



Oak Ridge
SCHOOLS

Employee Benefits Resource Guide



Benefits Enrollment Guide

At Oak Ridge Schools, we strive to offer a comprehensive and affordable benefits package. This guide provides a general overview of the benefits made available to New Hires. For additional information or assistance, please contact Tamara Jones, Human Resources Benefits Coordinator, at 865-425-9020 or tljones@ortn.edu.

ELIGIBILITY:

Employee benefits are available to those employed in a full-time, non-seasonal, non-temporary active-status position (Health insurance only is available to part-time certified staff at higher premiums. Contact Tamara Jones for additional information.)

NEW HIRE BENEFITS ENROLLMENT:

New Hires are eligible to enroll in benefits within the first 30 days of their date of hire. Elections made during the New Hire enrollment period will remain in effect until the end of the plan year. Changes to your benefit elections may only be made during the Annual Open Enrollment periods. Mid-year benefit changes may only be made due to a Qualifying Life Event (i.e. marriage, birth of a child, loss of coverage, etc.). For additional information regarding enrollment eligibility and/or benefit changes, please contact Tamara Jones.

Customer Service Contact Info			
	<u>Carrier</u>	<u>Phone</u>	<u>Website</u>
Health Insurance	State of TN	800-253-9981	www.tn.gov/partnersforhealth
Pharmacy Benefits	CVS Caremark	877-522-8679	info.caremark.com/stateoftn
Dental Insurance	Delta Dental	800-223-3104	www.DeltaDentalTN.com
Vision Insurance	VSP	800-877-7195	www.vsp.com
Life & Supplemental Plans	USABLE	800-370-5856	www.usablelife.com
Retirement Benefits	TCRS	800-922-7772	treasury.tn.gov

NOTICE TO TENNCARE ENROLLEES

Are You or Your Dependents Insured by TennCare?

Employees and their dependents are eligible for health insurance through a state-sponsored medical plan. These employees include:

- Regular full-time employees of participating agencies of state government
- Local education agencies
- Local government agencies

If you and/or your dependents are currently enrolled in TennCare, you are required to contact the Tennessee Health Connection (TNHC). This must be done within 10 days of your date of employment. You will need to report:

- your new job,
- salary, **and**
- that you now have access to medical insurance with your employer.

If you have chosen to sign up for state-sponsored medical insurance you will need to provide TNHC with the date your coverage will begin and the name of the insurance provider.

TennCare could decide that you may still be eligible to keep TennCare. If TennCare cancels your coverage or the coverage of your dependents at a future date, you will have 60 days from the termination date to apply to your employer for coverage on the state-sponsored plan.

For questions or instructions on how to apply after TennCare has cancelled your coverage please contact Finance and Administration, Benefits Administration at **800.253.9981**.

Tennessee Code Annotated 71-5-118

It is now a felony offense to obtain TennCare coverage under fraudulent means. Violators, if convicted, can be sent to prison.

It is now a felony offense for a person to knowingly obtain, attempt to obtain or aid and abet any other person to obtain, by fraudulent, means any coverage provided to TennCare enrollees.

In addition to any penalties for a felony offense, any person committing the offense and violating the law may be di disqualified from participating in the TennCare Program as an enrollee.

2025 ORS HEALTH INSURANCE PREMIUMS

BCBST NETWORK S and CIGNA LOCALPLUS

PREMIER PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$9,060.00	\$14,928.00	\$20,376.00	\$23,532.00
Total Monthly Premium	\$755.00	\$1,244.00	\$1,698.00	\$1,961.00
Monthly Board Share	\$641.75	\$870.80	\$1,188.60	\$1,372.70
Monthly Employee Share	\$113.25	\$373.20	\$509.40	\$588.30
20 Payperiods*	\$67.95	\$223.92	\$305.64	\$352.98
<i>Annualized Premiums</i>	<i>\$1,359.00</i>	<i>\$4,478.40</i>	<i>\$6,112.80</i>	<i>\$7,059.60</i>

STANDARD PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$8,412.00	\$13,872.00	\$18,924.00	\$21,864.00
Total Monthly Premium	\$701.00	\$1,156.00	\$1,577.00	\$1,822.00
Monthly Board Share	\$595.85	\$809.20	\$1,103.90	\$1,275.40
Monthly Employee Share	\$105.15	\$346.80	\$473.10	\$546.60
20 Payperiods*	\$63.09	\$208.08	\$283.86	\$327.96
<i>Annualized Premiums</i>	<i>\$1,261.80</i>	<i>\$4,161.60</i>	<i>\$5,677.20</i>	<i>\$6,559.20</i>

LIMITED PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$7,944.00	\$13,092.00	\$17,880.00	\$20,640.00
Total Monthly Premium	\$662.00	\$1,091.00	\$1,490.00	\$1,720.00
Monthly Board Share	\$562.70	\$763.70	\$1,043.00	\$1,204.00
Monthly Employee Share	\$99.30	\$327.30	\$447.00	\$516.00
20 Payperiods*	\$59.58	\$196.38	\$268.20	\$309.60
<i>Annualized Premiums</i>	<i>\$1,191.60</i>	<i>\$3,927.60</i>	<i>\$5,364.00</i>	<i>\$6,192.00</i>

LOCAL CDHP/HSA

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$6,936.00	\$11,436.00	\$15,600.00	\$18,024.00
Total Monthly Premium	\$578.00	\$953.00	\$1,300.00	\$1,502.00
Monthly Board Share	\$491.30	\$667.10	\$910.00	\$1,051.40
Monthly Employee Share	\$86.70	\$285.90	\$390.00	\$450.60
20 Payperiods*	\$52.02	\$171.54	\$234.00	\$270.36
<i>Annualized Premiums</i>	<i>\$1,040.40</i>	<i>\$3,430.80</i>	<i>\$4,680.00</i>	<i>\$5,407.20</i>

* NOTES Deductions taken per paycheck.

Stated premiums are for full-time employees. Effective January 1, 2025- December 31, 2025.

Board Share of premiums will be adjusted for licensed part time employees based on percentage of employment. Monthly premiums are deducted over twenty pays.

The Board pays 85% of the cost for Full Time Employee Only premiums and 70% of the cost for Full Time Employee + (Family) premiums.

2025 ORS HEALTH INSURANCE PREMIUMS

BCBST NETWORK P and CIGNA OPEN ACCESS

PREMIER PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$9,960.00	\$15,948.00	\$22,176.00	\$25,332.00
Total Monthly Premium	\$830.00	\$1,329.00	\$1,848.00	\$2,111.00
Monthly Board Share	\$705.50	\$930.30	\$1,293.60	\$1,477.70
Monthly Employee Share	\$124.50	\$398.70	\$554.40	\$633.30
20 Payperiods*	\$74.70	\$239.22	\$332.64	\$379.98
<i>Annualized Premiums</i>	<i>\$1,494.00</i>	<i>\$4,784.40</i>	<i>\$6,652.80</i>	<i>\$7,599.60</i>

STANDARD PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$9,312.00	\$14,892.00	\$20,724.00	\$23,664.00
Total Monthly Premium	\$776.00	\$1,241.00	\$1,727.00	\$1,972.00
Monthly Board Share	\$659.60	\$868.70	\$1,208.90	\$1,380.40
Monthly Employee Share	\$116.40	\$372.30	\$518.10	\$591.60
20 Payperiods*	\$69.84	\$223.38	\$310.86	\$354.96
<i>Annualized Premiums</i>	<i>\$1,396.80</i>	<i>\$4,467.60</i>	<i>\$6,217.20</i>	<i>\$7,099.20</i>

LIMITED PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$8,844.00	\$14,112.00	\$19,680.00	\$22,440.00
Total Monthly Premium	\$737.00	\$1,176.00	\$1,640.00	\$1,870.00
Monthly Board Share	\$626.45	\$823.20	\$1,148.00	\$1,309.00
Monthly Employee Share	\$110.55	\$352.80	\$492.00	\$561.00
20 Payperiods*	\$66.33	\$211.68	\$295.20	\$336.60
<i>Annualized Premiums</i>	<i>\$1,326.60</i>	<i>\$4,233.60</i>	<i>\$5,904.00</i>	<i>\$6,732.00</i>

LOCAL CDHP/HSA

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$7,836.00	\$12,456.00	\$17,400.00	\$19,824.00
Total Monthly Premium	\$653.00	\$1,038.00	\$1,450.00	\$1,652.00
Monthly Board Share	\$555.05	\$726.60	\$1,015.00	\$1,156.40
Monthly Employee Share	\$97.95	\$311.40	\$435.00	\$495.60
20 Payperiods*	\$58.77	\$186.84	\$261.00	\$297.36
<i>Annualized Premiums</i>	<i>\$1,175.40</i>	<i>\$3,736.80</i>	<i>\$5,220.00</i>	<i>\$5,947.20</i>

* NOTES Deductions taken per paycheck.

Stated premiums are for full-time employees. Effective January 1, 2025- December 31, 2025.

Board Share of premiums will be adjusted for licensed part time employees based on percentage of employment. Monthly premiums are deducted over twenty pays.

The Board pays 85% of the cost for Full Time Employee Only premiums and 70% of the cost for Full Time Employee + (Family) premiums.

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



PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care and maintenance medications.

Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST ⁽¹⁾		STANDARD PPO NETWORK STATUS & COST ⁽¹⁾		LIMITED PPO NETWORK STATUS & COST ⁽¹⁾		LOCAL CDHP/HSA NETWORK STATUS & COST ⁽¹⁾		
	COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY									
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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⁾ <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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]	
	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]	15%	40%	20%	40%	30%	50%	30%	50%
• Inpatient behavioral health and substance use ^{[2],[6]}								
• 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]	15%	40%	20%	40%	30%	50%	30%	50%
• Outpatient PT/ST/OT/ABA ^[5] ; Other therapy								
X-Ray, Lab and Diagnostics (Excludes advanced studies below) ^[5]		15%		20%		30%		30%
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 Plan,** the deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied.

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

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

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

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

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

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

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

2026 ORS HEALTH INSURANCE PREMIUMS

BCBST NETWORK S and CIGNA LOCALPLUS

PREMIER PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$9,516.00	\$15,684.00	\$21,396.00	\$24,720.00
Total Monthly Premium	\$793.00	\$1,307.00	\$1,783.00	\$2,060.00
Monthly Board Share	\$674.05	\$914.90	\$1,248.10	\$1,442.00
Monthly Employee Share	\$118.95	\$392.10	\$534.90	\$618.00
20 Payperiods*	\$71.37	\$235.26	\$320.94	\$370.80
<i>Annualized Premiums</i>	<i>\$1,427.40</i>	<i>\$4,705.20</i>	<i>\$6,418.80</i>	<i>\$7,416.00</i>

STANDARD PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$8,832.00	\$14,568.00	\$19,872.00	\$22,968.00
Total Monthly Premium	\$736.00	\$1,214.00	\$1,656.00	\$1,914.00
Monthly Board Share	\$625.60	\$849.80	\$1,159.20	\$1,339.80
Monthly Employee Share	\$110.40	\$364.20	\$496.80	\$574.20
20 Payperiods*	\$66.24	\$218.52	\$298.08	\$344.52
<i>Annualized Premiums</i>	<i>\$1,324.80</i>	<i>\$4,370.40</i>	<i>\$5,961.60</i>	<i>\$6,890.40</i>

LIMITED PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$8,340.00	\$13,752.00	\$18,780.00	\$21,684.00
Total Monthly Premium	\$695.00	\$1,146.00	\$1,565.00	\$1,807.00
Monthly Board Share	\$590.75	\$802.20	\$1,095.50	\$1,264.90
Monthly Employee Share	\$104.25	\$343.80	\$469.50	\$542.10
20 Payperiods*	\$62.55	\$206.28	\$281.70	\$325.26
<i>Annualized Premiums</i>	<i>\$1,251.00</i>	<i>\$4,125.60</i>	<i>\$5,634.00</i>	<i>\$6,505.20</i>

LOCAL CDHP/HSA

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$7,284.00	\$12,012.00	\$16,380.00	\$18,936.00
Total Monthly Premium	\$607.00	\$1,001.00	\$1,365.00	\$1,578.00
Monthly Board Share	\$515.95	\$700.70	\$955.50	\$1,104.60
Monthly Employee Share	\$91.05	\$300.30	\$409.50	\$473.40
20 Payperiods*	\$54.63	\$180.18	\$245.70	\$284.04
<i>Annualized Premiums</i>	<i>\$1,092.60</i>	<i>\$3,603.60</i>	<i>\$4,914.00</i>	<i>\$5,680.80</i>

* NOTES Deductions taken per paycheck.

Stated premiums are for full-time employees. Effective January 1, 2026- December 31, 2026.

Board Share of premiums will be adjusted for licensed part time employees based on percentage of employment.

Monthly premiums are deducted over twenty pays.

The Board pays 85% of the cost for Full Time Employee Only premiums and

70% of the cost for Full Time Employee + (Family) premiums.

2026 ORS HEALTH INSURANCE PREMIUMS

BCBST NETWORK P and CIGNA OPEN ACCESS

PREMIER PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$10,596.00	\$16,884.00	\$23,556.00	\$26,880.00
Total Monthly Premium	\$883.00	\$1,407.00	\$1,963.00	\$2,240.00
Monthly Board Share	\$750.55	\$984.90	\$1,374.10	\$1,568.00
Monthly Employee Share	\$132.45	\$422.10	\$588.90	\$672.00
20 Payperiods*	\$79.47	\$253.26	\$353.34	\$403.20
<i>Annualized Premiums</i>	<i>\$1,589.40</i>	<i>\$5,065.20</i>	<i>\$7,066.80</i>	<i>\$8,064.00</i>

STANDARD PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$9,912.00	\$15,768.00	\$22,032.00	\$25,128.00
Total Monthly Premium	\$826.00	\$1,314.00	\$1,836.00	\$2,094.00
Monthly Board Share	\$702.10	\$919.80	\$1,285.20	\$1,465.80
Monthly Employee Share	\$123.90	\$394.20	\$550.80	\$628.20
20 Payperiods*	\$74.34	\$236.52	\$330.48	\$376.92
<i>Annualized Premiums</i>	<i>\$1,486.80</i>	<i>\$4,730.40</i>	<i>\$6,609.60</i>	<i>\$7,538.40</i>

LIMITED PPO

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$9,420.00	\$14,952.00	\$20,940.00	\$23,844.00
Total Monthly Premium	\$785.00	\$1,246.00	\$1,745.00	\$1,987.00
Monthly Board Share	\$667.25	\$872.20	\$1,221.50	\$1,390.90
Monthly Employee Share	\$117.75	\$373.80	\$523.50	\$596.10
20 Payperiods*	\$70.65	\$224.28	\$314.10	\$357.66
<i>Annualized Premiums</i>	<i>\$1,413.00</i>	<i>\$4,485.60</i>	<i>\$6,282.00</i>	<i>\$7,153.20</i>

LOCAL CDHP/HSA

	Emp Only	Emp:Child(ren)	Emp:Spouse	Emp:Sp:Child(re
Total Annual Premium	\$8,364.00	\$13,212.00	\$18,540.00	\$21,096.00
Total Monthly Premium	\$697.00	\$1,101.00	\$1,545.00	\$1,758.00
Monthly Board Share	\$592.45	\$770.70	\$1,081.50	\$1,230.60
Monthly Employee Share	\$104.55	\$330.30	\$463.50	\$527.40
20 Payperiods*	\$62.73	\$198.18	\$278.10	\$316.44
<i>Annualized Premiums</i>	<i>\$1,254.60</i>	<i>\$3,963.60</i>	<i>\$5,562.00</i>	<i>\$6,328.80</i>

* NOTES Deductions taken per paycheck.

Stated premiums are for full-time employees. Effective January 1, 2026- December 31, 2026.

Board Share of premiums will be adjusted for licensed part time employees based on percentage of employment.

Monthly premiums are deducted over twenty pays.

The Board pays 85% of the cost for Full Time Employee Only premiums and

70% of the cost for Full Time Employee + (Family) premiums.

2026 Health Plan Comparison of Member Costs — Local Education and Local Government

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care and maintenance medications.

Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST ^[1]		STANDARD PPO NETWORK STATUS & COST ^[1]		LIMITED PPO NETWORK STATUS & COST ^[1]		LOCAL CDHP/HSA NETWORK STATUS & COST ^[1]	
	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								
<ul style="list-style-type: none"> Well-baby, well-child visits Adult annual physical exam Annual well-woman exam Immunizations Annual hearing and non-refractive vision screening Screenings, labs, nutritional guidance, & tobacco cessation counseling 	\$0	\$45	\$0	\$50	\$0	\$50	\$0	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA								
Primary Care Office Visit ^[8] <ul style="list-style-type: none"> Family practice, general practice, internal medicine, OB/GYN and pediatrics Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) Initial maternity visit Surgery in office setting Provider-based telehealth Allergy injections and serum 	\$25	\$45	\$30	\$50	\$35	\$55	30%	50%
Specialist Office Visit ^[8] <ul style="list-style-type: none"> Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) Surgery in office setting Provider-based telehealth Allergy injections and serum 	\$45	\$70	\$50	\$75	\$55	\$80	30%	50%
Behavioral Health and Substance Use ^{[2] [8]} <ul style="list-style-type: none"> Including provider-based virtual visits 	\$25	\$45	\$30	\$50	\$35	\$55	30%	50%
Telehealth Programs (MDLive/Teladoc/Talkspace)	\$15	N/A	\$15	N/A	\$15	NA	30%	N/A
Chiropractic and Acupuncture <ul style="list-style-type: none"> Annual limit of 50 visits each 	\$25/visit 1-20 \$45/visit 21-50	\$45/visit 1-20 \$70/visit 21-50	\$30/visit 1-20 \$50/visit 21-50	\$50/visit 1-20 \$75/visit 21-50	\$35/visit 1-20 \$55/visit 21-50	\$55/visit 1-20 \$80/visit 21-50	30%	50%
Convenience Clinic	\$25	\$45	\$30	\$50	\$35	\$55	30%	50%
Urgent Care Facility	\$45	\$70	\$50	\$75	\$55	\$80	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED								
30-Day Supply	\$7/\$40/\$90	copay + amount > MAC	\$14/\$50/\$100	copay + amount > MAC	\$14/\$60/\$110	copay + amount > MAC	30%	50% + amount >MAC
90-Day Supply 90-day pharmacy or mail order	\$14/\$80/\$180	N/A - no network	\$28/\$100/\$200	N/A - no network	\$28/\$120/\$220	N/A - no network	30%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order ^[3]	\$7/\$40/\$160	N/A - no network	\$14/\$50/\$180	N/A - no network	\$14/\$60/\$200	N/A - no network	20% before deductible	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25%	N/A - no network	25%	N/A - no network	25%	N/A - no network	25%	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY								
Generic/Preferred/Non-Preferred	30%	N/A - no network	30%	N/A - no network	30%	N/A - no network	30%	N/A - no network

2026 Local Education and Local Government Comparison. PPO services in this table ARE subject to a deductible unless noted with a [5]. Local CDHP/HSA services in this table ARE subject to a deductible and coinsurance except for in-network preventive care. **Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.**

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

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

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

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

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

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

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

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

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

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

Get answers to your questions, big and small

Juggling everything on your to-do list while taking care of your own health, both mental and physical, can be challenging. With additional stressors like relationship challenges, home repairs, childcare and eldercare, many people are feeling overwhelmed these days. **Here4TN** can help.

WorkLife Services

WorkLife Services help make life a little less stressful by connecting you with:



Child, family and parenting support services



Personal services



Education resources



Legal services



Adult care and eldercare support services



Financial services



Chronic illness and condition support services

Short-term counseling

Here4TN Emotional Wellbeing Solutions connects you with specialists 24/7 and offers five confidential* counseling sessions per issue, per individual, per year at no additional cost to you. **Here4TN** can help with topics including:

- Depression, anxiety and stress
- Living with chronic conditions
- Sleep disorders
- Substance use issues
- Relationship and family concerns

Call to speak confidentially* with a specialist or to get referrals or prior approval for services, including virtual visits.

Take Charge at Work

Trouble concentrating? Feeling sluggish? This may be a sign of something more. **Take Charge at Work** can help you recognize and manage stress and depression at your workplace. Start with an assessment, then work with a coach to create a personal plan.

Behavioral Health Services

Optum is your behavioral health and substance use benefits administrator, and **Here4TN** can help you learn about your benefits, search for in-network providers and connect for a virtual visit. To get details about what's covered and to view your member handbook and plan documents, visit tn.gov/partnersforhealth.

Substance use

If you or someone in your family has substance use concerns, connect with a highly trained and licensed advocate at **Here4TN**. Your advocate will talk with you about your unique situation, answer questions, help create a personalized treatment plan and help with family support. The service is completely confidential.

Talkspace

Regularly communicate with a therapist safely and securely from your phone or desktop with **Talkspace**. You can start therapy within hours of choosing your therapist, and it's secure and confidential.

Self Care by AbleTo

Self Care by AbleTo offers on-demand help for reducing worry and stress and improving mood. Download the **AbleTo app** from the App Store® or Google Play™. Use access code **Here4TN**.

Legal and financial support

Connect with legal assistance and mediation services that give you free and discounted confidential access to local attorneys and professional mediators.

Find financial services support to help you increase your savings, lower debt and improve credit, so you can dial down financial stress. Get an assessment; online learning; a 25% discount for preparation of all personal income tax documents; plus two calls with a Money Coach.



*This program is confidential in accordance with the law.

Here4TN Emotional Wellbeing Solutions is available to you and your family at no extra cost as part of your benefits. The five Emotional Wellbeing Solutions visits per year, per issue are per individual. Members are ineligible for Emotional Wellbeing Solutions visits while they are currently receiving Behavioral Health Services.

State and Higher Education: Emotional Wellbeing Solutions services are available to all benefits-eligible employees and their eligible family members, even if they are not enrolled in medical insurance.

Local Education and Local Government: The following Emotional Wellbeing Solutions services are offered to employees who are enrolled in medical insurance. Dependents are eligible even if they are not enrolled in medical insurance.

All members (employees and dependents) enrolled in medical insurance are also eligible for behavioral health benefits.

Please note: While access to **WorkLife Services** and all referrals are included as part of your benefits, you will have to pay for any **WorkLife Services** you decide to use. Our specialists cannot book or purchase services on your behalf. This is an educational, referral-based service only. Certain services may not be available in some benefits plans. Consult your benefits plan to know what is available.

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This program is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply.

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 866-576-0029 or 615-741-4517.

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“The person I spoke to had the kindest voice. They were professional and compassionate.”



Talk with a specialist who cares, 24/7:

855-Here4TN
(855-437-3486)

Or visit:

Here4TN.com



Oak Ridge Schools
HUMAN RESOURCES

DENTAL & VISION SEMI-MONTHLY PREMIUMS

DELTA DENTAL (Semi-Monthly Rates)

Plan	Employee Share	ORS Share	
Employee Only	No Cost	\$18.85	
Employee & Spouse	\$19.06	\$18.85	
Employee & Children	\$22.81	\$18.85	
Family	\$50.82	\$18.85	

VSP VISION (Semi- Monthly Rates)

Plan	Employee Share	ORS Share	
Employee Only	No Cost	\$5.41	
Employee & Spouse	\$5.41	\$5.41	
Employee & Children	\$6.17	\$5.41	
Family	\$13.16	\$5.41	

Premiums Rate through June 30, 2026.

Oak Ridge Schools
Delta Dental Benefits
Group#8527

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays	Nonparticipating Dentist Plan Pays
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Emergency Palliative Treatment - to temporarily relieve pain	80%	80%	80%
Minor Restorative Services - fillings	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Adjustments and Repairs - to bridges and dentures	80%	80%	80%
Major Services			
Crown Repair - to individual crowns	50%	50%	50%
Major Restorative Services - crowns	50%	50%	50%
Implant Repair - implant maintenance, repair, and removal	50%	50%	50%
Relines and Rebase - to dentures	50%	50%	50%
Prosthodontic Services - bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	through age 17 and under	through age 17 and under	through age 17 and under

- Oral exams are payable twice per benefit year.
- Prophylaxes (cleanings) are payable twice per benefit year.
- Fluoride treatments are payable once per benefit year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 13 and under.
- Bitewing X-rays are payable once per benefit year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Crowns and inlays are payable once per tooth in any five-year period. Veneers are payable on incisors, cuspids, and bicuspids once per tooth per five-year period for people age 12 and over when necessary due to fracture or decay.
- Composite resin (white) restorations are payable on posterior teeth.
- Inlays (any material) are Covered Services.
- Implants and implant related services are payable once per tooth in any five-year period for people age 19 and older.

Deductible: \$25 Deductible per person total per contract year limited to a maximum Deductible of \$75 per family per contract year. The Deductible does not apply to oral exams, preventive services, brush biopsy, X-rays, sealants, cephalometric films, diagnostic casts, photos, and orthodontic services.

Maximum Payment: \$1,000 per person total per contract year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Delta Dental of Tennessee*240 Venture Circle*Nashville, TN 37228* www.DeltaDentalTN.com*800.223.3104

YOUR VSP VISION BENEFITS SUMMARY

OAK RIDGE SCHOOLS and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

07/01/2025



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$25	Every plan year*
PRESCRIPTION GLASSES			
FRAME	<ul style="list-style-type: none"> \$170 featured frame brands allowance \$150 frame allowance 20% savings on the amount over your allowance \$80 Walmart*/Sam's Club*/Costco* frame allowance 	\$0	Every other plan year
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children 	\$0	Every plan year
LENS ENHANCEMENTS	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements 	\$0 \$95 - \$105 \$150 - \$175	Every plan year
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none"> \$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every plan year
DIABETIC EYECARE PLUS PROGRAMSM	<ul style="list-style-type: none"> Retinal screening for members with diabetes Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. 	\$0 \$20 per exam	As needed
ADDITIONAL PAIRS OF EYEWEAR			
FRAME	<ul style="list-style-type: none"> \$170 featured frame brands allowance \$150 frame allowance 20% savings on the amount over your allowance \$80 Walmart/Sam's Club/Costco frame allowance 	\$0	Every other plan year
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children 	\$0	Every plan year
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none"> \$150 allowance for additional contacts Contact lens exam (fitting and evaluation) 	Up to \$60	Every plan year
EXTRA SAVINGS	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. <p>Routine Retinal Screening</p> <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 		

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Plan year begins in July

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Classification: Restricted

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TCRS Legacy Plan

The Legacy Plan is a defined benefit plan administered by the Tennessee Consolidated Retirement System (TCRS).

- Defined Benefit Plan - Guaranteed lifetime monthly benefit upon service retirement
- Benefit paid upon service retirement is calculated with a set formula
- Vesting - 5 years
- Required contributory rate is 5% of member's earnable compensation
- Covered members may voluntarily participate in the Deferred Compensation Program (401(k) program)
Member contributions only; Employer contributions do not apply
- Survivorship options available

What determines your TCRS Retirement Benefit?

- **Average Final Compensation (AFC)** - The average of your highest 60 consecutive months of salary.
Not necessarily your last 60 months of salary prior to retirement
- **Years of Service** - Your total number of years and months of creditable service
- **Age at Retirement** - Determines early retirement deduction factors and benefits paid under the optional survivor benefits plans

Legacy Plan Retirement Requirements

- **Service Retirement**
 - Member must be age 60 and vested or have 30 years of service, regardless
- **Early Retirement**
 - Member must be age 55 and vested
 - Once reduction factor will be applied
- **25-Year Early**
 - Member must be under the age of 55 and have 25 years of service
 - Two reduction factors will be applied



TCRS Hybrid Plan

The Hybrid Plan is a combination of a defined benefit plan administered by the Tennessee Consolidated Retirement System (TCRS) and the State of Tennessee's deferred compensation plan (401(k)).

Components:

- TCRS Defined Benefit Plan (Defined Benefit (DB) portion of your benefit
- State of TN 401(k) Plan (Defined Contribution (DC) portion of your benefit

Vesting:

- 5 years vesting with TCRS
- Immediate vesting in the 401(k) (DC) plan

Service Retirement:

- 65 years of age OR rule of 90 (service credit + age = 90)

What determines your TCRS Retirement Benefit?

- **Average Final Compensation (AFC)** - The average of your highest 60 consecutive months of salary.
Not necessarily your last 60 months of salary prior to retirement
- **Years of Service** - Your total number of years and months of creditable service
- **Age at Retirement** - Determines early retirement deduction factors and benefits paid under the optional survivor benefits plans

TCRS Hybrid Plan Component Features

Defined Benefit Plan (TCRS)

- Required contributory rate-5% off earnable compensation
- Benefits are calculated with a set formula
- Lifetime monthly benefit at retirement once eligible
- Survivorship options available
- Employer bears investment risk

Defined Contribution Plan (401(k))

- Multiple distribution options
- Member contribution may be adjusted
- Participant selects investments
- Participant bears investment risk
- Benefit in retirement is based upon participant's account balance

Contributions to the Hybrid Plan			
	Employer³	Member	Total
TCRS	4%	5%	9%
401(k)	5%	2% ⁴	7%
TOTAL	9%	7%	16%

Deductions will not begin until completion of six-month probationary period (if applicable)



403(b) & 457(b) mutual fund retirement investment opportunity through the Southern Education Retirement Consortium managed by Corebridge Financial

All new, full-time staff members hired after July 11, 2025, will be auto enrolled at a 3% contribution rate to the SERC 403(b) plan. Employees will be offered a 30-day opt-out period and can also change their contributions at any time.



Jacob Hicks

Retirement Plan Consultant | Southeast Region

Retirement Services | VALIC Financial Advisors

Corebridge Financial

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Jacob.Hicks@corebridgefinancial.com | www.corebridgefinancial.com/retire



Continuing Insurance at Retirement

State Group Insurance Program

LOCAL EDUCATION



PARTNERS
FOR HEALTH

January 2024

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INTRODUCTION

Overview

This guide explains the insurance options available to you at retirement and the rules for each type of coverage. There are two eligibility and enrollment sections. It is important that you refer to the section that applies to you. If you are a Tennessee Consolidated Retirement System participant, see the requirements on page two. If you are a non-TCRS participant, see page four.

For More Information

Your agency benefits coordinator is your primary contact. He/she can provide you with forms and handbooks you need. For questions about eligibility, contact Benefits Administration. Our service center is your main point of contact regarding insurance once you retire.

All forms and handbooks referenced in this guide are on the Benefits Administration website www.tn.gov/Partnersforhealth. You can also get copies by calling our office at 615-741-3590 or 800-253-9981 or emailing retirement.insurance@tn.gov. You need to include your Edison ID (found on your Caremark card) and your address in your email.

If you have questions about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your health care provider or insurance company) contact the insurance company's member service number on your insurance card. See also, information at the end of this guide about your appeal rights.

ELIGIBILITY AND ENROLLMENT

TCRS Participants

Continuing Group Health Coverage

Detailed information on the rules to continue health insurance as a retiree can be found in the Local Education Medical Plan Document. This document is available on the publications webpage of the Benefits Administration website located here: www.tn.gov/Partnersforhealth/publications/publications.

To continue health insurance benefits, the agency from which you retire must continue to participate in the state plan. If your former agency leaves the State Group Insurance Program, your coverage on the state retiree group health will be canceled.

You must receive a monthly TCRS retirement benefit to continue coverage. If you choose a lump-sum retirement benefit, you are not eligible to continue health insurance at retirement.

If your spouse is also an employee enrolled in state group health insurance, you may continue coverage as a dependent on his/her contract instead of choosing retiree coverage. When your spouse ends employment, you may be eligible to apply via the special enrollment provision under your own eligibility as a retiree.

Retiree health coverage is only available to employees hired before July 1, 2015. If you started working for the state of Tennessee or a participating local education agency for the first time on or after July 1, 2015, you are not eligible to continue or enroll in insurance at retirement. If you started working for the state of Tennessee or a participating local education agency for the first time before July 1, 2015, you will not be prohibited from continuing or enrolling in insurance at retirement, provided you did not accept a lump-sum payment from the TCRS before July 1, 2015 and that you satisfy all other eligibility requirements.

The eligibility guidelines for continuing health insurance are:

- Ten years (120 months) of creditable service and at least three years of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) must be on or before the date your active state coverage ends. This requirement for immediate commencement of benefits will be waived if you leave the Local Education plan and become insured by an agency that participates in one of the other state-sponsored health plans.
- Twenty years (240 months) of creditable service and at least one year of continuous insurance coverage in the plan immediately prior to final termination of employment. The date retirement pension benefits start (effective date of retirement with TCRS) may be up to five years. The five-year requirement will be waived if you leave the state plan and become employed by an agency participating in one of the other state-sponsored health plans, resulting in no lapse in coverage on a state plan.

Creditable Service:

You can count employment with the state of Tennessee, a state higher education institution or a local education agency that participates on the state group plan to calculate total employment. Unused sick leave may also be counted. Military service that did not interrupt employment, service that was previously cashed out and not paid back to TCRS, educational leave, leave of absence or service with a local government agency cannot be counted.

Only creditable service will count. Years of service applies to the minimum length of service required to continue coverage at retirement. It does not necessarily count toward premium reduction. State premium support is provided on teaching service only.

If you are eligible to combine creditable state and local education service, you will be classified as a retiree under the plan from which you ended employment prior to retirement.

If you are eligible for retiree coverage without combining creditable service under more than one plan, you may choose to be classified as a retiree in the plan in which you first satisfied eligibility criteria, or in the plan from which your employment ended immediately preceding retirement.

Application to Continue Group Health Coverage

You must submit an application to continue coverage at retirement to your ABC within one full calendar month of the end of active insurance. If enrollment is approved, you will continue in the same health insurance option in which you are currently enrolled.

If you have 20 or more years of service and there is an allowed gap between your date of termination and date of retirement (the effective date of your TCRS pension benefit), you must submit the application to Benefits Administration within one full calendar month of the date of retirement.

Effective Date of Retiree Group Health Coverage

Retiree coverage is effective on the first day of the month following the end of active insurance coverage. If you have an allowed gap between your termination date and date of retirement, coverage will be effective on the first of the month following the date of retirement. The retirement date is the date you start your retirement benefits.

Individuals Eligible for Medicare

If you are enrolled in health insurance and meet the service requirements, you may continue coverage at retirement until you become eligible for Medicare due to age. You may also continue coverage on covered dependents until they become eligible for Medicare due to age or no longer qualify as eligible dependents.

You and your dependents who become entitled to Medicare prior to age 65 must enroll in Medicare parts A and B to continue group health coverage until becoming entitled to Medicare due to age or for covered children, until they turn 26 or meet plan provisions for incapacitated dependents.

Retirees who are Medicare eligible due to age are no longer eligible for the group health plan and are not eligible to apply to cover their dependents on the group health plan via the special enrollment provision.

If your initial date of employment with a qualifying employer is prior to July 1, 2015, you may be eligible to apply for the state's Supplemental Medical Insurance for Retirees with Medicare program called The Tennessee Plan.

Application for The Tennessee Plan Coverage

The Tennessee Plan is a supplemental medical insurance program designed to cover certain expenses not fully paid by your Medicare parts A and B coverage. It does not cover prescription drugs. If you participate in The Tennessee Plan, you will need a separate Part D plan for your prescription drug needs. The Tennessee Plan will not coordinate benefits if you are currently enrolled in or join a Medicare Advantage plan. This means if you have a Medicare Advantage plan, The Tennessee Plan will not pay out any benefits.

If you are enrolled in at least Medicare Part A and receive a monthly TCRS pension benefit at retirement, you can select The Tennessee Plan coverage on the Application to Continue Insurance at Retirement. You may also apply to cover your dependents who are eligible for Medicare when you enroll in The Tennessee Plan. You have 60 days from the initial eligibility date to enroll. If you qualify and enroll within 60 days of initial eligibility, you cannot be turned down for coverage due to age or health. The initial eligibility date is the date of TCRS retirement, the date active state group health coverage ends or the date of Medicare eligibility, whichever is later.

Coverage is effective the first of the month following the end of your active insurance coverage or the first of the month following your date of retirement, whichever is later. If the date of retirement is the later date and falls on the first of the month, your coverage may be effective on that date.

If you become eligible for Medicare due to age after retirement you will be sent an application approximately three months before your 65th birthday. The application must be submitted within 60 days of Medicare eligibility. Coverage will become effective on your date of Medicare entitlement provided the application is received timely. If you enroll in The Tennessee Plan and your spouse becomes entitled to Medicare at a later date, you have 60 days from the date of your spouse's eligibility to apply to add him/her to coverage.

If enrollment is not selected within 60 days of initial eligibility, you and your eligible dependent may apply through medical underwriting. Enrollment is subject to approval and may be denied. Benefits Administration will submit the application for review to the vendor. You must be enrolled in The Tennessee Plan to cover a dependent.

Once approved, you will receive an ID card from the vendor. It will show your name and identification number. If you are not satisfied with The Tennessee Plan, you can cancel it within 30 days after receipt. You will receive a refund of premiums paid in advance. Any claims paid during this period will be recovered.

End-stage Renal Disease

If you are eligible for Medicare as a result of end-stage renal disease, you may be eligible for extended group health benefits. Contact Benefits Administration for information on the eligibility criteria.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement. If you are enrolled in a state-sponsored dental plan, you have two options for continuing coverage:

COBRA Dental

You can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the Application to Continue Insurance at Retirement. If you choose to continue dental through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. Please note on the COBRA enrollment form that you are a TCRS retiree.

Retiree Dental

You may also choose to enroll in retiree dental coverage. Just select dental on your Application to Continue Insurance at Retirement. To enroll you must receive a monthly TCRS pension benefit. Dependent-only coverage is not available.

Vision Coverage

Continuation of vision insurance is NOT automatic at retirement. Retiree vision coverage is only available to retirees and dependents enrolled in one of the state-sponsored health insurance programs. If you are enrolled in the state-sponsored vision plan, you have two options for continuing coverage:

COBRA Vision

You can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the Application to Continue Insurance at Retirement. If you choose to continue vision through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due. COBRA vision premiums cannot be deducted from your TCRS pension check.

Retiree Vision

If you continue health insurance at retirement and receive a monthly pension from TCRS based on your own service, you are eligible for retiree vision coverage. If you do not select vision coverage at retirement, you can enroll during the annual enrollment period. Coverage will end when your group health enrollment ends. You may also cover dependents enrolled in retiree group health coverage. Dependent-only vision coverage is available when you are no longer enrolled on the retiree group health plan, provided they remain eligible dependents covered on the retiree group health plan.

ELIGIBILITY AND ENROLLMENT

Non-TCRS Participants

Continuing Group Health Coverage

Detailed information on the rules to continue health insurance as a retiree can be found in the Local Education Medical Plan Document. This document is available on the publications webpage of the Benefits Administration website located here: www.tn.gov/Partnersforhealth/publications/publications.

To continue health insurance benefits, the agency from which you retire must continue to participate in the state plan. If your former agency leaves the State Group Insurance Program, your and your dependent's health coverage will be canceled.

If your spouse is an employee enrolled in state group health insurance, you may continue coverage as a dependent on his/her contract instead of choosing retiree coverage. When your spouse ends employment, you may be eligible to apply via the special enrollment provision under your own eligibility as a retiree.

Retiree health coverage is only available to employees hired before July 1, 2015. If you started working for the state of Tennessee or a participating local education agency for the first time on or after July 1, 2015, you are not eligible to continue or enroll in insurance at retirement. If you started working for the

state of Tennessee or a participating local education agency for the first time before July 1, 2015, you will not be prohibited from continuing or enrolling in insurance at retirement, provided that you satisfy all other eligibility requirements.

The eligibility guidelines are:

- Ten years (120 months) of creditable service, must be age 55 at the time employment ends with the participating agency and at least three years of continuous insurance coverage in the plan immediately prior to final termination for retirement. The date retirement insurance benefits start must immediately follow active coverage ending. This requirement for immediate commencement of insurance benefits will be waived if you become insured by a state, local education or local government agency that participates in the State Group Insurance Program.
- Twenty years (240 months) of creditable service, must be age 55 and have at least one year of continuous insurance coverage in the plan immediately prior to final termination for retirement. The period of time between your final termination date and attainment of age 55 may be up to five years. This requirement for commencement of insurance benefits will be waived if you become insured by a state, local education or local government agency that participates in the State Group Insurance Program with no lapse in coverage.
- Twenty-five years (300 months) of creditable service and one year of continuous insurance coverage in the plan immediately prior to final termination for retirement. The period of time between your final termination date and commencement of retirement insurance may be up to five years. This requirement for commencement of insurance benefits will be waived if you become insured by a state, local education or local government agency that participates in the State Group Insurance Program with no lapse in coverage.

Creditable Service:

- You can count employment with the state of Tennessee, a state higher education institution or a local education agency that participates on the state group health plan to calculate total employment. Unused sick leave may also be counted. Military service that did not interrupt employment, educational leave, leave of absence or service with a local government agency cannot be counted.
- Only creditable service will count. Years of service applies to the minimum length of service required to continue coverage at retirement. It does not necessarily count toward premium reduction. State premium support is provided on teaching service only.
- If you are eligible to combine creditable state and local education service, you will be classified as a retiree under the plan from which you ended employment prior to retirement.

- If you are eligible for retiree coverage without combining creditable service under more than one plan, you may choose to be classified as a retiree in the plan in which you first satisfied eligibility criteria, or in the plan from which your employment ended immediately preceding retirement.

Application to Continue Group Health Coverage

You must submit an Application to Continue Insurance at Retirement to your ABC within one full calendar month of the end of active insurance. If enrollment is approved, you will continue in the same health insurance option in which you are currently enrolled.

If you have 20 or more years of service and there is an allowed gap between your date of termination and the date insurance benefits start, you must submit the application to Benefits Administration within one full calendar month of meeting conditions to enroll in coverage.

Effective Date of Retiree Group Health Coverage

Subject to timely submission of an enrollment application, the effective date of coverage will be the first of the month following attainment of conditions for continuing coverage.

Individuals Eligible for Medicare

If you are enrolled in health insurance and meet the service requirements, you may continue coverage at retirement until you become eligible for Medicare due to age. You may also continue coverage on covered dependents until they become eligible for Medicare due to age or no longer qualify as eligible dependents.

You and your dependents who become entitled to Medicare prior to age 65 must enroll in Medicare parts A and B to continue group health coverage until becoming entitled to Medicare due to age, or for covered children, until they turn 26 or meet plan provisions for incapacitated dependents.

Retirees who are Medicare eligible due to age are no longer eligible for the group health plan and are not eligible to apply to cover their dependents on the state group health plan via the special enrollment provision.

If your initial date of employment with the state or other qualifying employer is prior to July 1, 2015, you may be eligible for the state's Supplemental Medical Insurance for Retirees with Medicare program called The Tennessee Plan.

Application for The Tennessee Plan Coverage

The Tennessee Plan is a supplemental medical insurance program designed to cover certain expenses not fully paid by your Medicare parts A and B coverage. It does not cover prescription drugs. If you participate in The Tennessee Plan, you will need a separate Part D plan for your prescription drug needs. The Tennessee Plan will not coordinate benefits if you are currently enrolled in or join a Medicare Advantage plan. This means if you have a Medicare Advantage plan, The Tennessee Plan will not pay out any benefits.

If you are enrolled in at least Medicare Part A at retirement, you can select The Tennessee Plan coverage on the Application to Continue Insurance at Retirement. You may also apply to cover your dependents who are eligible for Medicare when you enroll in The Tennessee Plan. You have 60 days from the initial eligibility date to enroll. If you qualify and enroll within 60 days of initial eligibility, you cannot be turned down for coverage due to age or health. The initial eligibility date is the date active state group health coverage ends or the date of Medicare eligibility, whichever is later.

Coverage is effective the first of the month following the end of your active insurance coverage or the date of your Medicare entitlement, whichever is later. If the date of retirement is the later date and falls on the first of the month, your coverage may be effective on that date.

If you become eligible for Medicare due to age after retirement and you are covered on the state retiree group health plan, you will be sent an application approximately three months before your 65th birthday. The application must be submitted within 60 days of Medicare eligibility. Coverage will become effective on your date of Medicare entitlement provided the application is received timely. If you enroll in The Tennessee Plan and your spouse becomes entitled to Medicare at a later date, you have 60 days from the date of your spouse's eligibility to apply to add him or her to coverage.

If enrollment is not selected within 60 days of initial eligibility, you and your eligible dependent may apply through medical underwriting. Enrollment is subject to approval and may be denied. Benefits Administration will submit the application for review to the vendor. You must be enrolled in The Tennessee Plan to cover a dependent.

Once approved, you will receive an ID card from the vendor. It will show your name and identification number. If you are not satisfied with The Tennessee Plan, you can cancel it within 30 days after receipt. You will receive a refund of premiums paid in advance. Any claims paid during this period will be recovered.

End-stage Renal Disease

If you are eligible for Medicare as a result of end-stage renal disease, you may be eligible for extended group health benefits. Contact Benefits Administration for information on the eligibility criteria.

Dental Coverage

Continuation of dental insurance is NOT automatic at retirement. If you are enrolled in a state-sponsored dental plan, you have two options for continuing coverage.

COBRA Dental

You can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue dental through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due.

Retiree Dental

If you are an ORP participant, you may also choose to enroll in retiree dental coverage. Just select dental on your application to continue insurance at retirement. Dependent-only coverage is not available.

Vision Coverage

Continuation of vision insurance is NOT automatic at retirement. Retiree vision coverage is only available to retirees and dependents enrolled in one of the state-sponsored health insurance programs. If you are enrolled in the state-sponsored vision plan, you have two options for continuing coverage.

COBRA Vision

You can continue your coverage for 18 months under COBRA. A notice will be mailed to your home once your active coverage ends. The COBRA enrollment form is separate from the application to continue insurance at retirement. If you choose to continue vision through COBRA, you must submit the enrollment form to Benefits Administration within 60 days of the end of your active coverage. You will be billed directly for the premiums due.

Retiree Vision

If you are an ORP retiree and continue health insurance at retirement, you are eligible for retiree vision coverage. If you do not select vision coverage at retirement, you can enroll during the annual enrollment period. Coverage will end when your group health enrollment ends. You may also cover dependents who are enrolled in group health coverage. Dependent-only vision coverage is available when you are no longer enrolled on the retiree group health plan as long as the dependents remain eligible dependents covered on the retiree group health plan.

GENERAL INFORMATION FOR ALL PLAN MEMBERS

Disability Participants

If you started working for the state of Tennessee or a participating local education agency for the first time on or after July 1, 2015, you are not eligible to continue or enroll in health insurance at retirement. If you experience an injury or illness which results in disability, your initial date of employment with the state of Tennessee or a participating local education agency was prior to July 1, 2015, and you have at least five years of creditable service, you will not be prohibited from continuing or enrolling in health coverage as a disability retiree, provided you did not accept a lump-sum payment from the TCRS before July 1, 2015 and that you satisfy all other eligibility requirements. There can be no lapse in coverage. The date retirement benefits start (retirement date) must be on or before the date your active state coverage ceased.

If you are eligible for a service retirement, you must prove that total disability existed at the time of retirement. Proof of total disability must be shown by submitting an award letter from the Social Security Administration or approval by TCRS based on review of medical records. The required proof must show total disability existed on or before the date your active coverage ended.

Once you are eligible for Medicare Part A, you may continue in the plan to the point at which Medicare eligibility would have been attained had the disability not occurred. You must remain eligible for the disability allowance and retain Medicare Part B. If you do not enroll in Part B at the first opportunity, coverage will be terminated as of July 1 following refusal to take Part B.

Medicare will be the primary coverage, and the local education plan will be secondary. Coverage will terminate once you reach the normal age for Medicare Part A.

If the effective date of your disability retirement is determined to be after the date that your active coverage ended, you are not eligible for reinstatement of health coverage.

Dependent Coverage

You may continue coverage for eligible dependents if they are covered at your retirement. If you want to cover newly acquired dependents, they must be added within 30 days. If you are no longer eligible for the group health plan you cannot add dependents to your coverage.

Dependent Eligibility

The following dependents are eligible for coverage:

- Your spouse (legally married)
- Natural or adopted children
- Stepchildren
- Children for whom you are the legal guardian, custodian or conservator

All eligible dependents must be listed by name on the application to Continue Insurance at Retirement in part seven (www.tn.gov/content/dam/tn/partnersforhealth/documents/2023_forms/1045_2023.pdf). You are also required to provide a valid Social Security number for a dependent (if eligible for one). Other required information includes date of birth, relationship and gender.

A dependent can only be covered once within the local education plan but can be covered under two separate plans (state, local education or local government). Dependent children are usually eligible for coverage through the last day of the month of their 26th birthday. Orders for guardianship, custody or conservatorship may expire at an earlier age. If you have a dependent who is not your child, but is placed with you by a placement order, coverage will be terminated when the order expires unless additional eligibility requirements are met.

Individuals Not Eligible for Coverage as a Dependent

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children in the care, custody or guardianship of the Tennessee Department of Children's Services or equivalent placement agency who are placed with the head of contract for temporary or long-term foster care
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

Children who are mentally or physically disabled and not able to earn a living may continue health, dental and vision coverage beyond age 26 if they were disabled before their 26th birthday and they were already insured under the State Group Insurance Program. The child must meet the requirements for dependent eligibility listed above. A request for extended coverage must be provided to Benefits Administration before the dependent's 26th birthday. The insurance carrier will decide if a dependent is eligible based on disability. Coverage will end and will not be restored once the child is no longer disabled.

Adding New Dependents

To add new dependents to your coverage, submit a retiree insurance change application within 30 days of the date the dependent is acquired. The acquire date is the date of birth, marriage or, in case of adoption, when a child is adopted or placed for adoption. Proof of the dependent's eligibility is required. Refer to the dependent definitions and required documents chart for the types of proof you must provide (www.tn.gov/content/dam/tn/finance/fa-benefits/documents/deva_eligible_docs.pdf).

Premium changes start on the first day of the month in which a child is added due to birth, adoption or placement for adoption. Premium changes when adding a new spouse and/or a new stepchild, or a child pursuant to an order of guardianship will start the first day of the first calendar month after Benefits Administration receives the request for special enrollment. A child named under a qualified medical support order must be added within 40 days of the court order.

If adding dependents due to the birth, adoption or placement for adoption while on single coverage, you must request the correct family coverage tier for the month the dependent was acquired so claims are paid for that month. This change is retroactive, and you must pay the premium for the entire month the dependent is insured.

To add a dependent more than 30 days after the acquire date, see sections on Annual Enrollment period and special enrollment provisions in this guide.

Updating Personal Information

You must update personal information, such as home address and email, by contacting the Benefits Administration service center. You will be required to provide the last four digits of your Social Security number or Edison ID, date of birth and previous address. You must also confirm authorization of the change before our office can update your information. It is your responsibility to keep your address and phone number current with Benefits Administration. TCRS retirees must submit a separate request directly to TCRS.

Annual Enrollment Period

During the fall of each year, you can make changes in your health, vision or dental coverage. Information is mailed to your home address and provided on the Partners for Health website in detail prior to the enrollment period. The options you choose during the enrollment period will take effect on the following Jan. 1. Coverage will remain in effect through Dec. 31 subject to eligibility.

Canceling Health, Vision and Dental Coverage

You may only cancel coverage outside of the annual enrollment period for yourself and/or your dependents, if:

- You lose eligibility for the State Group Insurance Program, or
- You experience an event that results in you/your dependents becoming newly eligible for coverage under another plan, or
- You are enrolled in the Dental Health Maintenance Organization-Prepaid Provider plan and there is not a participating general dentist within a 25-mile radius of your home address

You must notify Benefits Administration within one full calendar month of any event that causes you or your dependents to become ineligible for coverage. You must repay any claims paid in error. Refunds for any premium overpayments are limited to three months from the date notice is received.

When canceled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for a child generally ends on the last day of the month in which the child reaches age 26, unless otherwise stated in the plan.

You have 60 days from the date that you and/or your dependents become newly eligible for other coverage to turn in an insurance cancel request application and proof to Benefits Administration. This application is available in the forms section of the Benefits Administration website under retirement (www.tn.gov/content/dam/tn/Partnersforhealth/documents/2023_forms/1048_2023.pdf). Cancellation reasons and the required documentation are shown on the application.

Divorce —If you request to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 36-4-106 and the requirement that you provide notice of termination of health insurance to your covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. As the retiree, it is your responsibility to make sure that any request to terminate your dependent spouse is consistent with those legal requirements.

If You Do Not Apply When First Eligible

If you do not apply to continue health coverage within a full calendar month of your initial eligibility, you may only apply later if you experience a special qualifying event. To apply, you must still be eligible for retiree health coverage and meet the criteria to continue coverage at the time your employment ended. If you are no longer eligible for health coverage, you may not enroll your dependents through a special enrollment event.

Special Enrollment Provisions

If you or a dependent lose eligibility for coverage under any other group health insurance plan, or if you acquire a new dependent during the plan year, you may have additional opportunities to enroll in health coverage.

Enrollment opportunities for voluntary programs like dental and vision are available to you and your dependents if you meet the requirements stated in the certificates of coverage for those programs. Certificates of coverage can be found at www.tn.gov/PartnersForHealth under Publications.

NOTE: Application for special enrollment (www.tn.gov/content/dam/tn/Partnersforhealth/documents/2023_forms/1044_2023.pdf) must be made:

- within 60 days of the loss of eligibility for other health insurance coverage; or
- within 30 days of a new dependent's acquire date.

You must also submit proof as listed on the enrollment application.

Retroactive coverage (a coverage effective date that begins before an enrollment is completed and submitted to BA) **is not allowed except in the event of a birth, adoption and placement for adoption.** For all other events, the earliest effective date allowed for health coverage under this plan is the first day of the month following the date that your enrollment request, including all required documentation, is completed and submitted to BA. Note: Effective dates for voluntary dental and vision are specified in the certificates of coverage for those programs. Enrollment should be completed and submitted to BA as soon as possible to ensure the earliest possible effective date.

You can find events that afford special enrollment opportunities, the effective dates for coverage and the documentation you will need to provide on page 3 of the [1044 application](#) identified above.

Reinstatement Following Voluntary Cancellation

If you cancel coverage and change your mind, coverage can be reinstated if you meet all of the following conditions:

- Premiums are paid current on the coverage termination date;
- You and your dependents continue to meet the eligibility requirements; and
- You submit a written request for reinstatement within one full calendar month of the coverage termination date.

Coverage for Dependents in the Event of Your Death

Survivor insurance is a continuation of insurance that allows covered dependents to apply to continue enrollment in the event of your death. There is no provision to allow enrollment of your non-covered dependents after your death.

Group Health

Your surviving dependents will receive up to six months of extended health insurance coverage without charge. Dependents must be covered at the time of your death and continue to meet eligibility rules. The surviving dependent must apply to continue coverage within 60 days of the expiration of the six months of extended coverage or within 60 days of the notice of the termination of coverage, whichever is later.

The Tennessee Plan

Coverage under your policy will terminate at the end of the month in which you pass away. Your surviving dependents may continue coverage if they were enrolled in The Tennessee Plan at the time of your death. Surviving dependents must apply to continue coverage within 60 days of the end of coverage under your enrollment or within 60 days of the notice of the termination of coverage, whichever is later.

Dental and Vision Coverage

Coverage under your policy will terminate at the end of the month in which you pass away. Your dependents may be eligible for continuation of dental and vision coverage through COBRA or the retirement program as outlined below.

Your surviving dependents covered under your dental and/or vision plan on the date of your death may continue their enrollment in the plan with one of the two options listed below. (Note: your dependents must continue enrollment in the retiree health plan to be able to continue retiree vision insurance.)

- If you are eligible for continuation of coverage as a retiree at the time of your death, your dependents may elect COBRA or retiree continuation of dental and/or vision elections in effect for them on the date of your death; or
- If you are not eligible for continuation of coverage as a retiree at the time of your death, your dependents may elect COBRA continuation for dental and/or vision elections in effect for them on the date of your death.

The surviving spouse should contact BA to confirm eligibility. Application must be made within 60 days of the end of coverage under your enrollment or within 60 days of the notice of the termination of coverage, whichever is later.

Premiums for Surviving Dependents

Premiums will be deducted from any continuing TCRS retirement benefits. Otherwise, individuals will be billed directly. Dependents acquired by the survivor(s) after your death are not eligible for coverage.

Premium Payment

TCRS Retiree

Premiums are deducted from your monthly TCRS pension benefit. If the premium is greater than your retirement benefit, you will be billed directly by Benefits Administration each month. If the premium is greater than your retirement benefit, you can also choose to pay by bank draft.

Non-TCRS Retiree

You will be billed directly by Benefits Administration each month or you can choose to pay by bank draft.

Direct Billing

If you send a check for your premium, it must be received by the last day of the month for the next month's coverage. For example, your January premium is due no later than Dec. 31.

If you pay your premiums by automatic deduction from your bank account, the premium is withdrawn for the current month on or after the 15th of the month. For example, your January premium will be withdrawn from your bank account on or after Jan. 15.

Non-payment of Premiums

The plan permits a period of one full calendar month deferral of premium for premiums being billed directly instead of through payroll deductions. Coverage will be canceled retroactively to the last month paid if premiums are not paid in full within one full calendar month of the due date. If your coverage is canceled due to failure to pay premiums you may request a one-time-only exception for reinstatement within 30 days of being notified that coverage was canceled.

Claims

If continuing group health coverage, you will continue to use your current ID cards after you retire. You may receive a new card if changes are made. Questions regarding payment of claims should be directed to the insurance company. Questions about Medicare claims processing should be directed to Medicare.

AVAILABLE BENEFITS

This section provides a brief overview of the benefits available to you. For more detailed information, visit the Benefits Administration website at www.tn.gov/Partnersforhealth, or consult your member materials.

Health Insurance

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

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

Pharmacy and Behavioral Health Benefits

All health plan members and enrolled dependents have access to pharmacy benefits and behavioral health and substance use disorder services.

- For information on pharmacy benefits, visit www.tn.gov/Partnersforhealth/health-options/pharmacy.
- For all behavioral health programs and services, and to find a provider, contact Optum at 855-Here4TN (855.437.3486), 24/7, or Here4TN.com.

Emotional Wellbeing Solutions

Emotional Wellbeing Solutions is a service available to you if you are enrolled in health coverage. Services are also available to your eligible dependents even if they are not enrolled in a health plan. Information is at tn.gov/PartnersForHealth under Other Benefits and Emotional Wellbeing Solutions. For all programs and services, and to find a provider, contact Optum at 855-Here4TN (855.437.3486), 24/7, or Here4TN.com.

Dental Insurance

The state offers two dental options, the Cigna Dental Health Maintenance Organization Prepaid Provider which requires use of a network general dentist and the Delta Dental Preferred Provider Organization which allows you to use any dentist. You pay the full monthly premium. Dental coverage is offered to you if are an eligible retiree receiving a monthly pension from TCRS based on your own service. Visit www.tn.gov/Partnersforhealth/other-benefits/dental for more information.

Vision Insurance

Voluntary vision coverage through EyeMed is available to local education TCRS retirees and dependents who are enrolled on the state group health plan. You must pay 100% of the premium for coverage. A basic and an expanded plan are available. Visit www.tn.gov/Partnersforhealth/other-benefits/vision for more information.

Wellness Program

To help you achieve your health goals, the 2024 wellness program is offered to enrolled retirees and adult dependents who qualify.

Sharecare is the wellness program vendor for 2024. Members enrolled in health benefits will have access to lifestyle counseling, chronic condition management, a weight management program, digital health devices and biometric screenings. A diabetes remission and Diabetes Prevention Program will also be offered to members who qualify.

Information about programs and activities is at www.tn.gov/Partnersforhealth/other-benefits/wellness-program.

Notice Regarding Wellness Program

The Partners for Health Wellness Program is a voluntary wellness program. Local education and local government employees and retirees enrolled in health coverage have access to certain programs like disease management and the web portal. 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.

The information from your health questionnaire 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 the Diabetes Prevention Program and other programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the state of Tennessee may use aggregate information it collects to design a program based on identified health risks in the workplace, the Partners for Health

Wellness Program will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed for you to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and will never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law 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 health care professionals) and their vendor partners (case managers with the medical and behavioral health vendors) in order to provide you with services under the wellness program.

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

OTHER INFORMATION

Coordination of Benefits

If you are covered under more than one insurance plan, health benefits will be coordinated for reimbursement. At no time should the combined reimbursement of all plans and your member cost share exceed 100% of charges. When this plan pays secondary, you will be responsible for your member cost share.

Primary and secondary benefits can depend on factors such as whether you are the head of contract or a dependent in those plans and whether the plan is an employee or retiree plan:

- As a retiree, your health insurance coverage through your former employer is generally considered primary for you unless you have Medicare.
- Your health plan may be primary for a period of time if you have Medicare due to end-stage renal disease.
- If you are the head of contract in more than one retiree plan, the oldest plan is considered your primary coverage.
- If your spouse has coverage through his or her employer, that coverage will generally be primary for your spouse and secondary for you.
- Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage.

The plans require an annual verification of other coverage. This information must be returned to your health insurance carrier in order to process claims. Claims will not be processed until this information is received.

Coordination of dental benefits should be reviewed in each program's certificate of coverage. Vision benefits do not coordinate with other plans.

Subrogation

The medical plan and The Tennessee Plan have the right to subrogate claims. This means that the medical plan and The Tennessee Plan can recover the following:

- Any payments made as a result of injury or illness caused by the action or fault of another person
- A lawsuit settlement that results in payments from a third party or insurer of a third party
- Any payments made due to a workplace injury or illness

These payments would include payments made by workers' compensation insurance, automobile insurance or homeowners insurance whether you or another party secured the coverage.

You must assist in this process and should not settle any claim without written consent from the Benefits Administration subrogation section. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses the plan has already paid for, you may be subject to collections activity.

Fraud, Waste and Abuse

Making a false statement on an enrollment or claim form is a serious matter. Only those persons defined by the group insurance program as eligible may be covered. Eligibility requirements for retirees and dependents are covered in detail in this guide.

If your covered dependent becomes ineligible, you must inform Benefits Administration and submit an application within one full calendar month of the loss of eligibility. Once a dependent becomes ineligible for coverage, he or she cannot be covered even if you are under court order to continue to provide coverage.

If there is any kind of error in your coverage or an error affecting the amount of your premium, you must notify Benefits Administration. Any refunds of premiums are limited to three months from the date a notice is received by Benefits Administration. Claims paid in error for any reason will be recovered from you.

Financial losses due to fraud, waste or abuse have a direct effect on you as a plan member. When claims are paid or benefits are provided to a person who is not eligible for coverage, this reflects in the premiums you pay for the cost of your health care. It is estimated that between 3-14 percent of all paid claims each year are the result of provider or member fraud. You can help prevent fraud and abuse by working with your plan administrator to fight those individuals who engage in fraudulent activities. Please contact Benefits Administration to report fraud, waste or abuse of the plan. All calls are strictly confidential.

How You Can Help

- Pay close attention to the explanation of benefits forms sent to you when a claim is filed under your contract and always call the carrier to question any charge that you do not understand
- Report anyone who permits a relative or friend to "borrow" his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who makes false claims or alters amounts charged on claim forms

To File an Appeal

If you have a problem with coverage or payment of medical, behavioral health and substance use, or pharmacy services, there are internal and external procedures to help you. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

You should direct any specific questions regarding initial levels of appeal (the internal appeal process) to the insurance carrier member service numbers provided on your insurance cards. Benefits Administration is not involved in the appeal process. The appeal process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations.

Benefit Appeals

Before starting an appeal related to benefits (e.g., a prior-authorization denial or an unpaid claim), you or your authorized representative should first contact the insurance carrier to discuss the issue. You or your authorized representative may ask for an appeal if the issue is not resolved as you would like.

Different insurance carriers manage approvals and payments related to your medical, behavioral health, substance use and pharmacy benefits. To avoid delays in the processing of your appeal, make sure that you submit your request on time and direct it to the correct insurance carrier. For example, you or your authorized representative will have 180 days to start an internal appeal with the medical insurance carrier following notice of an adverse determination with regard to your medical benefits.

Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), you or your authorized representative should call the toll-free member service number on your insurance card. You or your authorized representative may file an appeal/member grievance by completing the correct form or as otherwise instructed.

The insurance company will process internal levels of appeal — Level I and Level II appeals. Decision letters will be mailed to you at each level. These letters will tell you if you have further appeal options (including independent external review) and if so, how to pursue those options and how long you have to do so.

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.

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 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.

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

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

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

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

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

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

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

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚስተለውቁጥር ይደውሉ 1-866-576-0029 (ማስማት ለተሳናቸው: 1-800-848-0298)።

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

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

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

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

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करें। ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848- 0298).

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

The Notice of Privacy Practices

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. 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, 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 Practices is located on the Benefits Administration website at www.tn.gov/Partnersforhealth. 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 or the state-sponsored health plans. The summary describes your 2024 health coverage options. You can view it online at www.tn.gov/Partnersforhealth/summary-of-benefits-and-coverage 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 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 www.tn.gov/Partnersforhealth/publications.

Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at www.tn.gov/Partnersforhealth/publications, including, but not limited to, a sample basic term life/basic AD&D certificate, sample voluntary AD&D certificate, brochures and handbooks for medical, pharmacy, dental, vision and the plan document, brochure and handbook for The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare).

Q&A

If I am Medicare eligible when I retire, can I continue to cover my spouse who is not yet Medicare eligible?

If you meet the criteria to continue group health coverage and are in paying status (with TCRS participant), you may continue your spouse's group health coverage. If you do not continue spouse coverage immediately upon retirement, you cannot add your spouse to coverage at a later date.

If you are enrolled in coverage based upon the eligibility of your deceased spouse, you cannot add your new spouse to coverage if you remarry.

If I become eligible for Medicare prior to the age of 65, will my insurance be terminated? What about my dependents?

If you or your covered dependent becomes entitled to Medicare prior to the age of 65, Medicare parts A and B must be obtained to keep group health coverage until you or your affected dependent would have become Medicare eligible by virtue of age.

Medicare will become primary and the state group health plan will pay secondary. If parts A and B are not taken when first eligible, coverage will be terminated.

Is my spouse eligible for The Tennessee Plan?

If you are enrolled in The Tennessee Plan, you may apply to cover your Medicare-enrolled spouse. If you do not apply within 60 days of initial eligibility, your spouse must apply as a late applicant and will be subject to approval.

If you are enrolled in coverage based upon the eligibility of your deceased spouse, you cannot add your new spouse to coverage if you remarry.

If I do not continue group health coverage when I retire because I will have coverage through my spouse, can I apply for coverage later?

If you met the minimum criteria to continue group health coverage when you retired, you may apply for the state's group health plan through a special enrollment provision if you lose other creditable health coverage. You must still meet the plan eligibility rules.

Can I change my health insurance option or carrier when I continue coverage at retirement?

You will continue with the same health insurance option you were enrolled in immediately prior to retirement.

VISION COVERAGE

If I am over age 65 and enrolled in the state's The Tennessee Plan, am I eligible to enroll in the retiree vision plan?

No. You must be covered by the retiree group health plan to enroll in the retiree vision plan. If you were covered by the vision plan

as an active employee, you should receive a COBRA notification and may apply to continue the vision coverage through COBRA. Premiums for COBRA vision will be billed directly to you.

If I continue coverage in the retiree group health plan for my spouse only, can my spouse enroll in the retiree vision plan?

Yes. As long as your spouse is covered under the retiree group health plan, you may apply for spouse-only coverage in the retiree vision plan.

If I continue coverage in the retiree group health plan for myself only, can my spouse and I both enroll in the retiree vision plan?

No. If your spouse is not enrolled in the health plan, you cannot enroll him or her in vision.

DENTAL COVERAGE

How do I know if I am eligible for retiree dental benefits?

To qualify for retiree dental coverage, you must receive a monthly retirement check from TCRS.

How do I know if my dependents are eligible for dental benefits?

If you are eligible for retiree dental coverage, your dependents are also eligible. You must provide documentation to verify your dependents' eligibility before they can be enrolled in coverage.

How do I find out which dentists are considered in network?

To find up-to-date network information, call the dental carrier directly or do an online search on the carrier's website.

My old school system provides other dental coverage. Can I still apply for state-sponsored dental coverage?

If your school system provides dental coverage to retirees, you can enroll in the school system's dental plan, one of the state's dental plans or a combination of the two. If you wish to enroll in both the school system and state's plans, you will need to contact the dental carriers to see if coordination of benefits is possible. Benefits Administration can only assist you with questions about the state-sponsored dental coverage.

How will the state deduct my dental premiums?

Premiums will be deducted from your TCRS check each month. If there is not enough money in your TCRS check, the state will send a bill to your home.

If I live out of state, can I still enroll in dental coverage?

Yes. If you select the DHMO plan you must still select and use a network dentist.

What if I recently retired and now have COBRA dental coverage?

If you had dental coverage when you stopped working, then you can often keep this coverage at the COBRA premium. This coverage lasts for 18 months. If you meet the eligibility criteria, you can enroll in retiree dental coverage when your COBRA coverage expires. You will need to contact Benefits Administration 60 days prior to the expiration of your COBRA coverage to request an application. You must indicate the requested future effective date when you submit your application.

Can I cancel retiree dental coverage if I change my mind?

You may only cancel coverage during the fall enrollment period unless you have a qualifying event. Requests to cancel coverage must be submitted within 60 days of the qualifying event. Supporting documents must be provided. The insurance cancel request application provides information about qualifying events. It is available on the forms section of the Benefits Administration website at www.tn.gov/Partnersforhealth/publications/forms.

Who do I call if I have questions about my dental benefit?

For information on covered services, please contact the dental carriers directly.

If you need help... For additional information about a specific benefit or program, refer to the chart below.

BENEFITS	CONTACT	PHONE	WEBSITE
Plan Administrator	Benefits Administration	800.253.9981 or 615.741.3590 — M-F, 8-4:30	tn.gov/Partnersforhealth
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	Optum Financial	866.600.4984 — 24/7	optumbank.com/Tennessee
Pharmacy Benefits	CVS Caremark	877.522.8679 — 24/7	info.caremark.com/stateoftn
Behavioral Health, Substance Use and Emotional Wellbeing Solutions	Optum Health	855.HERE4TN — 24/7 (855.437.3486)	here4TN.com
Wellness Program	Sharecare	888.741.3390 — M-F, 8-8 CT	sharecare.com/tnwellness/
Dental Insurance	Cigna	800.997.1617 — 24/7	cigna.com/stateoftn
	Delta Dental	800-552-2498 — M-F, 7-5	tennessee.deltadental.com/stateoftn/
Vision Insurance	EyeMed	855.779.5046 Mon.-Sat., 7 a.m. – 10 p.m. CT, Sun. 10 a.m. – 7 p.m. CT. Retiree Basic Code: 1038916 Retiree Expanded Code: 1038919 COBRA Basic Code: 1038917 COBRA Expanded Code: 1038920	eyemed.com/stateoftn
The Tennessee Plan	UMR	888.477.9307	umr.com/thetennesseeplaninfo


Online resources...

Visit the Partners for Health website at tn.gov/Partnersforhealth. It has the enrollment forms and handbooks referenced in this guide. It also has information about all the benefits described in this guide. The website is updated often with new information.

Our Zendesk help center is located at benefitssupport.tn.gov/hc/en-us, where you can search the help center, find articles or submit questions. To access Zendesk, you can also click the “Questions?” button on the website.

Follow us on social media...



	TN Department of Finance and Administration, Authorization No. 317119, January 2024. This public document was promulgated at a cost of \$0.01 per copy.
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USABLE Supplementary Benefits

New employees are eligible for USABLE supplementary benefits offered to Oak Ridge Board of Education employees. New hires have 30 days from their date of hire to enroll in eligible benefits. Enrollment in USABLE products is processed directly through USABLE. To enroll, or for additional information, please contact Brian Gass at Brian.gass@usablelife.com or 423-653-8126.

Voluntary Group Term Life Insurance – Life insurance coverage that you can take out since you are an eligible member of the group:

- Employee – Guaranteed Issue up to \$200,000 or 5x salary – whichever is lower
 - o \$2.15/month per \$10,000 of coverage
- Spouse – Guaranteed Issue up to \$30,000 or 50% of Employee Coverage – whichever is lower
 - o \$2.15/month per \$10,000 of coverage
- Child – Blanket Coverage - \$10,000 on all children under age 26
 - o \$1.76/month

Disability – Educator LTD 3:

- USABLE Life has a special disability program for the Education Industry
- It is short term and long term combined into 1 plan
- There are different elimination periods – elimination period is how long you have to be out of work before USABLE Life would start to pay you a benefit.
 - o 1st day/4th day – starts to pay out immediately on accident or hospitalization, 4th day of illness
 - o 7/7 – Starts to pay after being out of work for 7 days
 - o 15/15 - Starts to pay after being out of work for 15 days
 - o 30/30 - Starts to pay after being out of work for 30 days
 - o 60/60 - Starts to pay after being out of work for 60 days

You have 2 opportunities to sign up for the coverage with no health questions asked (Guaranteed Issued):

- Now – signed applications must be dated and returned no later than 30 days after your hire date
 - o Enrollment Limited to Guaranteed Issue Products - Voluntary Group Life Insurance and Disability Insurance
- 1st Annual Enrollment following your hire date – our open enrollment occurs in September of each year, and the coverage becomes effective 1/1 of the following year.
 - o All products offered including FSA plans

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved

OMB No. 1210-0149

PART A: General Information

There is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace is held annually in the fall. Check the www.healthcare.gov website for more information and deadlines.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if

your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the

Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tamara Jones .

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Oak Ridge Schools		4. Employer Identification Number (EIN) 62-6014956	
5. Employer address 304 New York Avenue		6. Employer phone number 865-425-9008	
7. City Oak Ridge		8. State Tennessee	9. ZIP code 37830
10. Who can we contact about employee health coverage at this job? Tamara Jones			
11. Phone number (if different from above)		12. Email address: tjones@ortn.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees.
 - Some employees. Eligible employees are:
 - Any employee scheduled to work at least 30 hours per week in a non-seasonal, non-temporary position
 - Any member of the chief legislative body of the county or municipal government (defined as only those elected officials who have the authority to pass local legislation)
 - Utility board members appointed or elected pursuant to TCA 7-82-307, but only during their term of service
 - County officials as defined in TCA 8-34-101(9) (A) and (B), regardless of whether the agency participates in the plan, pursuant to TCA 8-27-704
 - All other individuals cited in state statute, approved as an exception by the Local Government Insurance Committee, or defined as full time employees for health insurance purposes by federal law
 - With respect to dependents:
 - We do offer coverage. Eligible dependents are:
 - Your spouse (legally married); individual agencies may deny eligibility to the spouses of employees who are eligible for group health insurance through the spouse's employers
 - Natural or adopted children
 - Stepchildren
 - Children for whom you are the legal guardian
 - Children for whom the plan has qualified medical child support orders
 - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
- ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy)
(Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$104.04

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)