Annual Enrollment for 2026 Benefits

Oct. 3–Oct. 31, 2025

PARTNERS FOR HEALTH

Local Education Employees and COBRA Participants

Partners for Health—Benefits Cafe

Annual Enrollment for 2026 Benefits, Oct. 3-31, 2025

Each year, Annual Enrollment is your chance to choose your Partners for Health plan benefits that will be effective the following Jan. 1 through Dec. 31. Your annual enrollment period for 2026 benefits is Oct. 3-31, 2025.

This guide gives you important information about your 2026 benefits choices. You'll find a menu of benefit options. These include your health, dental, vision and other benefits. In this guide, you'll also learn how to enroll and find links to helpful videos. Lastly, there is a section where you'll learn about the Annual Enrollment confirmation statement, and find website links and vendor contact information for all the benefits described in this guide.

We encourage you to review your network options for health, dental and vision care each year. If you don't want to make changes, you don't have to do anything during Annual Enrollment. Please review the Important 2026 Benefits Changes section for information about 2026 premiums, benefits changes and vendor changes.

If you're enrolled now and don't make changes, you'll continue enrollment in the same plan options for medical, dental and vision products, if dental and vision are offered by your agency, and you'll pay 2026 premium amounts. No premium dollars will be deducted from your paycheck for any coverage in which you choose not to enroll or re-enroll.

To add, remove or make changes to your insurance coverage, go to How to Enroll in Your Benefits.

Now, let's open your menu of benefits!

A full menu of benefits,
served with peace of mind.

Important 2026 Benefits Updates 1

BENEFITS CAFÉ MENU

Health Benefits

Included with Health Benefits

Additional Benefits

Select Your Benefits

Served with Peace of Mind

Important 2026 Benefits Updates

Benefits Administration offers a wide choice of benefits. For 2026, health insurance premiums will increase by an **average of 5.0%** due to the higher cost of delivering health care. Specific premium increases will vary slightly depending on the health plan, network and coverage tier you choose.

For 2026, pharmacy costs are increasing mainly due to weight loss and specialty medications. Here are the 2026 pharmacy cost-sharing changes:

- Members will pay 25% coinsurance for medications prescribed for weight loss for all plans.
- Members will pay 30% coinsurance for in-network specialty medications for all plans.
- A separate maximum out-of-pocket amount will be added for specialty drugs obtained through the pharmacy benefit. The amount varies based on employee tier and plan selected.

BlueCross BlueShield and Cigna will remain the health insurance carriers, and you can choose from the same four provider networks, but the **monthly cost for the expanded networks will increase in 2026** for all tiers.

- **BlueCross BlueShield Network S and Cigna LocalPlus:** These are efficient networks, and you will save money with them. If your providers are in these networks, either may be your best choice.
- **BlueCross BlueShield Network P and Cigna Open Access Plus**: If you can't find your providers in the efficient networks, then you could consider these expanded networks. The monthly premiums for the expanded networks are higher because providers charge more in the expanded networks.For all health plan options, the 2026 additional monthly costs will be:
  - Employee-only tier – $90 per month
  - Employee+child(ren) tier – $100 per month
  - Employee+spouse and employee+spouse+child(ren) tiers – $180 per month

The Dental Preferred Provider Organization carrier **will change to MetLife** in 2026. The Dental Health Maintenance Organization - Prepaid Provider carrier will **continue to be Cigna**.

- Dental DPPO plan rates will stay the same for the employee-only and employee+spouse tiers. Rates will increase by 25% per month for the employee+child(ren) tier and 20% per month for the employee+spouse+child(ren) tier.
- 2026 DPPO benefit changes eliminate waiting periods for all enrolled members.
- DHMO Prepaid Provider plan rates will stay the same for all plan members.

TASC will be the new vendor for health savings accounts for members who enroll in the local consumer-driven health plan.

Health Benefits

Health Insurance Plan Options (choose one)

You have a choice of four health plans from Partners for Health. Each plan has different out-of-pocket costs. Examples of these costs include copays, deductibles and coinsurance.

All health plan options cover the same services and treatments, but coverage decisions may vary between BlueCross BlueShield of Tennessee and Cigna. 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 when paying for care.

Standard PPO: Lower monthly premium than Premier PPO, higher out-of-pocket costs when paying for care.

Limited PPO: Lower monthly premiums than the other PPOs, higher out-of-pocket costs than the other PPOs when paying for care.

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 into your HSA each year, but HSA maximum contributions are increasing in 2026, as permitted by the IRS:

- $4,400 for employee-only coverage;
- $8,750 for all other family tiers; and
- Members age 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 2026 maximums listed above are not tax deductible and are subject to a 6% excise tax. Monitor your HSA contributions carefully.

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

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

Important: TASC will be your new health savings account vendor starting on Jan. 1, 2026. The TASC HSA account will be available to all members who enroll in the CDHP for 2026. If you currently have a consumer-driven health plan/HSA with Optum Financial, you will need to complete a transfer form and submit it to Optum. If you switch your HSA to TASC, Partners for Health will continue to pay your monthly administrative fee. If you choose to keep your HSA with Optum, it will no longer be an employer-sponsored plan, and you will be charged

a monthly HSA maintenance fee by Optum. The transfer form will be available in December. You will have until June 30, 2026, to request that your funds be transferred. All 2026 CDHP/HSA members will receive a new debit card from TASC in December in a plain white envelope. The new TASC website, www.stateoftntasc.com, will provide updates.

HSA and FSA restrictions: There are 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 for dental and vision costs if one is offered by your employer.

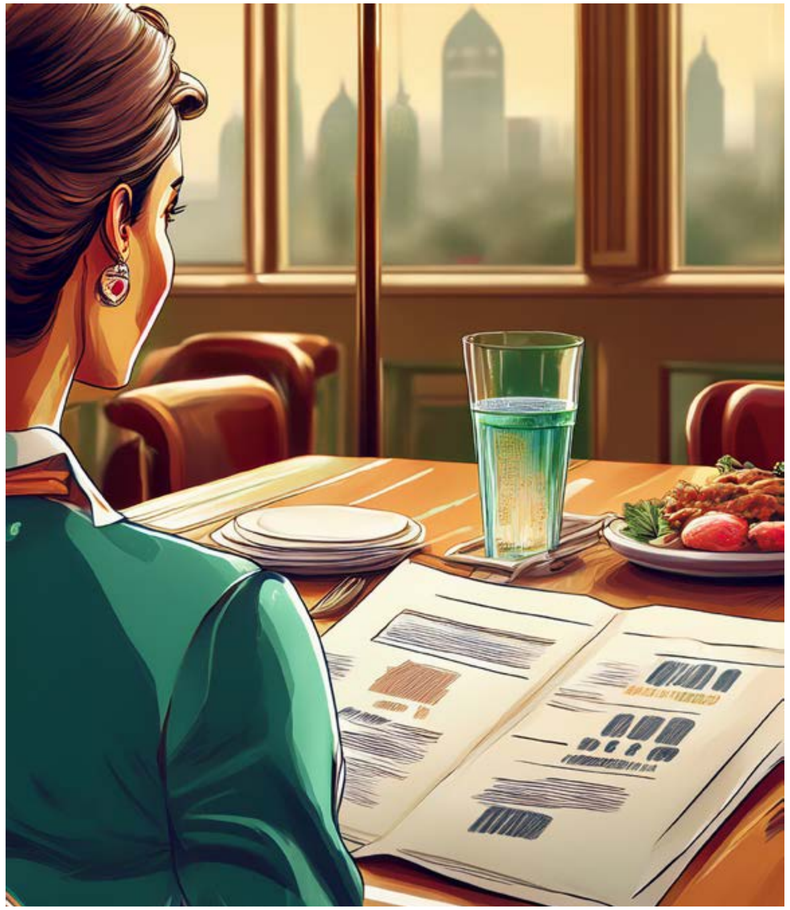
If you enroll in Social Security at age 65, you'll automatically be enrolled in Medicare Part A, and if enrolled in a CDHP, this may have tax consequences affecting your HSA contribution. Consult your tax advisor for advice.

Go to the end of this guide for website links for more information about health plans, HSA restrictions, 2026 maximum contribution amounts and debit card details.

For more details about premiums, please visit the Partners for Health Premiums webpage.

Health Insurance Network Options (choose one)

BlueCross BlueShield of Tennessee and Cigna, our health insurance carriers, offer expansive networks of doctors, hospitals and facility providers. Each carrier's networks cover the same benefits; however, the coverage decisions between carriers may differ. The only difference among the networks is the providers and hospitals that are in-network.



You can choose from four networks for your medical care.

BlueCross BlueShield Network S
Cigna LocalPlus

These are efficient networks, and you will save money with them. These networks include more than 95% of the providers and 85% of the hospitals that are in the expanded networks. If your providers are in BCBST Network S or Cigna LocalPlus, either may be your best choice for saving money on premiums and claims costs.

BlueCross BlueShield Network P
Cigna Open Access Plus

These are expanded networks, which include more hospitals and facilities, **but the monthly premiums are higher because providers charge more in the expanded networks. In 2026, for all health plans, the additional cost is increasing and will be:**

- Additional $90 per month for the employee-only tier
- Additional $100 per month for the employee + child(ren) tier
- Additional $180 per month for the employee + spouse and employee + spouse + child(ren) tiers.

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 efficient networks.

It's important to check the networks carefully. The network choice you make during Annual Enrollment is for the entire 2026 calendar year (Jan. 1 until Dec. 31). You may be able to make changes allowed by the plan if you have a qualifying event. You'll find information about qualifying events in the Enrollment Change Application found on the Partners for Health website under Publications, then Forms.

Network providers and facilities can and do change. Partners for Health 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 Partners for Health website and then going to the Publications webpage. If you have questions about your benefits or medical criteria for a specific service, contact the carriers' member services.

Go to the end of this guide for Partners for Health carrier network website links and carrier contact information.

Click Here to View Insurance Comparison Chart

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE — OFFICE VISITS - AS RECOMMENDED & MEDICALLY NECESSARY						
• Well-baby, well-child visits • Adult annual physical exam • Annual well-woman exam • Immunizations • Annual hearing and non-refractive vision screening • Screenings, labs, nutritional guidance, & tobacco cessation counseling	$0	$45	$0	$50	$0	40%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA						
Primary Care Office Visit [2] • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Initial maternity visit • Surgery in office setting • Provider-based telehealth • Allergy injections and serum	$25	$45	$30	$50	20%	40%
Specialist Office Visit [2] • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Surgery in office setting • Provider-based telehealth • Allergy injections and serum	$45	$70	$50	$75	20%	40%
Behavioral Health and Substance Use [2] [3] • Including provider-based virtual visits	$25	$45	$30	$50	20%	40%
Telehealth Programs (MDLive/Teladoc/Talkspace)	$15	N/A	$15	N/A	20%	N/A
Chiropractic and Acupuncture • Visit limit of 50 visits each	$25/visit 1-20 $45/visit 21-50	$45/visit 1-20 $70/visit 21-50	$30/visit 1-20 $50/visit 21-50	$50/visit 1-20 $70/visit 21-50	20%	40%
Convenience Clinic	$25	$45	$30	$50	20%	40%
Urgent Care Facility	$45	$70	$50	$75	20%	40%
PHARMACY - GENERIC/PREFERRED/NON-PREFERRED						
30-Day Supply	$7/$40/$90	copay + amount > MAC	$14/$50/$100	copay + amount > MAC	20%	40% + amount > MAC
90-Day Supply 90-day pharmacy or mail order	$14/$80/$180	N/A - no network	$28/$100/$200	N/A - no network	20%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order [4]	$7/$40/$160	N/A - no network	$14/$50/$180	N/A - no network	10% before deductible	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25%	N/A - no network	25%	N/A - no network	25%	N/A - no network
SPECIALTY PHARMACY MEDICATIONS - 30-DAY SUPPLY						
Generic/Preferred/Non-Preferred	30%	N/A - no network	30%	N/A - no network	30%	N/A - no network

July 2025 Learn more at tn.gov/partnersforhealth

Included with Health Benefits

Along with your medical coverage, your health plan provides the following benefits: pharmacy, behavioral health, an emotional wellbeing solutions program and a wellness program.

Learn about benefits such as Carrum Centers of Excellence services, telehealth, the Diabetes Prevention Program, behavioral health virtual visits and more by going to the Partners for Health website and then going to the Included Benefits Extras webpage.

Did you know we now have information organized by health topics and life events on our new Your Life, Your Benefits webpage? You'll find information about weight management.

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, including copay, coinsurance, deductible and out-of-pocket maximum.

How much you pay for prescriptions depends on several things including:

- The drug tier: Your choice of a generic, preferred brand, non-preferred brand or specialty drug will help determine price.
- The day supply you receive: A 30-day (or less than a 30-day supply) or 90-day (greater than a 31-day supply).
- Where you fill your prescription: You can fill at a retail, Retail-90, mail order or specialty pharmacy.

In 2026, pharmacy costs will increase mainly due to weight loss and specialty medications. Here are the 2026 pharmacy cost-sharing changes:

- Members will pay 25% coinsurance for medications prescribed for weight loss for all plans.
- Members will pay 30% coinsurance for in-network specialty medications for all plans.
- A separate maximum out-of-pocket amount will be added for specialty drugs obtained through the pharmacy benefit. The amount varies based on employee tier and plan selected.

As a reminder, specialty drugs and medications prescribed for weight loss are limited to a 30-day supply.

Go to the end of this guide for the pharmacy website link and contact information for CVS Caremark.

Behavioral Health

Managed by Optum Behavioral Health

All members enrolled in medical insurance with Partners for Health have behavioral health benefits through Optum Behavioral Health. All health plans include access to outpatient and facility-based behavioral health and substance use disorder services.

Optum Behavioral Health can help members find a provider for in-person or virtual visits, explain benefits, identify best treatment options, schedule appointments and answer questions. **Virtual Behavioral Coaching** provides personalized, self-paced support to those who need help managing symptoms of depression, stress and anxiety.

You have access to preferred substance use treatment facilities at no cost for PPO plans and no coinsurance after deductible for the CDHP plan. Your benefits include applied behavior analysis therapy.

Members have a separate Optum Behavioral Health ID card to use for their services.

Go to the end of this guide for the behavioral health website link and Optum Behavioral Health contact information.

Emotional Wellbeing Solutions

Managed by Optum Behavioral Health

Here4TN emotional wellbeing services are available to all those enrolled in a Partners for Health medical plan and benefits-eligible dependents, even if your dependents are not enrolled in medical insurance. COBRA participants are also eligible.

Specialists are available 24/7 to assist with stress, legal, financial, mediation and work/life services. With EWS, those who are eligible get five counseling visits, either in-person or virtual, per problem, per year, per individual at no cost to you.

Your benefits include the **Calm app,** available 24/7 to help build coping skills and resilience to navigate life's uncertainties; **Talkspace** online therapy; and **Take Charge at Work**, a coaching program that helps those working and eligible for EWS deal with stress and depression.

Go to the end of this guide for the Emotional Wellbeing Solutions website link and Optum Behavioral Health contact information.

Wellness Program

Managed by Sharecare

To help you achieve your health goals, the wellness program is available for local education employees, spouses and adult dependents enrolled in medical insurance through Partners for Health.

Members enrolled in health benefits will have access to the Sharecare online platform and the Sharecare mobile app, RealAge Test, lifestyle management coaching, chronic condition management coaching, the Eat Right Now weight management program, Unwinding Anxiety program, quarterly challenges and biometric screenings.

A Diabetes Prevention Program is also offered to members who qualify through health insurance carriers BlueCross BlueShield or Cigna.

Go to the end of this guide for the wellness program website link and Sharecare contact information.

Additional Benefits

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

Dental Insurance

(if offered by your agency)

Offered through Cigna and MetLife

Partners for Health offers two different dental plans.

Cigna: Dental Health Maintenance Organization – Prepaid Provider

Total premiums will not increase for active employees.

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.

MetLife: Dental Preferred Provider Organization

In 2026, DPPO plan rates will stay the same for the employee-only and employee+spouse tiers. Rates will increase by 25% per month for the employee+child(ren) tier and 20% per month for the employee+spouse+child(ren) tier.

Use any dentist but save money by choosing an in-network dentist. The MetLife DPPO plan will use MetLife's PDP+ network.

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

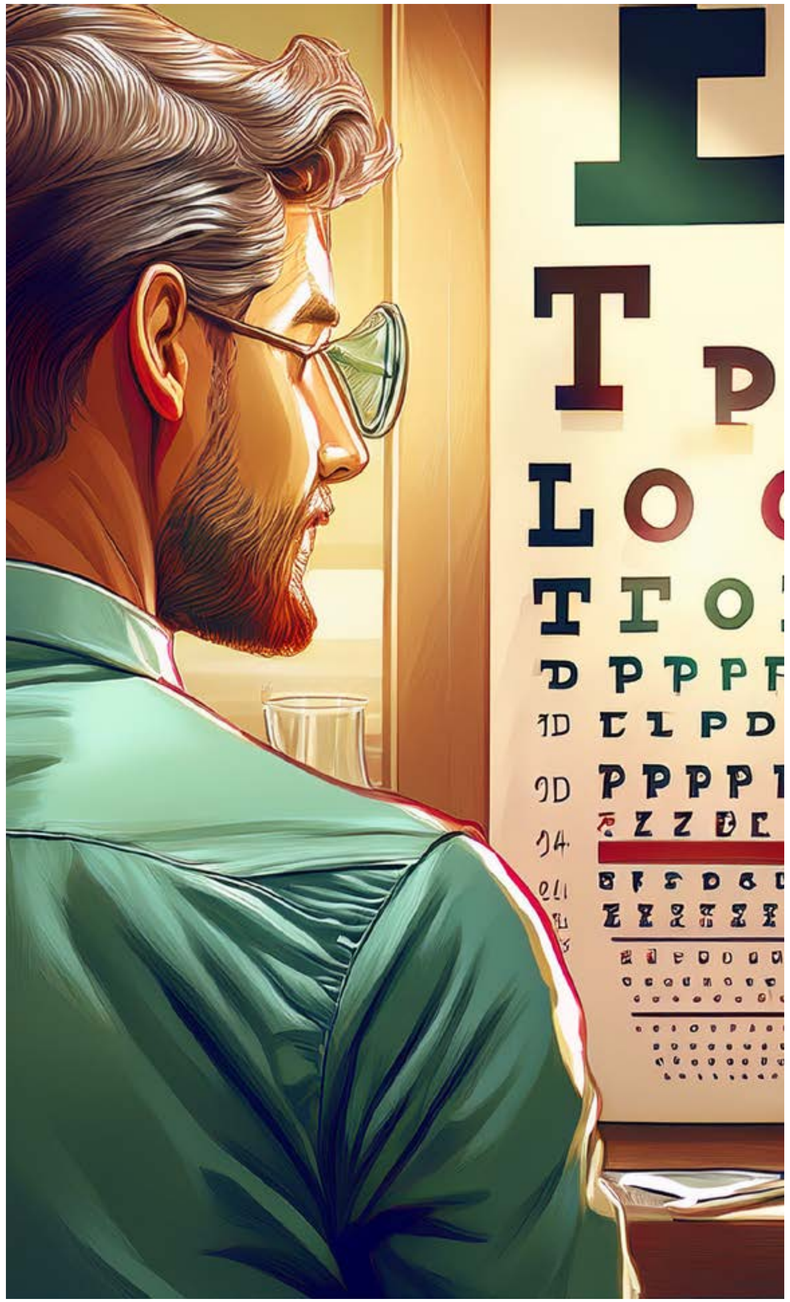
2026 DPPO benefits changes:

- There are no waiting periods for any services
- In-network deductibles will change from $25 to $50 per individual and from $75 to $150 per family with the DPPO
- Two routine office exams and two problem-focused exams will be covered each calendar year
- The orthodontia plan benefit lifetime maximum will increase to $1,500

There are other 2026 DPPO plan design changes. We encourage you to review the dental plan comparison chart found on the Partners for Health website on the Publications webpage under Insurance Comparison Charts.

The premium rates for the Cigna DHMO plan are less than for the DPPO plan; however, there are fewer providers in the DHMO. You 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, MetLife DPPO handbook and a comparison of the two plans on the Partners for Health website on the Publications tab.

Go to the end of this guide for the dental insurance website link for more information. Find the dental premiums and contact information for dental vendors Cigna and MetLife at the end of this guide.



Vision Insurance

(if offered by your agency)

Offered through EyeMed

Premiums and benefits will stay the same in 2026. You'll save money when using in-network providers.

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

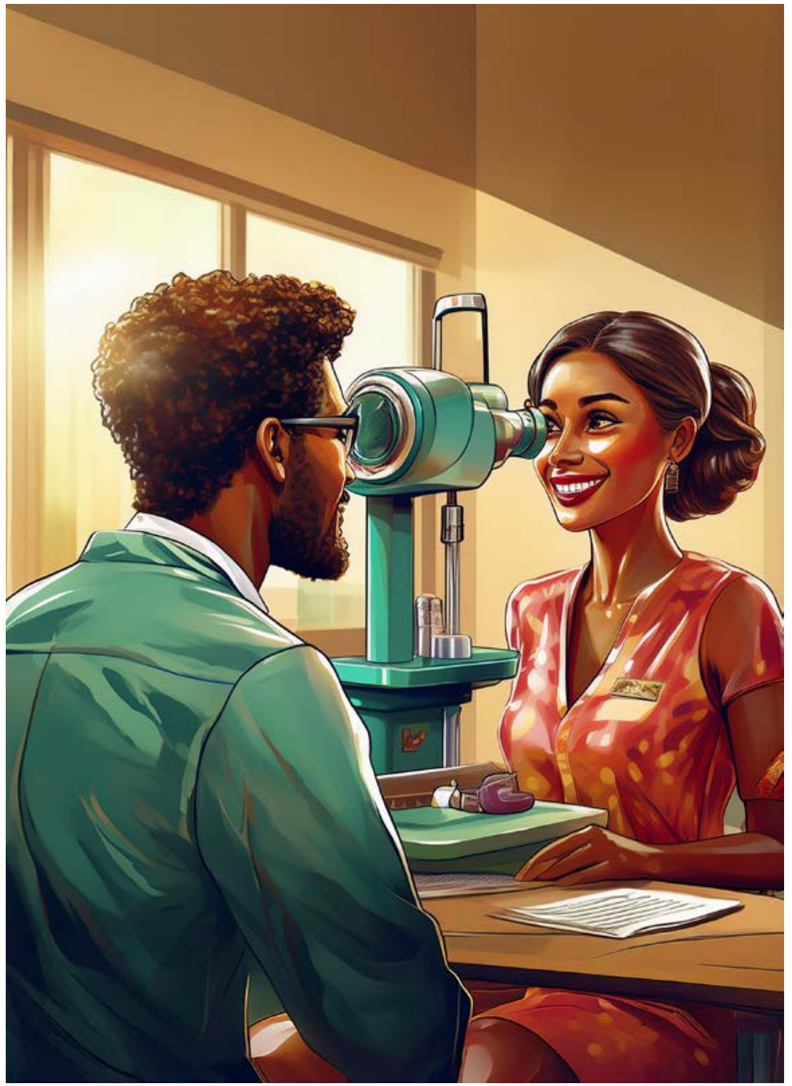
All members in both vision plans get:

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

Basic Plan: Pays for your eye exam after you pay a $10 copay and provides various allowances, or dollar amounts paid by the plan, for materials such as eyeglass frames and contact lenses. **Frames are available once every two calendar years.**

Expanded Plan: Annual eye exam with $0 copay. Includes greater allowances versus the Basic Plan. **Frames are available once every calendar year.**

In both plans, you pay copays; when the cost exceeds the allowed dollar amount paid by the plan, you pay the cost of materials and services above the allowance. Discounts may be available for select materials. Find the EyeMed handbook on the Partners for Health website by going to the Publications webpage and then going to Vision Insurance.



Go to the end of this guide for the vision insurance website link for more information and a comparison of the two plans. Find the vision premiums and contact information for EyeMed at the end of this guide.

SELECT YOUR BENEFITS

How to Enroll in Your Benefits

Employee Self Service in Edison

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

- Look for the green Benefits Enrollment button.
- Click the green Benefits Enrollment button, then click the Login button to log in to Edison using your Access ID. This is not your eight-digit Edison employee ID. To get your Access ID, go to Edison, click the green Benefits Enrollment button, and then click the Retrieve Access ID button.
- Effective June 2025, the password length for all Edison account users changed. If you have not done so, all Edison users MUST change their account passwords to a minimum of 15 characters. Once you have set up this new 15-character password, you will not be required to change it for 365 days**.**
- Once logged in, choose the Annual Enrollment tile to start your enrollment.
- All the insurance plans you are currently enrolled in, or that are available to you, are listed in Edison.
- You can enroll on your computer or mobile device. Use the web browser native to its operating system.

If you're adding new dependents or a spouse, we need documents to prove their relationship to you.

- Dependent verification documents MUST be submitted by the Annual Enrollment deadline of Oct. 31, 2025.
- Find a list of required documents online by going to the Partners for Health website, then go to Publications at the top of the page and then click on Forms, where you'll find Active Employees and COBRA. Required documents are found in the Dependent Eligibility Verification Documents link.

Get Help with Your Enrollment

You can find enrollment instructions and help with passwords:

- Find step-by-step enrollment login instructions by going to Annual Enrollment and then go to Enrollment Materials.
- For password reset help, call Edison at 866.376.0104.

If you change your mind: Employees have one opportunity to revise Annual Enrollment elections as described in Local Education Plan Document Section 2. The Plan Document is posted on the Partners for Health website by going to the Publications page.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward the other coverage. However, you must request enrollment within 60 days after the other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption. Application must be made within 30 days of a birth, adoption or placement for adoption for the coverage to be retroactive to the date of birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact your agency benefits coordinator or Benefits Administration.

On-demand Videos

Find videos to help you learn about your benefits by going to the Partners for Health videos webpage. You can watch them when it's convenient for you:

Annual Enrollment Video

Welcome to the Partners for Health Annual Enrollment Benefits Café

Benefits Videos

BlueCross BlueShield Medical Network Options

Cigna Medical Network Options

EyeMed Vision Options

Cigna Dental DHMO Option

MetLife DPPO Option

TASC HSA Option
(for those enrolled in a CDHP health plan)

Optum Behavioral Health
(including Emotional Wellbeing Solutions)

Sharecare Wellness Program

Contact Us

Find resources on the Partners for Health website at tn.gov/partnersforhealth

You'll find:

- A Questions? button to contact our help desk: https://benefitssupport.tn.gov/hc/en-us
- A green Help button to chat during business hours.
- Call Benefits Administration at 615.741.3590 or 800.253.9981, M-F 8 a.m. to 4:30 p.m. CT.

Insurance Premiums

2026 Monthly Health Premiums

2026 Monthly Dental Premiums

2026 Monthly Vision Premiums

For more details about premiums, please visit the Partners for Health Premiums webpage.

After Enrollment

Annual Enrollment Confirmation Statement

After you click the Submit Enrollment button in Edison, an email will be sent to your primary email address in Edison letting you know that your benefits enrollment has been submitted. After the Annual Enrollment period ends, you will get another email letting you know your confirmation statement is available in Edison. The email you receive will include instructions on how to access this statement. There are a couple of different ways you can access the enrollment confirmation statement:

- From the Edison homepage if you log in through the green Benefits Enrollment button: You will click Benefit Details, and then click on Benefits Statement. If you do not see the Benefit Details tile, check the drop-down in the upper left corner to make sure the Employee Self Service menu is selected.
- From the Edison homepage if you log in through the red Employee Portal login button: You will click Benefits & Health and then click on Benefit Statements under the Benefits section.

Let's Keep in Touch!

Benefits Administration sends emails to members with important insurance information throughout the year. Emails are from Partners for Health and are sent from an email service provider**. You can unsubscribe at any time, but if you do, you won't receive any insurance-related updates.** Please log in to Edison and **make sure your primary email address is correct.** It's easy! Click on your name next to the home icon in the top right corner. This will open an **Update Email Addresses & MFA Methods** pop-up window.

Click on the pencil icon near the **Primary Email** field to type in your updated email. Once complete, click Submit at the bottom of the pop-up window.

Important Partners for Health Website Links

Health Plans

CDHP/HSA Insurance Options

Network Information
(BlueCross BlueShield and Cigna)

Pharmacy

Behavioral Health

Dental Insurance

Vision Insurance

Wellness Program

Emotional Wellbeing Solutions

Included Benefits Extras

Your Life, Your Benefits

Contact Information

Benefits Administration
800.253.9981 or 615.741.3590
Monday-Friday, 8 a.m.-4:30 p.m. CT
Fax: 615.741.8196
e-mail: benefits.administration@tn.gov

HEALTH INSURANCE

BlueCross BlueShield of Tennessee
800.558.6213
Monday-Friday, 7 a.m.-5 p.m. CT
bcbst.com/members/tn_state/

Cigna
800.997.1617
24/7
cigna.com/stateoftn

HEALTH SAVINGS ACCOUNT

TASC
800.575.6277
24/7
www.stateoftntasc.com

PHARMACY

CVS Caremark
877.522.TNRX (8679)
24/7
info.caremark.com/stateoftn

BEHAVIORAL HEALTH/ EMOTIONAL WELLBEING SOLUTIONS

Optum Behavioral Health
855.HERE4TN (855.437.3486)
24/7
Here4TN.com

WELLNESS PROGRAM

Sharecare
888.741.3390
Monday-Friday, 8 a.m.-8 p.m. CT
sharecare.com/tnwellness/

DENTAL INSURANCE

Cigna Dental Health Maintenance Organization-Prepaid Provider
800.997.1617
24/7
cigna.com/stateoftn

MetLife – Dental Preferred Provider Organization
855.700.8001 Option 1
Monday-Friday, 7 a.m. to 5 p.m. CT
metlife.com/StateOfTN

VISION

EyeMed
855.779.5046

Monday-Saturday, 7 a.m. – 10 p.m. CT,
Sunday, 10 a.m. – 7 p.m. CT
eyemed.com/stateoftn

Legal Notices

Anti-Discrimination Compliance and Civil Rights Complaint Procedures

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

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243 or email FA.CivilRights@tn.gov.

F & A Policy No. 36. Non-Discrimination Policy and Complaint procedure may be found at the following link: Policy 36 - 10.24.2024 pdf

You may also contact the:

U.S. Department of Health & Human Services Region IV Office for Civil Rights
Sam Nunn Atlanta Federal Center,
Suite 16T70 61 Forsyth Street, SW
Atlanta, Georgia 30303-8909
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 Office of Attorney General and Reporter
Civil Rights Enforcement Division
P.O. Box 20207
Nashville, TN 37202

Language/Communication Assistance. Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing benefits.assistance@tn.gov and FA.CivilRights@tn.gov or calling 800-253-9981. If you think you have been denied free language or communications assistance, please call 615-532-9617 for the F&A Civil Rights Coordinator or follow the F & A complaint procedures in F & A Policy No. 36. Non-Discrimination Policy and Complaint Procedure which is available at the following link: Policy 36 - 10.24.2024 pdf

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298)

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

Chinese
注意：如果□會說中文，則提供免費的語言協助服務。請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

Vietnamese
CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn. Gọi 1-866-576-0029 (TTY: 1-800-848-0298).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0029)번으로 전화해 주십시오.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

Laotian
ຂ້ອນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີ. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298.

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

Gujarati
સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY: 1-800-848-0298).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください

Tagalog
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).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

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

The Notice of Privacy Practice

Your health record contains personal information about you and your health. This information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services is referred to as protected health information (PHI). The Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), and 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. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

Prescription Drug Coverage and Medicare

Medicare prescription drug coverage is available to everyone with Medicare. However, as a member of the State Group Insurance Program (SGIP), you have options for your drug coverage. For information about your current prescription drug coverage with the SGIP and your options under Medicare's prescription drug coverage, review the Medicare Part D notice on the Partners for Health website.

Summary of Benefits and Coverage

As required by law, a Summary of Benefits and Coverage is available which describes your 2026 health coverage options. The SBC will be available for review on the Partners for Health website no later than Sept. 1. The digital guide contains much of the same information. To get an 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 and Certificates of Coverage

The information contained in this guide provides a summary 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 in this guide and the formal plan documents and certificates

of coverages, the plan documents and certificates of coverage will govern in all cases. You can find a copy of these documents on the Partners for Health website on the Publications webpage.

Other Publications

In addition to the documents mentioned above, the Partners for Health 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 Partners for Health Wellness Program is a voluntary wellness program available to all state, higher education, local education, local government employees, spouses and adult dependents as well as retirees enrolled in health coverage. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the assessment or other medical examinations. Although you are not required to complete the health questionnaire, only active state and higher education employees and spouses who do so are eligible to receive cash incentives. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Partners for Health Wellness Program at 888.741.3390.

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

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law and the State of TN's contract with Sharecare to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive, if eligible. Anyone who receives your information for purpose of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the wellness vendor (nutritionists, nurses, nurse practitioners, registered dietitians, health coaches, and other health care professionals) and their vendor partners (case managers with the medical and behavioral health vendors, diabetes

remission program vendor, and the biometric screening vendor) to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate safeguards will be taken to avoid any data breach, and in the event a data breach occurs involving information in connection with the wellness program, you will be notified promptly. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Partners for Health at partners.wellness@tn.gov.

2026 Active Employees Monthly Health Premiums

ALL NETWORKS, PLANS AND TIERS				
	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
PREMIER PPO				
Employee Only	$793	$793	$883	$883
Employee + Child(ren)	$1,307	$1,307	$1,407	$1,407
Employee + Spouse	$1,783	$1,783	$1,963	$1,963
Employee + Spouse + Child(ren)	$2,060	$2,060	$2,240	$2,240
	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
STANDARD PPO				
Employee Only	$736	$736	$826	$826
Employee + Child(ren)	$1,214	$1,214	$1,314	$1,314
Employee + Spouse	$1,656	$1,656	$1,836	$1,836
Employee + Spouse + Child(ren)	$1,914	$1,914	$2,094	$2,094
	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
LIMITED PPO				
Employee Only	$695	$695	$785	$785
Employee + Child(ren)	$1,146	$1,146	$1,246	$1,246
Employee + Spouse	$1,565	$1,565	$1,745	$1,745
Employee + Spouse + Child(ren)	$1,807	$1,807	$1,987	$1,987
	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
LOCAL CDHP/HSA				
Employee Only	$607	$607	$697	$697
Employee + Child(ren)	$1,001	$1,001	$1,101	$1,101
Employee + Spouse	$1,365	$1,365	$1,545	$1,545
Employee + Spouse + Child(ren)	$1,578	$1,578	$1,758	$1,758

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.

2026 Monthly Dental Premiums

	CIGNA DHMO (PREPAID PROVIDER) PLAN			METLIFE DPPO PLAN		
	TOTAL PREMIUM (LOCAL EDUCATION, LOCAL GOVERNMENT, AND STATE OFFLINE AGENCIES)	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYEE PREMIUM	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYER PREMIUM	TOTAL PREMIUM (LOCAL EDUCATION, LOCAL GOVERNMENT, AND STATE OFFLINE AGENCIES)	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYEE PREMIUM	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYER PREMIUM
ACTIVE MEMBERS						
Employee Only	$14.69	$7.34	$7.35	$20.32	$10.16	$10.16
Employee + Child(ren)	$30.50	$15.25	$15.25	$67.54	$33.77	$33.77
Employee + Spouse	$26.03	$13.01	$13.02	$39.96	$19.98	$19.98
Employee + Spouse + Child(ren)	$35.79	$17.89	$17.90	$99.47	$49.73	$49.74

COBRA PARTICIPANTS		
Employee Only	$14.98	$20.73
Employee + Child(ren)	$31.11	$68.89
Employee + Spouse	$26.55	$40.76
Employee + Spouse + Child(ren)	$36.51	$101.46

COBRA DISABILITY PARTICIPANTS		
Employee Only	$22.04	$30.48
Employee + Child(ren)	$45.75	$101.31
Employee + Spouse	$39.05	$59.94
Employee + Spouse + Child(ren)	$53.69	$149.21

2026 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

	BASIC PLAN	EXPANDED PLAN
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

	BASIC PLAN	EXPANDED PLAN
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

2026 Health Plan Comparison of Member Costs — Local Education and 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. **Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.**

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY								
• Well-baby, well-child visits • Adult annual physical exam • Annual well-woman exam • Immunizations • Annual hearing and non-refractive vision screening • Screenings, labs, nutritional guidance, & tobacco cessation counseling	$0	$45	$0	$50	$0	$50	$0	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA								
Primary Care Office Visit [8] • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Initial maternity visit • Surgery in office setting • Provider-based telehealth • Allergy injections and serum	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit [8] • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Surgery in office setting • Provider-based telehealth • Allergy injections and serum	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use [2] [8] • Including provider-based virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Programs (MDLive/Teladoc/Talkspace)	$15	N/A	$15	N/A	$15	NA	30%	N/A
Chiropractic and Acupuncture • Annual limit of 50 visits each	$25/visit 1-20 $45/visit 21-50	$45/visit 1-20 $70/visit 21-50	$30/visit 1-20 $50/visit 21-50	$50/visit 1-20 $75/visit 21-50	$35/visit 1-20 $55/visit 21-50	$55/visit 1-20 $80/visit 21-50	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED								
30-Day Supply	$7/$40/$90	copay + amount > MAC	$14/$50/$100	copay + amount > MAC	$14/$60/$110	copay + amount > MAC	30%	50% + amount >MAC
90-Day Supply 90-day pharmacy or mail order	$14/$80/$180	N/A - no network	$28/$100/$200	N/A - no network	$28/$120/$220	N/A - no network	30%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day 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	20% before deductible	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25%	N/A - no network	25%	N/A - no network	25%	N/A - no network	25%	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY								
Generic/Preferred/Non-Preferred	30%	N/A - no network	30%	N/A - no network	30%	N/A – no network	30%	N/A - no network

2026 Local Education and Local Government Comparison. 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 except for in-network preventive care. **Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.**

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE – OUTPATIENT FACILITIES – AS RECOMMENDED & MEDICALLY NECESSARY								
Screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans [5]	$0	40%	$0	40%	$0	50%	$0	50%
OTHER SERVICES								
Hospital/Facility Services [4] [8] • 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 after first visit; Routine services & labor and delivery	15%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] [8] • 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 (Excludes advanced studies below) [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 (air and ground)	15%		20%		30%		30%	
Durable Medical Equipment, External Prosthetics and Medical Supplies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Limited Dental benefits, Hospice Care and Out-of-Country Charges. 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 — ELIGIBLE EXPENSES— MEDICAL, BEHAVIORAL, AND NON-SPECIALTY PHARMACY, COMBINED, INCLUDING APPLICABLE DEDUCTIBLE EXPENSES								
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
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES— SPECIALTY PHARMACY (ONLY), INCLUDING SPECIALTY PHARMACY DEDUCTIBLE EXPENSES								
Employee Only	$2,400	N/A	$2,400	N/A	$2,400	N/A	$2,400	N/A
Employee + Child(ren)	$3,600	N/A	$3,600	N/A	$4,800	N/A	$4,800	N/A
Employee + Spouse	$4,800	N/A	$4,800	N/A	$4,800	N/A	$4,800	N/A
Employee + Spouse + Child(ren)	$6,000	N/A	$6,000	N/A	$4,800	N/A	$4,800	N/A

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 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.

[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 is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] Additional information on the maintenance drug benefit 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] Enhanced benefit for select preferred Substance Use Treatment Facilities - PPO members won't 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.

[8] Member cost share for medications administered by a provider is determined by the place of service at the time of administration, i.e. provider office, infusion center, inpatient, or home.

Benefits Café

Tennessee Department of Finance and Administration. Authorization Number 317593, August 2025. This public document was promulgated at a cost of $0.00 per copy.