Annual Enrollment for 2025 Benefits

Oct. 1–Oct. 31, 2024

Local Education Employees and COBRA Participants

Destination Annual Enrollment

Annual Enrollment for 2025 Benefits, Oct. 1-31, 2024

Discover Your Options. Select Your Benefits. Secure Your Peace of Mind.

Each year, Annual Enrollment is your chance to choose your Partners for Health plan benefits or make changes that will be effective the following Jan. 1 through Dec. 31. Your Annual Enrollment period for 2025 benefits is Oct. 1-31, 2024.

This guide gives you important information about your 2025 benefits choices. You'll find a section where you can Discover Your Options. These include your health, dental and vision benefits. In the Select Your Benefits section, you'll find out how to enroll and find links to helpful videos. Lastly, there is the Secure Your Peace of Mind section, where you'll learn about the Annual Enrollment confirmation statement and find important website links and vendor contact information for all the benefits found in this guide.

We encourage you to review your network options for health, dental and vision care each year. If you don't want to make changes, you don't have to do anything during Annual Enrollment.

If you're enrolled now and don't make changes, you will continue enrollment in the same plan options for medical, dental and vision products, and you'll pay 2025 employee premium amounts. If you don't enroll in health insurance, no premium dollars for health insurance will be deducted from your paycheck.

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

Let's start your journey to Destination Annual Enrollment!

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DISCOVER YOUR OPTIONS

Important 2025 Benefits Updates

Benefits Administration strives to offer a wide choice of benefits while keeping premiums affordable. For 2025, health insurance premiums **will increase by an average of 5.9% for active members.** Premiums are increasing due to general inflation and the increased cost of delivering health care. Specific premium increases will vary slightly depending on the health plan, network and coverage tier you choose. Your premium is automatically deducted from your paycheck each month. You'll find health plan premium charts in the premium section of this guide.

There are no vendor changes for 2025. All member health plan cost sharing, such as deductibles or coinsurance, will stay the same except for the following two changes:

- **A third non-preferred brand drug specialty tier will be added to the Preferred Provider Organization options.** Pharmacy benefits currently have two cost-sharing tiers for specialty medications – generics and brands.
- **The copay for Talkspace will be lowered to $15 for the PPO options.** Talkspace lets members communicate with a therapist by audio or video from a smartphone or desktop. Currently, Talkspace visits under a preferred provider organization, or PPO, plan cost the same as an in-network primary care office visit.

Additional benefits change for Local CDHP members: Anti-obesity medications will no longer be on the preventive drug list for the Local Consumer-driven Health Plan option in 2025. Members enrolled in this plan will be subject to their plan's deductible before plan coverage begins for anti-obesity medications including, but not limited to, Qsymia, Wegovy, Zepbound and Saxenda.

Health Benefits

Health Plan Options

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

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

Here is a comparison of the four plans:

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

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

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

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

Learn more about Health Savings Accounts

HSA maximum contributions are increasing in 2025, as permitted by the IRS.

There are limits on how much money you can put in your HSA in 2025:

- $4,300 for employee-only coverage;
- $8,550 for all other family tiers; and
- Members 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.

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

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

Local CDHP HSA and FSA restrictions: There are certain restrictions about who can enroll in a plan with an HSA. If you enroll in the Local CDHP/HSA, you cannot enroll in another medical plan, including any government plan, and cannot have a medical flexible spending account or health reimbursement account, among other restrictions. You can enroll in the Local CDHP/HSA and a limited purpose FSA for dental and vision costs if one is offered by your employer.

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

Go to the end of this guide for website links to more information about health plans, HSA restrictions, 2025 maximum contribution amounts and debit card details. Click the premiums link in this guide for all premiums.

Health Plan Carrier Networks

BlueCross BlueShield of Tennessee and Cigna, our health insurance carriers, offer expansive networks of doctors, hospitals and facility providers.

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

BlueCross BlueShield Network S
Cigna LocalPlus

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

BlueCross BlueShield Network P
Cigna Open Access Plus

These networks include more hospitals and facilities. **There is an additional cost added to the monthly premium for these networks.**

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

You'll see the total cost for these networks in the premium chart. **You may also pay more per claim because the costs for services in these networks are generally higher than the other two networks.**

It's important to check the networks carefully. The network choice you make during Annual Enrollment is for the entire 2025 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 in the Enrollment Change Application.

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

Covered Services

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

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

Click here to view Insurance Comparison Charts

Included Health Benefits

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

Pharmacy

Managed by CVS Caremark

All health plans include full prescription drug benefits. The health plan you choose (Premier PPO, Standard PPO, Limited PPO or Local CDHP) determines your out-of-pocket prescription costs, including copay, coinsurance, deductible and out-of-pocket maximum.

How much you pay for prescriptions depends on three things:

- the drug tier – if you choose a generic, preferred brand, nonpreferred brand or specialty drug (three different cost tiers in the PPOs);
- the quantity, also known as the days supply, you receive; and
- where you fill your prescription – at a retail, Retail-90* or mail order pharmacy.

Benefits change for Local CDHP members: Anti-obesity medications will no longer be on the preventive drug list for the Local CDHP option in 2025. Members enrolled in this plan will be subject to their plan's deductible before plan coverage begins for anti-obesity medications including, but not limited to, Qsymia, Wegovy, Zepbound and Saxenda.

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

*The Retail 90 network is expanding in 2025 to include more pharmacies. Go to the pharmacy website link at the end of this guide to search for a list of these pharmacies.

Behavioral Health

Managed by 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 and eligible dependents find a provider for in-person or virtual visits, explain benefits, identify best treatment options, schedule appointments and answer questions.

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

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

Emotional Wellbeing Solutions

(formerly called Employee Assistance Program)

Managed by Optum Behavioral Health

Emotional wellbeing services are available to all enrolled local education health plan members and their eligible dependents, even if your dependents are not enrolled in a health plan.

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

- Five counseling visits, per problem, per year, per individual at no cost to you.
- In-person or virtual visits in the privacy and comfort of your own home.

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

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

Wellness Program

Managed by Sharecare

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

Members enrolled in health benefits will have access to the Sharecare member platform, Sharecare mobile app, RealAge Test, lifestyle management coaching, chronic condition management coaching, the Eat Right Now weight management program, Onduo intensive diabetes management program, quarterly challenges and biometric screenings. A Diabetes Prevention Program will also be offered to members who qualify through insurance carriers BlueCross or Cigna.

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

Additional Benefits

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

Dental Insurance

Offered through Cigna and Delta Dental of Tennessee
(if offered by your agency)

Partners for Health offers two different dental plans.

Cigna: Dental Health Maintenance Organization – Prepaid Provider

Total premiums will increase 3.5% for active employees and retirees.

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

Members pay copays. Review the patient charge schedule before having procedures performed. Lab fees may apply for some procedures.

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

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

Delta Dental: Dental Preferred Provider Organization

Total premiums will increase 1.5% for active employees and retirees.

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

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

Waiting periods apply to select procedures.

The premium rates for the Cigna DHMO plan are less than for the DPPO plan; however, the network options

are fewer in the DHMO. You should carefully review all details of each plan before making a selection. To learn about all dental benefits, find the Cigna DHMO handbook, Cigna patient charge schedule and the Delta Dental DPPO handbook by clicking on Publications.

Go to the end of this guide for the dental insurance website link for more information and a comparison of the two plans. Click on the premiums link in this guide, click on Dental premiums, and then go to **Other Insurance Coverages** – Dental. Find contact information for dental vendors Cigna and Delta Dental at the end of this guide.

Vision Insurance

Offered through EyeMed
(if offered by your agency)

Premiums and benefits will stay the same in 2025. You'll save money when using in-network providers.

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

All members in both vision plans get:

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

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

- Frames available once every two calendar years.

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

- Frames available once every calendar year.

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

Go to the end of this guide for the vision insurance website link for more information and a comparison of both plans. Click on the premiums link in this guide, click on Vision premiums, and then go to **Other Insurance Coverages – Vision.** Find contact information for EyeMed at the end of this guide.

SELECT YOUR BENEFITS

How to Enroll in Your Benefits

Employee Self Service in Edison

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

- Look for the green "Benefits Enrollment" button.
- Click the green "Benefits Enrollment" button, then click the "Login" button to log in to Edison using your Access ID. This is not your eight-digit Edison employee ID. To get your Access ID, go to Edison, click the green "Benefits Enrollment" button and then click the "Retrieve Access ID" button.
- Once logged in, choose the Annual Enrollment tile to start your enrollment.
- All the insurance plans you are currently enrolled in, or that are available to you, are listed in Edison.
- You can enroll on your computer or mobile device. Use the web browser native to its operating system.

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

- Dependent verification documents MUST be submitted by the Annual Enrollment deadline of Oct. 31, 2024.
- Find a list of required documents online by going to Forms and then go to Active Employees and COBRA. Click on Dependent Eligibility Verification Documents.

Get Help with Your Enrollment

Don't get lost! You can find enrollment instructions and help with passwords:

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

If you change your mind: Employees have one opportunity to revise Annual Enrollment elections as described in Local Education Plan Document Section 2. The Local Education Plan Document is posted on the Partners for Health website under Publications at tn.gov/PartnersForHealth.

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

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

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

On-demand Videos

Find videos to help you learn about your benefits. You can watch them when it's convenient for you:

Annual Enrollment Videos

Destination Annual Enrollment

2025 Premiums

Benefits Videos

BlueCross BlueShield Medical Network Options

Cigna Medical Network Options

EyeMed Vision Options

Cigna Dental DHMO Option

Delta Dental DPPO Option

Optum Financial HSA Option (for those enrolled in a Local CDHP health plan)

Optum Behavioral Health
(including Emotional Wellbeing Solutions)

Sharecare Wellness Program

Contact Us

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

You'll find:

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

SECURE YOUR PEACE OF MIND

After Enrollment

Annual Enrollment Confirmation Statement

After you click the enrollment submit button, you'll get an email letting you know that your enrollment has been submitted as long as you have a valid email address in Edison. After the Annual Enrollment period ends, you will get another email letting you know your Annual Enrollment confirmation statement is available in Edison. The email you receive will include instructions on how to access this statement. There are a couple different ways you can access the enrollment confirmation statement:

- If you log in through the green Benefits Enrollment button: Click Benefit Details, and then click Benefits Statement.
- From the regular Edison homepage (if you log in through the red login button): Click Benefits & Health and then click Benefit Statements under the Benefits section.

Let's Keep in Touch!

Benefits Administration sends emails to members with important insurance information throughout the year. Emails are from Partners for Health and are sent from an email service provider. You can unsubscribe at any time, but if you do, you'll no longer receive any insurance-related updates. Please log in to Edison and make sure your email address is correct. It's easy! Click on your name next to the home icon in the top right corner. This will open a Profile list on the left. Click on "My System Profile" and then click the link "Change or Set Up Email Address".

Important Partners for Health Website Links and Contact Information

Partners for Health Website Links:

Health Plans

CDHP/HSA Insurance Options

Carrier Information (BlueCross BlueShield and Cigna)

Pharmacy

Behavioral Health

Included Benefits Extras

Dental Insurance

Vision Insurance

Wellness Program

Emotional Wellbeing Solutions

Contact Information:

Benefits Administration

800.253.9981 or 615.741.3590

Monday - Friday, 8 a.m. - 4:30 p.m. CT

Fax: 615.741.8196

e-mail: benefits.administration@tn.gov

Health Insurance

BlueCross BlueShield of Tennessee

800.558.6213

Monday - Friday, 7 a.m. - 5 p.m. CT

bcbst.com/members/tn_state/

Cigna

800.997.1617

24/7

cigna.com/stateoftn

Health Savings Account

Optum Financial

866.600.4984

24/7

optumbank.com/Tennessee

Pharmacy

CVS Caremark

877.522.TNRX (8679)

24/7

info.caremark.com/stateoftn

Behavioral Health/ Emotional Wellbeing Solutions

Optum Behavioral Health

855.HERE4TN (855.437.3486)

24/7

Here4TN.com

Wellness Program

Sharecare

888.741.3390

Monday - Friday, 8 a.m. - 8 p.m. CT

sharecare.com/tnwellness/

Dental Insurance

Cigna Dental Health Maintenance Organization - Prepaid Provider

800.997.1617

24/7

cigna.com/stateoftn

Delta Dental – Dental Preferred Provider Organization

800.552.2498

Monday - Friday, 7 a.m. to 5 p.m. CT

DeltaDentalTN.com/StateofTN

Vision

EyeMed

855.779.5046

Mon.-Sat., 7 a.m. – 10 p.m. CT, Sun. 10 a.m. – 7 p.m. CT,

eyemed.com/stateoftn

Legal Notices

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 615.532.9617.

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

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

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

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing renee.woodall@tn.gov and FA.CivilRights@tn.gov or calling 615.253.9926.

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 OR U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 OR

Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

If you speak a language other than English, help in your language is available for free. Please request assistance by emailing renee.woodall@tn.gov and FA.CivilRights@tn.gov or calling 615.253.9926.

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：如果您會說中文，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
ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີຢູ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

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

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

Gujarati
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).

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 تماس 1-866-576-0029 (TTY: 1-800-848-0298) بگیرید.

The Notice of Privacy Practice

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

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

Prescription Drug Coverage and Medicare

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

Summary of Benefits and Coverage

As required by law, a Summary of Benefits and Coverage is available which describes your 2025 health coverage options. The SBC will be available for review at https://www.tn.gov/ParTNersForHealth/summary-of-benefits-and-coverage no later than Sept. 1. The digital benefits guide contains much of the same information. To get an SBC paper copy, free of charge, call 855.809.0071. Please include your name, complete mailing address and name of the SBCs you want: State and Higher Education Plan; Local Education Plan; or Local Government Plan.

Plan Document and Certificates of Coverage

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

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. Only active state and higher education employees and enrolled spouses are eligible to earn cash incentives. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the assessment or other medical examinations. Although you are not required to complete the health questionnaire, only active state and higher education employees and spouses who do so are eligible to receive cash incentives. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Partners for Health Wellness Program at 888.741.3390. The information from your health questionnaire and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. It may also be used to offer you services through wellness programs such as weight management, Diabetes Prevention Program, and other programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information (PHI). Although the wellness program and the State of Tennessee may use aggregate information it collects to design a program based on identified health risks in the workplace, the Partners for Health Wellness Program will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed for you to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law and the State of TN's contract with Sharecare to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive, if eligible. Anyone who receives your information for purpose of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the wellness vendor (nutritionists, nurses, nurse practitioners, registered dietitians, health coaches, and other health care professionals) and their vendor partners (case managers with the medical and behavioral health vendors, diabetes remission program vendor, and the biometric screening vendor) to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decisions. Appropriate safeguards will be taken to avoid any data breach, and in the event a data breach occurs involving information in connection with the wellness program, you will be notified promptly. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Partners for Health at partners.wellness@tn.gov.

Tennessee Department of Finance and Administration. Authorization Number 317593, July 2024. This public document was promulgated at a cost of $0.00 per copy.

2025 Active Employees Monthly Health Premiums

ALL REGIONS				
	BCBST NETWORK S	CIGNA LOCALPLUS	BCBST NETWORK P	CIGNA OPEN ACCESS
PREMIER PPO				
Employee Only	$755	$755	$830	$830
Employee + Child(ren)	$1,244	$1,244	$1,329	$1,329
Employee + Spouse	$1,698	$1,698	$1,848	$1,848
Employee + Spouse + Child(ren)	$1,961	$1,961	$2,111	$2,111
STANDARD PPO				
Employee Only	$701	$701	$776	$776
Employee + Child(ren)	$1,156	$1,156	$1,241	$1,241
Employee + Spouse	$1,577	$1,577	$1,727	$1,727
Employee + Spouse + Child(ren)	$1,822	$1,822	$1,972	$1,972
LIMITED PPO				
Employee Only	$662	$662	$737	$737
Employee + Child(ren)	$1,091	$1,091	$1,176	$1,176
Employee + Spouse	$1,490	$1,490	$1,640	$1,640
Employee + Spouse + Child(ren)	$1,720	$1,720	$1,870	$1,870
LOCAL CDHP/HSA				
Employee Only	$578	$578	$653	$653
Employee + Child(ren)	$953	$953	$1,038	$1,038
Employee + Spouse	$1,300	$1,300	$1,450	$1,450
Employee + Spouse + Child(ren)	$1,502	$1,502	$1,652	$1,652

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

2025 Monthly Vision Premiums

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

Click to view premiums webpage

2025 Monthly Dental Premiums

	CIGNA DHMO (PREPAID PROVIDER) PLAN			DELTA DENTAL DPPO PLAN		
ACTIVE MEMBERS	TOTAL PREMIUM (LOCAL EDUCATION, LOCAL GOVERNMENT, AND STATE OFFLINE AGENCIES)	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYEE PREMIUM	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYER PREMIUM	TOTAL PREMIUM (LOCAL EDUCATION, LOCAL GOVERNMENT, AND STATE OFFLINE AGENCIES)	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYEE PREMIUM	CENTRAL STATE GOVERNMENT AND STATE HIGHER EDUCATION EMPLOYER PREMIUM
Employee Only	$14.69	$7.34	$7.35	$20.32	$10.16	$10.16
Employee + Child(ren)	$30.50	$15.25	$15.25	$54.03	$27.01	$27.02
Employee + Spouse	$26.03	$13.01	$13.02	$39.96	$19.98	$19.98
Employee + Spouse + Child(ren)	$35.79	$17.89	$17.90	$82.75	$41.37	$41.38
COBRA PARTICIPANTS						
Employee Only/Single	$14.98			$20.73		
Employee + Child(ren)	$31.11			$55.11		
Employee + Spouse	$26.55			$40.76		
Employee + Spouse + Child(ren)	$36.51			$84.41		
COBRA DISABILITY PARTICIPANTS						
Employee Only/Single	$22.04			$30.48		
Employee + Child(ren)	$45.75			$81.05		
Employee + Spouse	$39.05			$59.94		
Employee + Spouse + Child(ren)	$53.69			$124.13		

2025 Health Plan Comparison of Member Costs — Local Education and Local Government

PARTNERS FOR HEALTH

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care and maintenance medications.
Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY								
• Well-baby, well-child visits • Adult annual physical exam • Annual well-woman exam • Immunizations • Annual hearing and non-refractive vision screening • Screenings, labs, nutritional guidance, tobacco cessation counseling & other	$0	$45	$0	$50	$0	$50	$0	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA								
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Initial maternity visit • Surgery in office setting • Provider-based telehealth	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Surgery in office setting • Provider-based telehealth	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use[2] • Including provider-based virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Programs (MDLive/Teledoc/Talkspace)	$15	N/A	$15	N/A	$15	NA	30%	N/A
Allergy Injection Without Office Visit Allergy serum – see page 2	$0	$0	$0	$0	$0	$0	30%	50%
Chiropractic and Acupuncture • Annual limit of 50 visits each	$25/visit 1-20 $45/visit 21-50	$45/visit 1-20 $70/visit 21-50	$30/visit 1-20 $50/visit 21-50	$50/visit 1-20 $75/visit 21-50	$35/visit 1-20 $55/visit 21-50	$55/visit 1-20 $80/visit 21-50	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED								
30-Day Supply	$7/$40/$90	copay + amount > MAC	$14/$50/$100	copay + amount > MAC	$14/$60/$110	copay + amount > MAC	30%	50% + amount >MAC
90-Day Supply 90-day pharmacy or mail order	$14/$80/$180	N/A - no network	$28/$100/$200	N/A - no network	$28/$120/$220	N/A - no network	30%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order[3]	$7/$40/$160	N/A - no network	$14/$50/$180	N/A - no network	$14/$60/$200	N/A – no network	20% before deductible	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY								
Generics Tier 1	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A – no network	30%	N/A - no network
Preferred Brands Tier 2	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A – no network	30%	N/A - no network
Non-Preferred Brands Tier 3	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	30%	N/A – no network

2025 Local Education and Local Government Comparison. PPO services in this table ARE subject to a deductible unless noted with a [5]. Local CDHP/HSA services in this table ARE subject to a deductible and coinsurance except for in-network preventive care. **Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.**

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE – OUTPATIENT FACILITIES – AS RECOMMENDED & MEDICALLY NECESSARY								
Screenings such as colonoscopy, mammogram, colorectal, lung imaging and bone density scans [5]	$0	40%	$0	40%	$0	50%	$0	50%
OTHER SERVICES								
Hospital/Facility Services [4] • Inpatient care [7]; outpatient surgery [7] • Inpatient behavioral health and substance use [2] [6]	15%	40%	20%	40%	30%	50%	30%	50%
• Emergency room services [7]	15%		20%		30%		30%	
Maternity • Global billing after first visit; Routine services & labor and delivery	15%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] • Home health; home infusion therapy	15%	40%	20%	40%	30%	50%	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4] • Outpatient PT/ST/OT/ABA [5]; Other therapy	15%	40%	20%	40%	30%	50%	30%	50%
X-Ray, Lab and Diagnostics (Excludes advanced studies below) [5]	15%		20%		30%		30%	50%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Pathology and Radiology Reading, Interpretation and Results [5]	15%		20%		30%		30%	
Ambulance (air and ground)	15%		20%		30%		30%	
Durable Medical Equipment, External Prosthetics and Medical Supplies [4]	15%	40%	20%	40%	30%	50%	30%	50%
Allergy Serum	15%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Limited Dental benefits, Hospice Care and Out-of-Country Charges. See Member Handbook for coverage details.							
DEDUCTIBLE — ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE								
Employee Only	$750	$1,500	$1,300	$2,600	$1,800	$3,600	$2,000	$4,000
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900	$2,500	$4,800	$4,000	$8,000
Employee + Spouse	$1,500	$3,000	$2,600	$5,200	$2,800	$5,500	$4,000	$8,000
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500	$3,600	$7,200	$4,000	$8,000
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES FOR MEDICAL, BEHAVIORAL AND PHARMACY, COMBINED, INCLUDING DEDUCTIBLE								
Employee Only	$3,600	$7,200	$4,400	$8,800	$6,800	$13,600	$5,000	$10,000
Employee + Child(ren)	$5,400	$10,800	$6,600	$13,200	$13,600	$27,200	$10,000	$20,000
Employee + Spouse	$7,200	$14,400	$8,800	$17,600	$13,600	$27,200	$10,000	$20,000
Employee + Spouse + Child(ren)	$9,000	$18,000	$11,000	$22,000	$13,600	$27,200	$10,000	$20,000

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

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

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

[3] Additional information on the maintenance drug benefit and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health-options/pharmacy.html.

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

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

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

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