

NEW HIRE GUIDE

PARTNERS
FOR HEALTH



Local Government Employees & COBRA Participants

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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.



Eligibility

Eligible

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

NOT Eligible

Individuals who do not meet the employee eligibility rules outlined above are ineligible UNLESS 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 and must be submitted to BA no later than 10 business days after the 30-day enrollment deadline. Refer to the dependent definitions and required documents chart at [tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf](https://www.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.

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_2022.pdf. You are also required to provide a valid Social Security number for a dependent (if they are eligible for one). Other required information includes date of birth, relationship, gender and acquire date.

Enrollment and Effective Date of Coverage

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

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

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

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

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

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

Choosing a Premium Level

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

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

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

Edison

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

Premium Payment

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

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

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

Updating Personal Information

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

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

Cancelling Coverage

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

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

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

Moving Between Plans

If you are eligible for coverage under more than one state-sponsored plan, you may move between the state, local education and local government plans. You may apply to change plans during the plan's designated Annual Enrollment period with an effective date of January 1 of the following year. 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 on page 3 of the enrollment change application explains the kinds of events that afford special enrollment or mid-year election opportunities, the effective dates for coverage and the documentation you will need to provide.

Important Reminders

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

Continuing Coverage During Leave or After Termination

EXTENDED PERIODS OF LEAVE

Family and Medical Leave Act

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

Leave Without Pay — Health Insurance Continued

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

Leave Without Pay — Insurance Suspended

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

Leave Due to a Work-related Injury

If you have a work-related injury or illness, contact your agency benefits coordinator about how this will affect your insurance. You must keep insurance premiums current until you receive a notice of lost-time pay from the Division of Claims Administration. You will receive a refund for any health insurance payments you make once you receive notice.

If approved for lost-time pay, only the premium for health insurance is paid by your agency. You must pay the premium for any voluntary coverage on a monthly basis. You are responsible for 100% of the premium when lost-time pay ends if you do not have any paid leave.

All benefits paid by the plan for work-related injury or illness claims will be recovered. This means that you are required to repay all claims paid related to a work-related injury.

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 at [tn.gov/content/dam/tn/finance/fa-benefits/documents/cobra.pdf](https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/cobra.pdf) on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

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

Continuing Coverage at Retirement

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.

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.

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.

How to Enroll

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



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 in this guide. You can also find those numbers on your insurance cards. Benefits Administration is not involved in the appeal process. The appeals process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations.

Benefit Appeals

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

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

Appealing to the Insurance Company

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

The insurance company will process internal levels of appeal — Level I and Level II appeals. Decision letters will be mailed to you

at each level. These letters will tell you if you have further appeal options (including independent external review) and if so, how to pursue those options and how long you have to do so.

Annual Enrollment Period

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

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

Annual Enrollment benefit selection will remain in effect for a full year (January 1 through December 31). You may not cancel other coverage outside of the enrollment period unless eligibility is lost or there is a qualifying event.

2023 Health Benefits

This document gives you important information about your 2023 benefits choices. These include your health, dental, and vision insurance and other benefits.

- **Premium charts** are found by [going to the Premiums webpage](#).
- **Insurance comparison charts** for health, dental and vision are found by [going to the Publications webpage](#) under **Insurance Comparison Charts**.

You are not required to enroll in health insurance. If you do not enroll, no premium dollars for health insurance will be deducted from your paycheck.

How to Enroll in Your Benefits

You will use **Employee Self Service in Edison** at www.edison.tn.gov to add, remove or make changes to your insurance coverage, unless otherwise noted.

- To get your Access ID, go to www.edison.tn.gov, click the green “Benefits Enrollment” button and the click “Retrieve Access ID” button.
- Once logged in, choose the Benefits Enrollment tile to start your enrollment.
- All the insurance plans that are available to you, are listed in Edison.
- You can enroll on your computer or mobile device. Use the web browser native to its operating system.

Adding new dependents or your spouse? We need documents to prove their relationship to you. This includes a spouse who has not been on coverage for six months or more.

- Dependent verification documents **MUST** be submitted by **your enrollment deadline**.
- Find a list of required documents online by [going to Forms](#) and then go to Health, Dental, Vision, Disability. [Click on Dependent Eligibility Verification Documents](#).

Get Help with Your Enrollment

Watch videos on how to enroll by [clicking the video webpage](#).

Health Plan Options

You have a choice of four health plans from ParTNers for Health. Eligible preventive care is **free** with all plans if you use an in-network provider. [Click on Health](#) for plan option details.

See details in the comparison chart by [going to the Publications webpage](#).

Here is a comparison of the four plans:

- Premier Preferred Provider Organization: Higher monthly premium, lower out-of-pocket costs (deductible, copays and coinsurance).
- Standard Preferred Provider Organization: Lower monthly premium than Premier PPO, higher out-of-pocket costs.
- Limited Preferred Provider Organization: Lower monthly premiums than the other PPOs, higher out-of-pocket costs than the other PPOs.
- Local Consumer-driven Health Plan/Health Savings Account: Lowest monthly premium. In-network preventive care has no member cost. For most other services, you pay your deductible first before the plan pays anything. Then you pay coinsurance, not copays.

Learn More about Health Savings Accounts

There are limits on how much money you can put in your HSA each year. These amounts include any contributions your employer may make to your HSA:

- \$3,850 for employee-only coverage in 2023;
- \$7,750 for all other family tiers in 2023; and
- Members 55+ can add \$1,000 more each year.

HSA contributions in excess of the IRS 2023 maximums listed above are not tax deductible and are subject to a 6% excise tax, so please monitor your HSA contributions carefully.

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

With the HSA, your total contribution is not available upfront. Your pledged amount is taken out of each paycheck, if

your employer offers payroll deduction. You may only spend the money that is in your HSA at the time of service, but you can pay yourself back later with HSA funds. Newly enrolled members get a **debit card** from Optum Financial to use for qualified expenses.

Local HSA and FSA restrictions: There are certain restrictions about who can enroll in a plan with an HSA. If you enroll in the Local CDHP/HSA, you **cannot** enroll in another medical plan, including any government plan, and **cannot** have a medical flexible spending account or health reimbursement account, among other restrictions. If you enroll in Social Security at age 65, you'll automatically be enrolled in Medicare Part A, and if enrolled in a CDHP, this may have tax consequences affecting your HSA contribution. Consult your tax advisor for advice. [Go to CDHP/HSA Insurance Options for Certain Restrictions, 2023 maximum contribution amounts, debit card details and more information](#).

Find premium charts, including COBRA by [going to the Premiums webpage](#).

Health Plan Carrier Networks

Narrow Networks include many providers, hospitals and facilities throughout Tennessee and across the country. Not all providers and hospitals are in the narrow networks, which helps keep premiums and claims costs low. No premium surcharge is applied to the narrow networks. Your ParTNers for Health narrow network options are:

- **BlueCross BlueShield Network S**
- **Cigna LocalPlus**

Broad Networks cost an additional \$65 per month for the employee only and employee + child(ren) tiers and an additional \$130 per month for the employee + spouse and employee + spouse + child(ren) tiers. These costs are added to your monthly premium. In a broad network you may also pay more per claim because the costs for services in these networks are generally higher than the narrow networks. Your ParTNers for Health broad network options are:

- **BlueCross BlueShield Network P**
- **Cigna Open Access Plus**

It's important to check the networks carefully. You may be able to make changes allowed by the plan if you have a qualifying event. Information about qualifying events is on page three of the [Enrollment Change Application](#).

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

Covered services

Covered services are generally the same whether you choose BlueCross BlueShield or Cigna. For some procedures, different

medical criteria may apply based on the carrier you select. For detailed information on covered services, exclusions and how the plans work, view the BCBST or Cigna Member Handbook and your Plan Document by [going to the Publications webpage](#). If you have questions about your benefits or medical criteria for a specific service, contact the carriers' member services.

Contact Our Carriers

Contact BlueCross or Cigna if you have questions about a provider or hospital in a network:

BlueCross, 800.558.6213, M-F 7 a.m. - 5 p.m. CT, bcbst.com/members/tn_state/

Cigna, 800.997.1617, 24/7, cigna.com/stateoftn

Learn More about Your Health Plan Options

[Click on Carrier Information](#) for network hospital lists and directories.

Learn More about Your Health Plan Options

[Click on Carrier Information](#) for network hospital lists and directories.

Find a complete health plan comparison chart, as well as dental and vision comparisons, by [clicking on Publications](#). On this page, go to [Insurance Comparison Charts](#).

IN-NETWORK 2023 HEALTH PLAN COMPARISON				
Your Costs for Covered Services	Premier PPO	Standard PPO	Limited PPO LE/LG	Local CDHP/HSA LE/LG
Annual Deductible				
Emp only	\$750	\$1,300	\$1,800	\$2,000
Emp + Child(ren)	\$1,125	\$1,950	\$2,500	\$4,000
Emp + Spouse	\$1,500	\$2,600	\$2,800	\$4,000
Emp + Spouse + Child(ren)	\$1,875	\$3,250	\$3,600	\$4,000
Maximum Out-of-Pocket				
Emp only	\$3,600	\$4,400	\$6,800	\$5,000
Emp + Child(ren)	\$5,400	\$6,600	\$13,600	\$10,000
Emp + Spouse	\$7,200	\$8,800	\$13,600	\$10,000
Emp + Spouse + Child(ren)	\$9,000	\$11,000	\$13,600	\$10,000
Preventive Care	No charge	No charge	No charge	No charge
Primary Care/ Convenience Care	\$25 copay	\$30 copay	\$35 copay	30% coinsurance after deductible
Specialist/Urgent Care	\$45 copay	\$50 copay	\$55 copay	30% coinsurance after deductible
Telehealth (approved carrier program only)	\$15 copay	\$15 copay	\$15 copay	30% coinsurance after deductible
Behavioral Health and Substance Use (and virtual visits)	\$25 copay	\$30 copay	\$35 copay	30% coinsurance after deductible
Routine X-Rays, Labs and Diagnostics	15% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance after deductible
Pharmacy (30-day supply)				
generic	\$7 copay	\$14 copay	\$14 copay	30% coinsurance after deductible
preferred brand	\$40 copay	\$50 copay	\$60 copay	
non-preferred brand	\$90 copay	\$100 copay	\$110 copay	
specialty tier 1 (generics)	20% coinsurance min \$100; max \$200	20% coinsurance min \$100; max \$200	20% coinsurance min \$100; max \$200	
specialty tier 2 (all brands)	30% coinsurance min \$200; max \$400	30% coinsurance min \$200; max \$400	30% coinsurance min \$200; max \$400	
Hospital/Facility Services	15% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Maternity	15% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient Physical, Speech and Occupational Therapy	15% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance after deductible
Emergency Room Visit	15% coinsurance after deductible	20% coinsurance after deductible	30% coinsurance after deductible	30% coinsurance after deductible

2023 MONTHLY HEALTH PREMIUMS

	LEVEL 1		LEVEL 2		LEVEL 3	
	BCBST NETWORK S & CIGNA LOCALPLUS	BCBST NETWORK P & CIGNA OPEN ACCESS	BCBST NETWORK S & CIGNA LOCALPLUS	BCBST NETWORK P & CIGNA OPEN ACCESS	BCBST NETWORK S & CIGNA LOCALPLUS	BCBST NETWORK P & CIGNA OPEN ACCESS
PREMIER PPO						
Employee Only	\$787.00	\$852.00	\$827.00	\$892.00	\$866.00	\$931.00
Employee + Child(ren)	\$1,221.00	\$1,286.00	\$1,282.00	\$1,347.00	\$1,344.00	\$1,409.00
Employee + Spouse	\$1,771.00	\$1,901.00	\$1,860.00	\$1,990.00	\$1,948.00	\$2,078.00
Employee + Spouse + Child(ren)	\$2,127.00	\$2,257.00	\$2,233.00	\$2,363.00	\$2,339.00	\$2,469.00
STANDARD PPO						
Employee Only	\$724.00	\$789.00	\$760.00	\$825.00	\$796.00	\$861.00
Employee + Child(ren)	\$1,123.00	\$1,188.00	\$1,179.00	\$1,244.00	\$1,235.00	\$1,300.00
Employee + Spouse	\$1,628.00	\$1,758.00	\$1,710.00	\$1,840.00	\$1,791.00	\$1,921.00
Employee + Spouse + Child(ren)	\$1,955.00	\$2,085.00	\$2,053.00	\$2,183.00	\$2,150.00	\$2,280.00
LIMITED PPO						
Employee Only	\$588.00	\$653.00	\$617.00	\$682.00	\$647.00	\$712.00
Employee + Child(ren)	\$912.00	\$977.00	\$958.00	\$1,023.00	\$1,003.00	\$1,068.00
Employee + Spouse	\$1,323.00	\$1,453.00	\$1,389.00	\$1,519.00	\$1,455.00	\$1,585.00
Employee + Spouse + Child(ren)	\$1,588.00	\$1,718.00	\$1,668.00	\$1,798.00	\$1,747.00	\$1,877.00
LOCAL CDHP/HSA						
Employee Only	\$543.00	\$608.00	\$570.00	\$635.00	\$597.00	\$662.00
Employee + Child(ren)	\$842.00	\$907.00	\$884.00	\$949.00	\$926.00	\$991.00
Employee + Spouse	\$1,221.00	\$1,351.00	\$1,282.00	\$1,412.00	\$1,343.00	\$1,473.00
Employee + Spouse + Child(ren)	\$1,466.00	\$1,596.00	\$1,539.00	\$1,669.00	\$1,612.00	\$1,742.00

Included Benefits

Along with your medical coverage, your health plan provides the following benefits: **pharmacy, behavioral health and Employee Assistance Program services** and a **wellness program**. Learn about benefits such as **telehealth**, the **Diabetes Prevention Program** and more by [going to Included Benefits Extras](#):

Pharmacy

Managed by CVS Caremark

All health plans include full prescription drug benefits.

- Your health plan (Premier Preferred Provider Organization, Standard PPO, Limited PPO or Local Consumer-driven Health Plan/Health Savings Account) determines your out-of-pocket prescription costs.
- How much you pay depends on three things:
 - the drug tier – if you choose a generic, preferred brand, non-preferred brand or specialty drug (two different cost tiers);
 - the day supply you receive – 30-day (or <30) or a 90-day (>31) supply; and
 - where you fill your prescription – at a retail, Retail-90 or mail order pharmacy.

Learn more about prescription drug benefits, vaccines and how to save money by [clicking on Pharmacy](#).

Contact: **CVS Caremark**, 877.522.8679, 24/7, info.caremark.com/stateoftn

Behavioral Health

Managed by Optum

All health plans include access to outpatient and facility-based behavioral health and substance use disorder services.

Optum can help you find a provider for in-person or virtual visits, explain benefits, identify best treatment options, schedule appointments and answer questions.

Your benefits also include **Talkspace online therapy, preferred no-cost substance use treatment facilities** (for PPO plans; no coinsurance after deductible for Local CDHP) and **virtual visits**.

Learn more about your behavioral health benefits by [clicking on Behavioral Health](#).

For all programs and services and help finding a provider, contact **Optum** at 855-HERE4TN (855.437.3486), 24/7 or visit HERE4TN.com.

Employee Assistance Program

Managed by Optum

EAP services are available to enrolled health plan members and eligible dependents, even if your dependents are not enrolled in a health plan. Master's level specialists are available 24/7 to assist with stress, legal, financial, mediation and work/life services. With EAP services:

- Get five counseling visits, per problem, per year, per individual at no cost to you. Available in person or by virtual visit to get the care you need in the privacy and comfort of your own home.

Your benefits include **Sanvello**, an on-demand mobile app to help with stress, anxiety and depression; **Talkspace online therapy**; and **Take Charge at Work**, a telephonic coaching program that helps those working and eligible for EAP services deal with stress and depression.

Learn more about your EAP benefits by [clicking on EAP](#).

For all EAP programs and services and help finding a provider, contact **Optum** 24/7 at 855 HERE4TN (855.437.3486) or HERE4TN.com

Wellness Program

Managed by ActiveHealth

To help you achieve your health goals, two wellness programs are available in 2023 to enrolled health plan members and adult dependents. Members must qualify for these programs.

Disease management is offered to those with chronic diseases like asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease to better manage these conditions.

Diabetes Prevention Program is available to eligible adult plan members to help prevent or delay Type 2 diabetes. Offered through health insurance carriers BlueCross or Cigna.

All members have access to ActiveHealth's online resources including health assessment, health education and digital coaching.

Find information about programs and activities by [clicking on Wellness](#).

Contact: **ActiveHealth**, 888.741.3390, M-F, 8 a.m. - 8 p.m. CT, go.activehealth.com/wellnesstn

Additional Benefits

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

Dental Insurance

Offered through Cigna and Delta Dental

ParTNers for Health offers two different dental plans.

Find 2023 dental premiums by [clicking on Premiums](#) and going to **Other Insurance Coverages – Dental**.

- **Cigna: Dental Health Maintenance Organization – Prepaid Provider**
 - You are required to select and use a Cigna network general dentist. You must notify Cigna of your choice. Find the list of dentists at cigna.com/stateoftn.
 - Members pay copays. Review the Patient Charge Schedule by [clicking on Publications](#) and Dental HMO – Prepaid Provider before having procedures performed. Lab fees may apply for some procedures.
 - Completion of crowns, bridges, dentures, implants, root canals or orthodontic treatment already in progress on a new member's effective date will not be covered.
 - To learn about all DHMO benefits, find the Cigna DHMO handbook by [clicking on Publications](#) and **Dental HMO – Prepaid Provider**.
- **Delta Dental: Dental Preferred Provider Organization**
 - Use any dentist but save money staying in network. Review Delta Dental's DPPO network by [clicking on Dental](#).
 - Discuss any estimated expenses with your dentist or specialist. Charges for dental procedures are subject to change. Members pay deductibles and co-insurance.
 - Waiting periods apply to select procedures.
 - To learn about all DPPO benefits, find the Delta Dental DPPO handbook under [Publications](#) and **Dental PPO**.

Find more information, including a comparison of the two plans, by [clicking on Dental](#).

Contact: **Cigna**, 800.997.1617, 24/7, cigna.com/stateoftn

Contact: **Delta Dental**, 800.552.2498, M-F, 7 a.m. – 5 p.m. CT, DeltaDentalTN.com/StateofTN

2023 MONTHLY DENTAL PREMIUMS FOR ALL PLANS

	CIGNA DHMO (PREPAID PROVIDER) PLAN	DELTA DENTAL DPPO PLAN
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

Vision Insurance

Offered through EyeMed

You'll save money when using in-network providers.

Find 2023 vision premiums by [clicking on Premiums](#), go to **Other Insurance Coverages – Vision**. Find the EyeMed handbook by [clicking on Publications](#) and **Vision Insurance**.

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

All members in both vision plans get:

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

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

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

- Frames now available once every calendar year.

In both plans, you pay copays, or when the cost exceeds the allowed dollar amount, you pay the cost of materials and services. **Some allowances and copays are changing in both plans.** Discounts may be available for select materials.

Find information including a comparison of both plans by [clicking on Vision](#).

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

2023 MONTHLY VISION PREMIUMS FOR ALL PLANS		
	BASIC PLAN	EXPANDED PLAN
Employee Only	\$3.18	\$6.30
Employee + Child(ren)	\$6.35	\$12.60
Employee + Spouse	\$6.03	\$11.98
Employee + Spouse + Child(ren)	\$9.33	\$18.54

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 615-532-9617.

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).

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

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 kalan- gan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገንዘብ ለማግኘት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298)።

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો 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 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).

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

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 www.tn.gov/content/dam/tn/finance/fa-benefits/documents/hipaa.pdf. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

Prescription Drug Coverage and Medicare

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

Summary of Benefits and Coverage

As required by law, a Summary of Benefits and Coverage is available which describes your 2023 health coverage options. The SBC is found at www.tn.gov/ParTNersForHealth/summary-of-benefits-and-coverage on or after Sept. 1. The digital document contains much of the same information. To get a SBC paper copy, free of charge, call 855.809.0071. Please include your name, complete mailing address and name of the SBCs you want: State and Higher Education Plan; Local Education Plan; or Local Government Plan.

Plan Document

The information contained in this document 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 document and the formal plan documents, the plan documents will govern in all cases. You can find a copy on the Benefits Administration website at 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, including, but not limited to, brochures and handbooks for medical, pharmacy, dental and vision and the brochure and handbook for the Supplemental Medical Insurance to Retirees with Medicare.

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 health-care 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. Here is the link to the wellness page: www.tn.gov/content/tn/partnersforhealth/other-benefits/wellness-program.html

