

State | Higher Education | Local Education | Local Government

STATE OF TENNESSEE 2020 MEMBER HANDBOOK

Premier PPO | Standard PPO | Limited PPO | CDHP/HSA | Local CDHP/HSA



State of Tennessee
Group Insurance Program

**PARTNERS
FOR HEALTH**

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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NEW THIS YEAR.

- ▶ **Acupuncture benefits**
- ▶ **No member cost for certain preferred substance use treatment facilities**
See benefit charts and the “Covered Medical Expenses” section in this handbook for more details.
- ▶ **Members will receive a separate ID card for behavioral health and substance use disorder services** (Benefits managed by Optum, not Cigna.)

Benefit Updates

MEDICAL

(Claims are administered by Cigna; call 800.997.1617 for more information)

*Acupuncture benefits

Coverage is now available for regular acupuncture treatments. The benefit is the same as chiropractic, but with a separate 50-visit limit.

*Cost savings for approved transplants at certain preferred transplant facilities

- › Cigna LifeSource Facilities
- › In-Network facilities when there is no Cigna LifeSource facility option
- › PPO members – no cost; deductible and coinsurance are waived
- › CDHP members – no cost after deductible; coinsurance is waived

*Cost savings for certain approved orthopedic procedures (effective 4/1/2020)

- › Medically necessary total hip and knee replacements, laminectomy and lumbar spinal fusion surgeries with select providers and facilities participating in Cigna’s surgical treatment and support program
- › PPO members – no cost; deductible and coinsurance are waived
- › CDHP members – no cost after deductible; coinsurance is waived
- › Personalized member support to help make health care decisions
- › Travel benefit to offset travel expenses if you must travel more than 60 miles – up to \$600 per procedure

BEHAVIORAL HEALTH AND SUBSTANCE USE

(Claims are administered by Optum Health; call 855.437.3486 for more information)

*Cost savings for facility-based treatment at certain preferred substance use facilities

- › PPO members – no cost; deductible and coinsurance are waived
- › CDHP members – no cost after deductible; coinsurance is waived

Members will receive a separate ID card for behavioral health and substance use disorder services

* See benefit charts, the “Covered Medical Expenses” and “Cost Savings Programs” sections on pages 4–7; 10–14; and 17 in this handbook for more details. Standard benefits will apply when members elect treatment with non-preferred providers and facilities. Prior authorization is required for inpatient care.

Important Notices

This combined member handbook tells you what you need to know about ALL medical plans sponsored by the State of Tennessee Group Insurance Program. Those plans include the Premier Preferred Provider Organization (PPO), Standard PPO, Limited PPO, Consumer-Driven Health Plan/Health Savings Account (CDHP/HSA) and Local CDHP/HSA.

Make sure you know the name of the plan you've chosen, and pay special attention when that plan is mentioned. Much of the information in this handbook, like covered and excluded services, applies to all plans. Some of the information, like what services will cost you, is specific to the plan you're enrolled in. You'll see plan names mentioned when information is plan-specific.

The ParTners for Health website (www.tn.gov/partnersforhealth) contains an electronic version of this handbook and many other important publications including a Summary of Benefits and Coverage (SBC) and a Plan Document. The Plan Document is the official legal publication that defines eligibility, enrollment, benefits and administrative rules of the State Group Insurance Program.

Want a coverage summary you can hold in the palm of your hand? Take a look at your Member ID card. It has the name of your plan, your cost for common services, your plan's network and important phone numbers. See a sample Member ID card on page iii.

Need Help With a Bill? If you receive a bill for medical services that is more than you expected to pay, call Cigna Member Services at 800.997.1617. Ask us to look at your claim and discuss the bill you received from your provider. Have your Cigna Explanation of Benefits (EOB) and the bill from your provider in front of you so that we can review them together. No worries if you don't have a printed copy of your EOB. You can find it by signing in to your secure and personal myCigna account at <https://mycigna.com/>.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 866.576.0029 or 615.741.4517.



WELCOME TO CIGNA

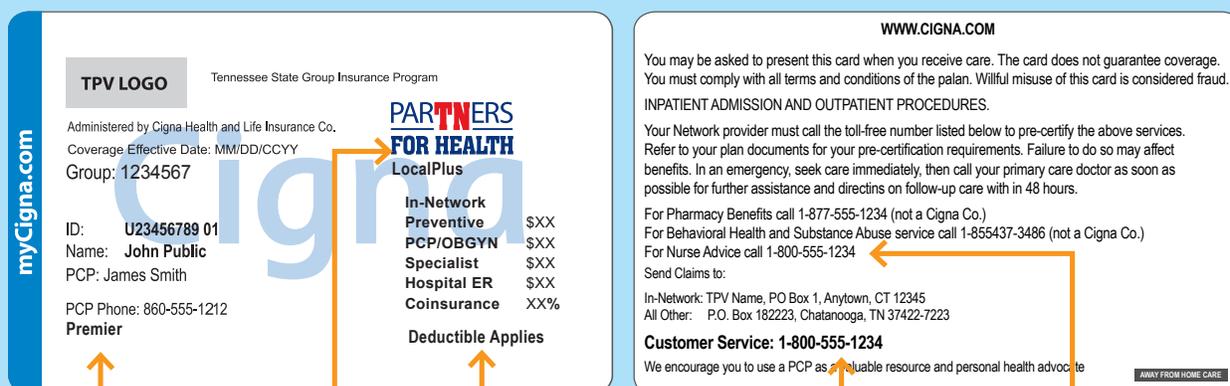
State, higher education, local education and local government members:

Cigna is your statewide plan administrator, and our business is your health. Your plan provides access to quality care, close to where you live and work. You have the freedom to choose your doctor—either in or out of network—and convenient, no-referral access to specialists. We encourage you to use our online tools and resources to help you get the most out of your plan and to stay healthy. We stand ready to help, so just call the dedicated toll-free number on your Cigna ID card if you have questions or concerns.

ID Cards

You have ID cards for yourself and each of your covered dependents. Each covered person gets a card with their name on it. The cards show the name of your selected health option and the name of the network you chose. Review this information carefully and call if you have any questions.

See your actual ID card.



The name of your plan will appear here. You will see one of the following:
Premier PPO
Standard PPO
Limited PPO
CDHP/HSA
Local CDHP/HSA

In-network amounts (copayment or coinsurance for various health care services)

The name of the network for your plan will appear in this field. Note whether your card says LocalPlus (LP) or Open Access Plus (OAP). Be sure to schedule services with providers specific to your plan's network to receive maximum in-network benefits

Your main number for questions and assistance; providers should call this number for prior authorization.

Other important numbers

Network Choices

Cigna offers two network options for plan members. Your choice of network affects your monthly premium cost.

- ▶ The LocalPlus network has providers and facilities across Tennessee. There is no additional premium charge when you select this network.
- ▶ Open Access Plus is a large network with more doctors and facilities than the LocalPlus network. A monthly surcharge applies if you select this network.

If your usual plan network is LocalPlus, but you are outside of the LocalPlus service area, you have access to Cigna's national "Open Access Plus" network of providers.

Plan Administration and Claims Administration

Benefits Administration, a division of the Department of Finance and Administration, is the plan administrator, and Cigna is the claims administrator. This program uses the benefit structure approved by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund made up of your premiums and any employer contributions. Cigna is contracted by the state to process claims, establish and maintain adequate provider networks and conduct utilization management reviews.

Claims paid in error for any reason may be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting Benefits Administration.

If You Have Questions:

- ▶ about eligibility or enrollment (e.g., becoming insured, adding dependents, when your coverage starts, transferring between plans, ending coverage) - contact your agency benefits coordinator. They will work with Benefits Administration to help you.
- ▶ about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your health care provider or Cigna) - contact Cigna member services at 800.997.1617. See also, information at the end of this handbook about your appeal rights.

Adding Dependents

If you want to add dependents to your coverage you must provide documentation verifying the dependent's eligibility to Benefits Administration. A list of acceptable documents is available from your agency benefits coordinator or the ParTNers for Health website.

Important Contact Information

Please call member services for information about specific health care claims. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting member services, you will be asked to verify your identity and give information from your identification card.

Cigna

Cigna Member Services
800.997.1617

Cigna Medical Claims

PO Box 182223
Chattanooga, TN 37422-7223

Here4TN Behavioral Health, Substance Use and Employee Assistance

Optum Health
855-Here4TN (855.437.3486)

Pharmacy

CVS/caremark
877.522.8679

ParTNers for Health Wellness Program

888.741.3390
<http://goactivehealth.com/wellnesstn>

Website

For general information about Cigna, visit Cigna.com and see what we are all about.

Once you enroll, myCigna.com is your personalized, convenient and secure website.

On myCigna.com you can:

- ▶ Locate doctors, hospitals and other health care providers.
- ▶ Verify plan details such as coverage, copays and deductibles.
- ▶ View and keep track of claims.
- ▶ Find information and estimate costs for medical procedures and treatments.
- ▶ Learn about health conditions, treatments, etc.

Cost Sharing

The term “cost sharing” means your share of costs, or what you must pay out of your own pocket, for services covered by your health plan. Sometimes these costs are called “out-of-pocket” costs.

Some examples of cost sharing are copayments, deductibles and coinsurance. Other costs, including your premiums or the cost of care not covered by your plan, aren’t considered cost sharing.

A **copayment** (or copay) is a fixed amount you pay for a covered health care service, usually when you receive the service. An example of a copayment is \$25.

Coinsurance is your share of the cost of a covered health care service, calculated as a percentage. An example of coinsurance is 20 percent of the allowed amount for a service. Generally, if coinsurance applies to a health care service, you will have to “meet” or “satisfy” a deductible first. In other words, you will pay your deductible plus coinsurance.

A **deductible** is the amount you owe during the plan year for covered health care services before your plan begins to pay. A deductible applies to some services under the state-sponsored PPO plans and almost all services under the state-sponsored CDHP/HSA plans.

Copayment, coinsurance and deductible amounts vary depending on the plan you’re enrolled in and the type of services you receive.

You have benefits and separate cost-sharing amounts for eligible services from both in-network and out-of-network providers. Your cost sharing is less for in-network care. See the benefit grids in this handbook for more details and look for information specific to your plan.

PPO Plans

Your PPO plan is a preferred provider organization plan. It requires that you pay either a copayment or a deductible and coinsurance for covered services.

Whether you’re enrolled in the Premier PPO, the Standard PPO or the Limited PPO:

- ▶ In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.

You pay copays for other covered services like:

- ▶ office visits to primary care providers and specialists,
- ▶ outpatient behavioral health and substance use services,
- ▶ telehealth,
- ▶ visits to convenience clinics,
- ▶ urgent care facilities,
- ▶ emergency rooms, and
- ▶ most prescription medications

You pay deductible and coinsurance for things like:

- ▶ inpatient hospital care,
- ▶ outpatient surgery,
- ▶ advanced imaging,
- ▶ ambulance services, and
- ▶ durable medical equipment

CDHP Plans

Your CDHP includes a tax-free HSA, which you own and can use to pay for qualified medical expenses. Qualified expenses may include things that may not be covered by your health insurance plan (like vision and dental expenses, hearing aids, contact lens supplies, and more). More information follows in the HSA section of this handbook.

Whether you’re enrolled in the CDHP/HSA or the Local CDHP/HSA:

- ▶ In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- ▶ You pay coinsurance for ALL other covered services.
- ▶ You must meet your deductible before the plan starts paying for covered expenses, EXCEPT for in-network preventive care and 90-day supply maintenance medications (e.g., certain medications to treat high blood pressure, diabetes, depression, high cholesterol, etc.).
- ▶ Your cost for prescription medications is the discounted network rate for the prescriptions until the deductible is met. Then you pay your coinsurance, which is a percentage of the discounted network rate.
- ▶ If you buy your prescriptions by mail order and want to use your HSA funds to pay, you must provide CVS/caremark with your HSA debit card number before the prescription is filled and shipped. Otherwise, CVS/caremark will charge the order to the credit card they have on file.

Health Savings Account (HSA)

When you enroll in a CDHP, a HSA will be opened for you automatically. The HSA is managed by PayFlex, a company contracted by the state. Contact information is under the “Important Contact Information” section of this handbook. You own your HSA account, and it is your responsibility to register for your online account access at stateoftn.payflexdirect.com. The state will pay the monthly fee for your HSA while you are enrolled in the state’s CDHP. You must pay standard banking fees such as non-sufficient funds, stop payments, overdrafts and investment fees. If you leave your job, move to COBRA or choose a PPO option in the future and keep funds in your HSA, you must pay the monthly HSA fees. These fees will be taken from your HSA automatically.

You and your employer may put money into your HSA. The money saved in your HSA (both yours and any employer contributions, if offered) rolls over each year and collects interest. You don’t lose it at the end of the year. The money is yours! You take your HSA with you if you leave or retire.

- ▶ You can put money into your HSA through online bank transfer or by mailing a check.
- ▶ In 2020, IRS guidelines allow total annual tax-free contributions up to \$3,550 for those with single coverage and \$7,100 for those with any other coverage. At age 55 and older, you can make an additional \$1,000/year contribution (\$4,550 for individuals or \$8,100 for families). The maximum includes any employer contribution.
- ▶ If you have questions about employer contributions, contact your human resources office or your agency benefits coordinator.
- ▶ Your full HSA contribution is not available upfront at the beginning of the year or after you enroll. Your pledged amount is taken out of each paycheck each pay period (if payroll deduction is offered by your employer). You may only spend the money that is available in your HSA at the time of service or care.

You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses. Once funds are in your HSA, PayFlex makes it easy to pay for your eligible expenses.

- ▶ Use the PayFlex Card® — your account debit card. It’s a convenient way to pay for eligible expenses. Expenses are paid automatically, as long as funds are available. If you have family coverage, additional debit cards may be ordered online or by phone.
- ▶ Use PayFlex’s online feature to pay your provider directly from your account.
- ▶ Pay yourself back: Pay for eligible expenses with cash, check or your personal credit card. Then withdraw funds from your HSA to pay yourself back. You can even have your payment deposited directly into your linked checking or savings account.

PayFlex Free Mobile App

- ▶ This app makes it easy for you to manage your account virtually 24/7. It’s available for iPhone® and iPad® mobile digital devices, Android® and BlackBerry® smartphones. It will give you access to your online account, to transfer funds, make payments or view a list of qualified medical expenses. It even lets you upload photos of your receipts for qualified expenses to keep for tax purposes.
- ▶ Both employee and employer contributions (if offered) are tax free. Withdrawals for qualified medical expenses are tax free. Interest accrued on your HSA balance is tax free.

Note: Payroll deductions are made before tax. Contributions made directly from employees’ bank accounts need to be recorded as a tax deduction.

Go to www.tn.gov/partnersforhealth under CDHP/HSA Insurance Options to learn more.



CDHP/HSA PLANS

TABLE 1: CDHP/HSA PLANS - Services in this table ARE subject to a deductible with the exception of in-network preventive care and 90-day supply maintenance medications. % = your coinsurance percentage.

CDHP/HSA HEALTH CARE OPTION	CDHP/HSA State and Higher Education		LOCAL CDHP/HSA Local Education and Local Government	
	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	40%	No charge	50%
OUTPATIENT SERVICES				
Primary Care Office Visit <ul style="list-style-type: none"> ▶ Family practice, general practice, internal medicine, OB/GYN and pediatrics ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider ▶ Inc surgery in office setting and initial maternity visit 	20%	40%	30%	50%
Specialist Office Visit <ul style="list-style-type: none"> ▶ Including surgery in office setting ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist 	20%	40%	30%	50%
Behavioral Health and Substance Use Treatment² including virtual visits	20%	40%	30%	50%
Telehealth approved carrier programs only	20%	40%	30%	50%
Allergy Injection without Office Visit	20%	N/A	30%	N/A
Chiropractic and Acupuncture <ul style="list-style-type: none"> ▶ Limit of 50 visits of each per year 	20%	40%	30%	50%
Convenience Clinic	20%	40%	30%	50%
Urgent Care Facility	20%	40%	30%	50%
Emergency Room Visit	20%		30%	
PHARMACY – Benefits managed by CVS/caremark – see your prescription card for information				
30-Day Supply generic preferred brand non-preferred	20%	40% plus amount exceeding MAC	30%	50% plus amount exceeding MAC
90-Day Supply generic preferred brand non-preferred (90-day network pharmacy or mail order)	20%	N/A – no network	30%	NA – no network
90-Day Supply generic preferred brand non-preferred (certain maintenance medications from 90-day network pharmacy or mail order) ³	10% without first having to meet deductible	N/A – no network	20% without first having to meet deductible	N/A – no network
Specialty Medications (30-day supply from a specialty network pharmacy)	20%	N/A – no network	30%	N/A – no network
PREVENTIVE CARE – outpatient facilities				
<ul style="list-style-type: none"> ▶ Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended 	No charge	40%	No charge	50%
OTHER SERVICES				
Hospital/Facility Services⁴ <ul style="list-style-type: none"> ▶ Inpatient care; outpatient surgery ▶ Inpatient behavioral health and substance use^{2,5} 	20%	40%	30%	50%

CDHP/HSA PLANS

TABLE 2: CDHP/HSA PLANS: Services in this table ARE subject to a deductible with the exception of in-network preventive care. % = your coinsurance percentage.

CDHP/HSA HEALTH CARE OPTION	CDHP/HSA State and Higher Education		LOCAL CDHP/HSA Local Education and Local Government	
	In-Network ¹	Out-of- Network ¹	In-Network ¹	Out-of- Network ¹
OTHER SERVICES (cont.)				
Maternity Global billing for labor and delivery and routine services beyond initial office visit	20%	40%	30%	50%
Home Care ⁴ ▶ Home health; home infusion therapy	20%	40%	30%	50%
Rehabilitation and Therapy Services ▶ Inpatient and skilled nursing facility; ⁴ outpatient	20%	40%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	20%	40%	30%	50%
Advanced X-Ray, Scans and Imaging ▶ Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ⁴	20%	40%	30%	50%
All Reading, Interpretation and Results	20%		30%	
Ambulance (air and ground)	20%		30%	
Equipment and Supplies ⁴ ▶ Durable medical equipment and external prosthetics ▶ Other supplies (i.e., ostomy, bandages, dressings)	20%	40%	30%	50%
Also covered	Certain dental benefits, hospice care and out-of-country charges - See separate sections in this handbook for details.			
DEDUCTIBLE				
Employee Only	\$1,500	\$3,000	\$2,000	\$4,000
Employee + Child(ren)	\$3,000	\$6,000	\$4,000	\$8,000
Employee + Spouse	\$3,000	\$6,000	\$4,000	\$8,000
Employee + Spouse + Child(ren)	\$3,000	\$6,000	\$4,000	\$8,000
OUT-OF-POCKET MAXIMUM – medical and pharmacy combined – eligible expenses, including deductible, count toward the out-of-pocket maximum				
Employee Only	\$2,500	\$4,500	\$5,000	\$8,000
Employee + Child(ren)	\$5,000	\$9,000	\$10,000	\$16,000
Employee + Spouse	\$5,000	\$9,000	\$10,000	\$16,000
Employee + Spouse + Child(ren)	\$5,000	\$9,000	\$10,000	\$16,000
CDHP HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION				
State contribution made to HSA for individuals enrolled in the CDHP/HSA - State and Higher Education only	\$250 for employee only \$500 for all other coverage levels		N/A	

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge (MAC) will not be counted. 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 \$8,150 to the in-network family out-of-pocket maximum total. See the "Out of Pocket Maximums" section in the Member Handbook for more details. Coinsurance is after deductible is met unless otherwise noted.

1. Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise noted in this handbook or the Plan Document.
2. The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.
3. Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.
4. Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.
5. Select Substance Use Treatment Facilities are preferred with an enhanced benefit - members must meet their deductible first, then coinsurance is waived. Deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

PPO PLANS

TABLE 1: PPO PLANS - Services in this table ARE NOT subject to a deductible. \$ = your copayment amount; % = your coinsurance percentage; 100% covered = you pay \$0 in-network. The Limited is open to Local Education and Local Government members only.

PPO HEALTH CARE OPTION	PREMIER		STANDARD		LIMITED	
COVERED SERVICES	In-Network ¹	Out-of-Network ¹	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	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 ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider ▶ Inc surgery in office setting and initial maternity visit 	\$25	\$45	\$30	\$50	\$35	\$55
Specialist Office Visit <ul style="list-style-type: none"> ▶ Including surgery in office setting ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist 	\$45	\$70	\$50	\$75	\$55	\$80
Behavioral Health and Substance Use Treatment² including virtual visits	\$25	\$45	\$30	\$50	\$35	\$55
Telehealth approved carrier programs only	\$15	N/A	\$15	N/A	\$15	N/A
Allergy Injection without Office Visit	100% covered	100% covered up to MAC	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	Visits 1-20: \$35 Visits 21-50: \$55	Visits 1-20: \$55 Visits 21-50: \$80
Convenience Clinic	\$25	\$45	\$30	\$50	\$35	\$55
Urgent Care Facility	\$45	\$70	\$50	\$75	\$55	\$80
Emergency Room Visit	\$150		\$175		\$200	
PHARMACY						
30-Day Supply generic preferred brand non-preferred	\$7 \$40 \$90	copay plus amount exceeding MAC	\$14 \$50 \$100	copay plus amount exceeding MAC	\$14 \$60 \$110	copay plus amount exceeding MAC
90-Day Supply generic preferred brand non-preferred (90-day network pharmacy or mail order)	\$14 \$80 \$180	N/A – no network	\$28 \$100 \$200	NA – no network	\$28 \$120 \$220	NA – no network
90-Day Supply generic preferred brand non-preferred (certain maintenance medications from 90-day network pharmacy or mail order) ³ [\$7 \$40 \$160	N/A – no network	\$14 \$50 \$180	N/A – no network	\$14 \$60 \$200	N/A – no network
Specialty Medications (30-day supply from a specialty network pharmacy)	In-Network for all plans = 10%; minimum \$50; maximum \$150 Out-of-Network for all plans = NA – no network					
PREVENTIVE CARE – outpatient facilities						
<ul style="list-style-type: none"> ▶ Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended 	No charge ⁵	40%	No charge ⁵	40%	No charge ⁵	50%

PPO PLANS

TABLE 2: PPO PLANS: Services in this table ARE subject to a deductible unless noted with a [5]. % = your coinsurance percentage. The Limited is open to Local Education and Local Government members only.

PPO HEALTH CARE OPTION	PREMIER		STANDARD		LIMITED	
	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹
OTHER SERVICES						
Hospital/Facility Services⁴ ▶ Inpatient care; outpatient surgery ▶ Inpatient behavioral health and substance use ^{2,6}	10%	40%	20%	40%	30%	50%
Maternity Global billing for labor and delivery and routine services beyond initial office visit	10%	40%	20%	40%	30%	50%
Home Care⁴ ▶ Home health; home infusion therapy	10%	40%	20%	40%	30%	50%
Rehabilitation and Therapy Services ▶ Inpatient and skilled nursing facility; ⁴ outpatient ▶ Outpatient IN-NETWORK physical, occupational and speech therapy ⁵	10%	40%	20%	40%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) ⁵	10%		20%		30%	
Advanced X-Ray, Scans and Imaging ▶ Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ⁴	10%	40%	20%	40%	30%	50%
All Reading, Interpretation and Results	10%		20%		30%	
Ambulance (air and ground)	10%		20%		30%	
Equipment and Supplies⁴ ▶ Durable medical equipment and external prosthetics ▶ Other supplies (i.e., ostomy, bandages, dressings)	10%	40%	20%	40%	30%	50%
Also covered	Certain dental benefits, hospice care and out-of-country charges - See separate sections in this handbook for details.					
DEDUCTIBLE						
Employee Only	\$500	\$1,000	\$1,000	\$2,000	\$1,800	\$3,600
Employee + Child(ren)	\$750	\$1,500	\$1,500	\$3,000	\$2,500	\$4,800
Employee + Spouse	\$1,000	\$2,000	\$2,000	\$4,000	\$2,800	\$5,500
Employee + Spouse + Child(ren)	\$1,250	\$2,500	\$2,500	\$5,000	\$3,600	\$7,200
OUT-OF-POCKET MAXIMUM – medical and pharmacy combined – eligible expenses, including deductible, count toward the out-of-pocket maximum						
Employee Only	\$3,600	\$4,000	\$4,000	\$4,500	\$6,800	\$10,400
Employee + Child(ren)	\$5,400	\$6,000	\$6,000	\$6,750	\$13,600	\$20,800
Employee + Spouse	\$7,200	\$8,000	\$8,000	\$9,000	\$13,600	\$20,800
Employee + Spouse + Child(ren)	\$9,000	\$10,000	\$10,000	\$11,250	\$13,600	\$20,800

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge (MAC) will not be counted. 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.

1. Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise noted in this handbook or the Plan Document.
2. The following behavioral health services are treated as “inpatient” for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as “inpatient,” prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor’s clinical staff.
3. Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.
4. Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.
5. Deductible DOES NOT apply.
6. Select Substance Use Treatment Facilities are preferred with an enhanced benefit – members won’t have to pay a deductible or coinsurance for facility-based substance use treatment; Copays will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

Engaging in Your Health care

Choosing a new doctor is an important decision that can feel overwhelming. Quality varies so it is critical to do your homework and choose someone who will meet your needs and provide quality care. But how do you know which providers are of the highest quality or which have the best outcomes? Fortunately, Cigna offers provider designations to help you make an informed choice. Read on for some of the decision making tools available to you.

Cigna - Quality Ratings & Recognitions

The online directory on www.Cigna.com or www.myCigna.com includes information about a physician's Quality Ratings & Recognitions including Board Certification, compliance with Evidence Based Medicine criteria and National Committee for Quality Assurance credentialing.

For members in the Cigna OAP Network

The **Cigna Care Designation** is assigned to physicians and physician groups that are ranked in the top 40 percent for both quality and cost efficiency results as compared to their physician peers in the market. Cigna Care Designated physicians are identified by the symbol  in the online directory at www.Cigna.com and on www.myCigna.com.

For members in the Cigna Local Plus Network

Information regarding a physician's Cost-Efficiency Performance is displayed on www.myCigna.com. Cost efficiency measures the effectiveness of the doctor in treating the most common conditions within their specialty. A star rating system is used to communicate this performance.

- ★★★ Results in top 34% for cost-efficiency
- ★★ Results in middle 33% for cost-efficiency
- ★ Results in bottom 33% for cost-efficiency.

Quality and Safety in Health care

Think about the last time you purchased a car or a major appliance. Did you do your homework? Did you compare features, warranties, costs? Now think about the last time you or a family member went to the hospital or had a medical procedure or service. You probably didn't even know you might have a choice. And it's unlikely that you compared services or quality of your health care.

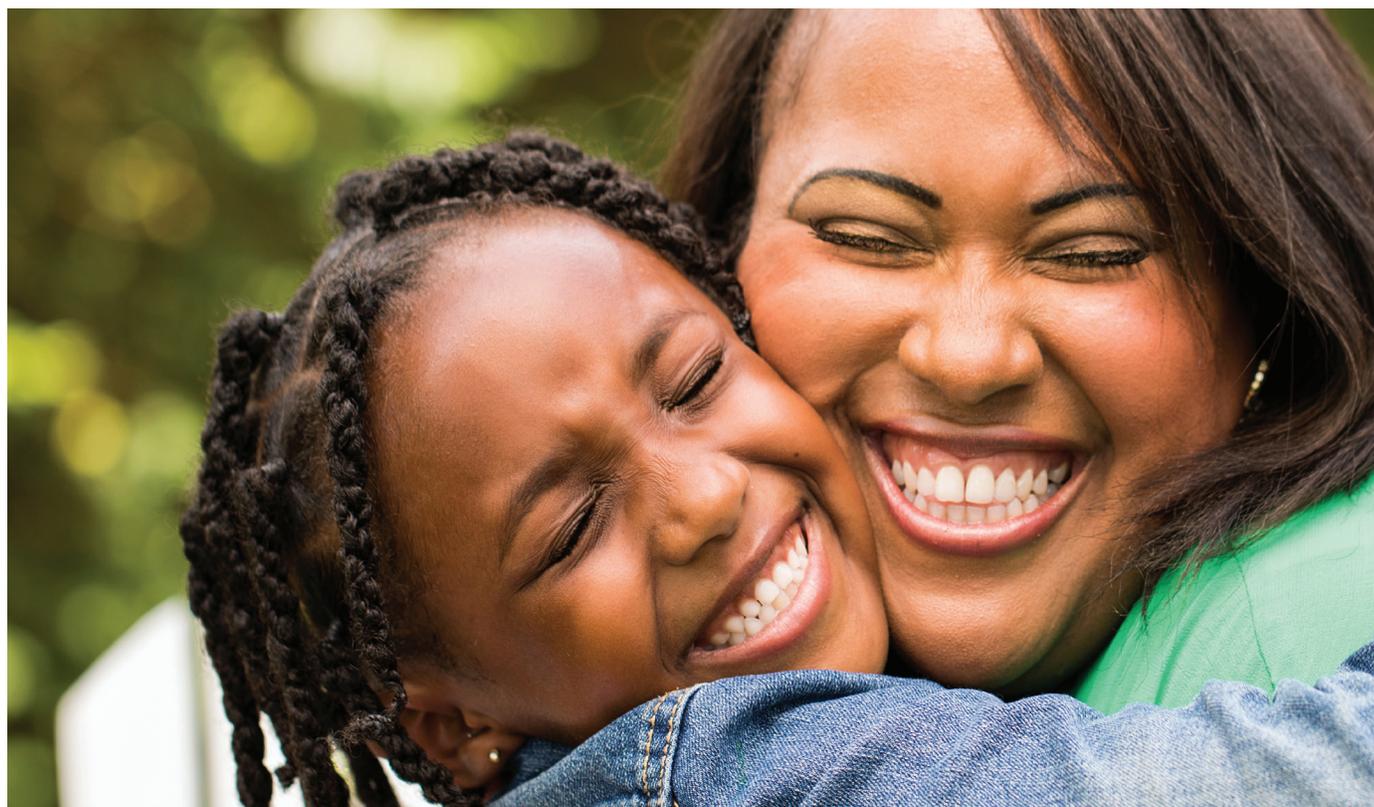
Quality and safety vary widely in health care. These resources can help you and your family find the best place to receive high quality care.

They also offer suggestions about:

- › Questions to ask your doctor
- › How to talk with your doctor about choosing the health care you need, and
- › Which medical tests and treatments you may or may not need
- › **Know Your Health** - A campaign by PartNers for Health to educate members on how to engage in their health care and to empower you to become a smarter health care consumer. Includes resources to help you and your family talk with your doctors about choosing the health care you need, what you may not need and the best place to receive care. www.tn.gov/partnersforhealth/know-your-health.html
- › **Leapfrog Hospital Safety Grade** - A consumer-friendly letter grade rating of hospitals on their records of patient safety. www.hospitalafetygrade.org

Spring 2019 Tennessee Hospital Safety Grades

- ▶ **Compare Hospitals** - Interactive tool that helps you choose the best hospital for you. www.leapfroggroup.org/compare-hospitals
- ▶ **Choosing Wisely** - Promoting conversations between patients and clinicians. An initiative of the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding unnecessary medical tests treatments and procedures. www.choosingwisely.org



Covered Medical Expenses

Services, treatment and expenses will be considered covered expenses if:

- **They are not listed in the Excluded Services and Procedures section of this handbook or the Plan Document; and**
- **They are consistent with plan policies and guidelines; and**
- **They are determined to be medically necessary and/or clinically necessary by the claims administrator, or**
- **Coverage is required by applicable state or federal law**

If you are unsure about whether a procedure, type of facility, equipment or any other expense is covered, ask your physician to submit a pre-determination request form to the claims administrator describing the condition and planned treatment. Pre-determination requests may take up to three weeks to review.

If you have scheduled a visit for a colonoscopy or a mammogram, it is very important that you talk to your health care provider about the type of service you will have. There is no charge for in-network preventive services. However, you will be charged for services scheduled for diagnostic purposes or billed as anything other than preventive care.

Claims for prescription drugs obtained from a retail pharmacy or mail order are processed under pharmacy benefits. Behavioral health claims are processed under behavioral health benefits.

If you have questions about pharmacy or behavioral health expenses, see publications specific to those programs at the ParTNers for Health website at www.tn.gov/partnersforhealth. Phone numbers are also provided under the "Important Contact Information" section of this handbook.

New! Medical Benefit Improvements:

- **Acupuncture Benefits - same as chiropractic benefits but with a separate 50-visit limit; see benefit charts in this handbook for cost.**
- **Cost waiver for facility-based substance use disorder treatment at certain preferred substance use treatment facilities.**
 - Find preferred Optum providers at HERE4TN.com or by calling 855-HERE4TN
 - PPO members who use these high-quality facilities won't pay a deductible or coinsurance
 - CDHP/HSA member coinsurance is waived after deductible
 - Cost sharing still applies for standard outpatient treatment services

Charges for the following services and supplies are eligible covered expenses under the State of Tennessee Group Insurance Program.

1. Immunizations, including but not limited to, hepatitis B, tetanus, measles, mumps, rubella, shingles, pneumococcal, and influenza, unless the employer is mandated to pay for the immunization. Immunization schedules are based on the Centers for Disease Control and Prevention guidelines and are subject to change (cdc.gov/vaccines).
2. Well-child visits to physicians including checkups and immunizations. Annual checkups for ages 6-17 and immunizations as recommended by the Centers for Disease Control and Prevention (cdc.gov/vaccines).
3. Physician-recommended preventive health care services for women, including:
 - Annual well woman exam
 - Screening for gestational diabetes
 - Human papillomavirus (HPV) testing
 - Counseling for sexually transmitted infections (annually)
 - Counseling and screening for human immune-deficiency virus (annually)
 - Contraceptive methods and counseling (as prescribed)
 - Breast feeding support, supplies and counseling (in conjunction with each birth)
 - Hospital grade electric breast pumps are eligible for rental only; not to exceed three months, unless medically necessary
 - Screening and counseling for interpersonal and domestic violence (annually)
4. Prostate screening annually for men who have been treated for prostate cancer with radiation, surgery, or chemotherapy and for men over the age of 45 who have enlarged prostates as determined by rectal examination. This annual testing is also covered for men of any age with prostate nodules or other irregularity noted upon rectal exam. The PSA test will be covered as the primary screening tool of men over age 50 and transrectal ultrasound will be covered in these individuals found to have elevated PSA levels.
5. Hearing impairment screening and testing (annually per plan year) for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the test/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.
6. Visual impairment screening/exam for children and adults, when medically necessary as determined by the claims administrator in the treatment of an injury or disease,

including but not limited to: (a) screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years; (b) visual screenings conducted by objective, standardized testing; and (c) routine screenings for adults (annually per plan year) considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.

7. Other preventive care services based on your doctor's recommendations, including but not limited to the items listed below. To learn more about evidence-based recommendations from the U.S. Preventive Services Task Force (USPSTF) and coverage for preventive services required by the Affordable Care Act, visit www.uspreventiveservicestaskforce.org.
 - Adult annual physical exam – age 18 and over
 - Alcohol misuse counseling – screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women in primary care settings, limited to eight per plan year.
 - CBC with differential, urinalysis, glucose monitoring – age 40 and over or earlier based on doctor's recommendations and medical necessity
 - Cholesterol screening
 - Colorectal screenings. Screening for colorectal cancer (CRC) in adults using fecal occult blood testing, sigmoidoscopy, or colonoscopy
 - Depression screening for adolescents and adults.
 - Healthy diet counseling for medical conditions other than diabetes, limited to three visits per plan year.
 - Mammogram screenings.
 - Over-the-counter, generic forms of aspirin with a maximum quantity of up to 100 every 90 days. Males 45 and older - 75mg, 81mg, 162mg, and 325mg covered. Females 45 and older - 75mg, 162 mg and 325mg covered. In addition, Females age 12 and older - at risk for pre-eclampsia - 81mg covered. A prescription is required.
 - Routine osteoporosis screening (bone density scans).
 - Routine women's health, including, but not limited to, the following services: (a) Chlamydia screening; and (b) Cervical cancer screening including preventive screening lab charges and associated office visits for Pap smears covered per plan year beginning with age 18. Testing prior to the age of 18 will also be covered if recommended by a physician and determined to be medically necessary; and (c) Gonorrhea screening; and (d) Screening for iron deficiency anemia in asymptomatic pregnant women; and (e) Asymptomatic bacteriuria screening with urine culture for pregnant women.
 - Tobacco use counseling – including tobacco cessation interventions for non-pregnant adults who use tobacco products and augmented, pregnancy-tailored counseling to those pregnant women who smoke, limited to twelve per plan year.
8. Office visits to a physician or a specialist due to an injury or illness, or for preventive services.
9. Charges for diagnostic tests, laboratory tests and X-ray services in addition to office visit charges.
10. Charges for the taking and/or the reading of an x-ray, CAT scan, MRI, PET or laboratory procedure, including physician charges and hospital charges. Covered persons or their provider must obtain prior authorization prior to incurring charges for use of advanced imaging technology.
11. Medically necessary ground and air ambulance services to the nearest general hospital, specialty hospital, or facility which is equipped to furnish the approved medically necessary treatment.
12. Hospital room and board and general nursing care and ancillary services for the type of care provided if preauthorized.
13. Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person's physician.
14. Charges for medically necessary surgical procedures.
15. Charges by a physician, anesthesiologist or nurse anesthetist for anesthesia and its administration. This shall include acupuncture performed by a physician or a registered nurse as an anesthetic in connection with a surgical procedure.
16. Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.
17. Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where the covered person is confined to a hospital as a bed patient and certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.
18. Certain organ and bone marrow transplant medical expenses and services only at Medicare-approved facilities (prior authorization required). Hotel and meal expenses will be paid up to \$150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is \$15,000 per transplant.

19. Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator. Covered persons or their provider must obtain prior authorization and coverage is subject to utilization management review.
20. Cosmetic surgery only when in connection with treatment of a congenital anomaly that severely impairs the function of a bodily organ or due to a traumatic injury or illness.
21. Reconstructive breast surgery following a covered mastectomy (but not a lumpectomy), as well as surgery to the non-diseased breast to establish symmetry; medically necessary prostheses and mastectomy bras.
22. Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable.
 - Pregnancy Care. Normal maternity and complications of pregnancy will be covered without being subject to any special pregnancy limitations, exclusions, extensions and benefit restrictions that might be included in this plan.
 - Newborn Care. Coverage for a newborn child shall be provided to covered employees who have elected family coverage. Covered expenses of a newborn child shall include:
 - Any charges directly related to the treatment of any medical condition of a newborn child;
 - Any charges by a physician for daily visits to a newborn baby in the hospital when the baby's diagnosis does not require treatment;
 - Any charges directly related to a circumcision performed by a physician; and
 - The newborn child's usual and ordinary nursery and pediatric care at birth are covered.
23. Family planning and infertility services including history, physical examination, laboratory tests, advice, and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing, and treatment for organic impotence. If fertility services are initiated (including, but not limited to, artificial insemination and in-vitro fertilization), benefits will cease.
24. Preauthorized surgical weight reduction procedures. Only Centers of Excellence shall perform all bariatric procedures (weight reduction surgeries). Centers of Excellence include facilities with this designation from either the insurance carrier, the American Society for Metabolic and Bariatric Surgery (ASMBS), the American College of Surgeons (ACS), or the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). Remember, services received from out-of-network providers will cost more than services received from in-network providers.
25. Reasonable charges for transportation (reasonable charges include round-trip coach air fare, the state standard mileage rate or actual fuel expenses for round-trip usage of a personal car or other mode of transportation if pre-approved by the claims administrator) to a hospital or between hospitals for medical services that have been authorized by the claims administrator as a unique exception under the plan (excluding any transportation from or to points outside the continental limits of the United States). Benefits will be available for one caregiver to accompany the patient.
26. Therapy. Speech, physical and/or occupational. Preauthorized inpatient therapy benefits and medically necessary outpatient therapy benefits are covered, including habilitative and rehabilitative services as defined in the Affordable Care Act's Uniform Glossary of Health Coverage and Medical terms. Specific to rehabilitation therapy, coverage is available for conditions resulting from an illness or injury, or when prescribed immediately following surgery related to the condition. No therapy services will be covered if the claims administrator determines services are not medically necessary or if the covered person is no longer progressing toward therapy goals.
 - Cardiac rehabilitation services will be covered when determined to be medically necessary by the claims administrator.
 - Outpatient pulmonary rehabilitation will be covered for certain conditions when determined to be medically necessary by the claims administrator.
27. Durable medical equipment (DME), consistent with a patient's diagnosis, recognized as therapeutically effective and prescribed by a physician and not meant to serve as a comfort or convenience item. Benefits are provided for either rental or purchase of equipment, however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
28. Hearing aids for dependent children under eighteen (18) years of age every three (3) years, including ear molds and services to select, fit and adjust the hearing aids. Covered persons or their provider must obtain prior authorization.

Reminder:

- **Physical, Occupational and Speech Therapies – PPO members no longer have to meet a deductible for in-network, outpatient physical, occupational and speech therapies. You only pay coinsurance.**
- **Cardiac Rehab – PPO members pay no deductible or coinsurance for in-network, outpatient services; CDHP/HSA members pay deductible, but no coinsurance.**

29. Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants determined to be medically necessary by the claims administrator. Covered persons or their provider must obtain prior authorization.
30. Bone anchored hearing devices. Covered persons or their provider must obtain prior authorization.
31. The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery (including examination charge and refraction).
32. Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus. Intrastromal Corneal Ring Segments (ICRS) for vision correction are also covered with a diagnosis of keratoconus when certain medical appropriateness criteria are met.
33. Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age 18, or as a result of injury or illness.
34. Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for up to 28 days after surgery.
35. The initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury and subsequent purchases due to physical growth for a covered dependent through age 18. One additional limb prosthesis past age 18 will be covered if additional surgery has altered the size or shape of the stump, or if a severe medical condition could result from improper fitting of the initial prosthesis. Replacement prosthetic due to normal wear and tear or physical development, with written approval.
36. Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, back braces, knee braces, surgical collars, lumbosacral supports, rehabilitation braces, fracture braces, childhood hip braces, braces for congenital defects, splints and mobilizers, corsets-back and special surgical, trusses, and rigid back or leg braces.
37. Foot orthotics, including therapeutic shoes, if an integral part of a leg brace, therapeutic shoes (depth or custom-molded) and inserts for covered persons with diabetes mellitus and any of the following complications: peripheral neuropathy with evidence of callus formation; or history of pre-ulceratic calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation (limited to one pair per plan year), rehabilitative when prescribed as part of post-surgical or post-traumatic casting care, prosthetic shoes that are an integral part of the prosthesis (limited to one pair per lifetime), and ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses. Such items will be covered when prescribed by a physician if medically necessary as determined by the claims administrator unless otherwise excluded.
38. "Space" or molded shoes, limited to once per lifetime, and only when used as a substitute device due to all, or a substantial part, of the foot being absent.
39. Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to six visits per plan year. Coverage for additional training and education is available when determined to be medically necessary by the claims administrator. Health coaching for diabetic members is also available through the ParTNers for Health wellness program.
40. Charges for treatment received by a licensed doctor of podiatric medicine or for treatment by a licensed doctor of chiropractic or acupuncture provided treatment was within the scope of his/her license, unless listed as an exclusion.
41. Routine foot care for diabetics including toenail clipping and treatment for corns and calluses.
42. Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator. Coverage includes licensed professional medical services under the supervision of a physician and those special dietary formulas that are medically necessary for therapeutic treatment.
43. Enteral Nutrition (EN) and Total Parenteral Nutrition (TPN). The plan will cover medically necessary nutrition prescribed by a physician and administered either through a feeding tube or central venous catheter when determined to be medically necessary by the claims administrator.
44. Home health care when certified as medically necessary and preauthorized by the claims administrator. Covered services are limited to 125 visits per plan year for part-time or intermittent home nursing care given or supervised by a registered nurse. Home Health aide care is also covered, limited to 30 visits per plan year.
45. Skilled Nursing Facility Care. Charges for room, board and general nursing care, provided:
 - A physician recommends skilled nursing facility care for rehabilitation or recovery of a covered illness or injury;
 - The covered person is under the continuous care of a physician during the entire period of facility care;
 - The facility care is required for other than custodial services; and
 - Services were preauthorized by the claims administrator.

Eligible charges for facility room, board and general nursing care shall only include:

- Charges not to exceed the charge for its greatest number of semi-private rooms; and
 - Charges up to and including the 100th day of skilled nursing facility care during any plan year.
46. An approved hospice program that is designed to provide the terminally ill patient with more dignified, comfortable, and less costly care during the six months before death.
 47. Covered dental expenses. Orthodontic treatment for correction of facial hemiatrophy or congenital birth defect which impairs bodily function, removal of impacted wisdom teeth, excision of solid-based oral tumors, and treatment of accidental injury or damage (other than by eating or chewing) to sound natural teeth and/or jaw. Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person's ability to masticate and maintain a healthy weight. Expenses for temporomandibular joint malfunctions (TMJ) including history, exams, and office visits; x-rays of the joint, diagnostic study casts; appliances (removable or fixed); physical medicine procedures such as surgery; and medications.
 48. Eligible medical expenses for treatment of Autism Spectrum Disorders as specified in TCA 56-7-2367.
 49. Routine patient costs related to clinical trials as defined by TCA 56-7-2365.
 50. Charges for laser procedures, other than those specifically excluded.
 51. Pharmacy benefits such as covered drugs and medicines, including certain preferred anti-obesity medications (as determined by the pharmacy benefits manager), subject to prior authorization.; FDA approved medications which are prescribed for accepted off-label indications; limited prescription agents and over-the-counter nicotine replacement therapies; medically necessary insulin and diabetic supplies. Pharmacy benefits are not administered by Cigna. See the pharmacy section in this handbook for more details about pharmacy benefits.

Excluded Services and Procedures

Charges for the following services and supplies are excluded under the State of Tennessee Group Insurance Program unless otherwise specified as covered expenses in this handbook or the Plan Document or if coverage is required by applicable state or federal law.

1. Services rendered prior to the effective date of coverage.
2. Services incurred after plan coverage is terminated.
3. Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by the plan.
4. Services provided by a participant's immediate family member, whether by blood, marriage, or adoption.
5. Services not ordered or furnished by an eligible provider, including but not limited to, services given by a pastoral counselor.
6. Ecological or environmental medicine, diagnosis and/or treatment.
7. Charges in excess of the maximum allowable charge or charges determined not to be medically necessary or clinically necessary.
8. Medical or surgical treatments, procedures, facilities, equipment, drugs, or supplies determined by the claims administrator to be experimental, investigational, or unproven. (Members are held harmless for charges or services from in-network providers unless they have signed a waiver accepting responsibility for the cost.)
9. Treatment in connection with any injury or illness which arose out of or in the course of employment; on the job injuries and illnesses; charges that would be considered a covered injury paid under workers' compensation, regardless of the presence or absence of workers' compensation coverage.
10. Examinations and services provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes; related expenses for reports, including report presentation and preparation; vocational therapy, vocational rehabilitation, education therapy, and recreational therapy
11. Sensitivity training, educational training therapy or treatment for an education requirement.
12. Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.
13. Treatment of an injury or illness due to declared or undeclared war.
14. Comfort or convenience items (e.g. television, telephone, radio, air conditioner, beauty shop and barber services, guest meals and guest beds, bathroom chairs, stools, and tub handrails).
15. Humidifiers, dehumidifiers, air filters, whirlpools, heating pads, sun or heat lamps, air conditioners, air purifiers and exercise devices.

16. Arch supports, corn plaster (pads, etc.), foot padding (adhesive moleskin, etc.) orthotic or orthopedic shoes and other foot orthoses (including inner soles or inserts), foot orthoses primarily used for cosmetic reasons or for improved athletic performance or sports participation, and routine foot care including charges for the removal of corns or callus or trimming of toenails unless there is a diabetic diagnosis.
17. Garter belts and elastic stockings, except Jobst or similar quality support hose, when medically necessary as determined by the claims administrator.
18. Hearing aids for adults 18 years and older, including examinations and fittings.
19. Midwife services outside a licensed health care facility.
20. Nonsurgical service for weight control or reduction, including prescription medication and weight loss programs, fitness clubs and programs. This exclusion does not apply to certain preferred anti-obesity medications, healthy diet counseling as described in the covered expenses section of this handbook, ParTNers for Health sponsored programs, or participation in an integrated clinical program as part of the bariatric surgery benefit.
21. Organ transplants involving artificial organs and nonhuman organ transplants, as well as any services or supplies in connection with experimental or investigational treatment, drugs, or procedures, unless determined to be medically necessary by the claims administrator.
22. Radial keratotomy, LASIK, or other procedures to correct refractive errors; eyeglasses, sunglasses, or contacts including examinations and fitting charges.
23. Surgery or treatment for, or related to, psychogenic sexual dysfunction or transformation other than psychological treatment or counseling.
24. Services or supplies in connection with fertility preservation, artificial insemination, in-vitro fertilization, or any procedure intended to create a pregnancy.
25. Wigs.
26. Ear or body piercing.
27. Custodial care, unapproved sitters, day and evening care centers (primarily for rest or for the elderly), or diapers.
28. Programs considered primarily educational and materials such as books or tapes.
29. Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, or collection and handling fees.
30. Drugs and supplies which can be obtained without a prescription, including nutritional supplements, vitamins, and oral nutritional formulas for infants and adults which can be obtained at retail or over-the-counter without a written prescription. Nutritional treatment of inborn errors of metabolism, Enteral Nutrition (EN), and Total Parenteral Nutrition (TPN) are not excluded.
31. Hotel charges unless pre-approved through the organ transplant program.
32. Cosmetic surgery and related expenses including, but not limited to, scar revision, rhinoplasty, prosthetic penile implants, saline injection of varicose veins, and reconstructive surgery where no significant anatomic functional impairment exists.
33. Dental care, treatment, or oral surgery relating to the teeth and gums including, but not limited to, dental appliances, dental prostheses (such as crowns, bridges, or dentures), implants, orthodontic care, fillings, extractions, endodontic care, treatment of caries, gingivitis, or periodontal disease.
34. Reversal of sterilization procedures.
35. Charges incurred outside the United States unless traveling for business or pleasure.



How the Plan Works

Choice of Doctors

This plan does not require you to choose a primary care physician. There is also no required referral process for specialist services. The network is made up of physicians, hospitals and other health care providers who have contracted with us to provide discounts to plan participants. You will save money and get the most from your benefits if you use in-network providers.

While you are not required to select a primary care provider, you should seek routine care from the same primary-type provider whenever possible. This helps establish your medical home. A primary care provider can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician assistants and nurse midwives may also be considered primary-type providers when working under the supervision of a primary care provider.

Members sometimes have a need to see a specialist for a medical condition. Simply choose a specialist who participates in the network and schedule an appointment. If an in-network specialist determines that you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it is a good idea for you to contact us to confirm benefits for hospital admissions or other services that require prior authorization.

If you need help finding and scheduling an appointment with an in-network provider, who is accepting new patients or has reasonable availability (i.e., urgent visit in 24 hours, wellness visit in two months, routine medical visit in 14 days, specialist visit in 30 days or routine mental health visit in four days), you can call either Cigna or Optum.

Telehealth

Telehealth services allow you to receive care through virtual visits. You can contact a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents for anywhere, at any time. You must go through MDLive or Amwell to use your telehealth benefits. There is no coverage for telephone consultations, unless you use MDLive or Amwell through Cigna. Pre-registration is very helpful so

you can access telehealth services quickly when you need them. Call member services if you have any questions or need help signing up.

For PPO plans, the cost is only \$15 per telehealth visit. For CDHP/HSA plans, you pay the negotiated rate until you reach your deductible, then the primary care office coinsurance applies. The cost listed above does not apply to telemedicine services received from a different program or provider.

Yearly Benefits

The Plan Year begins on January 1 and ends on December 31. Benefits reset each year. This means that if your doctor recommends that you have a certain service every year, then that service will be covered once, anytime within the plan year. Services must be considered medically necessary, and are subject to any plan limits.

Maternity Benefits

Coverage for maternity benefits involves an initial office visit cost to verify the pregnancy. Later visits for routine care are covered under what is called "global billing." These charges are included in the cost of labor and delivery. Should complications arise that require additional services of a specialist, additional charges will apply.

Hospice Benefits

Your plan covers approved hospice programs designed to provide terminally ill patients with more dignified, comfortable and less costly care during the six months before death. Prior authorization is required.

Plan	Coverage
Premier PPO	100% covered
Standard PPO	100% covered
Limited PPO	100% covered
CDHP/HSA	100% covered after deductible
Local CDHP/HSA	100% covered after deductible

Dental Treatment

Your medical plan covers certain limited benefits for dental treatment – extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury or damage to sound natural teeth and/or jaw (other than by eating or chewing). Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person’s ability to masticate and maintain a healthy weight.

Member Costs by Plan:

All benefits are after plan deductible.

Plan	Oral Surgeons		Non-Contracted Providers (i.e., dentists, orthodontists)
	In-Network	Out-of-Network	
Premier PPO	10%	40%	10%
Standard PPO	20%	40%	20%
Limited PPO	30%	50%	30%
CDHP/HSA	20%	40%	20%
Local CDHP/HSA	30%	50%	30%

Cost Savings Programs

Transplants

Prior authorization is required for ALL transplants.

Your plan provides extra cost savings if you have an approved transplant at:

- a Cigna LifeSource facility; or
- at an in-network approved facility if there is no Cigna LifeSource facility for the type of transplant you need

Orthopedic Surgeries

Effective April 1, 2020, your plan provides extra cost savings if you have approved, medically necessary procedures with providers and facilities in Cigna’s surgical treatment and support program.

- Total hip replacement
- Knee replacement
- Laminectomy
- Lumbar spinal fusion

The program includes personalized member support to help you make health care decisions. Travel benefits are also available – up to \$600 per

procedure - if you must travel more than 60 miles for your surgery.

If you elect to have covered transplant or orthopedic services with other providers or facilities when there is a cost-savings option available, you will pay the usual member cost share. The chart below shows the difference between the cost-savings benefit and other in-network benefits.

Call Cigna Member Service at 800-997-1617 for more information, including help in locating a cost-savings program provider.

Plan	Cost Savings	Usual In-Network Member Share
Premier PPO	100% covered	Deductible plus 10% coinsurance
Standard PPO	100% covered	Deductible plus 20% coinsurance
Limited PPO	100% covered	Deductible plus 30% coinsurance
CDHP/HSA	100% covered after deductible	Deductible plus 20% coinsurance
Local CDHP/HSA	100% covered after deductible	Deductible plus 30% coinsurance

Plan Deductible

A plan deductible is the amount you pay each year before the plan pays for services that require coinsurance.

For PPO plans, members in a family plan DO have an individual deductible equal to the “employee only” amount.

For CDHP plans, members in a family plan DO NOT have an individual deductible limit. Each family member will contribute to the overall family deductible which must be met before the plan begins to pay for any family member’s claims subject to a deductible.

See the “Benefits At a Glance” benefit grids in this handbook for deductible amounts.

After the deductible has been met, the plan pays a certain percentage of coinsurance for eligible expenses, and you are responsible for the balance.

Ineligible expenses, including amounts that exceed the maximum allowable charge, are not applied to the deductible. There is also an in-network deductible and an out-of-network deductible.

The two deductibles add up separately. In-network charges cannot be applied to an out-of-network deductible, and out-of-network charges cannot be applied to an in-network deductible.

Out-of-Pocket Maximums

An out-of-pocket maximum limits how much you have to pay in any year. If your spending reaches the out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year.

For PPO plans, members in a family plan DO have an individual out-of-pocket maximum amount equal to the “employee only” amount.

For the CDHP/HSA plan, state and higher education members in a family plan DO NOT have an individual out-of-pocket limit. Each family member will contribute to the overall family out-of-pocket amount which must be met before the plan covers the family’s eligible in-network expenses at 100 percent for the remainder of the plan year.

For the Local CDHP/HSA plan, local education and local government members in a family plan DO have an individual out-of-pocket limit FOR IN-NETWORK EXPENSES ONLY. No one family member will pay more than the \$8,150. Once a family member has eligible in-network expenses out-of-pocket costs totaling \$8,150, the plan will cover that family member’s eligible in-network expenses at 100 percent for the remainder of the plan year. All other family members will contribute to the remaining overall family out-of-pocket limit which must be met before the plan covers the family’s eligible in-network expenses at 100 percent for the remainder of the plan year.

See the “Benefits At a Glance” benefit grids in this handbook for out-of-pocket limits.

Note: There are separate out-of-pocket maximums for in-network and out-of-network expenses. As with the deductible, in-network charges cannot be applied to an out-of-network out-of-pocket maximum, and out-of-network charges cannot be applied to an in-network out-of-pocket maximum. Charges in excess of the maximum allowable charge and non-covered expenses do not count toward the out-of-pocket maximum.

Benefits: In-Network or Out-of-Network

Check your insurance card to verify whether you have the **LocalPlus Network** or the **OAP Network**. In-network benefits apply when you receive care

from doctors and hospitals participating in your plan’s network. Receiving in-network care allows the highest level of benefits.

You can receive care from providers who do not participate in the network, but in most cases, reduced out-of-network benefits will apply, and you will be required to pay the difference between the maximum allowable charge (MAC) and the actual charge.

SEE ALSO: Sections on emergency care and hospital-based providers at in-network facilities.

Reminder: Your health care coverage does not allow payment if Cigna determines a service is not, or was not, medically necessary for your condition.

Maximum Allowable Charge Defined

In the simplest terms, the MAC is the maximum amount that we will pay to a particular provider for a particular service. Providers who have contracted with us to provide in-network services have agreed to accept that amount as payment in full. This means they off the rest of the charge after any applicable cost is paid by the member. Out-of-network providers have not agreed to the contracted rate and may balance bill you for the amount above the MAC.

Convenient Care and Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. “Convenient care” and “Urgent care” is care that is important, but does not result from a life-threatening condition. You can search for a provider online or refer to a provider directory to find in-network facilities.

Convenient care clinics can help with common conditions like burns and sprains, sinus infections, sore throats, skin rashes and upset stomachs. These types of clinics are often located in grocery or drug stores. Your cost for a convenient care clinic visit is the same as a primary care visit.

Urgent care centers treat more serious injuries or illnesses like urinary tract infections, broken bones or deep cuts, that may require x-rays or more complicated lab tests. They are often near a hospital but can also be free standing. Your cost for an urgent care center visit is the same as a specialist visit. If you need urgent care, seek treatment at an urgent care center or contact your doctor or specialist. Many physicians’ offices use an answering

service after hours. When you call after regular hours, be prepared to describe your symptoms and leave a number where the doctor can call you back. Your doctor will offer advice and the best course of treatment for you.

Emergency Care

If you have a medical emergency, seek treatment at the nearest medical facility. Contact your doctor or our member services area within 24 hours if you are in the state of Tennessee or 48 hours if you are out-of-state. Your doctor will make arrangements for your follow-up care.

The emergency room (ER) should be used only in the case of an emergency or for urgent care as directed by your doctor. The highest level of benefits is available for any emergency room visit that meets the definition of an emergency explained below. If out-of-network facilities or providers are used, you may be billed for amounts exceeding the allowable charge (maximum amount eligible for payment). You will be responsible for those amounts if it is determined that the situation was not an emergency or not medically necessary. If your situation was determined to be an emergency and you receive a bill for amounts exceeding the allowable charge from an out-of-network provider, call Cigna and they will provide you with assistance to make sure you are not responsible for those amounts.

If you receive a bill for emergency services asking you to pay more than you expected to pay, call Cigna customer service. Be prepared to provide a copy of the bill you received, and ask for a review of your claim to see if insurance can pay anything more.

An “emergency” medical condition is an illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you don’t get medical attention right away. If you don’t get medical attention you could reasonably expect one of the following:

- Your health would be put in serious danger (or, with respect to pregnant women, the health of the woman or her unborn child)
- You would have serious problems with your bodily functions
- You would have serious damage to any part or organ of your body

For each covered emergency room visit, you will pay your portion of the emergency room cost. If you are admitted for more than 23 hours, the emergency room visit is considered part of your inpatient services. If the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room, the visit is included in your original emergency room costs.

If you also receive services such as an MRI or CT, you will be charged for those services in addition to your emergency room visit. Should an out-of-network ER require you to pay in full, file the billing statement, along with a claim form, with our office, and you will be reimbursed subject to the terms and conditions of the plan.

Hospitalization

If you need to be hospitalized, your doctor should make the necessary arrangements at an in-network facility. Be sure to ask if the facility is in-network or call us to confirm. Your doctor should also coordinate your care and prior authorization with our office. If you are admitted to a hospital (in-network or out-of-network) without our prior authorization, your benefits will be greatly reduced.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should notify your doctor of any urgent care hospitalization within 24 hours (48 hours if you are out-of-state) of your admission. This allows your doctor to make necessary arrangements for any follow-up care. Maternity admissions do not require pre-authorization.

Hospital-Based Providers at In-Network Facilities

Hospital-based providers are not employed by the hospital but may provide medical services and care for you at a hospital. Sometimes providers are out-of-network even at an in-network facility. These providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists, and pathologists.

You are eligible for in-network benefits for covered services received from these providers.

Claims for these types of services may not process to apply in-network benefits the first time. If you receive a bill from one of these out-of-network

hospital-based providers that you saw at an in-network facility, and you are asked to pay more than you expected to pay, call Cigna member services. Cigna will provide you with assistance to make sure you are not responsible for those amounts. You may be asked to provide a copy of the bill you received from the provider.

Utilization Management

Utilization management (UM) programs review requirements and determine authorization for payment of benefits. Programs include:

- › Pre-admission certification
- › Post-certification of emergency admissions
- › Weekend admissions
- › Optional second surgical opinions
- › Certain outpatient procedures
- › Home health
- › Case management
- › Private duty nursing
- › Durable medical equipment
- › Pharmacy program

These programs are not meant to supersede the physician/patient relationship. The level and duration of medical care is always the patient's decision in conjunction with his/her physician.

UM decisions are based only on medical appropriateness of care/service and coverage eligibility. The UM organization does not reward practitioners or other individuals for issuing denials of coverage or care.

Prior Authorization

Prior authorization (PA) is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with the medical needs of the member and with patterns of care in an established managed care environment for treatment of a particular illness, injury or medical condition.

PA is required for certain services including some of the more common specific services listed below. Other specific services are included in broader categories that appear on the list, like inpatient hospital services and same-day surgery procedures. Contact Cigna member services before receiving

services if you have a question about benefits requiring prior authorization.

- › Inpatient hospital services
- › Skilled nursing facility stays
- › Home health care
- › Inpatient rehabilitation services
- › 23 hour or less observation room stays
- › Hospice
- › Inpatient cardiac rehabilitation
- › Home infusion therapy (certain drugs)
- › Private duty nursing
- › Advanced X-rays, scans, and imaging
- › Durable medical equipment
- › Same-day surgery procedures, including procedures at an ambulatory surgical center (does not apply to screening colonoscopy)
- › Chemotherapy and radiation therapy
- › Non-emergent ambulance transport (air and ground)

All providers for the above services should request these authorizations prior to delivering services, except in the case of a maternity admission or an emergency situation. If a network provider fails to obtain required authorization, no benefits will be paid, and both the plan and the covered person shall be held harmless.

Out-of-network providers are not contracted. If you receive medically or clinically necessary care from an out-of-network provider, you are responsible for verifying with Cigna that prior authorization has been requested and approved before receiving care.

When PA is required but not obtained, benefits for medically necessary services received out-of-network will be reduced by half, subject to the maximum allowable charge.

PA is not required for maternity admissions or emergency care.

Cigna does not manage PA for pharmacy benefits or behavioral health and substance use treatment. Contact information for those programs is provided under the "Important Contact Information" section of this handbook.

Advanced Radiological Imaging

Cigna will coordinate review of certain non-routine diagnostic services and the setting for such services in regards to medical appropriateness and necessity before the services are performed. Services subject to such review include Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Positron Emission Tomography (PET) scans and nuclear cardiac imaging studies.

Durable Medical Equipment

The plan covers certain durable medical equipment (DME) determined to be medically necessary on the basis of an individual's medical and physical condition.

Some equipment requires prior authorization (PA). Generally, PA only applies to items with high risk and high utilization. Providers should request PA, if needed, before providing equipment to you. You can also contact Cigna to see if the equipment you need requires PA and if any necessary PA has been approved.

Depending on the type of equipment needed, DME may be furnished on a rental basis or purchased. Types of equipment include blood glucose monitors and breathing equipment such as oxygen tanks, tents, regulators and flow meters. DME is not for comfort or convenience. Items are typically prescribed by a physician when recognized as therapeutic for a patient's diagnosis.

CareCentrix, one of the nation's leading providers of home health care services, is the exclusive provider of durable medical equipment (DME), home health care, and home infusion services for Cigna customers.

CareCentrix will provide the following services:

- › Durable medical equipment (e.g., beds, wheelchairs, walkers)
- › Respiratory equipment (e.g., oxygen, CPAP, ventilators)
- › Enteral nutrition (e.g., pumps and nutritional support)
- › Home health care (e.g., nursing, therapies, social work and home health aides)
- › Home infusion products
- › Other specialty services (e.g., insulin pumps and supplies, CPM machines and supplies, wound vacuums and supplies)
- › Through its network of credentialed providers, CareCentrix will now coordinate and manage the full range of home health, infusion and respiratory services. The benefit to you is access to one-stop CareCentrix service which includes:
 - A single call coordinating care for complete home health care, infusion and DME services;
 - 24/7 availability of service;

You can reach CareCentrix at 888.999.2422

Hearing Aids (for children under 18)

Hearing aids for children under the age of 18 are covered at one per ear, every three years, at the applicable deductible and coinsurance level. Amplifon Hearing Health Care, one of the largest distributors of hearing aids and services in the world, is Cigna's exclusive in-network national supplier of digital and digitally programmable analog hearing aids and supplies.

Customers can choose the participating health care professional most convenient for them, including ENTs, Audiologists and free standing hearing centers that are directly-contracted (in-network) with Cigna, as well as Amplifon subcontracted health care professionals who also hold a contract with Cigna (dually contracted). If a customer chooses an out-of-network health care professional, or obtains a hearing aid from a supplier other than Amplifon, claims will be paid according to the plan's coverage for out-of-network services. The cost to customers could be substantial.

Using Amplifon to provide hearing aids to our customers ensures they receive quality devices at a more consistent and cost-effective expense. By using Amplifon customers will have:

- › A single source for ordering hearing aids from multiple manufacturers at discounted prices
- › Increased benefit transparency
- › More accurate claims processing; and
- › Quick delivery

How getting hearing aids and supplies from Amplifon works

- Health care professionals will verify patient benefit and eligibility information and order hearing aids and supplies directly from Amplifon
- After verifying patient benefit and eligibility information, the health care professional will provide the customer with a completed disclosure form showing the patient's benefit level and cost share, if any.
- The health care professional will order devices directly from Amplifon.
- Health care professionals will submit claims to Cigna for processing and claims will be paid according to benefit coverage.

Coordination of Benefits with Other Insurance Plans

Once a year you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments. The completed form letter must be received before any further claims processing can take place. You may also update this information on-line using the personalized and secure member website **myCigna.com**.

If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100 percent of allowable charges. At no time should reimbursement be more than 100 percent of actual expenses. If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document. Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g. active, retired, COBRA).

If your spouse has coverage through his or her employer, and has you covered, then that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits.

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. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to our office.

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. For example, if a married dependent child under the age of 26 is covered by a parent under this plan and also has coverage under their spouse's plan, the primary plan will be the plan which has covered the dependent child for the longer period of time.

Claims Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third party or insurer of a third-party. This would include automobile or homeowners insurance, whether yours or another's.

You are required to assist in this process and should not settle any claim without written consent from our subrogation department. Failure to respond to the plan's requests for information, and to reimburse the plan for any money received for medical expenses, may result in the covered person's disenrollment from the plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person.

Benefit Level Exceptions

Two types of exceptions — unique care and continuous care — may be granted. These exceptions allow benefits to be paid at the in-network level to an out-of-network provider or facility. Any charges above the maximum allowable charge are the patient's responsibility. All requests for exceptions are reviewed by Cigna. Exceptions will be granted only for medical necessity, not for convenience.

To apply for a unique or continuous care exception, work with your provider to submit the following information in a letter to Cigna, attention State Unique Care Coordinator. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all information can be gathered.

- › Patient name and ID number
- › Name and type of provider you are requesting
- › Diagnosis and treatment plan, date(s) of service
- › A statement explaining why this treatment cannot be received at an in-network facility or provided by an in-network physician

Unique Care Exceptions

A unique care exception can be granted for treatment not routinely available from an in-network provider in a member's geographic area. This exception is based on the patient's condition or need for a particular physician and must be requested before receiving care. We will determine whether an in-network provider is available to provide treatment for the illness or injury.

If a unique care exception is granted, benefits are paid at the in-network level. Any charges above the maximum allowable are the patient's responsibility. If distance (out-of-state) traveling is required, reimbursement will be at 80 percent of commercial coach airfare or ground travel at the state approved mileage rate or for actual fuel.

When unique care exceptions are granted, a time frame for this approval is given. If more time for unique care is needed beyond the stated time frame, then another unique care request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required. The review of this unique care approval extension request will include a review of the available network to determine if the required care can now be accessed within the network.

Continuous Care Exceptions

A continuous care exception can be granted when a patient is undergoing an active treatment plan for a serious medical condition (i.e., pregnancy or cancer). This exception takes into account a

patient's established relationship with an out-of-network provider. The Cigna medical director will determine the time frame in which continuous care can be covered. Any charges above the maximum allowable are the patient's responsibility.

Coverage for Second Surgical Opinion Charges

In some instances, you have the option to receive a second surgical opinion. Second surgical opinions are not required. The second surgical opinion must be obtained from a surgeon qualified to perform the surgical procedure, but who is not in the same medical group as the physician who originally recommended surgery.

For PPO plan members, charges for the second surgical opinion and any tests performed in obtaining the second surgical opinion will be paid at 100 percent of the maximum allowable charge if an in-network provider is used. **CDHP plan members** must first meet the annual deductible requirement.

If you wish to obtain a second surgical opinion about a procedure not included on the list below, normal plan benefits and rules apply. Any surgeries (including those listed) must be medically necessary to be approved.

- › Bone and joint surgery of the foot
- › Cataract extraction with and without implant
- › Cholecystectomy
- › Elective C-section
- › Hysterectomy
- › Knee surgery
- › Mastectomy
- › Prostatectomy
- › Septoplasty/sub-mucous resection
- › Spinal and disc surgery
- › Tonsillectomy and adenoidectomy



Case Management

Case management is a program that promotes quality and cost effective coordination of care for members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing regarding alternative treatment plans. Members or providers may also contact member services if they believe they would benefit from case management.

Filing Claims

Cigna is responsible for all medical plan claims processing. When you visit an in-network doctor or facility, be sure to show your identification card. The provider will file your claim directly. These in-network providers must file your claim within six months of the date of service. All questions regarding claims, including requests for claim forms, should be addressed to member services.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims yourself. Out-of-network providers may also require payment in full at the time of service. The correct form must be used and a separate claim form must be completed for each individual who received services. More than one bill can be submitted on a claim form. For out-of-network providers, you have 13 months from the date of service to file claims and be eligible for reimbursement.

Cigna is not responsible for processing claims for pharmacy or behavioral health and substance use treatment. Contact information for those programs is provided under the “Important Contact Information” section of this handbook.

Out-of-State Providers

Members who live outside of Tennessee still have access to in-network providers through our national network.

You can locate providers anywhere in the nation using the general Cigna website at Cigna.com. You will then select provider directory and indicate what type of provider you are looking for. Your network name is either LocalPlus or Open Access Plus. See your ID card to determine the network you selected.

You can also contact Cigna at the toll-free member service number on your ID card. We will be happy to assist you with locating a network provider in your area.

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses incurred for medically necessary emergency and urgent care services are covered at the in-network level. Other medically necessary care will be covered at the out-of-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the

United States. Claims from a non-English speaking country should be translated to standard English at the covered person’s expense. Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

Out-of-Country Benefits – non-emergency and non-urgent care Out-of-Network benefits only; deductible applies

Plan	Coinsurance
Premier PPO	40%
Standard PPO	40%
Limited PPO	50%
CDHP/HSA	40%
Local CDHP/HSA	50%

Healthy Rewards Program®*

Cigna Healthy Rewards provides access to a range of health and wellness programs and services not covered by many traditional plans including, but not limited to, Weight Watchers®, Jenny Craig, tobacco cessation programs, fitness club memberships, laser vision care, massage therapy, health & wellness products and discounts on popular magazines. This program can save you money by providing discounts on these services when you use Healthy Rewards participating providers. There are no referrals, no claim forms, and no catch! To locate participating providers, call 800.870.3470 or visit myCigna.com.

*Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan coverage. A discount program is NOT insurance, and you must pay the entire discounted charge.

Cigna Healthy Babies®

The Cigna Healthy Babies program gives mothers-to-be the information and support they need to make the best choices for mom and baby.

When you enroll in Healthy Babies you’ll get valuable educational materials, including:

- ▶ Guidelines for a healthy pregnancy and baby.
- ▶ Information on health issues that can impact pregnant women and their babies, including stress, depression and gum disease.
- ▶ A guide to pregnancy-related topics available through the Cigna 24-Hour Health Information Line.
- ▶ A list of informative online and telephone resources.

- Information on prenatal care from the March of Dimes® – a recognized source of information on pregnancy and babies.

You may also be eligible for support from a registered nurse case manager if you or your baby has special health care needs.

To enroll, just call the toll-free number on your Cigna ID card, any time during your pregnancy.

Please note: The Healthy Babies program is offered in addition to the services covered as part of a Cigna medical benefit plan. Covered services depend on the Cigna plan offered by your employer.

Pharmacy Benefits

Pharmacy benefits are administered by CVS/caremark and not Cigna. Please call 877.522.8679 for further information or visit info.caremark.com/stateoftn. Once there, you can view the State of Tennessee Group Insurance Program Prescription Drug List, Specialty Drug List, Vaccine Network Pharmacy List and the Retail-90 Network Pharmacy List. Any medication classified as a specialty medication can only be filled for a 30-day supply and must be filled through a pharmacy in the CVS/caremark Specialty Network.

Three levels of benefits are available for prescription drugs, and your choice determines the amount you pay each time you have your drugs dispensed by a pharmacy.

- Generic drugs are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand name drugs, and are available in many instances.
- Preferred brands are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list. This list includes many popular brand-name drugs.
- Non-preferred brands are in the third tier and will cost you the most.

When a generic is available and the member's physician has indicated "may substitute" but the pharmacy dispenses the brand name **based on the member's request**, the member will pay the difference between the brand name drug and the generic drug plus the brand copay or coinsurance.

Medication Assisted Treatment (MAT)

Medication assisted treatment (MAT) combines behavioral therapy and medications to treat substance use disorders. Members do not have to pay for specific medications used to treat opioid dependency.

Maintenance Drugs

When you fill a prescription for chronic maintenance medications, you can save money by paying a lower copay or coinsurance when you have your doctor write a prescription for a 90-day supply and you fill it through either mail order or from a participating Retail-90 pharmacy. A list of participating Retail-90 pharmacies is located at info.caremark.com/stateoftn. Maintenance drugs include certain medications for high blood pressure, high cholesterol, coronary artery disease (CAD), congestive heart failure (CHF), depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).

Med Sync for Maintenance Drugs

Maintenance drugs are described above. You can request that refills of your maintenance drugs be synchronized so that you can have them all filled on the same day. If you're enrolled in a PPO, you will pay pro-rated copays for any maintenance drugs being synchronized. Persons enrolled in a CDHP will pay the plan discounted drug cost. If you want to sync your maintenance drugs, you will need to work with your retail pharmacy or mail order pharmacy to coordinate synchronization of your refills.

Compound Drugs

Any and all compound drugs (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 drugs require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Statin Drugs

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

Weight Management

Some obesity medications are available for members who meet certain requirements. This

gives members a less costly, non-surgical option for losing weight. Go to the caremark website at info.caremark.com/stateoftn to look for covered medications. They are found under “Antiobesity” on the Preferred Drug List (PDL).

Tobacco Cessation Products

Members who want to stop using tobacco products can get free tobacco quit aids. Chantix, Bupropion (Generic Zyban), over-the-counter generic nicotine replacement products (including gum, patches and lozenges), and Nicotrol oral and nasal inhalers are FREE under the pharmacy benefit. Members may receive up to two, 12-week courses of treatment per calendar year (up to 168 days of treatment) with no lifetime maximum. A licensed clinician is required to write a prescription to get any tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your CVS/caremark card at the pharmacy counter (not at the check-out registers) to fill at \$0 copay. The plan only covers generic over-the-counter tobacco cessation products (not brand names).

Copay Installment Program

Members can spread the cost of 90-day mail order prescriptions over a three-month period – at no additional cost. You may enroll online at info.caremark.com/stateoftn, register and log in, or by calling CVS/caremark customer care at 877.522.8679. This benefit is only for 90-day mail order prescriptions provided by CVS/caremark mail order. This does not apply to specialty medications.

Flu and Pneumonia Vaccines

Each year, members can get free flu and pneumonia vaccines (if eligible) through certain pharmacies or at a participating doctor’s office. Contact CVS/caremark (pharmacy benefits) or Cigna (medical benefits) for more information, or go to tn.gov/partnersforhealth and click on Pharmacy.

Here4TN Behavioral Health, Substance Use and Employee Assistance Program

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Health. Optum can be reached toll-free at 855-Here4TN (855.437.3486) any time, day or night, to speak confidentially with a trained

professional for a referral. Services generally include the following:

- › Outpatient assessment and treatment
- › Virtual Visits - visits with a provider through private, secure video conferencing
- › Inpatient assessment and treatment
- › Enhanced benefit for facility-based substance use treatment at select facilities – call 855-Here4TN for assistance
- › Partial hospitalization
- › Residential treatment
- › Intensive outpatient treatment
- › Treatment follow-up and aftercare

Certain services are specifically excluded under the terms and conditions of the state group insurance program. For more information, contact Optum.

To receive maximum benefit coverage, participants must use an in-network provider and obtain prior authorization for inpatient services as well as some outpatient services including psychological testing, electro-convulsive treatment, Applied Behavior Analysis, and transcranial magnetic stimulation. Out-of-network behavioral health benefits are available; however, your cost will be higher. You are also subject to balance billing by the out-of-network provider, meaning that you will pay the difference between the maximum allowable charge and the actual charge. Additionally, you are at risk of having inpatient benefits totally denied.

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

EAP is now available through virtual visits as well. Go to www.Here4TN.com for more information. In addition to counseling support, your EAP provides a variety of consulting services including financial, legal, childcare, eldercare, and identity theft support. Prior authorization is required to see an EAP provider and can be obtained by either logging on to www.Here4TN.com or calling 855-Here4TN (855.437.3486). The website provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, on-line trainings, search for providers, access a map of your provider's location, and obtain driving directions. You may set up your own unique account number and password for confidential and anonymous access to a wide variety of information and resources. This includes viewing claims information online.

Optum also has its own policies and procedures to protect your privacy. These policies guide Optum staff, providers, and visitors on how to keep information private. By signing Optum's Authorization to Use or Disclose Protected Health Information Form, you permit Optum to disclose your personal information. If you have a guardian or someone selected by the court, they can sign the form for you. Optum can only give your information to you or the designated person. To get the form, please call 855.437.3486.

ParTNers for Health Wellness Program

The ParTNers for Health Wellness Program is voluntary and members are not required to complete any wellness program activities. ActiveHealth Management, the wellness vendor, will send more information directly to members about the programs, tools and resources that are available in 2020. Go to <http://goactivehealth.com/wellnesstn> for updates.

- ▶ State and higher education members and enrolled spouses can earn money by completing certain wellness activities. The money will be deposited into the head of contract's paycheck. Members choose activities from an approved list. Each activity will have a dollar value, and you can earn up to \$250 each. That is \$500 for the employee and spouse.

- ▶ Local education and local government employees, retirees, COBRA participants and enrolled spouses will have access to a health assessment and coaching support (online personal or group coaching, or by phone) for disease management programs such as asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD). You will get emails about coaching support that's available to you. It is completely voluntary and won't cost you anything. In addition you will have access to the web portal and mobile app where you can get access to your coaches, the health assessment and tips and trackers.
- ▶ There is also a Diabetes Prevention Program (DPP) for those who are pre-diabetic and qualify for the program.
- ▶ In addition to the ParTNers For Health DPP, Cigna is partnering with Omada to offer an online lifestyle change program that can help members lose weight, feel good and develop long term health habits. The program is free to eligible plan members and their dependents. To see if you are eligible go to omadahealth.com/partnersforhealth or call 888.409.8687.



Member Rights and Responsibilities

Member Rights

You have the right to:

- › Be treated with respect and dignity.
- › Expect that any information you give will be treated in a confidential manner.
- › Information about policies and services of the plan.
- › Information regarding in-network providers.
- › Medically necessary and appropriate medical care.
- › Information about your health.
- › Make decisions about your health care with practitioners.
- › Voice complaints about your health care providers, the care given to you, or the plan. You can expect an answer within a reasonable time. You also have the right to formally appeal this answer if you do not agree.
- › A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage

Confidentiality and Privacy

Your health is your own private business. Be assured that we will treat your medical records and claims payment history in a confidential manner. When you enroll in the plan, you give routine consent for certain matters. That allows the company to release information without your prior written consent for these purposes:

- › Claim processing.
- › Performing peer review, utilization review, and medical audits.
- › Administration of programs established by us for quality health care and control of health care costs.
- › Medical research and education

Important steps are taken to protect your privacy.

- › Employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out the established policies.
- › Contracted practitioners and providers follow confidentiality guidelines set forth by the state in which they practice.

- › Vendors must sign confidentiality agreements if they receive personal health information for purposes of plan administration such as measurement of data to improve quality.
- › It is the policy not to release member-specific health information to employers unless allowed by law.
- › Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

Members can take comfort in knowing that confidentiality is important. You are encouraged to call one of the member service representatives if you have questions about privacy policies and practices.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any stage of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurances as other services.

Member Responsibilities

Members are responsible for:

- › Reading the member materials in their entirety and complying with the rules and limitations as stated.
- › Contacting in-network providers to arrange for medical appointments as necessary.
- › Notifying in-network providers in a timely manner of any cancellations of appointments.
- › Paying the coinsurance and deductibles as stated in the benefit plan documents at the time service is provided.
- › Receiving prior authorization for services when required, and complying with the limits of the prior authorization.
- › Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.

- › Using in-network providers consistent with the applicable benefit plan.
- › Providing, to the extent possible, information needed by professional staff in order to care for the member.
- › Following instructions and guidelines given by those providing health care services.

Appeal Procedures

If you have a problem with coverage or payment of medical, behavioral health and substance use, or pharmacy services, there are established 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.

Specific questions regarding initial levels of appeal (the internal appeal process) should be directed to the claims administrator member service numbers provided below. 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.

Behavioral Health and Substance Use Appeals

Contact Optum at 855.437.3486 for EAP, behavioral health and substance use appeals.

Pharmacy Appeals

Contact CVS/caremark at 877.522.8679 for pharmacy appeals.

Medical Service Appeals

If you are in disagreement with a coverage decision or the way a claim has been paid or processed, you or your authorized representative should first call Cigna member service at 800.997.1617 to discuss the issue. If the issue cannot be resolved through member service, you, or your authorized representative, may file an appeal/member grievance by completing the correct form or as otherwise instructed. **You, or your authorized**

representative, will have 180 days to start an internal appeal with Cigna following notice of an adverse determination. The appeals/grievance form can be found on the Cigna Member Home Page at [Cigna.com/sites/stateoftn](https://www.cigna.com/sites/stateoftn). Once a determination is made, you will be notified in writing and advised of any further appeal options and timeframes for filing additional appeals. All requests must be filed within the specified timeframes.

When an appeal decision made by Cigna is unfavorable and the appeal qualifies for external review, Cigna will advise you, or your authorized representative, of the right to initiate an external appeal. External appeals are considered by an Independent Review Organization (IRO). If you choose to pursue an external appeal, you or your authorized representative, must submit a request within four months of the notice of the appeal decision you receive from Cigna.

If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., emergency or life threatening procedures), then you, or your authorized representative, may request an expedited reconsideration. If the treating provider fails to request the reconsideration and decides not to provide urgently needed services, then you, or your authorized representative, may request the expedited reconsideration. If Cigna agrees that it is appropriate to conduct an expedited reconsideration, we will inform you, or your authorized representative, of our decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

Please Note: The expedited reconsideration process only applies in situations where a benefit determination or a prior authorization denial has been made prior to services being received.

Notification of decisions will be made within the following time frames and all decision notices shall advise of any further appeal options:

- › No later than 72 hours after receipt of the appeal for urgently needed services
- › 30 days for denials of non-urgent care not yet received
- › 60 days for denials of services already received

Q&A

Q. Is my child who is attending college out of state covered at the in-network level?

A. Yes, Cigna offers a broad national network of providers. You can locate a network provider in your child's specific area by either logging into **Cigna.com**, selecting the provider directory search or contacting the toll-free member services number. We will be happy to assist you with locating a network provider in the area.

Q. Other than the benefit level, are there other differences if I use out-of-network providers?

A. Out-of-network providers can bill you for any difference between actual charges and the maximum amount allowed by the plan plus any services deemed not medically necessary or not authorized. When you use an out-of-network provider, the charges for which you are responsible may be substantial.

Q. Do I have a choice of hospitals?

A. We have contracted with certain hospitals to provide in-network care to you. If specialty care is not available at the contracted in-network hospital(s), arrangements will be made with the appropriate out-of-network hospital. A request for unique care exception benefits may be required.

Q. I received a bill from an out-of-network provider that I wasn't expecting. What can I do?

A. Call Cigna. We will review your claim and EOB with you to determine and explain your cost share. You may be asked to provide a copy of the bill from the provider. In some cases you may not be responsible for expenses which exceed the maximum allowable charge. See page 18 for more information on emergency care and page 19 for more information on hospital-based providers. If you receive a bill for more than you expected to pay, call Cigna to ask if your insurance will pay anything more.

Q. What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?

A. A provider appeals process is available for this situation.

Q. What if my physician is out of the office?

A. Physicians "cover" for each other on a rotating schedule. This means there may be times when you will not be able to speak with your physician. The nurse or physician on call will be able to help you.

You can also use the telehealth service, which allows you to receive care through virtual visits.

For PPO plans, The cost is only \$15 per telehealth visit. **For CDHP plans,** you pay the negotiated rate until you reach your deductible, then the primary care office visit coinsurance applies.

Q. What if I must reach my physician after regular office hours or my doctor is out of the office?

A. Doctors "cover" for each other on a rotating schedule. This means you may not always be able to talk with your doctor. Most physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk with a representative from the answering service. The on-call nurse or doctor will be able to help you. They may ask for some identifying information and will need a general description of your urgent medical need.

Another option is telehealth, which allows you to receive care through virtual visits. You can contact a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents for anywhere, at any time. **For PPO plans,** The cost is only \$15 per telehealth visit. **For CDHP plans,** you pay the negotiated rate until you reach your deductible, then the primary care office visit coinsurance applies.

Pre-registration is very important so you can access telehealth services when you need them.

Call member services if you have any questions or need assistance with the registration process.

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해 주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).





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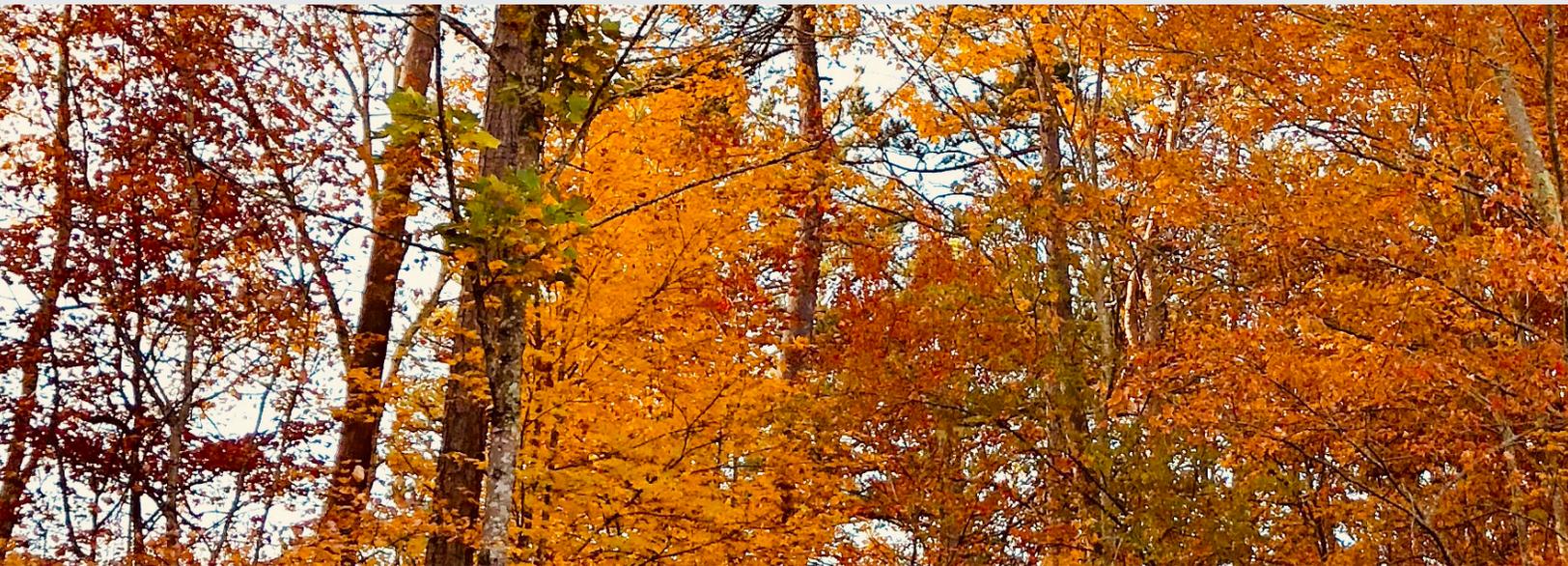


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Chattanooga, TN 37422



State of Tennessee
Group Insurance Program



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