NEW HIRE GUIDE – 2024

Local Government Employees & COBRA Participants

PARTNERS FOR HEALTH

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PARTNERS FOR HEALTH

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

Eligibility

Eligible

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

NOT Eligible

Individuals who do not meet the employee eligibility rules outlined above are ineligible UNLESS they otherwise meet the definition of an eligible employee under applicable state or federal laws or by approval of the Local Government Insurance Committee. As an example, the following individuals are normally ineligible but might qualify for coverage if they meet the federal definition of a full-time employee under the Patient Protection and Affordable Care Act:

- Individuals performing services on a contract basis

Dependents

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

Eligible

- Your spouse (legally married); individual agencies may deny eligibility to the spouses of employees who are eligible for group health insurance through the spouse's employer
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian, custodian or conservator

Proof of the dependent's eligibility is also required and must be submitted to BA no later than 10 business days after the 30-day enrollment deadline. Refer to the dependent definitions and required documents chart at **tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf** for the types of proof you must provide.

Not Eligible

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

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

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

An employee may not be enrolled as both head of contract and dependent within the Local Government Plan. A newly hired employee can choose coverage for his/her spouse as a dependent when that spouse is an eligible employee who declined coverage when first eligible. The employee spouse will have dependent status unless he or she requests to change during the Annual Enrollment period or later qualifies under the special enrollment provisions.

All eligible dependents must be listed by name on the enrollment change application in part 7 **https://www.tn.gov/content/dam/tn/partnersforhealth/documents/2023_forms/1043_2023.pdf**. You are also required to provide a valid Social Security number for a dependent (if they are elibible for one). Other required information includes date of birth, relationship, gender and acquire date.

Enrollment and Effective Date of Coverage

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

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

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

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

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

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

Choosing a Premium Level

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

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

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

Edison

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

Premium Payment

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

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

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

Updating Personal Information

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

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

Cancelling Coverage

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

- You lose eligibility for the State Group Insurance Program (e.g., changing from full-time to part-time)
- You experience a special qualifying event, family status change or other qualifying event as approved by Benefits Administration

How to Enroll

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

You must notify your agency benefits coordinator of any event that causes you or your dependents to become ineligible for coverage. You must repay any claims paid in error. Refunds for any premium overpayments are limited to three months from the date notice is received.

When cancelled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for dependent children generally ends on the last day of the month in which the child reaches age 26, unless otherwise stated in plan rules.

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

Cancelling coverage in the middle of the plan year — You may only cancel coverage for yourself and/or your dependents in the middle of the plan year if you lose eligibility or you experience an event that results in you/your dependents becoming newly eligible for coverage under another plan. There are no exceptions. You have 60 days from the date that you and/or your dependents become newly eligible for other coverage to turn in an application and proof to your agency benefits coordinator **https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/2023_forms/1047_2023.pdf.** The required proof is shown on the application. Events that might result in becoming newly eligible for coverage elsewhere are:

- Marriage, divorce, legal separation, annulment
- Birth, adoption/placement for adoption
- Death of spouse, dependent
- New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependents)
- Entitlement to Medicare, Medicaid or TRICARE
- Court decree or order
- Open enrollment
- Change in place of residence or workplace out of the national service area (i.e., move out of the U.S.)
- Marketplace enrollment (Marketplace enrollments are those offered under the Patient Protection and Affordable Care Act) Once your application and required proof are received, the coverage end date will be either:
- The last day of the month before the eligibility date of other coverage
- The last day of the month that the event occurred
- The last day of the month that documentation is submitted (to cancel DHMO-prepaid provider dental)

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

Moving Between Plans

If you are eligible for coverage under more than one state-sponsored plan, you may move between the state, local education and local government plans. You may apply to change plans during the plan's designated Annual Enrollment period with an effective date of January 1 of the following year. In no case may you move to another state-sponsored plan and remain on your current plan as the head of contract.

If You Don't Apply When First Eligible

If you do not enroll in coverage when you are first eligible, you must wait for the Annual Enrollment period. You can apply to enroll or make changes to your coverage during the year, but ONLY if you experience a special qualifying event, or you have a recognized status change as described in the chart below.

Special Enrollment Provisions and Enrollment Due to Acquire Events or Loss of Eligibility for Other Coverage Events

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

Enrollments Due to Acquire Events or Loss of Eligibility for Other Coverage Events - You or eligible dependents may also enroll in voluntary dental and vision if you meet the requirements stated in the certificates of coverage for those programs.

NOTE:Application for special enrollment or enrollment due to an acquire event or loss of eligibility for other eventt (**https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/1043_2023.pdf**) **must be made:**

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

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

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

The chart on page 3 of the enrollment change application explains the kinds of events that afford special enrollment or enrollment due to experiencing an acquire event or loss of eligibility event for other coverage, the effective dates of coverage and the documentation you will need to provide.

Important Reminders

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

Continuing Coverage During Leave or After Termination

EXTENDED PERIODS OF LEAVE

Family and Medical Leave Act

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

Leave Without Pay — Health Insurance Continued

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

Leave Without Pay — Insurance Suspended

You may suspend coverage while on leave if your premiums are paid current. All insurance programs are suspended, including any voluntary coverages. You may reinstate coverage when you return to work. If cancelled for nonpayment, you must wait for the next Annual Enrollment period to re-enroll, unless you have a qualifying event under the special enrollment provisions.

To Reinstate Coverage After You Return

You must submit an application to your agency benefits coordinator within 30 days of your return to work. You must enroll in the same health option you had before. If you do not enroll within 30 days of your return to work, you must wait for the next Annual Enrollment period to re-enroll unless you have a qualifying event under the special enrollment provisions during the year. Coverage goes into effect the first of the next month after you return to work.

If you and your spouse are both insured with the State Group Insurance Program, you can be covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract. To transfer coverage, submit an enrollment application to suspend your coverage. Your spouse should submit an enrollment application to add you as a dependent. Benefits Administration must be contacted to assist with this change and to transfer deductibles and out-of-pocket expenses.

Reinstatement for Military Personnel Returning from Active Service

An employee who returns to work after active military duty may reinstate coverage on the earliest of the following:

- The first day of the month, which includes the date discharged from active duty
- The first of the month following the date of discharge from active duty
- The date returning to active payroll
- The first of the month following return to the employer's active payroll

If restored before returning to the employer's active payroll, you must pay 100% of the total premium. In all instances, you must pay the entire premium for the month. Reinstatement of coverage is not automatic. Military personnel must re-apply within 90 days from the end of leave.

Leave Due to a Work-related Injury

If you have a work-related injury or illness, contact your agency benefits coordinator about how this will affect your insurance.

Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration. A COBRA notice to continue health, dental and vision coverage will be mailed to you.

In the event that your spouse is also insured as a head of contract under either the state, local education or local government plan, you have the option to move to your spouse's contract as a dependent. Application must be made within 60 days of your loss of eligibility for other coverage. See section on special enrollment provisions for details.

Continuing Coverage through COBRA

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

- Coverage is lost due to a qualifying event (refer to the COBRA brochure at **tn.gov/content/dam/tn/finance/fa-benefits/documents/cobra.pdf** on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

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

Continuing Coverage at Retirement

Please note that your agency must have opted in to offering the continuation of coverage on the retirement group health plan in addition to other eligibility criteria. There are separate eligibility guides for retirement insurance. The Guide to Continuing Insurance at Retirement for Local Government is available on the ParTNers for Health website under "Publications" at **https://www. tn.gov/partnersforhealth**.

Coverage for Dependents in the Event of Your Death

If you die while actively employed, your covered dependents will be offered continuation of whatever state health, dental and vision insurance they have on the date of your death. Your surviving dependent(s) should contact Benefits Administration to confirm the type of coverage continuation for which they are eligible.

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

If you are a member of the Tennessee Consolidated Retirement System, election of a monthly pension benefit is one of the required criteria to continue insurance for your covered dependents if you die. Your covered dependents do not have to be the pension beneficiaries, but if either you or your designated pension beneficiary elected to take a lump sum pension payout, this will result in your surviving dependents losing the right to continue retiree health insurance coverage even if the other eligibility criteria are met.

If eligible, premiums for continued coverage of your eligible surviving dependents will be deducted from your monthly TCRS pension check if a covered dependent is your designated pension beneficiary. Covered surviving dependents must submit insurance premiums directly to Benefits Administration if your TCRS pension check is insufficient to cover the premiums or if your designated pension beneficiary is someone other than a dependent covered on your insurance at the time of your death.

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

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

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

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

If You Are Covered Under COBRA

Your covered dependents will have up to a total of 36 months of COBRA, provided they continue to meet the eligibility requirements.

Other Information

Coordination of Benefits

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

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

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance

coverage. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time.

From time to time, carriers will send letters to members asking for other coverage information. This is necessary because it is not uncommon for other coverage information to change. This helps ensure accurate claims payment. In addition to sending a letter, the carriers may also attempt to gather this information when members call. You must respond to the carrier's request for information, even if you just need to report that you have no other coverage.

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

Subrogation

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

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

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

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

On-the-job Illness or Injury

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

Fraud, Waste and Abuse

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

If your covered dependent becomes ineligible, you must inform your agency benefits coordinator and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered even if you are under court order to continue to provide coverage.

If there is any kind of error in your coverage or an error affecting the amount of your premium, you must notify your agency benefits coordinator. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from you.

Financial losses due to fraud, waste or abuse have a direct effect on you as a plan member. When claims are paid or benefits are provided to a person who is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your health care. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or member fraud. You can help prevent fraud and abuse by working with your employer and plan administrator to fight those individuals who engage in fraudulent activities.

Updating Personal Information

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

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

How You Can Help

- Pay close attention to the explanation of benefits forms sent to you when a claim is filed under your contract and always call the carrier to question any charge that you do not understand
- Report anyone who permits a relative or friend to "borrow" his/her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who makes false claims or alters amounts charged on claim forms

Please contact Benefits Administration to report fraud, waste or abuse of the plan. All calls are strictly confidential.

To File an Appeal

If you have a problem with coverage or payment of medical, behavioral health and substance use or pharmacy services, there are internal and external procedures to help you. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

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

Benefit Appeals

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

Different insurance carriers manage approvals and payments related to your medical, behavioral health, substance use and pharmacy benefits. To avoid delays in

the processing of your appeal, make sure that you submit your request on time and direct it to the correct insurance carrier. For example, you or your authorized representative will have 180 days to start an internal appeal with the medical insurance carrier following notice of an adverse determination with regard to your medical benefits.

Appealing to the Insurance Company

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

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

Annual Enrollment Period

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

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

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

2024 Health Plan Options

You have a choice of four health plans from ParTNers for Health. Each health plan has different out-of-pocket costs. Some examples include your copays, deductibles and coinsurance.

All health plan options cover the same services and treatments, but coverage decisions may vary by carrier (see Health Plan Carrier Networks). Eligible preventive care is free with all plans if you use an in-network provider.

Here is a comparison of the four plans:

Premier Preferred Provider Organization: Higher monthly premium, lower out-of-pocket costs (deductible, copays and coinsurance).

Standard Preferred Provider Organization: Lower monthly premium than Premier PPO, higher out-of-pocket costs.

Limited Preferred Provider Organization: Lower monthly premiums than the other PPOs, higher out-of-pocket costs than the other PPOs.

Local Consumer-driven Health Plan/Health Savings Account: Lowest monthly premium. In-network preventive care has no member cost. For most other services, you pay your deductible first before the plan pays anything. Then you pay coinsurance, not copays.

Learn more about Health Savings Accounts

There are limits on how much money you can put in your HSA each year:

- $4,150 for employee-only coverage in 2024;
- $8,300 for all other family tiers in 2024; and
- Members 55+ can add $1,000 more each year.

These limits include any contributions your employer may make to your HSA. HSA contributions in excess of the IRS maximums listed above are not tax deductible and are subject to a 6% excise tax, so monitor your HSA contributions carefully.

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

With the HSA, your total contribution is not available up-front. Your pledged amount is taken out of each paycheck, if your employer offers payroll deduction. You may only spend the money that is in your HSA at the time of service, but you can pay yourself back later with HSA funds. Newly enrolled members get a debit card from Optum Financial to use for qualified expenses. Current enrolled members who stay in the Local CDHP/HSA will use their same debit card.

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

See health plan options, deductibles, copays and coinsurance in the Health Plan Comparison Chart by **clicking on Enrollment Materials**.

Find premium charts, including COBRA, by **clicking on Premiums**.

Click on Health for plan option details.

Health Plan Carrier Networks

BlueCross BlueShield of Tennessee and Cigna, our health insurance carriers, administer our network options. Both carriers offer expansive networks of doctor, hospital and facility providers.

You can choose from four carrier networks for your medical care.

BlueCross BlueShield Network S Cigna LocalPlus

These networks include many providers, hospitals and facilities throughout Tennessee and across the country. Not all providers and hospitals are in the BlueCross Network S and Cigna LocalPlus networks, which helps keep premiums and claims costs low. There is no additional monthly cost added to the premium for the BlueCross Network S or Cigna LocalPlus networks.

BlueCross BlueShield Network P
Cigna Open Access Plus

These networks include more hospitals and facilities. There is an additional cost added to the monthly premium for the BlueCross Network P and Cigna OAP networks. You'll see the total cost for these networks in the premium chart. **You may also pay more per claim because the costs for services in these networks are generally higher** than the other two networks.

- Additional $75 per month for the employee-only tier
- Additional $85 per month for the employee + child(ren) tier
- Additional $150 per month for the employee + spouse and employee + spouse + child(ren) tiers

It's important to check the networks carefully. The network choice you make during Annual Enrollment is for the entire calendar year (Jan. 1 until Dec. 31). You may be able to make changes allowed by the plan if you have a qualifying event. Information about qualifying events is on page three of the **Enrollment Change Application.**

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

Covered Services

Covered services are generally the same whether you choose BlueCross BlueShield or Cigna. For some procedures, different medical criteria may apply based on the carrier you select. For detailed information on covered services, exclusions and how the plans work, view the BCBST or Cigna Member Handbook and your Plan Document by **going to the Publications webpage**. If you have questions about your benefits or medical criteria for a specific service, contact the carriers' member services.

Contact the Carriers

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

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

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

Learn More about Your Health Plan Carrier Networks

Click on Carrier Information for network hospital lists and directories.

How to Enroll

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

Included Health Benefits

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

Pharmacy

Managed by CVS Caremark

All health plans include full prescription drug benefits.

The health plan you choose (Premier PPO, Standard PPO, Limited PPO or Local CDHP/HSA) determines your out-of-pocket prescription costs.

How much you pay depends on three things:

- the drug tier – if you choose a generic, preferred brand, nonpreferred brand or specialty drug (two different cost tiers in the PPOs);
- the day supply you receive – 30-day (or <30) or 90-day (>31) supply; and
- where you fill your prescription – at a retail, Retail-90 or mail-order pharmacy.

Learn more about prescription drug benefits, the preferred drug list, vaccines and how to save money by **clicking on Pharmacy**.

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

Behavioral Health

Managed by Optum Health

All health plans include access to outpatient and facility-based behavioral health and substance use disorder services. Optum can help members and eligible dependents find a provider for in-person or virtual visits, explain benefits, identify best treatment options, schedule appointments and answer questions.

Your benefits also include applied behavior analysis therapy and preferred no-cost substance use treatment facilities (for PPO plans, no coinsurance after deductible for Local CDHP).

Learn more about your behavioral health benefits by **clicking on Behavioral Health**.

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

Employee Assistance Program

Managed by Optum Health

EAP services are available to all enrolled health plan members and eligible dependents, even if your dependents are not enrolled in a health plan.

Master's level specialists are available 24/7 to assist with stress, legal, financial, mediation and work/life services. With EAP services:

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

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

Learn more about your EAP benefits by **clicking on EAP**.

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

Wellness Program

Managed by new vendor Sharecare in 2024

To help you achieve your health goals, the wellness program is available to local government employees, spouses and adult dependents enrolled in the health plan.

Sharecare will be the wellness program vendor beginning in 2024. Members enrolled in health benefits will have access to lifestyle counseling, chronic condition management, a weight management program, digital health devices, the website, mobile app and biometric screenings. A diabetes remission and Diabetes Prevention Program will also be offered to members who qualify. The Diabetes Prevention Program is offered through health insurance carriers BlueCross or Cigna.

Additional Benefits

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

Dental Insurance (if offered by your agency)

Offered through Cigna and Delta Dental

ParTNers for Health offers two different dental plans.

Cigna: Dental Health Maintenance Organization – Prepaid Provider

You are required to select and use a Cigna network general dentist. You must notify Cigna of your choice. Find the list of dentists at **cigna.com/stateoftn**.

Members pay copays. Review the Patient Charge Schedule before having procedures performed. Lab fees may apply for some procedures.

Completion of crowns, bridges, dentures, implants or root canals already in progress on a new member's effective date will not be covered.

Members can contact Cigna customer service for additional information about coverage for orthodontic services in progress.

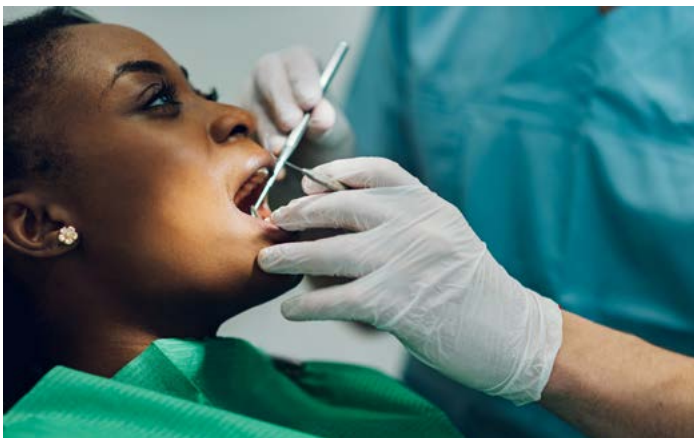
Delta Dental: Dental Preferred Provider Organization

Use any dentist but save money by choosing an in-network dentist.

Discuss any estimated expenses with your dentist or specialist. Charges for dental procedures are subject to change. Members pay deductibles and coinsurance.

Waiting periods apply to select procedures.

Find 2024 dental premiums by **clicking on Premiums** and going to **Other Insurance Coverages – Dental**.



Review the **dental DHMO and DPPO network options**, get a comparison of the two plans and find more information by **clicking on Dental**. The premium rates for the Cigna DHMO plan are less than for the DPPO plan; however, the network options are fewer in the DHMO. Employees should carefully review all details of each plan before making a selection.

To learn about all dental benefits, find the Cigna DHMO handbook, Cigna Patient Charge Schedule and the Delta Dental DPPO handbook by **clicking on Publications**.

Contact our dental carriers:

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

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

Vision Insurance (if offered by your agency)

Offered through EyeMed

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

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

All members in both vision plans get:

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

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

- Frames available once every two calendar years.

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

- Frames available once every calendar year.

Find 2024 vision premiums by **clicking on Premiums**, then go to Other Insurance Coverages – Vision.

Find information including a comparison of both plans by **clicking on Vision**.

Find the EyeMed handbook by **clicking on Publications** and Vision Insurance.

Contact: EyeMed, 855.779.5046, M-S, 7 a.m. – 10 p.m. CT, Sun. 10 a.m. – 7 p.m. CT, eyemed.com/stateoftn

Legal Notices

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, contact the Finance and Administration Civil Rights Coordinator at **FA.CivilRights@tn.gov** or or 615.532.9617.

Have you been denied services or treated differently for the above stated reasons? Find the Department of Finance and Administration's Nondiscrimination Policy and Complaint Procedures and Form under F&A Department Policies at **https://www.tn.gov/finance/looking-for/policies.html** (Policy 36); contact the F&A Civil Rights Coordinator; or mail a complaint to F&A Civil Rights Coordinator/Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

Need free language help? Have a disability and need free help or an auxiliary aid or service such as Braille or large print? If you speak a language other than English, help in your language is available for free. Contact the F&A Civil Rights Coordinator at 615.532.9617.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.576.0029 (TTY: 1.800.848.0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.(800.848.0298. هاتف الصم والبكم: 1 866)رقم .576.0029.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.866.576.0029 (TTY:1.800.848.0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1.866.576.0029 (TTY:1.800.848.0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.576.0029 (TTY: 1.800.848.0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.866.576.0029 (ATS : 1.800.848.0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalan- gan oh ntingidieng ni lokaiahn Pohnpei. Call 1.866.576.0029 (TTY: 1.800.848.0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር ይደውሉ 1.866.576.0029 (መስማት ለተሳናቸው: 1.800.848.0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.576.0029 (TTY: 1.800.848.0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.866.576.0029 (TTY:1.800.848.0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけま　866.576.0029（TTY:1.800.848.0298）まで、お電話にてご連絡くい。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.866.576.0029 (TTY: 1.800.848.0298).

ध्यान दे: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1.866.576.0029 (TTY: 1.800.848.0298) पर कॉल करे।ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.576.0029 (телетайп: 1.800.848. 0298).

زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان فراهم می باشد. با تماس تلفنی: اگر به 1.800.848.0298) (TTY: 866.576.0029 برای شما

If you have questions about civil rights compliance or concerns, you may also contact:

- U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909 or 1.800.368.1019 or TTY/TDD at 1.800.537.7697.
- U.S. Office for Civil Rights, Office of Justice Programs, U.S. Department of Justice, 810 7th Street, NW, Washington, DC 20531.
- Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

The Notice of Privacy Practice

Your health record contains personal information about you and your health. This information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services is referred to as protected health

information, or PHI. The Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act, or HIPAA, including Privacy and Security Rules. The notice also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practices is located on the Partners for Health website at **https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/hipaa.pdf**. You may also request the notice in writing by emailing **benefits.privacy@tn.gov**.

Prescription Drug Coverage and Medicare

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

Summary of Benefits and Coverage

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

Plan Document

The information contained on the Partners for Health website provides a detailed overview of the benefits available to you through the State of Tennessee. Specific plan information is contained within the formal plan documents and certificates of coverage. If there is any discrepancy between the information on the website and the formal plan documents and certificates of coverage, the plan documents and certificates of coverage will govern in all cases. You can find a copy of these documents on the Benefits Administration website at **www.tn.gov/PartnersForHealth/publications/publications.html**

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications, including, but not limited to, brochures and handbooks for medical, pharmacy, dental and vision and the brochure and handbook for the Supplemental Medical Insurance for Retirees with Medicare.

Notice Regarding Wellness Program

The law requires the Plan to provide you with certain notices and information regarding the Wellness Program. Please find the Notices regarding the Wellness Program online at tn.gov/Partnersforhealth under Wellness. To request a mailed copy of the Wellness Program Notices, you may send an email to **benefits.info@tn.gov**.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact ParTNers for Health at **partners.wellness@tn.gov**. Here is the link to the wellness page: **www.tn.gov/content/tn/partnersforhealth/other-benefits/wellness-program.html**

2024 Active Employees Monthly Health Premiums

	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
PREMIER PPO				
Employee Only	$826.01	$826.01	$901.01	$901.01
Employee + Child(ren)	$1,281.52	$1,281.52	$1,366.52	$1,366.52
Employee + Spouse	$1,899.82	$1,899.82	$2,049.82	$2,049.82
Employee + Spouse + Child(ren)	$2,232.43	$2,232.43	$2,382.43	$2,382.43
STANDARD PPO				
Employee Only	$760.13	$760.13	$835.13	$835.13
Employee + Child(ren)	$1,179.31	$1,179.31	$1,264.31	$1,264.31
Employee + Spouse	$1,748.30	$1,748.30	$1,898.30	$1,898.30
Employee + Spouse + Child(ren)	$2,054.38	$2,054.38	$2,204.38	$2,204.38
LIMITED PPO				
Employee Only	$617.23	$617.23	$692.23	$692.23
Employee + Child(ren)	$957.60	$957.60	$1,042.60	$1,042.60
Employee + Spouse	$1,419.62	$1,419.62	$1,569.62	$1,569.62
Employee + Spouse + Child(ren)	$1,668.16	$1,668.16	$1,818.16	$1,818.16
LOCAL CDHP/HSA				
Employee Only	$569.59	$569.59	$644.59	$644.59
Employee + Child(ren)	$883.70	$883.70	$968.70	$968.70
Employee + Spouse	$1,310.06	$1,310.06	$1,460.06	$1,460.06
Employee + Spouse + Child(ren)	$1,539.42	$1,539.42	$1,689.42	$1,689.42

The premium amounts shown reflect the total monthly premium. Please see your agency benefit coordinator for your monthly deduction and your employer's contribution, if applicable.

PARTNERS FOR HEALTH

2024 Monthly Dental Premiums

	CIGNA DHMO (PREPAID PROVIDER) PLAN	DELTA DENTAL DPPO PLAN
ACTIVE MEMBERS	**TOTAL PREMIUM (EDUCATION AND LOCAL GOVERNMENT)**	**TOTAL PREMIUM (LOCAL EDUCATION AND LOCAL GOVERNMENT)**
Employee Only	$14.19	$20.02
Employee + Child(ren)	$29.47	$53.23
Employee + Spouse	$25.15	$39.37
Employee + Spouse + Child(ren)	$34.58	$81.53
COBRA PARTICIPANTS		
Employee Only/Single	$14.47	$20.42
Employee + Child(ren)	$30.06	$54.29
Employee + Spouse	$25.65	$40.16
Employee + Spouse + Child(ren)	$35.27	$83.16
COBRA DISABILITY PARTICIPANTS		
Employee Only/Single	$21.29	$30.03
Employee + Child(ren)	$44.21	$79.85
Employee + Spouse	$37.73	$59.06
Employee + Spouse + Child(ren)	$51.87	$122.30

PARTNERS FOR HEALTH

2024 Monthly Vision Premiums

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	$3.18	$6.30
Employee + Child(ren)	$6.35	$12.60
Employee + Spouse	$6.03	$11.98
Employee + Spouse + Child(ren)	$9.33	$18.54
COBRA PARTICIPANTS		
Employee Only/Single	$3.24	$6.43
Employee + Child(ren)	$6.48	$12.85
Employee + Spouse	$6.15	$12.22
Employee + Spouse + Child(ren)	$9.52	$18.91
COBRA DISABILITY PARTICIPANTS		
Employee Only/Single	$4.77	$9.45
Employee + Child(ren)	$9.53	$18.90
Employee + Spouse	$9.05	$17.97
Employee + Spouse + Child(ren)	$14.00	$27.81

2024 Health Plan Comparison of Member Costs — Local Government

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

HEALTH PLAN OPTION	PREMIER PPO		STANDARD PPO		LIMITED PPO		LOCAL CDHP/HSA	
COVERED SERVICES	IN-NETWORK [1]	OUT-OF-NETWORK [1]	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								
• 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	No charge	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA								
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Provider-based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Including surgery in office setting • Provider-based telehealth • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use [2] • Including virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Carrier Programs (MDLive/ Teledoc)	$15	N/A	$15	N/A	$15	N/A	30%	N/A
Allergy Injection Without an Office Visit • Allergy serum has additional member cost	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	30%	50%
Chiropractic and Acupuncture • Limit of 50 visits of each per year	Visits 1-20: $25 Visits 21-50: $45	Visits 1-20: $45 Visits 21-50: $70	Visits 1-20: $30 Visits 21-50: $50	Visits 1-20: $50 Visits 21-50: $75	Visits 1-20: $35 Visits 21-50: $55	Visits 1-20: $55 Visits 21-50: $80	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY								
30-Day Supply	$7 generic; $40 preferred brand; $90 non-preferred	copay plus amount exceeding MAC	$14 generic; $50 preferred brand; $100 non-preferred	copay plus amount exceeding MAC	$14 generic; $60 preferred brand; $110 non-preferred	copay plus amount exceeding MAC	30%	50% plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 generic; $80 preferred brand; $180 non-preferred	N/A - no network	$28 generic; $100 preferred brand; $200 non-preferred	N/A - no network	$28 generic; $120 preferred brand; $220 non-preferred	N/A - no network	30%	N/A - no network
Maintenance Medications (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 generic; $40 preferred brand; $160 non-preferred	N/A - no network	$14 generic; $50 preferred brand; $180 non-preferred	N/A - no network	$14 generic; $60 preferred brand; $200 non-preferred	N/A - no network	20% without first having to meet deductible	N/A - no network
Specialty Medication Tier 1 (generics; 30-day supply from a specialty network pharmacy)	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	30%	N/A - no network
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	30%; min $200; max $400		30%; min $200; max $400		30%; min $200; max $400			

Download the chart at

https://www.tn.gov/content/dam/tn/partnersforhealth/documents/2024_comparison_charts/benefit_grid_2024_le_lg.pdf

2024 Health Plan Comparison of Member Costs — Local Government

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

HEALTH PLAN OPTION	PREMIER PPO		STANDARD PPO		LIMITED PPO		LOCAL CDHP/HSA	
COVERED SERVICES	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**	**IN-NETWORK [1]**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OUTPATIENT FACILITIES								
• Recommended screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans	No charge [5]	40%	No charge [5]	40%	No charge [5]	50%	No charge	50%
OTHER SERVICES								
Hospital/Facility Services [4] • Inpatient care [7]; outpatient surgery [7] • Inpatient behavioral health and substance use [2] [6]	15%	40%	20%	40%	30%	50%	30%	50%
• Emergency room services [7]	15%		20%		30%		30%	
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	15%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] • Home health; home infusion therapy	15%	40%	20%	40%	30%	50%	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4] • Outpatient PT/ST/OT/ABA [5]; Other therapy	15%	40%	20%	40%	30%	50%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging) [5]	15%		20%		30%		30%	50%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Pathology and Radiology Reading, Interpretation and Results [5]	15%		20%		30%		30%	
Ambulance (medically necessary, air and ground)	15%		20%		30%		30%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	15%	40%	20%	40%	30%	50%	30%	50%
Allergy Serum	15%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered. See Member Handbook for coverage details.							
DEDUCTIBLE — ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE								
Employee Only	$750	$1,500	$1,300	$2,600	$1,800	$3,600	$2,000	$4,000
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900	$2,500	$4,800	$4,000	$8,000
Employee + Spouse	$1,500	$3,000	$2,600	$5,200	$2,800	$5,500	$4,000	$8,000
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500	$3,600	$7,200	$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	$3,600	$7,200	$4,400	$8,800	$6,800	$13,600	$5,000	$10,000
Employee + Child(ren)	$5,400	$10,800	$6,600	$13,200	$13,600	$27,200	$10,000	$20,000
Employee + Spouse	$7,200	$14,400	$8,800	$17,600	$13,600	$27,200	$10,000	$20,000
Employee + Spouse + Child(ren)	$9,000	$18,000	$11,000	$22,000	$13,600	$27,200	$10,000	$20,000

For PPO Plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. **For Local CDHP Plan,** the deductible and out-of-pocket maximum amount can be met by one or more persons, but must be met in full before it is considered satisfied for the family. No one family member may contribute more than $8,700 to the in-network family out-of-pocket maximum total.

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

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] CDHP list of eligible medications, PPO list of eligible medication classes, and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health-options/pharmacy.html.

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

[5] For PPO plans, the deductible DOES NOT apply to IN-NETWORK outpatient PT/ST/OT/ABA and other PPO services as noted.

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

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

Download the chart at

https://www.tn.gov/content/dam/tn/partnersforhealth/documents/2024_comparison_charts/benefit_grid_2024_le_lg.pdf

PARTNERS FOR HEALTH

https://www.tn.gov/partnersforhealth.html

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