PARTNERS FOR HEALTH

2018 Decision Guide

Local Government

active employees and COBRA participants

ANNUAL ENROLLMENT PERIOD

October 2-27, 2017

Revised 08/17/17

Your 2018 benefits

We are pleased to provide you with your 2018 Decision Guide. This guide includes all of the benefit options offered so that you and your family can make informed choices about what best fits your needs.

The State of Tennessee Division of Benefits Administration is committed to providing a wide range of comprehensive, affordable and dependable coverage options. In 2018, we are delighted to again offer you the choice of four health insurance plan options. We also want to be sure you know about the wellness program change. Effective January 1, 2018, the "Partnership Promise" will go away. This means members will not be required to complete any wellness activities and wellness will not be tied to any health plan. Local government members and spouses who meet eligibility requirements can participate in disease management and the Diabetes Prevention Program.

To help you understand all of your benefits, we have posted links to NEW animated videos on our ParTNers for Health website at partnersforhealthtn.gov. These short videos can help you learn about your plan options and what everything means.

You can also find more information on our website listed above. If you have questions about eligibility and enrollment, call the Benefits Administration Service Center at 800.253.9981, Monday - Friday, 8 a.m. - 4:30 p.m. Central time. We hope you find this guide helpful as you make your important benefits decisions.

Laurie Lee, Executive Director, Benefits Administration
State of Tennessee, Department of Finance & Administration

Want to learn more about your 2018 benefits?

Attend a webinar:

Wednesday, Oct. 4 — 11 a.m.-12 p.m.

Friday, Oct. 13 — 11 a.m.-12 p.m.

Monday, Oct. 16 — 1-2 p.m.

Monday, Oct. 23 — 1-2 p.m.

Wednesday, Oct. 25 — 11 a.m.-12 p.m.

Login instructions can be found at partnersforhealthtn.gov.
All times listed are in the Central Time Zone.

Watch a video:

Insurance 101

Plan versus network

Health insurance options

Voluntary products options

These and more are available at partnersforhealthtn.gov/.

Tennessee Department of Finance and Administration. Authorization Number 317378, 26,000 copies, August 2017.
This public document was promulgated at a cost of $0.37 per copy.

Are you ready?

✓ Enrollment checklist

☐ Read this guide.	At www.partnersforhealthtn.gov you will also find a pdf.
☐ Gather a list of your doctors, hospitals and medications.	Be sure to gather this same information for every family member.
☐ Gather your dependent verification documents if you are adding dependents for the first time.	You will upload documentation in Edison or fax it. Directions are on page 20.
☐ Contact providers.	Ask them if your doctors and hospitals are in-network in 2018. Find out if your prescriptions are on the list of covered drugs.
☐ Visit the ParTNers for Health website, www.partnersforhealthtn.gov.	For benefits information, insurance terms and FAQs.
☐ Watch animated videos at www.partnersforhealthtn.gov.	New this year, they include insurance 101, the difference between a plan and network and why a CDHP might be right for you, to name a few.
☐ Choose your health insurance option, tier and network.	You will enroll using ESS in Edison. Directions are on page 20.
☐ Choose your voluntary benefits — dental and vision.	You will enroll using ESS in Edison. Directions are on page 20.

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Need help?

The Benefits Administration service center is available M-F 8 a.m. - 4:30 p.m. (Central time) at 800.253.9981 or 615.741.3590 to answer questions about eligibility and enrollment. You can also search the help desk, find articles or submit a question at https://benefitssupport.tn.gov/hc/en-us.

Contact the vendor's customer service center or visit their website found on the inside back cover.

Contact your **agency benefits coordinator (ABC)**. This person is usually in the human resources (HR) office.

The ParTNers for Health website has a wealth of information on benefits at partnersforhealthtn.gov. It also includes definitions of insurance terms and frequently asked questions (FAQs).

Publications and forms are available on the Benefits Administration website at https://www.tn.gov/finance/section/fa-benefits. This includes brochures and handbooks for all benefits offered. Plan documents and summaries of benefits and coverage (SBC) are available.

Annual enrollment

Your annual enrollment period for 2018 insurance benefits is October 2 through October 27, 2017, for most programs.

- Deadline to make changes is October 27 at 4:30 p.m. Central time.
- Choices are effective January 1–December 31, 2018.

If you are adding dependents (spouse and/or children) for the first time to coverage:

- You must submit dependent verification documents by October 27 at 4:30 p.m. Central time.
- Proof of dependent's eligibility must show the date of birth, or marriage or placement of adoption as required.
- A list of dependent eligibility verification documents is found on the Benefits Administration website at www.tn.gov/finance/section/fa-benefits under Forms.

After annual enrollment, you can only add or cancel coverage if you:

- Lose eligibility
- Have a qualifying event/family status change (e.g., birth, marriage, adoption, loss of other coverage, divorce, etc.)

Types of coverage (premium tier)

- Employee only
- Employee+child(ren)
- Employee+spouse
- Employee+spouse+child(ren)

Family Coverage — Coverage other than "employee only" is considered family coverage.

What's important in 2018?

Even if you don't make any changes, you should review your enrollment every year. The plans, networks and benefits may change and impact you.

Health Plan Options

Four health plan options will be offered.

1. **Premier PPO** (formerly called the Partnership PPO)
   - » Premier PPO has the same benefits, coverage and out-of-pocket costs (copays, coinsurance, deductibles) as the 2017 Partnership PPO
   - » Premier PPO premiums will be **higher** than in 2017
   - » Partnership PPO (and No Partnership PPO) members **will automatically be moved** to the Premier PPO unless they enroll in a different plan **(members will receive a notice about this change)**
   - » Enrollment is not tied to wellness participation
2. **Standard PPO**
   - » Premiums will be **lower** than in 2017
   - » Benefits will be the same as in 2017
3. **Limited PPO**
   - » Premiums will be **higher** than in 2017
   - » Benefits will be the same as in 2017
4. **Local CDHP/HSA**
   - » Premiums will be **higher** than in 2017
   - » Out-of-pocket maximum is higher than in 2017

Networks

You will have the choice of three networks of doctors and facilities. Always check the network for your providers as changes can occur.

1. BlueCross BlueShield Network S
2. Cigna LocalPlus
3. Cigna Open Access Plus — this is a larger, broad network but costs more each month. Go to page 5 to learn more.

Changes

Wellness Program: Two voluntary programs will be offered to local government employees and spouses: disease management and the Diabetes Prevention Program. Members must meet certain criteria to qualify. Go to page 8 to learn more.

- Members are not required to complete any wellness program requirements.
- Wellness will no longer be part of any health plan.

Vision: The new vision insurance vendor will be Davis Vision. Premiums will decrease. If you have vision coverage (if offered by your agency) and want to keep it, you do **not** have to reenroll in Davis Vision. It is important for you to check the network for your provider. The network directory may be found at davisvision.com/StateofTN. There is not a specific name to enter.

Dental: Dental insurance premiums will increase — MetLife premiums by 3.6% and Cigna premiums by 3.5% (if offered by your agency).

Long-term Care: This program is closing to new members as of December 31, 2017. If enrolled, you can keep this coverage, but you will do so with the insurance company, MedAmerica. MedAmerica will mail information to enrolled members. All eligible employees and dependents can still enroll in this coverage through December 31, 2017. Payroll deductions will stop after premiums are collected for December 2017 coverage. After this date, members will pay premiums directly to MedAmerica.

What can I do?

- Review your current enrollment choices
- Enroll in or cancel health insurance for yourself and your eligible dependents
- Choose or change your health insurance plan option
- Choose or change your health insurance vendor and network
- Enroll in, cancel or change dental and vision insurance

What do I have to do?

If you want to stay in your current health plan, you don't have to reenroll during annual enrollment. But there are benefit changes. Please review your benefits to make sure they will be the best fit for you in 2018.

Note: Premiums for each plan will change. The benefits and cost sharing for the health plan options (your out-of-pocket costs and what the plan pays) will **not** change in 2018, except for the Local CDHP/HSA where the out-of-pocket maximum will increase. The Partnership PPO name will change to Premier PPO.

CDHP/HSA: If you enroll in the CDHP and your employer allows you to contribute to your HSA through payroll deduction, check with your employer if you must update this amount each year. Local government employees will provide this amount to their employer.

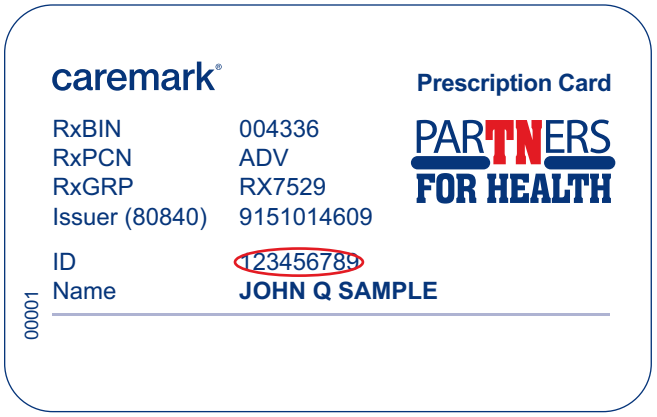
ID cards

- All members will get new medical ID cards.
- If you are new to health insurance, you will get a new pharmacy ID card. Members who are currently enrolled in health insurance but change their plan during annual enrollment will get a Welcome Kit from CVS/caremark, but not an ID card.
- If you are new to dental coverage or make a change to current coverage, you will get a new dental ID card.
- All members enrolled in vision coverage will get new vision ID cards.

Need a new card? You can call your insurance vendor to ask for extra cards or print a temporary card from their website. Some vendors also show ID cards on their mobile apps.

Caremark Pharmacy Card

You can find your Edison ID on your Caremark pharmacy card.



Debit card

Health Savings Account (HSA)

- If you enroll in the Local CDHP/HSA, you will receive a PayFlex debit card for your qualified expenses.
- If you received a card last year and keep your HSA, you can continue to use this same debit card.

2018 health benefits

Health insurance

You get the choice of a health plan and a network.

Health Plan Options

There are four health options — you choose one. Each option has different out-of-pocket costs for copays, deductibles, coinsurance and out-of-pocket maximums. For all options, you won't pay anything for eligible preventive care — it's covered at 100% as long as you use an in-network provider.

- **Premier PPO:** Highest premiums, but **you** pay **less** for copays at the doctor's office and pharmacy than the Standard PPO and less coinsurance than the other plans. It has the same coverage and cost sharing as last year's Partnership PPO.
- **Standard PPO:** Lower premiums than the Premier PPO, but **you** pay **more** for copays at the doctor's office and pharmacy than the Premier PPO. It has the same coverage and cost sharing as last year's Standard PPO.
- **Limited PPO:** Lower premiums than the other PPOs, but **you** pay **more** for copays at the doctor's office and pharmacy. It has the same coverage and cost sharing as last year's Limited PPO.
- **Local Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA):** Lower premiums, but you have a higher deductible. You get a HSA — to use for qualified healthcare expenses, including your deductible and to save for retirement.
  - » You can contribute to this account with pre-tax dollars from each paycheck (if offered by your employer) or with post-tax money.
  - » Instead of paying a high premium, you could take the money you save in premiums for this plan versus a PPO and put it in your HSA. You can use your HSA money to pay for your deductible and other healthcare costs or save it.
  - » And the account rolls over — you keep your money in your HSA at the end of the year!

How does the Local CDHP/HSA work?

- **You pay for your healthcare differently.** When you get care or need a prescription, you pay for those expenses until you reach your deductible. Then you pay coinsurance for your medical and pharmacy costs until you reach your out-of-pocket maximum. **For all of your care, as long as you use network providers, you get discounted network rates.**
  - » For certain 90-day maintenance drugs (e.g., hypertension, high cholesterol), you only pay coinsurance, and you do not have to meet your deductible first. You must use a Retail-90 network pharmacy or mail order to fill a 90-day supply of your medication to receive this lower cost benefit. Check with your pharmacist or CVS/caremark if you have questions.
- **You get a HSA to save!** You can contribute to this account, and some employers do too. Check with your employer on your options. For example, you can put the difference in premiums between the Local CDHP and PPO (premium savings) into your account each month. You can use your HSA money to pay for your out-of-pocket costs like your deductible, coinsurance for doctor's visits and prescription drugs.
  - » Your HSA money rolls over each year — you keep it if you leave or retire.
  - » When you turn 65, you can use money in your HSA for non-medical expenses (before age 65 non-medical expenses are both taxed and subject to a 20% penalty. After age 65, non-medical expenses are taxed, but the 20% penalty does not apply).
  - » There is a limit on how much money you can put in your HSA each year (includes employer contributions):
    - 2018 maximum HSA contribution amounts:

      $3,450 for employee only (includes any employer contribution if available)

      $6,900 for all other tiers (includes any employer contribution if available)

      Members 55 or older can save an extra $1,000 in a catch up contribution during the plan year
- **You save money on taxes!** Your HSA contributions can be pre-tax — put money from your paycheck directly into your account by payroll deduction (if offered by your agency). This lowers your taxable income, saving you money. Any employer contributions are tax free, and qualified medical expenses are also tax free.
- **You get a debit card with your HSA funds:** PayFlex will send you a debit card. You can use it to pay for your qualified healthcare expenses. Go to stateoftn.payflexdirect.com to learn more.
- **Certain restrictions**: You cannot enroll in the Local CDHP if you are enrolled in another plan, including a PPO, your spouse's plan or any government plan (e.g., Medicare A and/or B, Medicaid, TRICARE), or if you have received care from any Veterans Affairs (VA) facility or the Indian Health Services (IHS) within the past three months.
  - » Generally, members eligible to receive free care at any VA facility cannot enroll in the Local CDHP because a HSA is automatically opened for them. Individuals are not eligible to make HSA contributions for any month if they receive medical benefits from the VA at any time during the previous three months. However, members may be eligible if the following applies:
    - Member did not receive any care from a VA facility for three months, or
    - The member only receives care from a VA facility for a service-connected disability (and it must be a disability).
    - Go to https://www.irs.gov/irb/2004-33_IRB/ar08.html for HSA eligibility information.
  - » You cannot have a HSA if you or your spouse are enrolled in a medical flexible spending account (FSA) or a HRA. Instead, you can enroll in a limited purpose FSA for dental and vision costs if your employer offers one.

Member Costs at a Glance

ALL COSTS ARE IN-NETWORK	PREMIER PPO	STANDARD PPO	LIMITED PPO	LOCAL CDHP/HSA
Primary doctor's visit copays	$25	$30	$35	30% coinsurance (after you meet the deductible)
Coinsurance (after deductible)	10%	20%	30%	30%
Deductible	$500/$1,250	$1,000/$2,500	$1,600/$3,200	$2,000/$4,000
Out-of-pocket maximum	$3,600/$9,000	$4,000/$10,000	$6,600/$13,200	$5,000/$10,000

All healthcare options cover the same services and treatments, but medical necessity decisions may vary by vendor.

Network Options

You choose one of three networks of doctors and facilities.

- **BlueCross BlueShield Network S:** There is no additional cost for this network. In 2018 in the Memphis market, Methodist facilities will be out-of-network, and Baptist facilities will be in-network. All Methodist provider groups will remain in-network.
- **Cigna LocalPlus:** There is no additional cost for this network. This is a smaller network than Cigna Open Access Plus (OAP).
- **Cigna OAP:** This is a large network with a choice of more doctors and facilities, but you will pay more. In 2018 in the Memphis market, Baptist facilities will be out-of-network, but Methodist facilities will remain in-network. Monthly surcharges will apply:
  - » $40 more for employee only and employee+child(ren) coverage
  - » $80 more for employee+spouse and employee+spouse+child(ren) coverage

Each network has providers (doctors and facilities) across Tennessee and the country. Providers can move in and out of networks. It's important to check the networks carefully for the doctor(s) or hospital you want when making your choice. Note: If you use providers outside of the network, you will be charged out-of-network rates.

Did you know? Your network vendor's (BlueCross BlueShield or Cigna) website may have tools and resources to help you find out how much a procedure or test could cost. Contact information for our vendors is found below.

HEALTH INSURANCE VENDORS		
CONTACT	PHONE	WEBSITE
BCBST	800.558.6213 M-F, 7-5	bcbst.com/members/tn_state
Cigna	800.997.1617 24/7	cigna.com/stateoftn

Terms and definitions

CDHP— consumer-driven health plan, a type of medical insurance or plan that generally has a higher deductible and lower monthly premiums. Typically, you take responsibility for covering health care expenses until your deductible is met. Once you meet your deductible, coinsurance applies up to the out-of-pocket maximum.

coinsurance— the percentage of a dollar amount that you pay for certain services. Unlike a fixed copay, coinsurance varies, depending on the total charge for a service.

copay— a flat dollar amount that you pay for certain services like doctor office visits and prescriptions.

cost sharing— the share of costs covered by your insurance that you pay out of your own pocket.

deductible— a fixed dollar amount you must pay each year before the plan pays for services that require coinsurance.

network— a group of doctors, hospitals and other healthcare providers contracted with a health insurance carrier to provide services to plan members for set fees.

OOPM— out-of-pocket maximum, the most you will pay for services in any given year. The out-of-pocket maximum does not include premiums. Once you reach your out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year. There are separate maximums for in-network and out-of-network services.

plan— provides or pays a portion of the cost of medical care and determines how much you pay in premiums, copays and coinsurance.

PPO— preferred provider organization, gives plan participants access to a network of doctors and facilities that charge pre-negotiated (and typically discounted) fees for the services they provide to members. Plan participants may self-refer to any doctor or specialist in the network. The benefit level covered through the plan typically depends on whether the member visits an in-network or out-of-network provider when seeking care.

Benefits included with health insurance

Pharmacy

Pharmacy benefits are included when you and your dependents enroll in a health plan. The plan you choose determines the out-of-pocket prescription costs. How much you pay for your drug depends on whether it is a generic, brand or non-preferred brand and the day-supply.

Maintenance Drugs: There are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price for these certain medications, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication. The maintenance tier list includes certain medications for high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).

Certain Low-Dose Statins: Eligible members will be able to receive these medications in-network at zero cost share in 2018. These medications are primarily used to treat high cholesterol. No high dose or brand statins are included.

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

Weight Management: There are some obesity medications available for members who meet certain requirements. This gives members a less costly, non-surgical option for losing weight. Go to info.caremark.com/stateoftn to look for covered medications. They are found under "Antiobesity" on the Preferred Drug List (PDL).

Diabetic Supplies: OneTouch diabetic testing supplies are the only diabetic testing supplies covered at the preferred brand copay. Members will have lower copays by using OneTouch supplies. Diabetics may be eligible for a new OneTouch glucose meter at no charge from the manufacturer. For more information call 800.588.4456.

Flu and Pneumonia Vaccines: Each year, members can get free flu and pneumonia vaccines (if eligible) through certain pharmacies or at your doctor's office. You can go to partnersforhealthtn.gov and click on the Pharmacy page to learn more about vaccines.

Tobacco Cessation Products: Members who want to stop using tobacco products can get free tobacco quit aids.

The following quit aids are FREE under the pharmacy benefit:

- Chantix
- Bupropion (Generic Zyban)
- Over-the-counter generic nicotine replacement products, including gum, patches and lozenges
- Nicotrol oral and nasal inhalers

Members may receive up to two, 12-week courses of treatment per calendar year (up to 168 days of treatment) with no lifetime maximum. A licensed clinician is required to write a prescription to get any tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your Caremark card at the pharmacy counter (not at the check-out registers) to fill at $0 copay. The plan only covers generic over-the-counter tobacco cessation products (not brand names).

Did you know? CVS/caremark has website tools to help you compare costs for your prescriptions. You can also find out what you have spent in the past. To learn more, go to info.caremark.com/stateoftn. You must register to view your prescription history and costs.

PHARMACY (IN-NETWORK)*	PREMIER PPO	STANDARD PPO	LIMITED PPO	LOCAL CDHP
30-DAY SUPPLY				
Generic	$7	$14	$14	30% coinsurance after deductible is met
Brand	$40	$50	$60	
Non-preferred brand	$90	$100	$110	
90-DAY SUPPLY (90-day network pharmacy or mail order)				
Generic	$14	$28	$28	30% coinsurance after deductible is met
Brand	$80	$100	$120	
Non-preferred brand	$180	$200	$220	
90-DAY SUPPLY (certain maintenance medications from a Retail-90 network pharmacy or mail order)				
Generic	$7	$14	$14	20% coinsurance without having to meet deductible
Brand	$40	$50	$60	
Non-preferred brand	$160	$180	$200	
SPECIALITY PHARMACY**				
Coinsurance	10% (min $50; max $150)	10% (min $50; max $150)	10% coinsurance (min $50; max $150)	30% after deductible

*These are the in-network pharmacy benefits. If out of network pharmacy benefits are available, they are different and will cost you more.
**Specialty Pharmacy Tier: Specialty drugs must be filled through a Specialty Network Pharmacy and can only be filled every 30 days.

Telehealth

24/7 Care — When You Need It

All health plan members have access to Telehealth medical services. It is available as a part of your health insurance. You can talk to a doctor by phone or computer from anywhere, at any time.

When to use Telehealth

For non-emergency medical issues (allergies, asthma, bronchitis, cold & flu, infections, fever, ear aches, nausea, pink eye, sore throat).

- 24 hours a day, seven days a week — including nights, weekends and holidays
- Your doctor or pediatrician is unavailable
- It's not convenient to leave your home or work
- You are traveling and need medical care

Cost

- **PPO Members:** Copay is $15
- **CDHP Members:** You pay the negotiated rate per visit until you reach your deductible, then the primary care office visit coinsurance applies

More Information

You must pre-register with your network vendor to use Telehealth.

BlueCross BlueShield of Tennessee Members

- Log into BlueAccess at bcbst.com
- Look for PhysicianNow
- Or, call 888.283.6691

Cigna Members

- Log into MyCigna.com
- Look for MDLive or Amwell and select the vendor of your choice
- Or, call 888.726.3171 for MDLive or 855.667.9722 for Amwell

Behavioral Health & Substance Use Services

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Your enrolled dependents can use these benefits too.

Optum is your behavioral healthcare vendor. Using one of Optum's network providers gets you the most from this benefit, which is included when you and your dependents enroll in a health plan.

In addition to office visits, this benefit includes virtual visits. What does that mean? You can meet with a provider through private, secure video conferencing. It's called **Telemental Health**, and it allows you to get the care you need sooner and in the privacy of your home. The copay for Telemental Health is the same as an office visit. To get started, go to Here4TN.com, scroll down, select provider search, and click on Telemental Health to find a provider licensed in Tennessee, or call 855-Here4TN for assistance.

Learn more about your behavioral health benefit by visiting Here4TN.com. A provider directory with a search feature is available on the website.

Employee Assistance Program (EAP)

Here 4 TN
Support For Your Life

Your Employee Assistance Program (EAP) is also administered by Optum. It is available to all local government state group insurance program members and their eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

Master's level specialists are available around the clock to assist with stress, legal, financial, mediation and work/life services. They can even help you find a network provider, a plumber who works nights, find services for your elderly parents, theater tickets, all-night pharmacies and so much more.

Optum knows you are busy, and they want to provide you with information when you need it. All you have to do is call 855. Here4TN (855.437.3486).

Coming Soon! Take Charge at Work: Starting in the fall of 2017, you will have access to a telephonic program that helps you identify your triggers and recognize and manage symptoms of stress and depression. More details to come, including how to see if you qualify for the program.

2018 Voluntary Wellness Program

Starting January 1, 2018, the "Partnership Promise" will go away and will no longer be part of any health plan. This means that members **will NOT be required** to complete any wellness program activities.

Two voluntary wellness programs will be offered to enrolled local government employees and spouses. Note: members must meet certain criteria to qualify for these programs:

- **Disease management:** For members with chronic diseases that include asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease (COPD). They will still have access to this program to better manage a chronic condition.
- **Diabetes Prevention Program:** In-person classes for those who are pre-diabetic. Members must pre-qualify for this program.

More information about who is eligible and how to access these two programs will be shared early next year.

We want to make sure you are aware of available resources if you want to continue or start to improve your health! We recommend **Healthier Tennessee®**, which you may already be involved in through your community. Healthier Tennessee® is an initiative of the Governor's Foundation for Health and Wellness. This initiative promotes a healthy diet, strives to increase the number of Tennesseans who are physically active and works to reduce the number of those who use tobacco.

Healthier Tennessee's wellness tools are built around the concept of Small Starts®: simple, healthy actions you can turn into routine habits in as little as 10 minutes a day. Small Starts® tools are available for individuals. Learn more about the Small Starts® approach, tools and the free Streaks for Small Starts® app at healthiertn.com/streaks-for-small-starts.

And don't forget— with your health plan you won't pay anything for eligible preventive care – it's covered at 100% as long as you use an in-network provider. Members are encouraged to get age appropriate preventive services, which could include:

- annual preventive visit (i.e., physical exam)
- cholesterol test
- screening for colon cancer
- annual well-woman visit
- osteoporosis screening
- screenings for breast or cervical cancer (women only)
- screening for prostate cancer (men only)
- flu vaccine
- pneumococcal vaccine

Talk to your doctor to find out what screenings and tests are right for you.

Worth noting....

All members have access to wellness and fitness center discounts through your health insurance network vendor (BlueCross BlueShield or Cigna). Go to your vendor's website to learn more.

Cigna members will have access to the Cigna nurse advice line. BlueCross BlueShield does not have a nurse advice line available.

2011-2016 Partnership Promise Wellness Program Successes

- **High participation** - an average of 86% of plan members who agreed to the Partnership Promise consistently completed all requirements since the program began.
- **5:1** Return on Investment (ROI) for Disease Management in 2015 - that means for every one dollar spent, we saved five dollars.
- **Members** in a "Partnership" plan **received more appropriate care.**

Notice Regarding Wellness Program

The ParTNers for Health Wellness Program is a voluntary wellness program. 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.

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 expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified immediately.

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.

2018 benefit comparison

PPO services in this table ARE NOT subject to a deductible. Local CDHP/HSA services in this table ARE subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. For all plans, costs DO APPLY to the annual out-of-pocket maximum.

HEALTHCARE OPTION	PREMIER PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
PREVENTIVE CARE — OFFICE VISITS				
• Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No charge	$45 copay	No charge	$50 copay
OUTPATIENT SERVICES				
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25 copay	$45 copay	$30 copay	$50 copay
Specialist Office Visit • Including surgery in office setting	$45 copay	$70 copay	$50 copay	$75 copay
Behavioral Health and Substance Use [2] • Including telebehavioral health	$25 copay	$45 copay	$30 copay	$50 copay
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	10% coinsurance		20% coinsurance	
All Reading, Interpretation and Results	10% coinsurance		20% coinsurance	
Telehealth	$15 copay	N/A	$15 copay	N/A
Allergy Injection	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Allergy Injection with Office Visit	$25 copay primary; $45 copay specialist	$45 copay primary; $70 copay specialist	$30 copay primary; $50 copay specialist	$50 copay primary; $75 copay specialist
Chiropractic • Limit of 50 visits per year	Visits 1-20: $25 copay Visits 21-50: $45 copay	Visits 1-20: $45 copay Visits 21-50: $70 copay	Visits 1-20: $30 copay Visits 21-50: $50 copay	Visits 1-20: $50 copay Visits 21-50: $75 copay
PHARMACY				
30-Day Supply	$7 copay generic; $40 copay preferred brand; $90 copay non-preferred	copay plus amount exceeding MAC	$14 copay generic; $50 copay preferred brand; $100 copay non-preferred	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 copay generic; $80 copay preferred brand; $180 copay non-preferred	N/A - no network	$28 copay generic; $100 copay preferred brand; $200 copay non-preferred	N/A - no network
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 copay generic; $40 copay preferred brand; $160 copay non-preferred	N/A - no network	$14 copay generic; $50 copay preferred brand; $180 copay non-preferred	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10% coinsurance; min $50; max $150	N/A - no network	10% coinsurance; min $50; max $150	N/A - no network
CONVENIENCE CLINIC AND URGENT CARE				
Convenience Clinic	$25 copay	$45 copay	$30 copay	$50 copay
Urgent Care Facility	$45 copay	$70 copay	$50 copay	$75 copay
EMERGENCY ROOM				
Emergency Room Visit	$150 copay (services subject to coinsurance may be extra)		$175 copay (services subject to coinsurance may be extra)	

LIMITED PPO		LOCAL CDHP/HSA	
IN-NETWORK	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
No charge	$50 copay	No charge	50% coinsurance
$35 copay	$55 copay	30% coinsurance	50% coinsurance
$55 copay	$80 copay	30% coinsurance	50% coinsurance
$35 copay	$55 copay	30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	
$15 copay	N/A	30% coinsurance	N/A
100% covered	100% covered up to MAC	30% coinsurance	50% coinsurance
$35 copay primary; $55 copay specialist	$55 copay primary; $80 copay specialist	30% coinsurance	50% coinsurance
Visits 1-20: $35 copay Visits 21-50: $55 copay	Visits 1-20: $55 copay Visits 21-50: $80 copay	30% coinsurance	50% coinsurance
$14 copay generic; $60 copay preferred brand; $110 copay non-preferred	copay plus amount exceeding MAC	30% coinsurance	50% coinsurance plus amount exceeding MAC
$28 copay generic; $120 copay preferred brand; $220 copay non-preferred	N/A - no network	30% coinsurance	N/A - no network
$14 copay generic; $60 copay preferred brand; $200 copay non-preferred	N/A - no network	20% coinsurance without first having to meet deductible	N/A - no network
10% coinsurance; min $50; max $150	N/A - no network	30% coinsurance	N/A - no network
$35 copay	$55 copay	30% coinsurance	50% coinsurance
$55 copay	$80 copay	30% coinsurance	50% coinsurance
$200 copay (services subject to coinsurance may be extra)		30% coinsurance	

All services in this table ARE subject to a deductible (with the exception of hospice under the PPO options). Eligible expenses DO APPLY to the annual out-of-pocket maximum.

	PREMIER PPO		STANDARD PPO	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK [1]**	**IN-NETWORK**	**OUT-OF-NETWORK [1]**
Hospital/Facility Services • Inpatient care; outpatient surgery [4] • Inpatient behavioral health and substance abuse [2] [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Home Care [4] • Home health; home infusion therapy	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Rehabilitation and Therapy Services • Inpatient [4]; outpatient • Skilled nursing facility [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Ambulance • Air and ground	10% coinsurance		20% coinsurance	
Hospice Care [4] • Through an approved program	100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (even if deductible has not been met)	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	10% coinsurance for oral surgeons	40% coinsurance for oral surgeons	20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
	10% coinsurance non-contracted providers (i.e., dentists, orthodontists)		20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Out-of-Country Charges • Non-emergency and non-urgent care	N/A - no network	40% coinsurance	N/A - no network	40% coinsurance
DEDUCTIBLE				
Employee Only	$500	$1,000	$1,000	$2,000
Employee + Child(ren)	$750	$1,500	$1,500	$3,000
Employee + Spouse	$1,000	$2,000	$2,000	$4,000
Employee + Spouse + Child(ren)	$1,250	$2,500	$2,500	$5,000
separate pharmacy deductible applies	N/A		N/A	
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED				
Employee Only	$3,600	$4,000	$4,000	$4,500
Employee + Child(ren)	$5,400	$6,000	$6,000	$6,750
Employee + Spouse	$7,200	$8,000	$8,000	$9,000
Employee + Spouse + Child(ren)	$9,000	$10,000	$10,000	$11,250

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge (MAC) will not be counted. **For PPO Plans**, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. **For Local CDHP Plan**, the deductible and out-of-pocket maximum amount can be met by one or more persons, depending on premium level, but no one family member may contribute more than $7,350 to the in-network family out-of-pocket maximum total. **For Local CDHP Plan**, coinsurance is after deductible is met unless otherwise noted.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a service from an in-network provider. 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.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management, and Applied Behavior Analysis.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

LIMITED PPO		LOCAL CDHP/HSA	
IN-NETWORK	OUT-OF-NETWORK [1]	IN-NETWORK	OUT-OF-NETWORK [1]
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance		30% coinsurance	
100% covered up to MAC (even if deductible has not been met)		100% covered up to MAC (after the deductible has been met)	
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
30% coinsurance for oral surgeons	50% coinsurance for oral surgeons	30% coinsurance for oral surgeons	50% coinsurance for oral surgeons
30% coinsurance non-contracted providers (i.e., dentists, orthodontists)		30% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
30% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance
N/A - no network	50% coinsurance	N/A - no network	50% coinsurance
$1,600	$3,000	$2,000	$4,000
$2,200	$4,000	$4,000	$8,000
$2,500	$4,600	$4,000	$8,000
$3,200	$6,000	$4,000	$8,000
$100 per member		N/A	
$6,600	$10,000	$5,000	$8,000
$13,200	$20,000	$10,000	$16,000
$13,200	$20,000	$10,000	$16,000
$13,200	$20,000	$10,000	$16,000

2018 Active Employees Monthly Health Premiums

ALL REGIONS						
	LEVEL 1		LEVEL 2		LEVEL 3	
	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
PREMIER PPO						
Employee Only	$649	$689	$725	$765	$788	$828
Employee + Child(ren)	$1,007	$1,047	$1,124	$1,164	$1,222	$1,262
Employee + Spouse	$1,396	$1,476	$1,559	$1,639	$1,695	$1,775
Employee + Spouse + Child(ren)	$1,754	$1,834	$1,958	$2,038	$2,129	$2,209
STANDARD PPO						
Employee Only	$608	$648	$679	$719	$738	$778
Employee + Child(ren)	$943	$983	$1,053	$1,093	$1,145	$1,185
Employee + Spouse	$1,308	$1,388	$1,460	$1,540	$1,588	$1,668
Employee + Spouse + Child(ren)	$1,643	$1,723	$1,834	$1,914	$1,994	$2,074
LIMITED PPO						
Employee Only	$472	$512	$527	$567	$574	$614
Employee + Child(ren)	$732	$772	$818	$858	$889	$929
Employee + Spouse	$1,016	$1,096	$1,134	$1,214	$1,233	$1,313
Employee + Spouse + Child(ren)	$1,276	$1,356	$1,424	$1,504	$1,549	$1,629
LOCAL CDHP/HSA						
Employee Only	$425	$465	$474	$514	$515	$555
Employee + Child(ren)	$658	$698	$735	$775	$799	$839
Employee + Spouse	$913	$993	$1,019	$1,099	$1,108	$1,188
Employee + Spouse + Child(ren)	$1,147	$1,227	$1,280	$1,360	$1,392	$1,472

The premium amounts shown reflect the total monthly premium. The different premium levels are based on the demographics of your agency. Please see your agency benefits coordinator for your monthly deduction, your employer's contribution or if you are unsure as to which premium level applies to you.

Of Note

Generally, the higher the health plan premium, the less you'll pay out-of-pocket for your healthcare services. The lower the health plan premium, the more you'll pay out-of-pocket for your healthcare services.

Members who enroll in the Local CDHP/HSA can put savings from the lower premium into their HSA account to help pay out-of-pocket costs.

2018 COBRA Participants Monthly Health Premiums

ALL REGIONS						
	LEVEL 1		LEVEL 2		LEVEL 3	
	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS	BCBST & CIGNA LOCALPLUS	CIGNA OPEN ACCESS
PREMIER PPO						
Employee Only/Single	$661.98	$702.78	$739.50	$780.30	$803.76	$844.56
Employee + Child(ren)	$1,027.14	$1,067.94	$1,146.48	$1,187.28	$1,246.44	$1,287.24
Employee + Spouse	$1,423.92	$1,505.52	$1,590.18	$1,671.78	$1,728.90	$1,810.50
Employee + Spouse + Child(ren)	$1,789.08	$1,870.68	$1,997.16	$2,078.76	$2,171.58	$2,253.18
STANDARD PPO						
Employee Only/Single	$620.16	$660.96	$692.58	$733.38	$752.76	$793.56
Employee + Child(ren)	$961.86	$1,002.66	$1,074.06	$1,114.86	$1,167.90	$1,208.70
Employee + Spouse	$1,334.16	$1,415.76	$1,489.20	$1,570.80	$1,619.76	$1,701.36
Employee + Spouse + Child(ren)	$1,675.86	$1,757.46	$1,870.68	$1,952.28	$2,033.88	$2,115.48
LIMITED PPO						
Employee Only/Single	$481.44	$522.24	$537.54	$578.34	$585.48	$626.28
Employee + Child(ren)	$746.64	$787.44	$834.36	$875.16	$906.78	$947.58
Employee + Spouse	$1,036.32	$1,117.92	$1,156.68	$1,238.28	$1,257.66	$1,339.26
Employee + Spouse + Child(ren)	$1,301.52	$1,383.12	$1,452.48	$1,534.08	$1,579.98	$1,661.58
LOCAL CDHP/HSA						
Employee Only/Single	$433.50	$474.30	$483.48	$524.28	$525.30	$566.10
Employee + Child(ren)	$671.16	$711.96	$749.70	$790.50	$814.98	$855.78
Employee + Spouse	$931.26	$1,012.86	$1,039.38	$1,120.98	$1,130.16	$1,211.76
Employee + Spouse + Child(ren)	$1,169.94	$1,251.54	$1,305.60	$1,387.20	$1,419.84	$1,501.44

Vision benefits

If offered by your agency

The state will offer voluntary vision benefits through a new vendor in 2018, Davis Vision. The network will change. It is important to check the network for your provider and other providers in your area. You can look for your provider by going to davisvision.com/stateofTN. There is not a specific name to enter. There are many added values to this year's vision benefits, including an increased allowance for frames, lenses and contact lenses.

The state offers two vision options:

Basic Plan offers discounted rates and allowances for services.

Expanded Plan provides services with a combination of copays, greater allowances than the Basic Plan and discounted rates.

Both offer the same services including:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglass lenses or contact lenses once every calendar year
- Discount on LASIK/refractive surgery

Davis Vision offers some additional values which include:

- Zero ($0.00) copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location.
- Free pair of eyeglass frames from Davis' "The Exclusive Collection" under the in-network Expanded Plan.
- Free pair of "Fashion Selection" eyeglass frames from Davis' "The Exclusive Collection" under the in-network Basic Plan.
- Free pair of frames at Visionworks retail locations.
- 40% discount off retail under the in-network Expanded Plan and 30% discount off retail under the in-network Basic Plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations.
- 20% discount off retail cost of an additional pair of conventional or disposable contact lenses under the in-network Expanded Plan.
- One year warranty for breakage of most eyeglasses.

The basic and expanded plans are both managed by Davis Vision. In-network and out-of-network benefits are available. You will receive the maximum benefit when visiting a provider in Davis Vision's network.

Premium rates will decrease in 2018.

If you have vision coverage and want to keep it, you do **not** have to reenroll in Davis Vision.

New Vision Vendor

Davis Vision

800.208.6404

M-F, 7-10, Sat, 8-3 Sun, 11-3

Basic Client Code: 8155

Expanded Client Code: 8156

davisvision.com/stateofTN

2018 Monthly Vision Premiums

	BASIC PLAN	EXPANDED PLAN
ACTIVE MEMBERS		
Employee Only	$3.07	$5.56
Employee + Child(ren)	$6.13	$11.12
Employee + Spouse	$5.82	$10.57
Employee + Spouse + Child(ren)	$9.01	$16.35
COBRA PARTICIPANTS		
Employee Only/Single	$3.13	$5.67
Employee + Child(ren)	$6.25	$11.34
Employee + Spouse	$5.94	$10.78
Employee + Spouse + Child(ren)	$9.19	$16.68

Covered Vision Services

Here is a comparison of discounts, copays and allowed amounts for 2018 under the vision options. Copays represent what the member pays. Allowances and percentage discounts represent the cost the carrier will cover.

	BASIC PLAN	EXPANDED PLAN
Routine Eye Exam	$0 copay	$10 copay
Retinal Imaging Benefit	$39 copay	$39 copay
Frames	$55 allowance; 20% discount off balance above the allowance	$150 allowance; 20% discount off balance above the allowance
Eyeglass Lenses (includes plastic or glass)		
• Single	$0 copay	$0 copay
• Bifocal, trifocal, lenticular	$0 copay	$0 copay
• Standard progressive Lens	$55 allowance; 20% off balance over $55; not to exceed $65 out-of-pocket	$50 copay
• Premium progressive Lens	$55 allowance; 20% off balance over $55; not to exceed $105 out-of-pocket	$50-140 copay [1]
Eyeglass Lens Options (upgrades)	20% discount off all options with out-of-pocket not to exceed amount shown below	
• Anti-reflective	Up to $40	$40 copay
• Polycarbonate	Adults $35; Children $0	Adults $30; Children $0
• Photochromic	Up to $70	20% off retail price; not to exceed $70 out-of-pocket
• Scratch resistance coating	$0	$0 copay
• UV coating	Up to $15	$10 copay
• Tints	Up to $15	$15 copay
• Polarized	Up to $75	20% off retail; not to exceed $75 out-of-pocket
• Premium anti-reflective	Up to $55	$40-69 copay [1]
• Scratch protection plan: single vision/multifocal lenses	$20 copay/$40 copay	$20 copay/$40 copay
• All other eyeglass lens options		20% discount
Exam for Contact Lenses (fitting and evaluation)	20% discount off retail price	$50-60 copay
Contact Lenses [2]		
• Elective Conventional or disposable	$55 allowance; 20% off balance over $55	$140 allowance; 20% off balance over $140
• Medically necessary [3]	$155 allowance; 20% off balance over $155	covered at 100%
LASIK/Refractive Surgery (for select providers)	15% discount off retail price or 5% off promotional price	15% discount off retail price or 5% off promotional price
Out-of-Network Benefits		
• All eye exams	$35 allowance	up to $50 allowance
• Frames	up to $55 allowance (frames and lenses combined)	up to $75 allowance
• Eyeglass lenses		
◦ Single vision		up to $35 allowance
◦ Lined bifocal		up to $55 allowance
◦ Lined trifocal		up to $70 allowance
• Elective contacts (conventional or disposable)	$30 allowance	up to $55 allowance
• Medically necessary contacts [3]	$80 allowance	up to $200 allowance
• Lens options-UV, polycarbonate, photochromic/ transitions plastic		up to $10 allowance
Frequency		
• Eye exam	once every calendar year per person	once every calendar year per person
• Eyeglass lenses and contacts	once every calendar year per person	once every calendar year per person
• Frames	once every two calendar years per person	once every two calendar years per person

[1] Copays for premium progressive lens and premium anti-reflective coating are subject to change
[2] Instead of eyeglass lenses
[3] If medically necessary as first contact lenses following cataract surgery or multiple pairs of rigid contact lenses for treatment of keratoconus

Dental benefits

If offered by your agency

The state offers two voluntary dental insurance plans:

Prepaid Dental Plan (Cigna Dental Health Maintenance Organization — DHMO) provides services at fixed copay amounts paid by the member. A narrow network of participating Cigna general dentists and specialists must be used to receive benefits.

Dental Preferred Provider Organization (DPPO — MetLife) provides services with coinsurance paid by the member and MetLife. Any dentist may be used to receive benefits, but you will pay less if you use an in-network provider.

Dental questions?

Call or go online

Cigna DHMO: 800.997.1617 or cigna.com/stateoftn

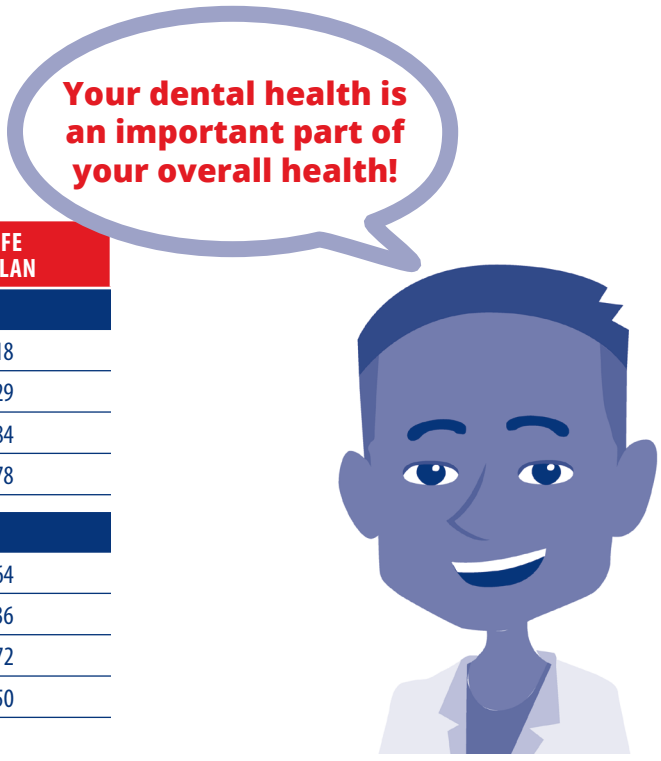
MetLife DPPO: 855.700.8001 or metlife.com/StateOfTN

Prepaid (DHMO) Plan — Cigna

- The **network is Cigna Dental Care DHMO.**
- You **must select a general dentist** from the Prepaid (DHMO) Dental Plan list and let Cigna know of your choice.
  - » You may select a network pediatric dentist as the network general dentist for your dependent child under age seven. At age seven, you must switch the child to a network general dentist or pay the full charge from the pediatric dentist.
- You must use your selected general dentist to receive benefits. There may be some areas in the state where network general dentists are limited or not available. Before enrolling, be sure to carefully check the network for your location.
  - » With the prepaid dental plan, you may be able to cancel this coverage if you enroll and later there are no network general dentists within 40 miles of your home.
- You pay copays for dental treatments.
- No deductibles to meet, no claims to file, no waiting periods, no annual dollar maximum.
- Pre-existing conditions are covered.
- **Referrals to specialists are required.**
- Orthodontic treatment is not covered if the treatment plan began prior to the member's effective date of coverage with Cigna.
- **Premiums will increase by 3.5% in 2018.**

DPPO — MetLife

- **The network is PDP.**
- You can use **any dentist**, but you receive maximum benefits when visiting an in-network MetLife DPPO provider. Deductible applies for basic and major dental care.
- You pay coinsurance for basic, major, orthodontic and out-of-network covered services.
- You or your dentist will file claims for covered services.
- Some services (e.g., crowns, dentures, implants and complete or partial dentures) require a six-month waiting period from the member's coverage start date before benefits begin.
- There is a 12-month waiting period from the member's coverage start date on replacement of a missing tooth and for orthodontics.
- Referrals to specialists are **not** required.
- Pre-treatment estimates are recommended for more expensive services.
- Dental treatment in progress at time of member's effective date with MetLife may have pro-rated benefits under the MetLife plan.
- **Premiums will increase by 3.6% in 2018.**



2018 Monthly Dental Premiums

	CIGNA PREPAID PLAN	METLIFE DPPO PLAN
ACTIVE MEMBERS		
Employee Only	$13.44	$23.18
Employee + Child(ren)	$27.91	$53.29
Employee + Spouse	$23.83	$43.84
Employee + Spouse + Child(ren)	$32.76	$85.78
COBRA PARTICIPANTS		
Employee Only/Single	$13.71	$23.64
Employee + Child(ren)	$28.47	$54.36
Employee + Spouse	$24.31	$44.72
Employee + Spouse + Child(ren)	$33.42	$87.50

Covered Dental Services

Here is a comparison of deductibles, copays and your share of coinsurance for 2018 under the dental options. Costs represent what the member pays.

	CIGNA PREPAID OPTION		METLIFE DPPO OPTION	
COVERED SERVICES	**GENERAL DENTIST**	**SPECIALIST DENTIST**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	none		$25 single; $75 family, per policy year [1]	$100 single; $300 family, per policy year [1]
Annual Maximum Benefit	none		$1,500 per person, per policy year	
Pre-existing Conditions	covered		some exclusions	
Office Visit	$10 copay [2]		no charge	20% of MAC
Periodic Oral Evaluation	no charge		no charge	20% of MAC
Routine Cleaning – Adult	no charge		no charge	20% of MAC
Routine Cleaning – Child	no charge	$15 copay	no charge	20% of MAC
X-ray — Intraoral, Complete Series	no charge	$5 copay	no charge	20% of MAC
Amalgam (silver) Filling Permanent teeth	$8 copay	$10 copay	20% of MAC	40% of MAC
Endodontics — Root Canal Therapy Molar (excluding final restoration)	$125 copay	$600 copay	20% of MAC	40 % of MAC
Major Restorations — Crowns	$200 copay, plus lab fees [3]		50% of MAC [4]	
Extraction of Erupted Tooth (minor oral surgery)	$15 copay	$70 copay	20% of MAC	40% of MAC
Removal of Impacted Tooth — Complete Bony (complex oral surgery)	$100 copay	$120 copay	50% of MAC	
Dentures — Complete Upper	$310 copay, plus lab fees [3]		50% of MAC [4]	
Orthodontics	$140 monthly copay for treatment equal or less than 24 months. Then, full charge.[6]		50% of MAC	
• Annual Deductible	none		none	
• Lifetime Maximum	$3,360 copay ($140 x 24 months) for treatment fee only. Then, member pays full charge after initial 24 months. [6]		$1,250 [5]	
• Waiting Period	none		12 months	
• Age Limit	none		up to age 19	

MAC—Maximum Allowable Charge is the lesser of the amount charged by the dentist or the maximum payment amount that in-network dentists have agreed to accept in full for the dental service. When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network dentist.

The benefits listed are a sample of the most frequently utilized dental treatments. Refer to vendor materials for complete information on coverage, limitations and exclusions.

[1] Does not apply to diagnostic and preventive benefits such as periodic oral evaluation, cleaning and x-ray.

[2] A charge may apply for a missed appointment when the member does not cancel at least 24 hours prior to the scheduled appointment.

[3] Members are responsible for additional lab fees for these services.

[4] A six-month waiting period applies.

[5] The orthodontics lifetime maximum is for a dependent member enrolled in the state group dental insurance program even if the member has been covered under different employing agencies.

[6] Additional copays apply for specific orthodontic procedures. Orthodontic treatment after a member's effective date will not be covered under the Cigna plan if it began prior to the member's effective date.

Edison employee self service

Edison is the State of Tennessee's Enterprise Resource Planning (ERP) system. When using Employee Self Service (ESS) in Edison to add/make changes to benefits, Internet Explorer 11 is the preferred browser. You may not be able to enroll if you use another browser, a mobile device or a tablet.

You must use ESS in Edison or have your ABC submit your changes online.

Login/passwords

Instructions for 1st Time Login/Password Reset can be found on the Edison homepage, www.edison.tn.gov. There is also a video for first-time users.

Local government employees should call the Benefits Administration service center at 800.253.9981 for assistance.

How do I make changes?

- Log into Edison, www.edison.tn.gov.
- Click **Self Service** > **Employee Work Center.**
- Click **Benefits Enrollment** under **My Benefits.**
- On the Welcome to Employee Self Service page under **Open Benefit Events** click **Select.**
- Click **Edit** next to the plan to add or change.
- Under **Select an Option**, click your plan choice.
- Under **Enroll Your Dependents**, check the box next to a dependent's name to cover him.
- Click **Update** and **Continue** to confirm your option.
- You will see a summary of the options you selected. To make changes, click **Discard Changes**. If no changes, click **Update Elections**.
- Once you have made all of your changes, click **Continue** on the Benefits Enrollment page.
- If adding dependents, you will see an **Action Needed** page that lets you know you will need to provide verification for your new dependents. Click **Continue**.
- If adding dependents, click on the **Upload Documents** link, then click the **Continue** button.
- Next, choose if you want your confirmation by mail or email. Make any changes needed. Click **Submit. You must complete this step for changes to be submitted.**
- You will be taken to a confirmation screen. Click **OK**.
- You can view confirmation of your selections on the Welcome to Employee Self Service page by logging back in and selecting **View** in the View/Print Confirmation Statement box.

How do I add dependents?

- Look for the **Enroll Your Dependents** section. Click **Add/Review Dependents**.
- Click **Add a Dependent** on the Add/Review Dependents page.
- Add the dependent's personal information and click **Save**, then **OK** on the next screen. Then click the **Return to Dependent Summary** link.
- To add additional dependents, click **Add a Dependent** on the Add/Review Dependents page. When done, click **Return to Event Selection**.
- Click the **Enroll** boxes under **Enroll Your Dependents**. Then click **Update Elections**.
- To add a dependent to dental or vision, click on the **Enroll** boxes under **Enroll Your Dependents**.
- You will see an Action Needed page after clicking **Continue** on the Benefits Enrollment page. Click **Continue** to add dependent verification.
- You can upload your dependent documentation into ESS. Scan your document and click **Upload Documents**. Click **Browse**, find the file and upload.
- You can upload as many documents as needed. When complete, click **Continue**.

You may also fax hard copies to 615.741.8196 and include your name and employee ID (found on the front of your Caremark card) on each page.

There is a link to a list of acceptable documentation on the ESS **Upload Dependent Verification Documents** page and the Benefits Administration website.

How do I update my personal information?

- **Local government employees:** Update information (address, phone, email) in Edison, or contact your agency benefits coordinator. You can also call the Benefits Administration service center to change your address.
  - » You must provide the last four digits of your Social Security number, Edison ID, date of birth, previous address and confirm authorization of the change before our office can update your information.
  - » It is up to you to keep your address and phone number current with your employer.

Legal notices

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits 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 Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 1-866-576-0029.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697

If you speak a language other than English, help in your language is available for free. This tells you how to get help in a language other than English.

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-576-0029 (TTY:1-800-848-0298) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1-800-848-0298).

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

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

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

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

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें।

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

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) فراهم می باشد. با 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), including Privacy and Security Rules. The notice also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practice is located on the Benefits Administration website at https://www.tn.gov/finance/section/fa-benefits. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

Prescription Drug Coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. By law, we are required to inform plan members of this coverage yearly. You can find a copy of the required notice regarding your options on the Benefits Administration website.

If you are actively employed or a pre-65 retiree enrolled in health coverage, you have pharmacy benefits. You do not need to enroll in Medicare prescription drug coverage regardless of your age. Once your retiree group health coverage terminates due to becoming Medicare eligible you may want to enroll in Medicare prescription drug coverage if you need pharmacy benefits.

Summary of Benefits and Coverage

As required by law, the State of Tennessee Group Health Plan has created a Summary of Benefits and Coverage (SBC). The SBC describes your 2018 health coverage options. You can view it online at tn.gov/finance/article/fa-benefits-sbc or request that we send you a paper copy free of charge. To ask for a paper copy, call Benefits Administration at 855.809.0071.

Plan Document

The information contained in this decision guide provides a detailed overview of the benefits available to you through the State of Tennessee. More information is contained within the formal plan documents. If there is any discrepancy between the information in this guide and the formal plan documents, the plan documents will govern in all cases. You can find a copy on the Benefits Administration website at tn.gov/finance/article/fa-benefits-publications.

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at tn.gov/finance/article/fa-benefits-publications, including, but not limited to, a sample basic term life/basic AD&D certificate, sample optional AD&D certificate, Medicare supplement plan document, brochures and handbooks for medical, pharmacy, dental, vision, life insurance and the Medicare supplement.

Eligibility Information

The following dependents are eligible for coverage:

- A legally married spouse
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian
- Children for whom the plan has qualified medical child support orders

Individuals not eligible for coverage as a dependent:

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse (with the exception of long-term care)
- Foster children
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

Notes/Questions

Notes/Questions

Contacts

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 or 615.741.3590 — M-F, 8-4:30	tn.gov/finance/section/fa-benefits partnersforhealthtn.gov
Health Insurance	BlueCross BlueShield of Tennessee	800.558.6213 — M-F, 7-5	bcbst.com/members/tn_state
	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
Health Savings Account	PayFlex	855.288.7936 — M-F, 7-7; Sat, 9-2	stateoftn.payflexdirect.com
Pharmacy Benefits	CVS/caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Abuse and Employee Assistance Program	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	TBD	TBD	TBD
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
Vision Insurance	Davis Vision	800.208.6404 — M-F, 7-10, Sat, 8-3 Sun, 11-3 Basic Client Code: 8155 Expanded Client Code: 8156	davisvision.com/stateofTN
Long-term Care Insurance	MedAmerica	866.615.5824 — M-F, 7:30-5	ltc-tn.com
OTHER PROGRAMS			
Edison	Tennessee Department of Finance & Administration	password reset for local government 800.253.9981 — M-F, 8-4:30	https://www.edison.tn.gov

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STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
19TH FLOOR, 312 ROSA L. PARKS AVENUE
WILLIAM R. SNODGRASS TENNESSEE TOWER
NASHVILLE, TENNESSEE 37243-1102

PARTNERS FOR HEALTH

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IMPORTANT BENEFITS INFORMATION ENCLOSED