Annual Enrollment for 2027 Benefits

OCT. 1-OCT. 30, 2026

LOCAL EDUCATION EMPLOYEES
AND COBRA PARTICIPANTS

Review the Changes.
Make Your Plan.
Choose Your Benefits.

PARTNERS FOR HEALTH

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Benefits Administration, a division of the Department of Finance and Administration, manages the State Group Insurance Program. Partners for Health is the official logo and brand for the State Group Insurance Program.

PARTNERS FOR HEALTH

2027 HIGHLIGHTS

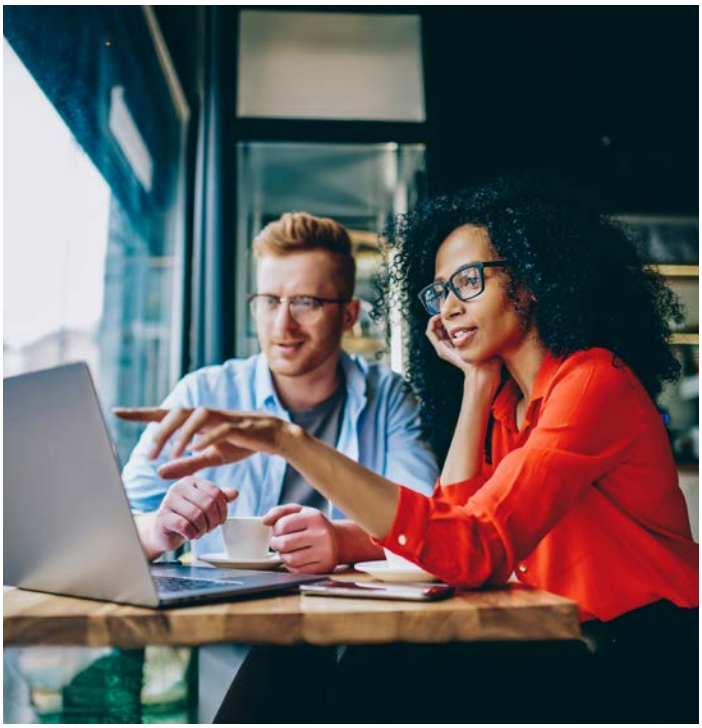
Review the Changes. Make Your Plan. Choose Your Benefits.

Thank you for considering Partners for Health for your insurance needs. We look forward to continuing to provide comprehensive, affordable, dependable and sustainable benefits to our members.

Annual Enrollment is when you can choose your Partners for Health benefits for the following Jan. 1-Dec. 31. Your annual enrollment period for 2027 benefits is Oct. 1-30, 2026.

2027 Premiums

For 2027, health insurance premiums will increase by an **average of 8.7%.** The increase is due to rising healthcare costs; however, it is lower than both national and state averages. Your specific increase may be different based on the health plan, network and coverage tier you choose. Tiers are employee only, employee+spouse, employee+children and employee+spouse+children.

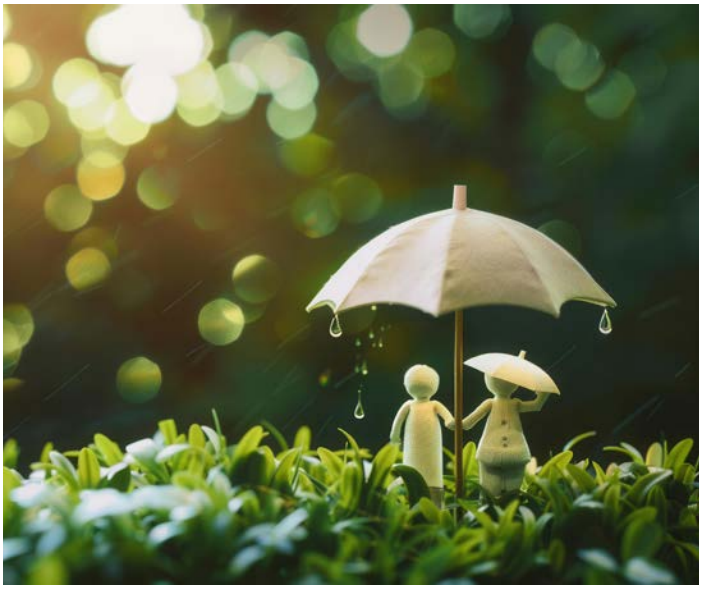


Health Plans

In 2027, you'll have the choice of five different health plan options, including the **new Copay Preferred Provider Organization:**

- With the **Copay PPO**, enrolled members will have lower premiums and no deductible.
- Copay PPO members will pay simple, predictable copay costs, so they'll know what care will cost ahead of time.
- Copay PPO members will use BlueCross BlueShield Network S providers. These providers will be in two different tiers—members will pay less when they choose providers in Tier 1 versus Tier 2.
- Copay PPO members will use the CVS Value Formulary for prescription drugs. This formulary is more selective in the medications it covers and only includes two tiers—generic medications and most preferred brand-name medications. Coinsurance for weight-loss and specialty drugs will apply with this plan.
- Copay PPO behavioral health and substance use services are covered and administered by Optum Behavioral Health.
- With the Copay PPO, there are out-of-pocket maximums to protect members from high costs.
- Details about the new Copay PPO are found on the ***Health webpage***, and you can watch a video to learn more.

With the other four health plan options: Premier PPO, Standard PPO, Limited PPO and the Local Consumer-driven Health Plan, there will be **no increase in health plan copays, deductibles or coinsurance.** These are your "cost share" for the out-of-pocket costs you pay when you get care.



Networks

BlueCross BlueShield and Cigna will stay as your health insurance carriers and will offer the same four provider networks.

- **BCBST Network S and Cigna LocalPlus:** These are efficient networks, and you will save money with them. If your providers are in these networks, either one may be your best choice.
- **BCBST Network P and Cigna Open Access Plus**: These are expanded networks, which include more hospitals and facilities than the efficient networks. However, the premiums are higher for the expanded networks, and you may pay more for services you receive from network providers. Visit the ***Premiums page*** > Health Insurance premiums to see the monthly premium charts and the increased cost if you select either of these networks.

Weight-loss Surgery

In 2027, weight-loss surgery will only be covered through the Carrum Health centers of excellence program. There will be no cost share for PPO members and no cost for Local CDHP members after meeting their deductible. If you use other providers for weight-loss surgery, it will not be covered.

Here is information about other available benefits:

- For agencies that offer this coverage, **dental and vision premium rates and benefits will not change next year.** The same carriers will administer these benefits.
- Optum Behavioral Health increased visits: Enrolled health plan members and eligible dependents will now get up to eight short-term counseling visits, per problem, per year, per individual at no cost.

Maybe your family or benefit needs have changed. Now is the time to review your options to make sure they make sense. This benefits guide provides important details and can help you make an enrollment plan.

- Note, if you're enrolled now and you don't make changes, you'll stay in the same plan options you have now, and you'll pay 2027 premium amounts.
- No premium dollars will be deducted from your paycheck for any coverage in which you choose not to enroll or choose to disenroll.

2027 HEALTH INSURANCE AND PREMIUMS

Choosing your health insurance coverage is a very important decision. Here you'll find your health plan options. Review, plan and select the right benefits for your budget, family and healthcare needs.

First, you'll choose your **health insurance plan option**, which affects your pharmacy coverage.

Then you'll choose your **network**, which includes your doctors, hospitals and other providers. With the **new Copay PPO, members will use BlueCross BlueShield Network S providers.**

For most plans, the network you choose affects your monthly **premium**, the amount taken out of your paycheck for coverage.

Monthly premiums are also determined by the coverage tier you choose, such as employee-only or a family coverage **tier**.

Health Insurance Plan Options (choose one)

In 2027, you'll have the choice of five different health plan options, including the new Copay Preferred Provider Organization. For all plans, in-network preventive care has no member cost sharing.

With the **Premier PPO, Standard PPO, Limited PPO** and the **Local Consumer-driven Health Plan with a health savings account:**

Each of these plans have different deductibles, copays and coinsurance. These are your out-of-pocket costs or your "cost share" when you get care.

- **Premier PPO:** Higher monthly premium, but you'll have lower out-of-pocket costs for care.
- **Standard PPO:** Lower monthly premium than the Premier PPO, but higher out-of-pocket costs when paying for care.
- **Limited PPO:** Lower monthly premium than the Premier and Standard PPOs, but higher out-of-pocket costs when paying for care.
- **Local CDHP/HSA:** Lower monthly premium than the Limited PPO. For most other services outside of in-network preventive care, you pay your deductible first before the plan pays for anything. Then you pay coinsurance, not copays.

WITH THE NEW COPAY PPO:

You'll pay simple, predictable copay costs, so you'll know what care will cost ahead of time. There is no deductible with this plan.

- The lowest monthly premiums compared to the other plan options.
- **Copay PPO members will use only BlueCross BlueShield Network S providers.** These providers will be in two different tiers, Tier 1 and Tier 2. Members will pay less when they choose providers in Tier 1.
- Copay PPO members will use the CVS Value Formulary for prescription drugs. This formulary covers generic and brand-name drugs but does not cover most non-preferred drugs. Coinsurance for weight-loss and specialty drugs will apply with this plan.
- Behavioral health and substance use services are covered and administered by Optum Behavioral Health.
- There are out-of-pocket maximums to protect members from high costs.
- Details about the new Copay PPO are found on the ***Health webpage***, and you can watch a video to learn more.

Resources to help you:

- *2027 Health Plan Comparison of Member Costs – Local Education and Local Government*
- *2027 Premium Charts*
- *Four Steps to Setting Up Health Insurance*

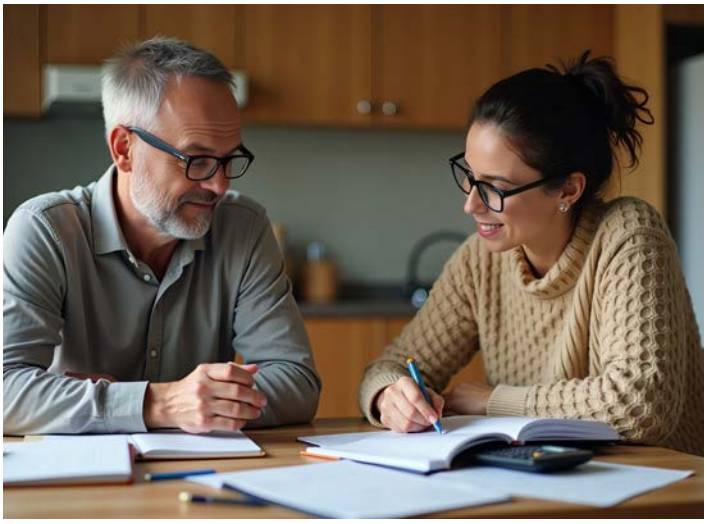
Learn more about health savings accounts

There are limits on how much money you can put into your HSA in 2027, as permitted by the IRS:

- $4,500 for employee-only coverage
- $9,000 for all other family tiers
- Members age 55+ can add $1,000 more each year
- These limits include any contributions your employer may make to your HSA. HSA contributions more than the IRS maximums listed above are not tax deductible and are subject to a 6% excise tax. Monitor your HSA contributions carefully.
- **Updating the HSA contribution amounts:** Local education employees who enroll in the Local CDHP will need to check whether your employer allows HSA contributions through payroll deduction. You may need to update this amount each year by providing your employer with the new amount.
- **HSA contribution is not available upfront:** If your employer offers payroll deduction, your pledged amount is taken out of each paycheck. You can only spend the money that is in your HSA at the time of service, but you can pay yourself back later with HSA funds.
- **HSA debit cards:** Currently enrolled HSA members will use the same debit card they have now. Members who are new to the Local CDHP/HSA will receive new debit cards from administrator TASC in December 2026.
- **HSA and flexible spending account restrictions:** There are restrictions on 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 FSA or health reimbursement account, among other restrictions. You can enroll in a limited purpose FSA for dental and vision costs, if one is offered by your employer.
- **Social Security and HSAs:** 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.

Visit *TASC* for more information.

All healthcare options cover the same medical services and treatments, but medical necessity decisions may vary by carriers BlueCross BlueShield of Tennessee and Cigna. Eligible preventive care billed as preventive is free if you use an in-network provider. Eligible preventive care coverage follows the United States Preventive Services Task Force recommended frequency and age limits for preventive screenings rated A or B. You can review the screening recommendations on the USPSTF website. Ask your doctor about your recommended preventive services.



Pharmacy

Managed by CVS Caremark
All Partners for Health medical plans include pharmacy benefits. When you choose your health plan option, this will determine your out-of-pocket prescription costs such as your copay or coinsurance and out-of-pocket maximum.

CVS caremark

If you choose the **Premier PPO, Standard PPO, Limited PPO or the Local CDHP,** here is how much you'll pay and where you'll get your prescriptions.

Here is information on your cost share:

A copay is a flat dollar amount you pay when filling a prescription. The exact amount depends on:

- Your health plan option
- The drug tier (generic, preferred brand or non-preferred brand)
- The number of days' supply you receive

Coinsurance is a percentage of the drug's cost that you pay when filling a prescription. Coinsurance applies to the **Local CDHP, specialty drugs and medications prescribed for obesity.**

Visit the ***pharmacy webpage*** to see which medications are covered. Here you'll find the Prescribing Guide–Standard Control for Clients with Advanced Control Specialty Formulary. This guidebook is updated quarterly.

If you choose the **new Copay PPO**, this is how much pay and where you'll get your prescriptions. You'll use the **CVS Value Formulary.**

Here is information about your cost share:

Copay PPO members will use the CVS Value Formulary beginning in 2027. This formulary is more selective in the medications it covers and only includes two tiers:

- Generic medications, and
- Most preferred brand-name medications

You'll pay copays. A **copay** is a flat dollar amount you pay when filling a prescription. The exact amount depends on:

- Your health plan option
- The drug tier (generic or brand)
- The number of days' supply you receive

Coinsurance is a percentage of the drug's cost that you pay when filling a prescription. Coinsurance applies to **specialty drugs and medications prescribed for obesity.**

Visit the ***pharmacy webpage*** to see which medications are covered. Here you'll find the **CVS Value Formulary**. This formulary is updated quarterly.

Where you get your prescription: You can fill your prescription at any pharmacy participating in the Partners for Health network.

- Retail-30 Network: Fill up to a 30-day supply of medications at most pharmacies.
- Retail-90 Network: Fill up to a 90-day supply of your medications at one time, often at a lower cost than filling multiple 30-day prescriptions. Not all pharmacies in the Retail-30 Network are part of the Retail-90 Network.
- Specialty Pharmacy Network: Your plan requires specialty medications to be filled through pharmacies in the Specialty Pharmacy Network.
- Use the Pharmacy Locator tool at the CVS Caremark website to help you.

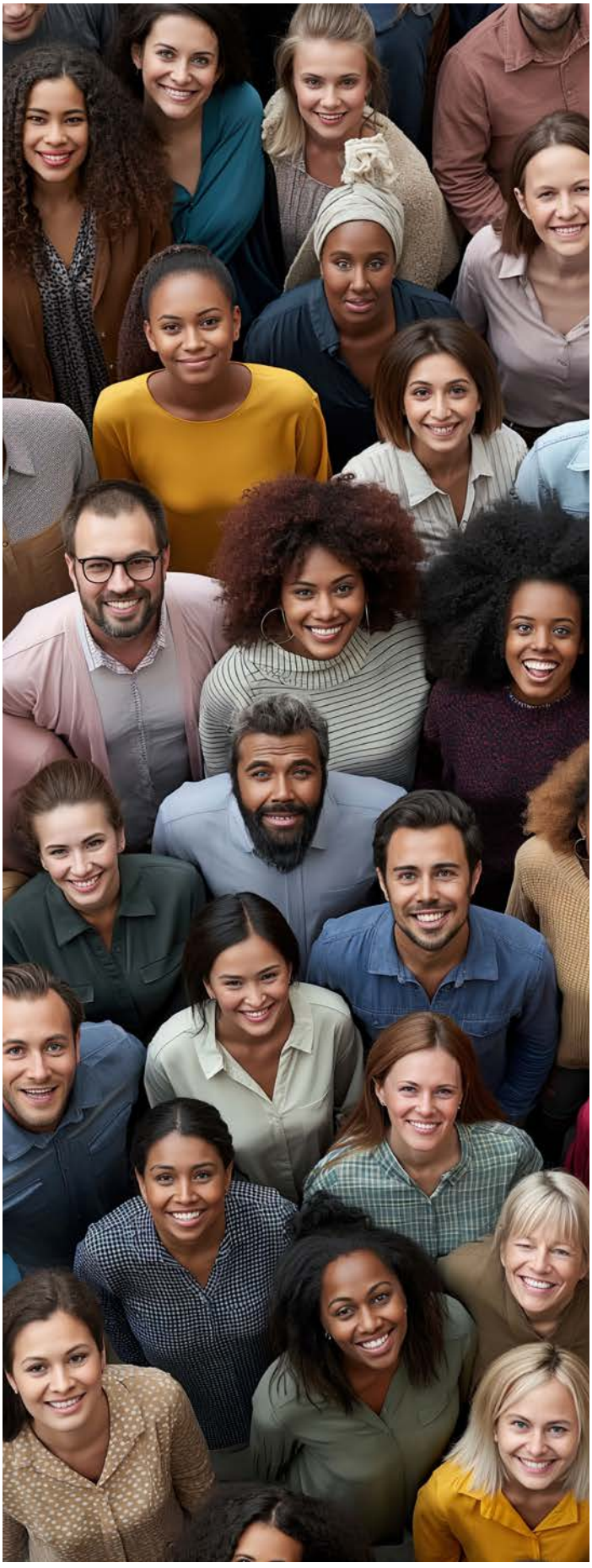
All Partners for Health medical plans include these pharmacy benefits

Specialty Drugs

Members pay 30% coinsurance for specialty medications with all plans. Specialty drugs are limited to a 30-day supply. Additionally, there is a separate maximum out-of-pocket for specialty drugs processed through the pharmacy benefit. This amount varies based on your coverage tier.

Weight-loss Medications

Members pay 25% coinsurance for weight-loss medications with all plans. Medications prescribed for weight loss are limited to a 30-day supply.



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 network covers the same benefits; however, coverage decisions between carriers may differ.

If you choose the Premier PPO, Standard PPO, Limited PPO or the Local CDHP, you'll choose from four network options for your medical care. The in-network providers and hospitals in each option may be different.

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 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 healthcare costs.

BlueCross BlueShield Network P
Cigna Open Access Plus
These are expanded networks that include more hospitals and facilities than the efficient networks. However, the premiums are higher for the expanded networks, and you may pay more for services you receive from network providers.

Search the carriers' websites for your providers:

Efficient Networks

BCBST Network S

Cigna LocalPlus

Expanded Networks

BCBST Network P

Cigna Open Access Plus

of Tennessee

cigna healthcare

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* > Publications. If you have questions about your benefits or medical criteria for a specific service, contact the carriers' member services.

If you choose the Copay PPO, you'll use BlueCross BlueShield Network S providers.

Copay PPO members will use BCBST Network S providers only. These providers will be in two different tiers, Tier 1 and Tier 2. Members will pay less when they choose providers in Tier 1.
Search the BCBST Tiered Network S directory for your providers and learn if they are in Tier 1 or Tier 2:
BCBST Tiered Network S

Covered Services
For detailed information on covered services, exclusions and how this plan works, view the BCBST Member handbook and your plan document by going to the *Partners for Health website* > Publications. If you have questions about these benefits or medical criteria for a specific service, contact BCBST member services.

It's important to check the networks carefully. **The network choice you make during Annual Enrollment is for the entire 2027 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 the *Help for Qualifying Enrollment Events* webpage.

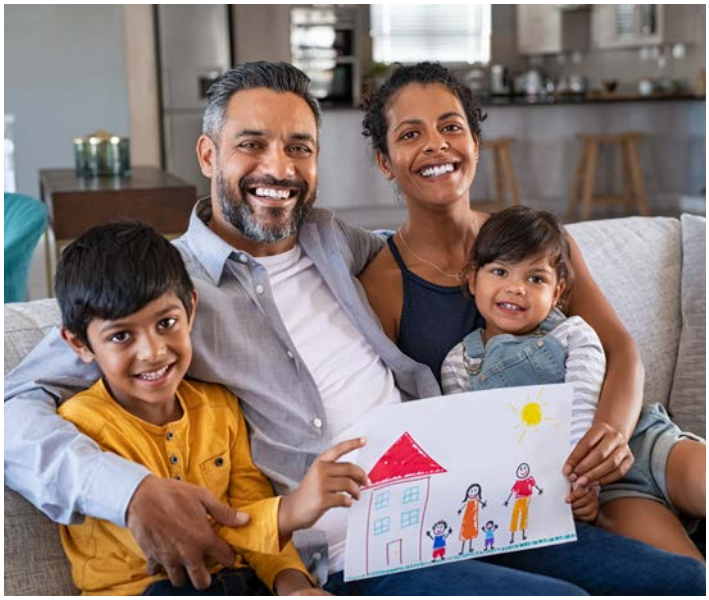
Network providers and facilities can and do change. Benefits Administration cannot guarantee that all providers and hospitals in a network at the beginning of the year will stay in that network for the entire year. A provider or hospital leaving a network is not a qualifying event and does not allow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

Premiums and Tiers

Visit *Premiums* to find the Insurance Premiums for 2027.

On the premiums webpage, you'll find health insurance and dental and vision premiums.

- Local education employees choose **Local Education Plan premiums**.
- Your monthly premium is the amount taken out of your paycheck for your coverage.



Find premium charts on the *Premiums webpage*.

The following things affect your health insurance premium costs:

Your choice of healthcare options

Your choice of networks (except for the new Copay PPO; those members will use BlueCross Network S).

The size and makeup of your family

There are four premium coverage levels, called **tiers**:

1. Employee only
2. Employee + spouse
3. Employee + child(ren)
4. Employee + spouse + child(ren)

Where you work

For local education employees, you will pay a portion or all the **employee** premium for your health insurance on the 2027 monthly premium charts. Contact your employer for your premium amounts.

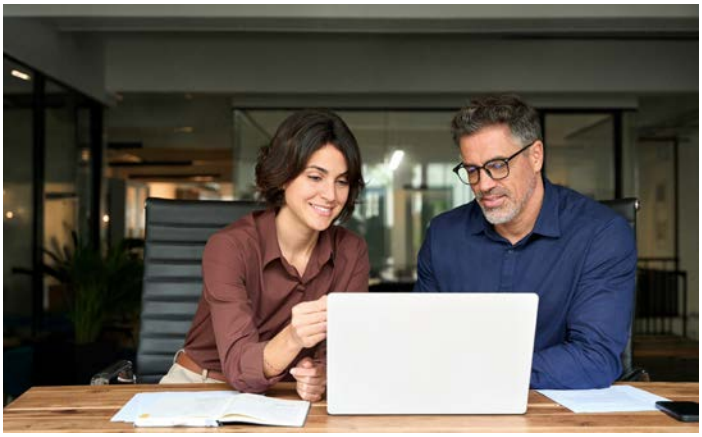
HOW TO ENROLL AND HELPFUL INFORMATION

Employee Self Service in Edison

- You'll use Employee Self Service in Edison to add, remove or make changes to your insurance coverage, unless otherwise noted.
- Annual Enrollment elections must be submitted through the Edison self-service portal. Your agency benefits coordinator can also submit your Annual Enrollment elections for you electronically via a Benefit eform. See your ABC about this option. Enrollment Change Applications are not a valid submission method and will not be processed for Annual Enrollment elections.

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.
- 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 device's built-in web browser.
- If you're adding new dependents or a spouse, we need documents to prove their relationship to you.
- Dependent verification documents MUST be received by Nov. 9, 2026, which is 10 days after the annual enrollment period ends.
- Find a list of required documents on the Partners for Health website, under Publications > Forms > Active Employees and COBRA. Required documents are listed in the ***Dependent Eligibility Verification Document.***



Enrollment Instructions and Password Reset

You can find enrollment instructions and help with passwords:

- ***Higher Education, Local Education, Local Government: How to Enroll***
- For password reset help, call Edison at 866.376.0104.

If you change your mind after the annual enrollment period has ended: Employees have one opportunity to revise their annual enrollment elections as described in the Local Education Plan Document Section 2. The plan document is posted on the Partners for Health website on the Publications page.

Enrollment Videos

How to Reset Your Password

How to Get Your Access ID

How to Log in for the First Time

Special Enrollment– Other Opportunities to Enroll

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 later if you or your dependents experience an event that results in losing 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.

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.

In addition, if you or your dependents become newly eligible for a premium subsidy under a State Children's Health Insurance Program or Medicaid, you may be able to enroll yourself and your dependents. You must apply within 60 days of receiving notice of eligibility for the premium subsidy.

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

Benefits Information from our Vendors

BlueCross BlueShield Medical Network Options

Cigna Medical Network Options

CVS Caremark

EyeMed Vision Options

Cigna Dental DHMO Option

MetLife DPPO Option

TASC Health Savings Account Option
(for those enrolled in a CDHP health plan)

Optum Behavioral Health

Sharecare Wellness Program

Helpful Terms and Definitions

There is a *definitions page* on the Partners for Health website to help you with any terms used in this guide and on the website.

Contact Us

On the Partners for Health website, you'll find:

- A *Questions* link to contact our help desk.
- The chat icon on the bottom-right corner to contact our help desk during business hours.

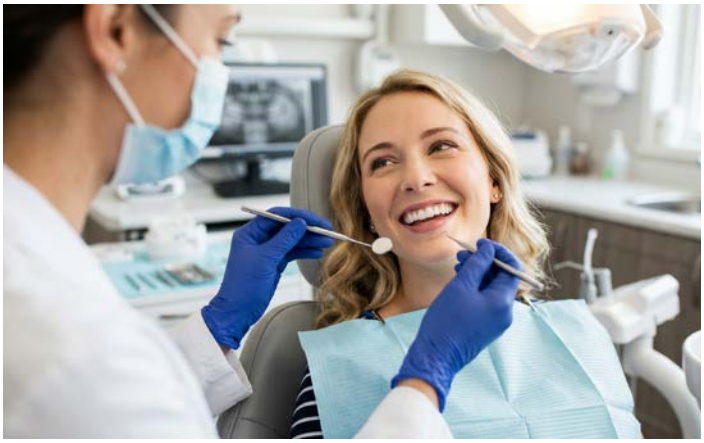
Call Benefits Administration at 615.741.3590 or 800.253.9981, M-F 8 a.m. to 4:30 p.m. CT or email us at *benefits.administration@tn.gov*.

Find premium charts on the *Premiums webpage*.

DENTAL AND VISION INSURANCE

Partners for Health offers dental and vision insurance options for you and your eligible dependents. Your employer determines whether to offer this coverage. Typically, employees pay 100% of the premiums. Your employer may contribute to the premium in some instances.

Find premium charts on the ***Premiums webpage***.



Dental Insurance

(if offered by your agency)
Offered through Cigna and MetLife

Partners for Health offers two different dental plans. Premiums and benefits stay the same in 2027 for both dental plans.

See the dental plan comparison chart on the ***Publications webpage*** > Insurance Comparison Charts – 2027 Dental Options.

Cigna: Dental
Health Maintenance Organization – Prepaid Provider
Members must choose a Cigna network general dentist and notify Cigna. View the ***list of dentists.***

- Members pay copays. Review the Cigna Dental Care® Plan 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 before coverage begins will not be covered.
- Members can contact Cigna for details on orthodontic services already in progress.

MetLife: Dental
Preferred Provider Organization
You may use any dentist, but in-network dentists cost less. In the DPPO plan, you'll search for providers in ***MetLife's PDP+ network***.

- Discuss estimated costs with your dentist or specialist. Charges for dental procedures are subject to change. Members pay deductibles and coinsurance.
- There are no waiting periods for any services.
- In-network deductibles: $50 per individual, $150 per family.
- Two routine office exams and two problem-focused exams will be covered each calendar year.
- Annual plan maximum: $1,500.
- Children orthodontia benefit lifetime maximum: $1,500.

Cigna DHMO premiums are lower than MetLife DPPO premiums, but the DHMO has fewer providers. Review all plan details before choosing. Find both plan handbooks and the Cigna patient charge schedule on the Partners for Health website under ***Publications***.

Visit ***Cigna DHMO*** for more information.

Visit ***MetLife DPPO*** for more information.

Vision Insurance

(if offered by your agency)
Offered through EyeMed

Typically members pay 100% of the monthly premium. In 2027, premiums and benefits will stay the same. You'll save money by using in-network providers.

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

Both include:

- One routine eye exam every calendar year
- Eyeglass lenses or contact lenses once each calendar year
- Low-vision evaluation and aids once every two calendar years

See the vision plan comparison on the ***Publications webpage*** > Insurance Comparison Charts – 2027 Vision Options.

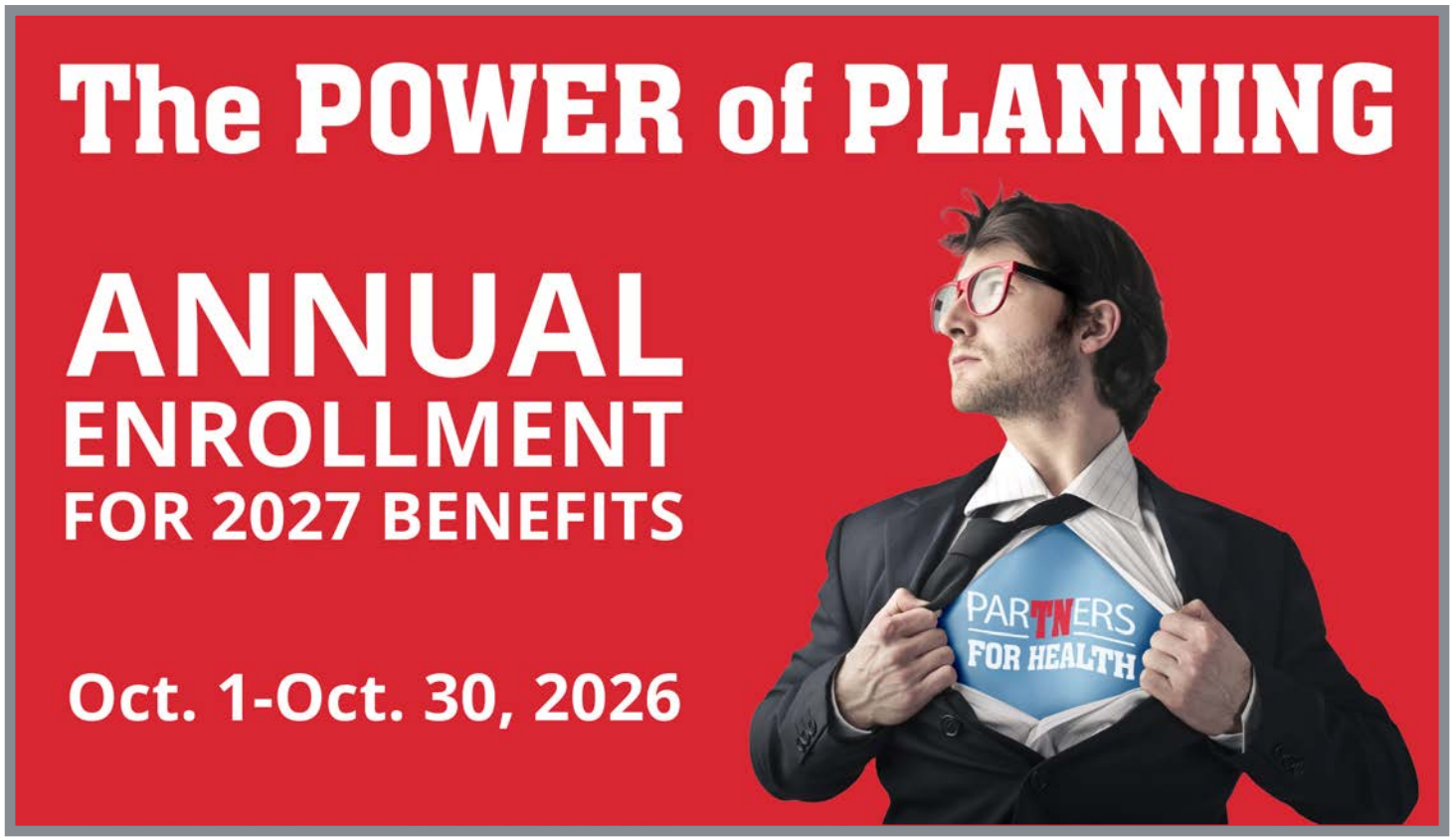
Basic Plan: $10 copay for an eye exam. Set dollar amounts paid by the plan for materials such as frames and contact lenses. **Frames are available once every two calendar years.**

Expanded Plan: $0 copay for an annual exam and dollar amounts paid by the plan are higher than the Basic Plan. **Frames are available once every calendar year.**

In both plans, you pay copays and any costs above the dollar amounts paid by the plan for materials and services. Discounts may apply to some materials.

Find the EyeMed handbook by going to the ***Publications webpage*** > Vision Insurance.

Visit *EyeMed* for more information.



BENEFITS INCLUDED WITH COVERAGE

Members enrolled in medical coverage also have the following benefits: behavioral health, an employee assistance program, a wellness program and centers of excellence services. Here's more information about these benefits.

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. Your benefits include applied behavior analysis therapy.

Members who use certain preferred substance use treatment facilities can have their costs waived.

- For PPO members, the deductible and coinsurance are waived.
- For Local CDHP members, coinsurance is waived after the deductible is met.
- Copays, deductible and coinsurance will still apply for standard outpatient treatment services.

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

Visit ***Here4TN.com*** for more information or call 855-437-3486.

Employee Assistance Program

Managed by Optum Behavioral Health

Members have access to an employee assistance program through Here4TN. Services are available to those enrolled in a Partners for Health medical plan and their benefits-eligible dependents, even if they 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. In 2027, eligible individuals will now get eight counseling visits, either in-person or virtual, per problem, per year, at no cost.

Your benefits include the **Calm Health 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 EAP deal with stress and depression.

Visit ***Here4TN.com*** for more information or call 855-437-3486.

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 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 digital weight loss and diabetes prevention program, Unwinding Anxiety program, quarterly challenges and biometric screenings.

Visit *Sharecare* to learn more about the program and find resources.

sharecare

Centers of Excellence Services

Available through Carrum Health

All members aged 18 and older enrolled in medical insurance with Partners for Health have centers of excellence services available through Carrum Health.

Carrum Health makes it simpler and more affordable for you to access top surgical and cancer care from some of the nation's leading surgeons and specialists.

In 2027, weight-loss surgery will only be covered through the Carrum Health centers of excellence program. There will be no cost share for PPO members and no cost for Local CDHP members after meeting their deductible. Weight-loss surgery performed by any other provider will not be covered.

Visit *Carrum Health* for more details.

carrumhealth

Carrum Health provides access to many non-emergency surgical and medical services, including:

- Joint and spine surgeries
- Heart surgery
- Comprehensive cancer care

Most, if not all, costs associated with Carrum Health services will be covered by your medical plan. Members in the Local CDHP will need to meet the federal minimum deductible, but your coinsurance is waived. For those enrolled in a PPO, all out-of-pocket costs are waived. Plus, Carrum Health offers second opinion services at no charge, with no deductible required.

Included Benefits Extras webpage:
Learn about services such as telehealth, Hinge Health personalized exercise therapy, expert medical opinion services and much more.

Your Life, Your Benefits webpage:
This page organizes resources by health topics and life events, so they're easy to find. Get information about weight management, diabetes support, stress and anxiety and maternity care.

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 confirming that your benefits enrollment has been submitted. After the Annual Enrollment period ends, you'll get another email letting you know your confirmation statement is available in Edison. This email will include instructions on how to access the statement, and there are a couple of different ways you can do it:

- From the Edison homepage, if you log in through the green Benefits Enrollment button: 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.
- Or from the Edison homepage, if you log in through the red Employee Portal login button: Click Benefits & Health and then click on Benefit Statements under the Benefits section.

ID and Debit Cards

ID Cards

Newly enrolled members and members who change their medical, dental or vision plans will receive new ID cards for 2027. If you do not change your medical, dental or vision plan, you will not get a new ID card.

If you enroll in the new Copay PPO, you will get new medical, behavioral health and pharmacy ID cards.

Medical plan members: Those who are newly enrolled, members who changed their last name and members

who change plans will receive new medical, behavioral health and pharmacy ID cards.

Debit Cards

Current local consumer-driven health plan/ health savings account members will use their same debit cards. Newly enrolled Local CDHP members will get a new debit card from TASC.

If you have an HSA and your agency has an independent contract with TASC for your limited purpose FSA, you will have two separate cards.

When Cards Will Mail

- **BlueCross BlueShield:** ID cards will mail by Dec.15, 2026.
- **Cigna** (both medical and dental)**:** ID cards will mail between Dec. 9-18, 2026.
- **CVS Caremark:** ID cards will mail between Dec.11-31, 2026.
- **MetLife Dental:** ID cards will mail between Dec. 9-18, 2026.
- **EyeMed:** ID cards will mail by Dec.17, 2026.
- **Optum Behavioral Health:** ID cards will mail by Dec.15, 2026.
- **TASC:** HSA/FSA debit cards will mail between Dec.10-31, 2026. They'll arrive in an unmarked envelope.

Members can request additional cards by contacting the vendor(s) or by using a vendor's mobile app or online member portal. Find vendor contact information on the *Benefits Contact Information webpage*.

Keep Your Email Address Current

Partners for Health sends important insurance emails to members throughout the year. Emails include the Partners for Health logo 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, including Annual Enrollment information.** To continue to receive these emails, make sure your email address is up to date.

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. On the screen with all your personal information, click on the pencil icon found by the **Email** section. This will open an **Update Email Addresses & MFA Methods** pop-up window.

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

PARTNERS FOR HEALTH WEBSITE LINKS AND CONTACT INFORMATION

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

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
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/ EMPLOYEE ASSISTANCE PROGRAM

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.-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 think you have been denied services or treated differently for these reasons you may submit a complaint to the Tennessee Department of Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov. Please include the following information in your email:

- Your name, address and phone number. You must provide 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.

Email to *FA.CivilRights@tn.gov* or

Mail to: State of Tennessee Department of Finance and Administration
Civil Rights Coordinator
312 Rosa L. Parks Avenue,
William R. Snodgrass Tennessee Tower,
19th Floor
Nashville, TN 37243

F & A Policy No. 36. Non-Discrimination Policy and Complaint procedure may be found on the F&A Policies webpage at *www.tn.gov/finance/looking-for/policies/.*

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. Do you speak a language other than English, and need free language help? Do you 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* 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 procedurees in F&A Policy No. 36 Non-Discrimination Policy and Complaint Procedure which is available on the F&A Policies webpage at *www.tn.gov/finance/looking-for/policies/.*

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. ໃຫ1-866-576-0029 (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
સુચના: જો તમે ગુજરાતી બોલતા હો, તો ન[ઃશુલ્ક 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, 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. 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, 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 2027 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 coverage, 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, the 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
Partners for Health is required by law to maintain the privacy and security of your personally identifiable health information. 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 Tennessee'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 the 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 separately 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*.