
ELIGIBILITY & ENROLLMENT GUIDE

2022 | Local Government Employees

PARTNERS **FOR HEALTH**



Tennessee State Group Insurance Program - **REV 11/22/21**

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 Financial	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 Health	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
	Delta Dental	800.552.2498 — M-F, 7-5	tennessee.deltadental.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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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, custodian or conservator

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

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

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

An employee may not be enrolled as both head of contract and dependent within the Local Government Plan. A newly hired employee can choose coverage for his/her spouse as a dependent when that spouse is an eligible employee who 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.



DEPENDENT ELIGIBILITY

Definitions and Required Documents



TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	<p>You will need to provide a document proving marital relationship AND one document from the additional documents list below:</p> <p>Proof of Marital Relationship</p> <ul style="list-style-type: none"> • Government-issued marriage certificate or license • Naturalization papers indicating marital status <p>Additional Documents</p> <ul style="list-style-type: none"> • 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 <p>If just married in the previous 12 months, only a marriage certificate is needed for proof of eligibility</p>
Natural (biological) child under age 26	A natural (biological) child	<p>The child's birth certificate (will accept mother's copy for newborn); or</p> <p>Certificate of Report of Birth (DS-1350); or</p> <p>Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or</p> <p>Certification of Birth Abroad (FS-545)</p>
Adopted child under age 26	A child the participant has adopted or is in the process of legally adopting	<p>Final court order granting adoption; or</p> <p>International adoption papers from country of adoption; or</p> <p>Court order placing child in custody of member for purpose of adoption</p>
Child under age 26 placed for guardianship, custody or conservatorship with the head of contract* (placement order active or expired due to age of majority)	A child under age 26 for whom the head of contract is or has been the legal guardian, custodian or conservator	Valid order by a court of competent jurisdiction (placement order) establishing guardianship, custody or conservatorship arrangement between child and head of contract; and an attestation signed by the head of contract upon initial enrollment and upon request
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
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.	<p>Certificate of Incapacitation for Dependent Child form must be submitted prior to the dependent's 26th birthday.</p> <p>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.</p>

*Head of contract is the person who elects coverage and has authority to change coverage elections.

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.

All eligible dependents must be listed by name on the enrollment change application in part 7 (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2021.pdf). You are also required to provide a valid Social Security number for a dependent (if they are eligible for one). Other required information includes date of birth, relationship, gender and acquire date.

Enrollment and Effective Date of Coverage

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

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

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

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

If you do not enroll in health coverage by the end of your enrollment period, you must wait for the annual enrollment period, unless you have a qualifying event during the year. Refer to the special enrollment provisions on pages 7-8 of this guide for more information.

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

You must be in a positive pay status on the day your coverage begins. 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.

Choosing a Premium Level

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

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

Family Coverage – 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

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

Premium Payment

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

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

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

Updating Personal Information

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

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

Annual Enrollment Period

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

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

Changes you request during annual enrollment start the following January 1. Benefit enrollments remain in effect for a full year (January 1 through December 31). You may not cancel coverage outside of the annual enrollment period unless eligibility is lost or there is a qualifying event. For more information, see the sections on cancelling coverage and special enrollment provisions that follow.

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 dependent children generally ends on the last day of the month in which the child reaches age 26, unless otherwise stated in plan rules.

Divorce — If you request to terminate coverage of a dependent spouse while a divorce case is pending, 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
- Open enrollment
- Change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)
- Marketplace enrollment (Marketplace enrollments are those offered under the Patient Protection and Affordable Care Act)

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)

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

Moving Between Plans

If you are eligible for coverage under more than one state-sponsored plan, you may move between the state, local education and local government plans. You may apply to change plans during the plan's designated annual enrollment period with an effective date of January 1 of the following year. In no case may you move 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 coverage when you are first eligible, you must wait for the annual enrollment period. You can apply to enroll or make changes to your coverage during the year, but ONLY if you experience a special qualifying event, or you have a recognized status change as described in the chart below.

Special Enrollment Provisions

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

Mid-Year Elections for Voluntary Programs — You or eligible dependents may also enroll in voluntary dental and vision if you meet the requirements stated in the certificates of coverage for those programs.

NOTE: Application for special enrollment (https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2021.pdf) **must be made:**

- **within 60 days** of the loss of eligibility for other health insurance coverage; or
- **within 30 days** of a new dependent's acquire date.

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

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

The chart below explains the kinds of events that afford special enrollment opportunities, the effective dates for coverage and the documentation you will need to provide.

QUALIFYING EVENT OR STATUS CHANGE*	EFFECTIVE DATE**	DOCUMENTATION REQUIRED***
An event causing the loss of eligibility for coverage from another group insurance plan	The effective date is the first day of the first calendar month after the date BA receives the request for enrollment	Written documentation from an employer, former employer, insurance company or former insurance company on company letterhead that lists (1) names of covered participants; (2) dates of coverage including your coverage at the time coverage in this plan was declined; (3) types of coverage (medical, dental, vision); (4) each participant that lost eligibility for coverage; (5) the date of loss of eligibility to continue coverage; and (6) the reason why eligibility for coverage was lost
An event that results in acquisition of a new dependent spouse or stepchild acquired by marriage, or a person placed with the head of contract pursuant to an order of guardianship, custody or conservatorship	The effective date is the first day of the first calendar month after the date BA receives the request for enrollment	<ol style="list-style-type: none"> 1. Marriage certificate 2. Birth certificate (will accept mother's copy for newborn) 3. Valid order of guardianship, custody or conservatorship (or legally equivalent order) by a court of competent jurisdiction ("placement order") and an applicable attestation signed by the head of contract
An event that results in acquisition of a new dependent acquired by birth, adoption or placement in legal custody for adoption	The effective date is the date of birth, adoption or placement for adoption	<ol style="list-style-type: none"> 1. Birth certificate (will accept mother's copy for newborn) 2. Final order of adoption or order of custody in anticipation of adoption
<p>*Qualifying events and status changes are program specific. The rules for health and voluntary dental and vision may differ. Eligible persons may only enroll in the types of coverage lost (medical/medical; dental/dental; vision/vision).</p> <p>**Effective dates are program specific, and the rules for health and voluntary programs may differ.</p> <p>***Documentation can be program specific. The rules for health and voluntary programs may differ.</p> <p>For more information on special enrollment and mid-year elections, including who is eligible to enroll: See the medical plan document for health coverage rules and the certificates of coverage for the voluntary programs for rules specific to those programs. Those documents can be found at tn.gov/partnersforhealth on the publications page. The direct link is https://www.tn.gov/partnersforhealth/publications/publications.html.</p>		

Important Reminders

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

CONTINUING COVERAGE DURING LEAVE OR AFTER TERMINATION

Extended Periods of Leave

Family and Medical Leave Act

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

Leave Without Pay — Health Insurance Continued

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

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any voluntary coverages. 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% 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 move to your spouse's contract as a dependent. Application must be made within 60 days of your loss of eligibility for other coverage. See section on special enrollment provisions for details.

Continuing Coverage through COBRA

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

- Coverage is lost due to a qualifying event (refer to the COBRA brochure 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 the type of coverage continuation for which they are eligible.

Health — Your covered dependents get six months of health coverage at no cost. After that, your dependents may continue health coverage under COBRA for a maximum of 36 months, as long as they remain eligible. Instead of COBRA, your eligible dependents may apply to continue coverage through retiree group health if you 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, 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
- Standard PPO
- Limited PPO
- Local Consumer-driven Health Plan/Health Savings Account

You also have a choice of four insurance carrier networks. There are two networks, BlueCross BlueShield Network S and Cigna LocalPlus, which exclude some providers to keep premiums and rate increases low. There are also two broad networks, BlueCross BlueShield Network P and Cigna Open Access Plus, for maximum choice. The broad networks include additional monthly premium costs: \$65 more each month for employee-only coverage or employee+child(ren) coverage and \$130 more each month for employee+spouse coverage or employee+spouse+child(ren) coverage.

- BlueCross BlueShield Network S
- BlueCross BlueShield Network P
- Cigna LocalPlus Network
- Cigna Open Access Plus Network

With each health insurance option, you can see any doctor you want. However, each carrier network has a list of doctors, hospitals and other health care 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.

Network providers and facilities can and do change. Benefits Administration cannot guarantee 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** health care 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 which can be used to cover your qualified medical expenses, including your deductible

Health Savings Account

If you enroll in the Local CDHP, an 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 Financial, a company selected and contracted by the state.

Benefits of an 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. 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 \$3,650 for individuals and \$7,300 for families in 2022.
- At age 55 and older, you can make an additional \$1,000/year contribution.

Your full HSA contribution is not available up-front 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 facility or the Indian Health Services within the past three months. Generally, members receiving free care at any VA facility cannot enroll in the Local CDHP because an 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 the 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 or health reimbursement account at either employer. But if your employer offers one, you can have a limited purpose 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, 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.

2022 Monthly Premiums for Health

ALL REGIONS						
	LEVEL 1		LEVEL 2		LEVEL 3	
	BCBST S & CIGNA LOCALPLUS	BCBST P & CIGNA OPEN ACCESS	BCBST S & CIGNA LOCALPLUS	BCBST P & CIGNA OPEN ACCESS	BCBST S & CIGNA LOCALPLUS	BCBST P & CIGNA OPEN ACCESS
PREMIER PPO						
Employee Only	\$727	\$792	\$812	\$877	\$882	\$947
Employee + Child(ren)	\$1,128	\$1,193	\$1,259	\$1,324	\$1,369	\$1,434
Employee + Spouse	\$1,599	\$1,729	\$1,785	\$1,915	\$1,941	\$2,071
Employee + Spouse + Child(ren)	\$1,964	\$2,094	\$2,193	\$2,323	\$2,384	\$2,514
STANDARD PPO						
Employee Only	\$681	\$746	\$760	\$825	\$827	\$892
Employee + Child(ren)	\$1,057	\$1,122	\$1,180	\$1,245	\$1,283	\$1,348
Employee + Spouse	\$1,498	\$1,628	\$1,673	\$1,803	\$1,819	\$1,949
Employee + Spouse + Child(ren)	\$1,840	\$1,970	\$2,054	\$2,184	\$2,234	\$2,364
LIMITED PPO						
Employee Only	\$527	\$592	\$589	\$654	\$640	\$705
Employee + Child(ren)	\$818	\$883	\$914	\$979	\$993	\$1,058
Employee + Spouse	\$1,160	\$1,290	\$1,296	\$1,426	\$1,409	\$1,539
Employee + Spouse + Child(ren)	\$1,425	\$1,555	\$1,591	\$1,721	\$1,730	\$1,860
LOCAL CDHP/HSA						
Employee Only	\$477	\$542	\$532	\$597	\$579	\$644
Employee + Child(ren)	\$739	\$804	\$826	\$891	\$898	\$963
Employee + Spouse	\$1,048	\$1,178	\$1,171	\$1,301	\$1,273	\$1,403
Employee + Spouse + Child(ren)	\$1,288	\$1,418	\$1,438	\$1,568	\$1,563	\$1,693

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.

2022 Health Plan Comparison, page 1

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_2022_le_lg_final.pdf

HEALTH CARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs	
	IN-NETWORK ^[1]	OUT-OF-NETWORK ^[1]	IN-NETWORK ^[1]	OUT-OF-NETWORK ^[1]
PREVENTIVE CARE — OFFICE VISITS				
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Family practice, general practice, internal medicine, OB/GYN and pediatrics Provider-based telehealth Nurse practitioners, physician assistants and nurse midwives (licensed health care 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 <ul style="list-style-type: none"> Including surgery in office setting Provider-based telehealth Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist 	\$45	\$70	\$50	\$75
Behavioral Health and Substance Use ^[2] <ul style="list-style-type: none"> Including virtual visits 	\$25	\$45	\$30	\$50
Telehealth (MDLive/PhysicianNow)	\$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 <ul style="list-style-type: none"> 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% coinsurance; min \$50; max \$150	N/A - no network	10%; min \$50; max \$150	N/A - no network

Using Edison ESS

Edison is the State of Tennessee's enterprise resource planning system. When using Edison ESS, if your device has Windows 10, the preferred browser for Edison is Microsoft Edge. Internet Explorer 11 will work on older devices that have previous versions of Windows.

Password/Login Help

If you have logged in to Edison before and don't remember your Access ID, go to the Edison home page and click on the Retrieve Access ID button. If you've never used Edison or have changed agencies since the last time you logged in, click the First Time Login/New Hire link. 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.

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

2022 Health Plan Comparison, page 2

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 copayment amount; % = your coinsurance; 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

HEALTH CARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs	
	IN-NETWORK ^[1]	OUT-OF-NETWORK ^[1]	IN-NETWORK ^[1]	OUT-OF-NETWORK ^[1]
PREVENTIVE CARE — OUTPATIENT FACILITIES				
• Recommended screenings such as colonoscopy, mammogram, colorectal and bone density scans	No charge ^[5]	40%	No charge ^[5]	40%
OTHER SERVICES				
Hospital/Facility Services ^[4] • Inpatient care ^[7] ; outpatient surgery ^[7] • 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 • IN-NETWORK outpatient PT/ST/OT ^[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%
Pathology and Radiology Reading, Interpretation and Results ^[5]	10%		20%	
Ambulance (medically necessary, 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.			
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	\$7,200	\$4,000	\$8,000
Employee + Child(ren)	\$5,400	\$10,800	\$6,000	\$12,000
Employee + Spouse	\$7,200	\$14,400	\$8,000	\$16,000
Employee + Spouse + Child(ren)	\$9,000	\$18,000	\$10,000	\$20,000

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 Member Handbook for coverage 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	\$13,600	\$5,000	\$10,000
\$13,600	\$27,200	\$10,000	\$20,000
\$13,600	\$27,200	\$10,000	\$20,000
\$13,600	\$27,200	\$10,000	\$20,000

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 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 \$8,700 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. The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization (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 and congestive heart failure; oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis), depression and some osteoporosis medications.

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

[5] For PPO Plans, the deductible DOES NOT apply.

[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; CDHP members must meet their deductible first, then coinsurance is waived. Copays for PPO and deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

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

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.

2022 Monthly Premiums for Dental

	CIGNA DHMO (PREPAID) PLAN	DELTA DENTAL DPPO PLAN
ACTIVE MEMBERS		
Employee Only	\$13.84	\$19.82
Employee + Child(ren)	\$28.75	\$52.70
Employee + Spouse	\$24.54	\$38.98
Employee + Spouse + Child(ren)	\$33.74	\$80.72

Cigna Dental Health Maintenance Organization (Prepaid)

- Must select and use a network general dentist from the prepaid dental plan list for each covered family member. The network is a select number of dentists in Cigna DHMO. You may select a network pediatric dentist as the network general dentist for your dependent child under age 13. At age 13, you must switch the child to a network general dentist 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/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.

Delta Dental Dental Preferred Provider Organization

- You can use any dentist, but you receive maximum benefits when visiting an in-network DPPO provider for the state's dental plan. Review Delta Dental's DPPO network.
- You pay deductibles and co-insurance for some dental care. Deductible does not apply to diagnostic and preventive benefits such as periodic oral evaluation.
- You or your dentist will file claims for covered services. Discuss any estimated expenses with your dentist or specialist. Charges for dental procedures are subject to change.
- Waiting periods apply for some services (e.g., crowns, dentures, implants and complete or partial dentures) from the member's coverage start date before benefits begin.
- Teledentistry is offered and claims are handled as if the patient received dental services in a dental office. Charges are considered as Type A: Diagnostic and Preventive and are subject to frequency limitations.
- There is a 12-month waiting period from the member's coverage start date that applies to dentures and implants to replace one or more natural teeth.
- Referrals to specialists are not required.

Continued on page 23

Covered Dental Services

Here is a comparison of your deductibles, copays and share of coinsurance for 2022 under the dental options. The benefits listed are a sample of the most frequently utilized dental treatments. For a complete list of copays for the Cigna DHMO (Prepaid Provider) option, please refer to the Patient Charge Schedule. Also, review the Cigna DHMO Certificate of Coverage for complete details on benefits, limitations and exclusions. Both documents may be found on the website cigna.com/stateoftn.

PNF—Provider Negotiated Fee is the highest dollar amount of reimbursement for specific dental procedures provided by Delta Dental DPPO in-network providers. The in-network dentists have agreed to not charge members or the plan more than the PNF. 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 average PNF for in-network providers 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”.

COVERED SERVICES	CIGNA DHMO (PREPAID) OPTION		DELTA DENTAL DPPO OPTION	
	GENERAL DENTIST	SPECIALIST DENTIST	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	none		\$25 single; \$75 family, per policy year ^[1]	\$100 single; \$300 family, per policy year ^[1]
Annual Maximum Benefit	none		\$1,500 per person, per policy year	
Pre-existing Conditions	covered		some exclusions	
Office Visit	\$10 copay ^[2]		no charge	20% of APNF
Periodic Oral Evaluation	no charge		no charge	20% of APNF
Routine Cleaning – Adult	no charge		no charge	20% of APNF
Routine Cleaning – Child	no charge	\$15 copay	no charge	20% of APNF
X-ray — Intraoral, Complete Series	no charge	\$5 copay	no charge	20% of APNF
Amalgam (silver) Filling Two Surfaces Permanent Teeth	\$8 copay	\$10 copay	20% of PNF	40% of APNF
Endodontics — Root Canal Therapy Molar (excluding final restoration)	\$125 copay ^[7]	\$600 copay ^[7]	20% of PNF	40% of APNF
Major Restorations — Crowns	\$190 copay, plus lab fees ^{[3][7]}		50% of PNF ^[4]	50% of APNF ^[4]
Extraction of Erupted Tooth (minor oral surgery)	\$15 copay	\$70 copay	20% of PNF	40% of APNF
Implant (endosteal)	\$1,025 copay ^[7]	\$1,025 copay ^[7]	50% of PNF ^{[4][8]}	50% of APNF ^{[4][8]}
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	\$100 copay	\$120 copay	50% of PNF	50% of APNF
Dentures — Complete Upper	\$310 copay, plus lab fees ^{[3][7]}		50% of PNF ^{[4][8]}	50% of APNF ^{[4][8]}
Orthodontics	\$140 monthly copay for treatment equal or less than 24 months. Then, full charge. ^[6]		50% of PNF	50% of APNF
• 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 DHMO if orthodontic treatment began prior to the member's effective date.

[7] Completion of crowns, bridges, dentures, implants, or root canal already in progress on member's effective date of coverage with Cigna DHMO 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.

- Dental treatment in progress at time of member's effective date with Delta Dental may have pro-rated benefits under the Delta Dental plan. If you are currently enrolled in the state's MetLife DPPO plan, Delta Dental will work with your dentist to ensure you continue to receive the benefits that are covered. For ortho claims, ask your orthodontist or dental office to submit a claim with the total fee, initial banding date and total number of months of treatment. This detail will allow us to calculate what we can pay.
- Time enrolled in the MetLife DPPO for the State Group Insurance Program will count toward waiting periods under the Delta Dental DPPO contract.
- See the Certificate of Coverage for coverage details.
- You pay coinsurance for many covered services and your share is based on the provider negotiated fee, or PNF agreed upon by the provider and Delta Dental of Tennessee. The PNF is the highest dollar amount of reimbursement for specific dental procedures provided by Delta Dental DPPO in-network providers. The in-network dentists have agreed to not charge members or the plan more than the PNF. 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 average PNF for in-network providers and respective plan coinsurance. The member then is responsible for all other charges by the out-of-network dentist.

NOTE: A complete description of the benefits, provisions, conditions, limitations and exclusions for both the Delta Dental 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>.

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

2022 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

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>.

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/Ulimate)	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/Ulimate)	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.

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

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 or EAP is administered by Optum. It is available to all members enrolled in medical insurance and their benefits-eligible (not necessarily enrolled) dependents. EAP services are offered at no cost to individuals eligible to participate. Master's level specialists are available 24/7 at 855.437.3486 to assist with stress, legal, financial, mediation and work/life services. They can even help you find a network EAP short-term counseling provider, a plumber who works nights, services for your elderly parents, theater tickets, all-night pharmacies and more.

- Short-term counseling includes five visits per problem, per year, per individual at no cost to you. Available in person, by phone or by virtual visit. Members are ineligible for EAP counseling visits while they are currently receiving behavioral health services.
- Preauthorization is required to use your EAP short-term counseling services. Simply call 855.437.3486 or go to Here4TN.com to obtain preauthorization.
- Virtual visits allow you to get the care you need in the privacy and comfort of your home. Call 855-Here4TN for assistance with an authorization and a referral to a licensed virtual visits provider.
- Legal services include one 30-minute telephonic or in-person consultation per issue per year at no cost to you.
- Mediation services with a professional mediator include one 30-minute telephonic or in-person consultation per issue per year at no cost to you.
- Financial services with a money coach include two 30-minute calls per issue per year.
- Work/Life services available to help you save time and reduce stress by pulling together information regarding many household, family and health care services specifically for you upon request.
- Use Sanvello, an on-demand mobile app to help with stress, anxiety and depression. Available anytime at no extra cost at HERE4TN.com.
- Participate in a telephonic coaching program called Take Charge at Work. It helps people (EAP-eligible and working) dealing with stress or depression improve performance at work. Available at no additional cost if you qualify. Participants can earn a wellness program cash incentive, if eligible.

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 or 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 2022, 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, congestive heart failure and chronic obstructive pulmonary disease 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 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. You must respond to the carrier's request for information, even if you just need to report that you have no other coverage.

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

Subrogation

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

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

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

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

On-the-job Illness or Injury

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

Fraud, Waste and Abuse

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

If your covered dependent becomes ineligible, you must inform your agency benefits coordinator and submit an application 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 health care. 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 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).

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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 cho bạn. 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).

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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 નિ:શુલ્ક 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 हैं। 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).

مہارف 866-576-0029 (TTY: 1-800-848-0298) امش یارب ناگیار تروصرب ینابز تالی هست، دی نک یم وگتفگ یسراف نابز هب رگا: هجوت دی ریگب سامت اب. دشاب یم

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, you have pharmacy benefits. You do not need to enroll in Medicare prescription drug coverage regardless of your age.

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 2022 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
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