



2018 **Decision Guide**

**Active employees and COBRA
participants**

**ANNUAL
ENROLLMENT PERIOD**

**Two Weeks
October 2-13, 2017**

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 among other new benefits. In 2018, we are delighted to offer a voluntary wellness program to replace the Partnership Promise. The voluntary wellness program is not tied to any health plan. All eligible members can participate and will be rewarded with money in their paychecks for completing certain requirements. There is more information about the program in the health benefits section. We will share additional wellness program information in late 2017 and throughout 2018.

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



**Watch a new
video or attend a
webinar to better
understand your
benefits!**

Want to learn more about your 2018 benefits?

Attend a webinar:

Tuesday, Oct. 3 — 1-2 p.m.

Friday, Oct. 6 — 1-2 p.m.

Monday, Oct. 9 — 11 a.m.-12 p.m.

Wednesday, Oct. 11 — 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/.



Are you ready?

✓ Enrollment checklist

<input type="checkbox"/> Read this guide.	At www.partnersforhealthtn.gov you will also find a pdf.
<input type="checkbox"/> Gather a list of your doctors, hospitals and medications.	Be sure to gather this same information for every family member.
<input type="checkbox"/> 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 23.
<input type="checkbox"/> 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.
<input type="checkbox"/> Visit the ParTNers for Health website, www.partnersforhealthtn.gov .	For benefits information, insurance terms and FAQs.
<input type="checkbox"/> 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.
<input type="checkbox"/> Choose your health insurance option, tier and network.	You will enroll using ESS in Edison. Directions are on page 23.
<input type="checkbox"/> Choose your voluntary benefits — disability, dental, vision and life.	You will enroll using ESS in Edison. Directions are on page 23.
<input type="checkbox"/> Decide if a flexible spending account (FSA) is right for you.	You can choose from medical, limited purpose, dependent care and transportation and parking. More on page 20.

Table of contents

Annual enrollment.....	2
What's important.....	2
What can I do?	3
What do I have to do?	3
2018 health benefits	4
Included with health	6
Pharmacy.....	6
Telehealth.....	7
Behavioral health	7
EAP.....	7
Wellness	8
2018 benefit comparison ...	10
Disability.....	14
Vision	16
Dental	18
FSA.....	20
Life	21
Other benefits.....	22
Edison ESS.....	23
Legal notices	24
Contacts.....	inside back cover

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)** Jodi Epps, 423-439-6126 or eppsji@etsu.edu

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, summaries of benefits and coverage (SBC) and sample life insurance certificates are available.

Annual enrollment

Your annual enrollment period for 2018 insurance benefits is October 2 through October 13, 2017, for most programs.

- Deadline to make changes is October 13 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 13 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

Three 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. CDHP/HSA

- » Premiums will be **lower** than in 2017
- » The state HSA funding will be **\$250/\$500 if enrolled prior to 9/2/18**
- » State HSA funds are not tied to wellness activities

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.

New

Disability: New Short-Term Disability insurance will be offered. Go to page 14 to learn more.

Changes

Wellness Program: Members in any plan can earn **cash incentives** for completing certain wellness activities. Go to page 8 to learn more.

- All wellness activities will be voluntary. This means that 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 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.

Dental: Dental insurance premiums will increase — MetLife premiums by 3.6% and Cigna premiums by 3.5%.

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 November 30, 2017, and after this date, members will pay premiums directly to MedAmerica.

Voluntary term life insurance has been changed to allow a member to port (continue) one half of the coverage value the member had as an active employee or spouse upon leaving employment. The employee maximum is \$250,000.

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 & network
- Enroll in, cancel or change dental and vision insurance
- Enroll in or cancel voluntary accidental death and dismemberment (AD&D) coverage
- Apply for, cancel, increase or decrease voluntary term life insurance coverage amounts (if eligible)
- Enroll in NEW short term disability insurance
- **Enroll in flexible spending accounts**

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. The state HSA funding will decrease. The Partnership PPO name will change to Premier PPO.

Flexible Spending Accounts (FSA): You must enroll or re-enroll in FSAs.

- Enroll on the PayFlex website (stateoftn.payflexdirect.com) for your FSA. Complete a paper form available in HR for your HSA.

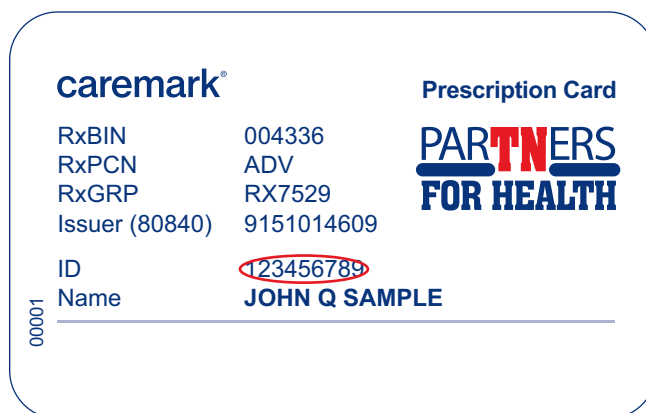
ID cards

- 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 cards

Health Savings Account (HSA) & Flexible Spending Account (FSA)

- If you enroll in a CDHP/HSA, a medical FSA or limited purpose FSA, you will receive a PayFlex debit card for your qualified expenses.
- If you enroll in a CDHP and have a limited purpose FSA, you will use one debit card with all of your information loaded on it. The limited-purpose FSA funds, when applicable, will be used before any of your HSA funds.
- If you received a PayFlex debit card last year, you can use the same card for any FSA or HSA accounts you have in 2018.

Every year you should review your health plan to see what best suits your current needs!



2018 health benefits

Health insurance

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

Health Plan Options

There are three 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 in coinsurance than the Standard and CDHP. 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. It has the same coverage and cost sharing as last year's Standard PPO.
- **Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA):** Lower premiums and a lower out of pocket maximum, but you have a higher deductible. You get a HSA — to use for qualified healthcare expenses, including your deductible and to save for retirement.
 - » The state contributes to your HSA (\$250 employee only/\$500 family tiers*), and you can contribute to this account with pre-tax dollars from each paycheck.
 - » 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!

***If your insurance coverage starts on or after Sept. 2 through the end of 2018, the state will not contribute funds to your HSA in 2018.**

How does the 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. Check with your pharmacist or CVS/caremark if you have questions.
- **You get a HSA to save!** The state will put money into your account, and you can contribute too. For example, you can put the difference in premiums between the 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 the \$250 state HSA contribution)

\$6,900 for all other tiers (includes the \$500 state HSA contribution)

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. This lowers your taxable income, saving you money. Your 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 stateofn.payflexdirect.com to learn more.
- **Certain restrictions:** You cannot enroll in a 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 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.**

Member Costs at a Glance

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

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

The state HSA funding will be \$250 employee only/\$500 for all other tiers. If your insurance coverage starts on or after Sept. 2 through the end of 2018, the state will not contribute funds to your HSA in 2018.

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.

disability elimination (waiting) period— the length of time between when an injury or illness begins and receiving benefit payments from an insurer.

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 the Caremark website at 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	CDHP/HSA
30-DAY SUPPLY			
Generic	\$7	\$14	20% coinsurance after deductible is met
Brand	\$40	\$50	
Non-preferred brand	\$90	\$100	
90-DAY SUPPLY (90-day network pharmacy or mail order)			
Generic	\$14	\$28	20% coinsurance after deductible is met
Brand	\$80	\$100	
Non-preferred brand	\$180	\$200	
90-DAY SUPPLY (certain maintenance medications from a Retail-90 network pharmacy or mail order)			
Generic	\$7	\$14	10% coinsurance without having to meet deductible
Brand	\$40	\$50	
Non-preferred brand	\$160	\$180	
SPECIALITY PHARMACY**			
Coininsurance	10% (min \$50; max \$150)	10% (min \$50; max \$150)	20% 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)

Your Employee Assistance Program (EAP) is also administered by Optum. It is available to all benefits-eligible employees and 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 Wellness Voluntary Rewards Program

In 2018, the wellness program will be voluntary. 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.

However, members and enrolled spouses can get **cash rewards** for participating in the voluntary wellness program. You can get money deposited through payroll* by completing certain activities and programs.

Here’s how it works:

Regardless of the health plan you choose, members and enrolled spouses will first complete two requirements that may make them eligible for other programs. These requirements are:

- Health risk assessment (online questionnaire)
- Biometric screening

After members complete these two requirements, they will receive a cash deposit into their paycheck. Then, they’ll find out if they qualify for other rewards and programs. Members who qualify can also get cash rewards for completing one or more programs. These additional programs could include:

- Weight loss/weight management program
- Tobacco cessation program
- Wellness counseling (diet, stress, exercise, etc.)
- Disease management program
- Diabetes Prevention Program (DPP)

There will also be wellness challenges, educational tools and other online wellness resources to help members track their results and progress.

The new voluntary wellness program begins on January 1, 2018. All eligible members and spouses will receive more information on how participants qualify for cash rewards **in the mail from the wellness vendor**.

***Members must be in a positive pay status to receive an incentive. The cash incentive for both the employee and eligible spouse will be deposited directly into the member’s paycheck and will be taxed.**

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.

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 available to all employees and spouses enrolled in health coverage. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health questionnaire (assessment) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). You will also be asked to complete a biometric screening, which will include a sample of your blood to determine blood sugar and cholesterol levels, blood pressure, height, weight and BMI. You are not required to complete the assessment or to participate in the biometric screening or other medical examinations.

Although you are not required to complete the health questionnaire or participate in the biometric screening, only 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.

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 the wellness program 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 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. 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, weight management vendor and the biometric screening vendor) 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. 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				
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Including surgery in office setting 	\$45 copay	\$70 copay	\$50 copay	\$75 copay
Behavioral Health and Substance Use ^[2] <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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)	

CDHP/HSA	
IN-NETWORK	OUT-OF-NETWORK ^[1]
No charge	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance plus amount exceeding MAC
20% coinsurance	N/A - no network
10% coinsurance without first having to meet deductible	N/A - no network
20% coinsurance	N/A - no network
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	

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.

2018 Monthly Premiums — Active Employees

ALL REGIONS				
	BCBST	CIGNA LOCALPLUS	CIGNA OPEN ACCESS	EMPLOYER SHARE
PREMIER PPO				
Employee Only	\$150	\$150	\$190	\$599
Employee + Child(ren)	\$225	\$225	\$265	\$898
Employee + Spouse	\$314	\$314	\$394	\$1,258
Employee + Spouse + Child(ren)	\$389	\$389	\$469	\$1,557
STANDARD PPO				
Employee Only	\$102	\$102	\$142	\$599
Employee + Child(ren)	\$153	\$153	\$193	\$898
Employee + Spouse	\$215	\$215	\$295	\$1,258
Employee + Spouse + Child(ren)	\$266	\$266	\$346	\$1,557
CDHP/HSA				
Employee Only	\$66	\$66	\$106	\$599
Employee + Child(ren)	\$98	\$98	\$138	\$898
Employee + Spouse	\$138	\$138	\$218	\$1,258
Employee + Spouse + Child(ren)	\$170	\$170	\$250	\$1,557

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

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
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
CDHP STATE HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION				
For individuals who enroll in the CDHP/HSA	N/A		N/A	

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 CDHP Plan**, the deductible and out-of-pocket maximum amount can be met by one or more persons. **For 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.

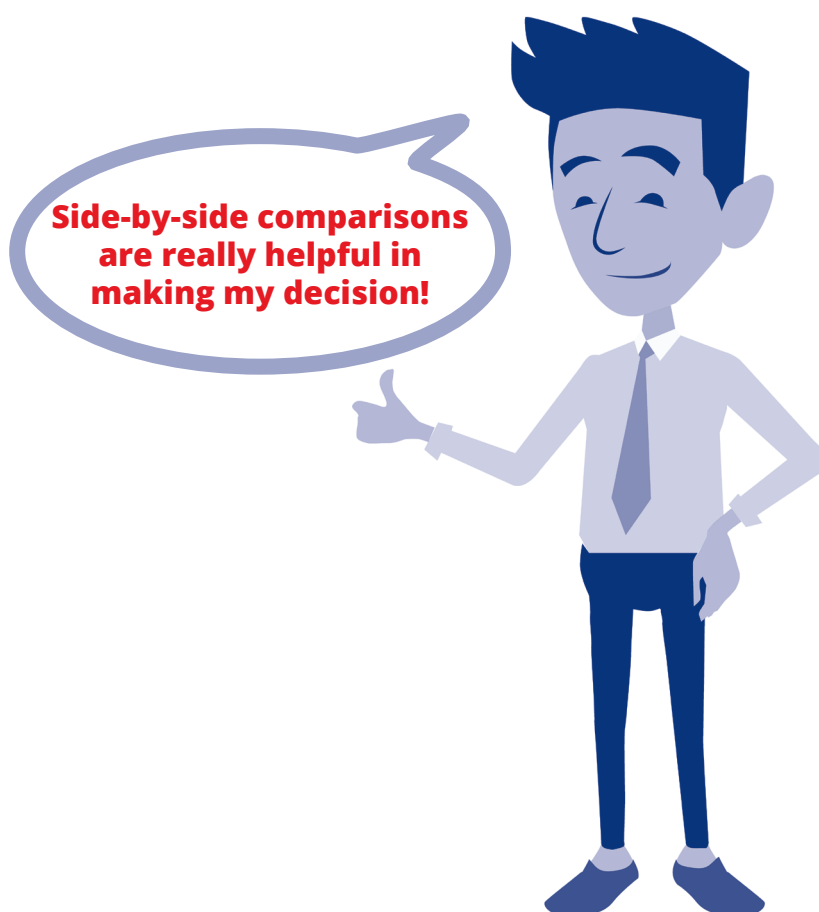
[4] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA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

CDHP/HSA	
IN-NETWORK	OUT-OF-NETWORK ^[1]
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	40% coinsurance
20% coinsurance	
100% covered up to MAC (after the deductible has been met)	
20% coinsurance	40% coinsurance
20% coinsurance for oral surgeons	40% coinsurance for oral surgeons
20% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
20% coinsurance	40% coinsurance
N/A - no network	40% coinsurance
\$1,500	\$3,000
\$3,000	\$6,000
\$3,000	\$6,000
\$3,000	\$6,000
\$2,500	\$4,500
\$5,000	\$9,000
\$5,000	\$9,000
\$5,000	\$9,000
State contribution to HSA: \$250 for employee only; \$500 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage	

2018 Monthly Premiums — COBRA Participants

ALL REGIONS			
	BCBST	CIGNA LOCALPLUS	CIGNA OPEN ACCESS
PREMIER PPO			
Employee Only/Single	\$763.98	\$763.98	\$804.78
Employee + Child(ren)	\$1,145.46	\$1,145.46	\$1,186.26
Employee + Spouse	\$1,603.44	\$1,603.44	\$1,685.04
Employee + Spouse + Child(ren)	\$1,984.92	\$1,984.92	\$2,066.52
STANDARD PPO			
Employee Only/Single	\$715.02	\$715.02	\$755.82
Employee + Child(ren)	\$1,072.02	\$1,072.02	\$1,112.82
Employee + Spouse	\$1,502.46	\$1,502.46	\$1,584.06
Employee + Spouse + Child(ren)	\$1,859.46	\$1,859.46	\$1,941.06
CDHP/HSA			
Employee Only/Single	\$678.30	\$678.30	\$719.10
Employee + Child(ren)	\$1,015.92	\$1,015.92	\$1,056.72
Employee + Spouse	\$1,423.92	\$1,423.92	\$1,505.52
Employee + Spouse + Child(ren)	\$1,761.54	\$1,761.54	\$1,843.14

*COBRA participants enrolled in the CDHP/HSA do not receive a state contribution to their HSA



Disability insurance

The state is pleased to offer voluntary disability benefits to full-time employees.

Important information if you are thinking about enrolling in coverage:

- **For this Annual Enrollment Period only, there will be no questions asked about your health to enroll in the new short-term disability.**
 - » Employees may purchase long-term disability from Lincoln Financial Group if not currently enrolled. Those currently enrolled will default into Option 3 with LFG.
- Those who enroll will pay 100% of the premium with after-tax dollars. By paying with after-tax dollars, any benefits paid to you will result in a tax free benefit.
- If you intend to enroll in both short term and long term disability, you should consider enrolling in one of the long term disability options with a 180 day elimination period. The 26-week short term disability insurance will best cover the 180 day elimination period for your long term disability, at a lower monthly cost.
- **You must use all of your accumulated leave (sick, annual and comp time) before your disability payments begin.**

Why is having disability insurance important?

If you are unable to work due to illness or injury, disability insurance can help pay your most important expenses. These include:

- Mortgage or rent
- Car payments
- Food
- Child care/tuition
- Utilities

Short term disability insurance

Short term disability insurance replaces a portion of your income during a disability, which could last up to 26 weeks. It may be good for those who:

- Have little annual or sick leave
- Take part in high-risk activities
- Don't have six-month emergency funds

To calculate your monthly premium, go to metlife.com/StateofTN, click on higher education employees, and then click on **Rates** at the top.

2018 Monthly Premiums for Short Term Disability (STD)

STD COST: PER \$100 OF MEMBER'S COVERED MONTHLY SALARY	
Option A: 60%, 14-day elimination period	\$1.34
Option B: 60%, 30-day elimination period	\$1.08

Short Term Disability Options

	Option A	Option B
Eligibility	All employees working not less than 30 hours/week or seasonal employees hired prior to July 1, 2015, with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year (July-June), or deemed eligible by applicable federal law, state law or action of the State Insurance Committee.	
% of Gross Annual Base Salary Paid Weekly	60% of salary paid weekly	
Maximum Weekly Benefit	Up to \$2,500	
Minimum Weekly Benefit	\$25	
Elimination (Waiting) Period	14 calendar days	30 calendar days
Duration of Benefit	26 weeks	
Evidence of Insurability (EOI)	Guaranteed Issue (no health questions asked) for 2018 Annual Enrollment and new hires who enroll within 31 days of eligibility date. EOI will be required for late enrollees and 2018 plan participants who choose a higher plan of benefit during the 2019 Annual Enrollment Period.	
Pre-existing Condition	None	

Vision benefits

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 re-enroll 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

"See" if one of these vision plans is right for you!

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) <ul style="list-style-type: none"> • Single • Bifocal, trifocal, lenticular • Standard progressive Lens • Premium progressive Lens 	\$0 copay \$0 copay \$55 allowance; 20% off balance over \$55; not to exceed \$65 out-of-pocket \$55 allowance; 20% off balance over \$55; not to exceed \$105 out-of-pocket	\$0 copay \$0 copay \$50 copay \$50-140 copay ^[1]
Eyeglass Lens Options (upgrades) <ul style="list-style-type: none"> • Anti-reflective • Polycarbonate • Photochromic • Scratch resistance coating • UV coating • Tints • Polarized • Premium anti-reflective • Scratch protection plan: single vision/multifocal lenses • All other eyeglass lens options 	20% discount off all options with out-of-pocket not to exceed amount shown below Up to \$40 Adults \$35; Children \$0 Up to \$70 \$0 Up to \$15 Up to \$15 Up to \$75 Up to \$55 \$20 copay/\$40 copay	\$40 copay Adults \$30; Children \$0 20% off retail price; not to exceed \$70 out-of-pocket \$0 copay \$10 copay \$15 copay 20% off retail; not to exceed \$75 out-of-pocket \$40-69 copay ^[1] \$20 copay/\$40 copay 20% discount
Exam for Contact Lenses (fitting and evaluation)	20% discount off retail price	\$50-60 copay
Contact Lenses ^[2] <ul style="list-style-type: none"> • Elective • Conventional or disposable • Medically necessary ^[3] 	\$55 allowance; 20% off balance over \$55 \$155 allowance; 20% off balance over \$155	\$140 allowance; 20% off balance over \$140 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 <ul style="list-style-type: none"> • All eye exams • Frames • Eyeglass lenses <ul style="list-style-type: none"> • Single vision • Lined bifocal • Lined trifocal • Elective contacts (conventional or disposable) • Medically necessary contacts ^[3] • Lens options-UV, polycarbonate, photochromic/transitions plastic 	\$35 allowance up to \$55 allowance (frames and lenses combined) \$30 allowance \$80 allowance	up to \$50 allowance up to \$75 allowance up to \$35 allowance up to \$55 allowance up to \$70 allowance up to \$55 allowance up to \$200 allowance up to \$10 allowance
Frequency <ul style="list-style-type: none"> • Eye exam • Eyeglass lenses and contacts • Frames 	once every calendar year per person once every calendar year per person once every two calendar years per person	once every calendar year per person once every calendar year 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

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.

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.
- Preexisting 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.**

Dental questions?

Call or go online

Cigna DHMO: 800.997.1617 or
cigna.com/stateoftn

MetLife DPPO: 855.700.8001 or
metlife.com/StateOfTN

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

Your dental health is an important part of your overall health!



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.

Flexible spending accounts

Flexible spending accounts (FSAs) help make your money go farther. Here's how they work:

They help you decrease your taxable income and increase your take-home pay. It allows you to pay certain expenses from your pre-tax income rather than after-tax income. The maximum amount you can contribute to a FSA is set by the Internal Revenue Service (IRS). The limits are subject to change yearly.

Three FSAs are offered:

Medical FSA

Used to pay for certain medical, dental, vision and prescription costs not covered by your insurance. You do NOT qualify for a medical FSA if you are enrolled in the CDHP/HSA. Up to \$500 of your unused FSA balance can be carried over into the next plan year instead of you "losing it."

Limited Purpose FSA (L-FSA)

May only be used to pay for certain dental and vision costs not covered by insurance. For employees enrolled in the CDHP/HSA, the limited purpose FSA is a great way to save on vision and dental expenses.

Dependent Care FSA (DC-FSA)

Used to pay for certain dependent-care costs, such as after school care, baby-sitting fees, adult or child daycare and preschool. Certain requirements must be met by the eligible employee and/or his or her spouse. For details, review the governing Plan Document located at <https://www.tn.gov/finance/article/fa-benefits-publications>.

Availability of Funds

Employees who enroll in a medical FSA or L-FSA will have their full election amount available to them the first week of January. DC-FSA funds are only available as they are taken from your paycheck; your full election amount is not available up front.

Debit Cards

- PayFlex will send all newly enrolled medical and limited purpose FSA participants a debit card in December.
- Plan members who currently have a medical or limited purpose FSA debit card will not receive a new debit card. Your current card will continue to work. You can use it at pharmacies, doctor's offices and other healthcare facilities to pay from your account.
- If you enroll in the CDHP/HSA and a limited purpose FSA, the same debit card will work for both accounts. PayFlex will pull any dental or vision expenses from your limited purpose FSA "purse" on the debit card before using any of your HSA funds. This allows your HSA funds to continue to grow.
- If you currently have a HSA with a debit card and plan to enroll in a limited purpose FSA, you will use the same debit card in 2018 for both your HSA and limited purpose FSA eligible purchases.
- Dependent care FSA participants will not use a debit card.

You should keep all receipts when using the debit card to pay for eligible healthcare expenses. PayFlex may contact you later and request them. If you cannot provide receipts, use of your debit card may be suspended.

2018 Contribution Limits

- The maximum you may contribute to a medical FSA is \$2,600.
- The maximum you may contribute to a limited purpose FSA is also \$2,600.
- The maximum that a family may contribute to the dependent care FSA is \$5,000 (up to \$2,500 each if both spouses are working).
- Please visit [IRS.gov](https://www.irs.gov) for more information.

Enrollment

To put money in a FSA for 2018, you will do this on PayFlex's website (stateoftn.payflexdirect.com).

Note: Flexible benefits for employees are only available to benefits-eligible employees; part-time employees may not enroll in these benefits.

Life insurance

Basic Term Life and Accidental Death & Dismemberment Insurance

The state provides basic term life insurance (\$20,000) and accidental death and dismemberment (AD&D) insurance (\$40,000) to all benefits eligible employees. If you are enrolled in health insurance as the head of contract, your coverage automatically increases with your salary — to a maximum of \$50,000 for basic term life insurance and \$100,000 for accidental death insurance.

- The amount of basic term life and basic AD&D insurance begins to decrease when you reach age 65.
- Dependents enrolled in health insurance have \$3,000 of basic term life insurance.
- Additional life insurance resources:
 - » Legacy Planning: A resource to assist with organizing important documents, end-of-life planning and funeral arrangements.
 - » Travel Assistance: Access to 24-hour emergency travel assistance services and resources when traveling 100 or more miles from home.
 - » Beneficiary Financial Counseling: Independent financial counseling to help beneficiaries make sound financial decisions at a difficult time.
- **The basic term life/basic AD&D insurance premium rates will remain unchanged for 2018.**

Note: If you are in the state plan and your spouse is also in the state plan, you can both choose your own health insurance coverage. This allows you to get a higher level of life insurance coverage as the head of contract.

Voluntary Accidental Death & Dismemberment Insurance

If you would like additional accident protection, you may enroll in voluntary accidental death and dismemberment insurance for yourself and your dependents.

- Coverage is available at low group rates — no questions asked.
- Premiums and coverage level vary by salary.
- The maximum benefit for employees is \$60,000.
- You must enroll using ESS in Edison.
- **The voluntary AD&D insurance premium rates will remain unchanged for 2018.**

Important information about your beneficiaries

Keep your life insurance beneficiaries up to date. For basic term life/AD&D insurance and voluntary AD&D insurance, you can make changes online in ESS in Edison. Ask H.R. for a complete beneficiaries packet.

Voluntary Term Life Insurance

If you qualify, you can purchase additional voluntary term life insurance coverage for yourself, your spouse and children.

- You can apply for up to seven times your annual base salary (to a maximum of \$500,000) for yourself and up to a maximum of \$30,000 for your spouse (\$15,000 for ages 55 and older).
- You can also apply for coverage for your children equal to \$5,000 or \$10,000.
- To apply, go to lifebenefits.com/stateoftn, fill out the Evidence of Insurability form and fax to Securian (Minnesota Life).

Note: Voluntary term life insurance coverage may start on the first of a month later than January 1, depending upon review and approval of health related questions.

- If you are currently enrolled and eligible for a guaranteed issue increase, information will be mailed to you. If not currently enrolled, you (and/or your spouse) will be required to present evidence of insurability by answering health related questions. A child term life insurance rider may be added to your certificate or your spouse's certificate without answering any health related questions for the children.
- **The voluntary term life insurance premium rates for employees and spouses will increase for 2018. The monthly administrative charge and the premium rates for the child term life insurance rider will decrease for 2018.**

Adding or Updating Beneficiaries for Voluntary Term Life:

Go to the Securian (Minnesota Life) website: lifebenefits.com/stateoftn.

- Beginning in 2018, an enrolled employee or spouse may only continue (port) one-half (1/2) of the voluntary term life insurance coverage he or she had at time of leaving active employment due to retirement or termination. The minimum amount of continued coverage is \$5,000 and the maximum amount is \$250,000. Continuation of coverage is not available if the reason for the cancellation of coverage was due to non-payment of premiums. Also, continuation of coverage is only available to an employee or spouse under the age of 70. If over 70, conversion to an individual policy is available.

All of this insurance coverage is provided through Securian (Minnesota Life).

Questions?

lifebenefits.com/stateoftn or call 866.881.0631 or email LifeBenefits@securian.com

Retire Ready Tennessee Deferred Compensation Program (401(k) & 457)

Those hired after July 1, 2014, are automatically enrolled in the 401(k) plan at 2 percent, but have the option to increase their contribution as needed to help meet their retirement savings goals. These plans are administered by the **Department of Treasury** along with **Empower Retirement**, providing record keeping and financial education to assist you in determining and taking action on your retirement goals. More information is available at [RetireReadyTN.gov](https://www.RetireReadyTN.gov).

22

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.

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.

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.
- You will be taken to a page that asks you to enter/verify your beneficiaries for basic life and voluntary AD&D (if enrolled). If you need to make updates, click the **Update Beneficiaries** button. Once you have made all of your changes, 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?

- Update information 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. (see page 22)

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

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
Disability Insurance	MetLife	855.700.8001 — M-F, 7-10	metlife.com/StateOfTN
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
Life Insurance	Securian (Minnesota Life)	866.881.0631 — M-F, 7-6	lifebenefits.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 higher education 800.253.9981 — M-F, 8-4:30; state call Edison help desk at 866.376.0104 — M-F, 7-4:30	https://www.edison.tn.gov
Flexible Benefits medical & dependent care transportation & parking (state employees only)	PayFlex Benefits Administration	855.288.7936 — M-F, 7-7, Sat, 9-2 800.253.9981 — M-F, 8-4:30	stateoftn.payflexdirect.com tn.gov/finance/section/fa-benefits
Deferred Compensation Program (state employees only)	Tennessee Department of Treasury	800.922.7772 — M-F, 8-7	treasury.tn.gov/dc
Employee Sick Leave Bank (state employees only)	Tennessee Department of Human Resources	615.741.5431 — M-F, 8-4:30	tn.gov/hr

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STATE OF TENNESSEE
BENEFITS ADMINISTRATION
DEPARTMENT OF FINANCE AND ADMINISTRATION
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