount of reimbursement for specific dental procedures provided by DPPO network providers. The in-network dentists have agreed to not charge members or the plan more than the MAC. When a member receives dental services from an out-of-network provider, the out-of-network dentist will be paid by the plan for covered procedures according to the in-network MAC and respective plan coinsurance. The member then is responsible for all other charges by the out-of-network dentist. Review additional information on the ParTNers for Health website tn.gov/partnersforhealth.html under Other Benefits and Dental.

	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 Two Surfaces Permanent teeth	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$125 copay[7]	$600 copay [7]	20% of MAC	40 % of MAC
Major Restorations — Crowns	$190 copay, plus lab fees [3] [7]		50% of MAC [4]	
Extraction of Erupted Tooth (minor oral surgery)	$15 copay	$70 copay	20% of MAC	40% of MAC
Implant (endosteal)	$1,025 copay [7]	$1,025 copay [7]	50% of MAC [4] [8]	
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][7]		50% of MAC [4] [8]	
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	

[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. (See #8 for additional information for dentures and implants.)

[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. Cigna will not cover orthodontic procedures after a member's effective date with Cigna Prepaid if orthodontic treatment began prior to the member's effective date. Orthodontic treatment started under the prior Cigna Prepaid contract with the state will continue to be covered under the new Cigna Prepaid contract effective January 1, 2021.

[7] Completion of crowns, bridges, dentures, implants, or root canal already in progress on member's effective date of coverage with Cigna Prepaid will not be covered.

[8] A 12-month waiting period applies to dentures and implants to replace one or more natural teeth missing before member's effective date of coverage.

Vision Insurance

Voluntary vision coverage is available to you and your dependents, if offered by your agency. You must pay 100% of the premium for this coverage. Two options are available: a Basic 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 (in lieu of eyeglass lenses) once every calendar year
- Discount on LASIK/Refractive surgery
- Discount on hearing aids (includes free hearing exam) through Your Hearing Network (YHN)

2021 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

What you pay for services depends on the plan you choose. The Basic plan pays for your eye exam and various "allowances" (dollar amounts) for materials such as eyeglass frames, lenses, contact lenses, etc. The Expanded plan Includes greater "allowances" (dollar amounts) and additional materials versus the Basic Plan. 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 "Fashion Selection" eyeglass frames from Davis Vision's "The Exclusive Collection" under the in-network Basic Plan. "Designer" and "Premier" Selections have $15 and $40 copays respectively.
- Free pair of eyeglass frames from any Davis Vision's "The Exclusive Collection", which includes "Fashion, Designer and Premier" Selections under the in-network Expanded 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 additional pair of conventional or disposable contact lenses under in-network Expanded plan
- One year warranty for breakage of most eyeglasses

Covered Vision Services

Copays represent what the member pays. Allowances and percentage discounts represent the cost the carrier will cover. Actual costs and benefits may vary based upon the plan design selected. Exclusions and limitations may apply. Out-of-network member costs can be found in the Davis Vision Handbook at https://www.tn.gov/partnersforhealth/publications/publications.html.

NOTE: New lense and coating benefits were added in 2020. Go to the website for a comparison of the plans' benefits.

SERVICE	BASIC PLAN IN-NETWORK COSTS [1]	EXPANDED PLAN IN-NETWORK COSTS [1]
Eye Exam With Dilation as Necessary	$0 copay	$10 copay
Retinal Imaging	$39 copay	$39 copay
Contact Lens fit and Follow up (standard/specialty)	80% of charge	$50/$60 copay
Eyeglass Benefit—Frame		
Retail Frame	80% of balance over $55[2]	80% of balance over $150[2]
Visionworks Frame	Covered in full	Covered in full
The Exclusive Collection[3] (Fashion/Designer/Premier)	In lieu of retail frame $0/$15/$40 copay	In lieu of retail and Visionworks frame $0/$0/$0 copay
Eyeglass Benefit—Spectacle Lenses		
Single Vision, Bifocal, Trifocal & Lenticular Lenses	$0 copay	$0 copay
Progressive Lenses (Standard/Premium/Ultra/Ultimate)	80% of balance over $55; not to exceed $65/$105/$140/$175 out of pocket	$50/$90/$140/$175 copay
High-index (1.67/1.74)	80% of charge not to exceed $60/$120	$60 copay/$120 copay
UV Treatment	80% of charge up to $15	$10 copay
Tint (solid and gradient)	80% of charge up to $15	$15 copay
Standard Polycarbonate (adults/children[4])	80% of charge up to $35/$0 copay	$30 copay/$0 copay
Anti-reflective Coating (Standard/Premium/Ultra/Ultimate)	80% of charge up to $40/$55/$69/$85	$40/$55/$69/$85 copay
Polarized	80% of charge up to $75	80% of charge up to $75
Plastic Photochromic Lenses	80% of charge up to $70	80% of charge up to $70
Scratch coating (standard plastic/premium scratch-resistant)	$0 copay/80% of charge up to $30	$0 copay/$30 copay
Scratch Protection Plan (single vision/multifocal lenses)	$20 copay/$40 copay	$20 copay/$40 copay
Trivex Lenses	80% of charge up to $50	$50 copay
Digital Single Vision (intermediate) lenses	80% of charge up to $30	$30 copay
Blue Light Filtering	80% of charge up to $15	$15 copay
Other Add-ons and Services	80% of charge	80% of charge
Contact Lenses		
Conventional and Disposable	80% of balance over $55	80% of balance over $140
Visually Required[5]	80% of balance over $155	$0 copay
Frequency of Vision Benefits		
Eye Exam	Once every calendar year	Once every calendar year
Eyeglass Lenses	Once every calendar year	Once every calendar year
Frames	Once every two calendar years	Once every two calendar years
Contact Lenses	Once every calendar year in lieu of eyeglasses	Once every calendar year in lieu of eyeglasses
Contact Lens Evaluation, Fitting and Follow-up	Once every calendar year in lieu of eyeglasses	Once every calendar year in lieu of eyeglasses

[1] Member pay will not be greater than the copay, but could be less based upon the actual charge.
[2] $0 copay for eyeglass frames at Visionworks.
[3] Collection is available at most participating eye care professional offices. Collection is subject to change.
[4] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.
[5] If visually required as first contact lenses following cataract surgery, or multiple pairs of rigid contact lenses for treatment of keratoconus.

Additional Vision Benefits

- High Index Lenses — 1.74
- Progressive Lenses — Ultimate Tier
- Anti-reflective Coating — Ultimate Tier
- Premium Scratch-resistant Coating
- Digital Single Vision Lenses
- Trivex Lenses
- Blue Light Filtering (Coatings & Lens Options)
- Scratch Protection Plan

NOTE: A complete description of the benefits, provisions, conditions, limitations and exclusions for the Davis Vision Basic and Expanded plans will be included in their respective Certificate of Insurance. If any discrepancies exist between the information listed above and the legal plan documents, the legal plan documents will govern. We recommend you review these documents. The documents are available at https://www.tn.gov/partnersforhealth/publications/publications.html.

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 (not necessarily enrolled) dependents. Receive five EAP visits, per problem, per year at no cost to you. EAP sessions are issued and authorized on a per-problem-per-year-per-person basis. For example the member receives five EAP counseling sessions for each problem. Should a different unrelated problem arise within the same plan year, the member would receive an additional five sessions to address the new problem. A different problem is either: 1) a new issue for which the member has received no previous counseling or 2) an existing issue that has not been treated in that plan year. Examples of different problems (not an exhaustive list): Relationship issues, Job stress, Parenting issues, Caregiving of a loved one, and Death of a loved one.

Prior authorization is required to see an EAP provider and can be obtained by either logging in to Here4TN.com or calling 855-Here4TN (855-437-3486). Available in person or by virtual visit. Virtual visits allow you to get the care you need sooner, in the privacy of your own home.

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, services for your elderly parents, theater tickets, all- night pharmacies and so much more.

Members have access to a telephonic coaching program called Take Charge at Work which helps people dealing with stress or depression. It's available at no additional cost to all benefits-eligible employees and dependents over the age of 18 who are working either full or part-time.

Talkspace, a digital platform that offers an effective alternative to face-to-face therapy through text, voice and video messaging, is available for EAP visits. Members have access to five EAP visits per year, per issue at no cost. One visit can be defined as either one week (five days) of unlimited text messaging or one video visit. Before scheduling, please contact 855-Here4TN or Here4TN.com for the required authorization and for more information on your EAP benefit.

Members can also use Sanvello, an on-demand mobile application, or app, to help with stress, anxiety and depression. It is available 24/7 at no extra cost at Here4TN.com.

Here4TN Behavioral Health & Substance Use Services

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Health. All enrolled members get an ID card from Optum to use for your behavioral health services.

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Optum can help you find a provider (in person or virtual visits), explain benefits, identify best treatment options, schedule appointments and answer your questions.

Costs are waived for members who use certain preferred substance use treatment facilities. PPO members who use these facilities won't pay a deductible or coinsurance for facility-based substance use treatment. Local CDHP/HSA members' coinsurance is waived after meeting their deductible. However, copays for PPO members and the deductible/coinsurance for Local CDHP/HSA members will still apply for standard outpatient treatment services.

To receive maximum benefit coverage, participants must use an in-network provider. For assistance finding a network provider, call 855.HERE4TN (855.437.3486).

For virtual visits, you can meet with a provider through private, secure video conferencing. Virtual visits allow you to get the care you need sooner and in the privacy of your home. Virtual visit costs are the same as an office visit.

To get started, go to Here4TN.com, scroll down, select provider search, and filter results by virtual visits to find a provider licensed in Tennessee, or call 855.Here4TN (855.437.3486) for assistance.

Talkspace online therapy is also available for all members with behavioral health benefits. Download the application (app) through Here4TN.com. You can communicate safely and securely 24/7 with a therapist from your smartphone or desktop. Talkspace sessions are subject to the same cost share or coinsurance rate (after deductible) as an outpatient office visit.

ParTNers for Health Wellness Program

In 2021, two 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: 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 Management will send you emails about the coaching support that's available to you. It is completely voluntary and won't cost you anything. You'll also have access to the web portal and mobile app where you can get access to your coaches, the health assessment and online resources.

Members have access to the online health assessment with ActiveHealth. After members complete the health assessment, they may use the online educational resources, including health education and digital coaching on their website. For more information, go to http://go.activehealth.com/wellnesstn.

Diabetes Prevention Program: Health plan members also have access to a free Diabetes Prevention Program if you meet eligibility criteria. The program can help you prevent or delay type 2 diabetes. It's offered as part of your health insurance at no cost if you use an in-network provider. There are two online programs offered; one for Cigna members through Omada, and another for BlueCross BlueShield members through Livongo. We also have an in-person program available through the ParTNers Health and Wellness Center.

For details, go to tn.gov/PartnersForHealth under Other Benefits and Wellness and scroll down to the Diabetes Prevention Program (DPP) webpage.

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program. Local education, local government and retirees enrolled in health coverage have access to certain programs like disease management and the web portal. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). You are not required to complete the assessment or other medical examinations.

The information from your health questionnaire will be used to provide you with information to help you understand your current health and potential risks. It may also be used to offer you services through the wellness program such as Diabetes Prevention Program and other programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information (PHI). Although the wellness program and the State of Tennessee may use aggregate information it collects to design a program based on identified health risks in the workplace, the ParTNers for Health Wellness Program will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed for you to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact ParTNers for Health at partners.wellness@tn.gov.

OTHER INFORMATION

Coordination of Benefits

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

As an active employee, your health insurance coverage is generally considered primary for you. However, if you have other health coverage as the head of contract, the oldest plan is your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage through his/her employer, that coverage would be primary for your spouse and secondary for you. Generally, Medicare will pay secondary unless the covered individual is enrolled in Medicare due to End Stage Renal Disease or disability, as other coordination of benefits rules may apply.

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

From time to time, carriers will send letters to members asking for other coverage information. 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 section. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses 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 have a problem with coverage or payment of medical, behavioral health and substance use or pharmacy services, there are internal and external procedures to help you. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

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

Benefit Appeals

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

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

Appealing to the Insurance Company

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

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

LEGAL NOTICES

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and 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, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

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 OR U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 OR Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

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 ሊያግዘዎት 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).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક 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 به 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.html. 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 2021 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/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/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.

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