

State | Higher Education | Local Education | Local Government

STATE OF TENNESSEE 2023 MEMBER HANDBOOK

Premier PPO | Standard PPO | Limited PPO | CDHP/HSA | Local CDHP/HSA



State of Tennessee
Group Insurance Program

PARTNERS
FOR HEALTH



Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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IMPORTANT REMINDERS

- › **Your health coverage is effective Jan. 1, 2023 through Dec. 31, 2023, subject to eligibility.** You won't be able to change plans or networks. You may be able to make changes allowed by the plan if you have a qualifying event. A provider or hospital leaving a network is not a qualifying event.
- › **Benefit Grids on pages 5–8 outline your responsibility for your cost share of medical expenses.** Your cost share applies even if this plan is your secondary coverage. See the Coordination of Benefits section on page 22 for more details.
- › **Take care when signing medical waivers** or other documents that might make you financially responsible for unpaid charges.
- › **See the “If You Have Questions” section on Page 1 and make contact as soon as possible.** A delay could cause you to miss important deadlines.
- › **Your Rights and Protections Against Surprise Medical Bills.** When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. For more information, see the important notice about surprise medical bills at https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/surprise_billing_model_notice.pdf.

BENEFIT HIGHLIGHTS

Members have three separate ID cards for medical services, behavioral health/substance use disorder services and pharmacy services. The back of each card has a specific customer service number. Using the correct card and calling the number on that card will improve your customer service experience.

MEDICAL – call **Cigna at 800.997.1617** for more information

***Cost savings for certain approved orthopedic procedures**

- › Medically necessary knee, hip and shoulder replacements, hip and knee arthroplasty, lumbar spinal fusion, laminectomy without fusion and low back disc surgeries with select providers and facilities participating in Cigna's Bone and Joint Health Benefit program.
- › You must enroll by calling **855.678.0042**
- › PPO members – no cost; deductible and coinsurance are waived
- › CDHP members – no cost after deductible; coinsurance is waived
- › Personalized member support to help make health care decisions
- › Travel benefit to offset travel expenses if you must travel more than 60 miles – up to \$600 per procedure

***Cost savings for expert medical opinion for diagnosis and treatment**

- › ParTNers for Health is pleased to offer ConsumerMedical's valuable services at **no cost** to all employees and eligible dependents enrolled in the Cigna health plan
- › Get a second opinion from top specialists for your condition or treatment, in person or virtually to confirm your diagnosis
- › **Connect with ConsumerMedical:**
1-888-361-3944
Monday–Friday, 8:30 a.m.–11 p.m. EST
myconsumermedical.com

To register, enter company code **Cigna State of TN**

***Cost savings for virtual exercise therapy**

- › Ease pain and get back to the activities you love with RecoveryOne™ for Cigna® – personalized exercise therapy available through your health plan benefits at no additional out of pocket cost.
- › Guided exercise videos available anytime, anywhere – no need for travel, appointments, or referrals
- › Get started at **recovereveryone.com/stateofTN**

***Cost savings for approved transplants at certain preferred transplant facilities**

- › Cigna LifeSource facilities
- › In-Network facilities when there is no Cigna LifeSource facility option
- › PPO members – no cost; deductible and coinsurance are waived
- › CDHP members – no cost after deductible; coinsurance is waived

BEHAVIORAL HEALTH AND SUBSTANCE USE – Claims are processed under behavioral health benefits. If you have questions, call **Optum Behavioral Health at 855.437.3486** for more information

***Cost savings for facility-based treatment at certain preferred substance use (alcohol/drug) facilities**

- › Find preferred Optum providers by calling 855-Here4TN or visiting Here4TN.com
- › PPO members – no cost; deductible and coinsurance are waived
- › CDHP members – no cost after deductible; coinsurance is waived
- › Cost sharing still applies for standard outpatient treatment services

PHARMACY – Claims are processed under pharmacy benefits. If you have questions, call **CVS Caremark at 877.522.8679** for more information

***Cost savings for 90-day supply of certain maintenance medications from 90-day network pharmacy or mail order**

- › certain antihypertensives for coronary artery disease and congestive heart failure; oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis), depression and some osteoporosis medications
- › PPO and CDHP plan members can receive a 90-day supply of maintenance medications for the same cost as a 30-day supply (generic and preferred brands only)
- › For CDHP members, these maintenance medications bypass the deductible and you pay the lower, discounted cost immediately.

* See Benefit Grids, the "Covered Medical Expenses" and "Cost Savings Programs" sections on pages 5–8; 10; and 12 in this handbook for more details. Standard benefits will apply when members elect treatment with non-preferred providers and facilities. Prior authorization is required for inpatient care.

Important Notices

This handbook tells you what you need to know about ALL medical plans sponsored by the State of Tennessee Group Insurance Program. Those plans include the Premier Preferred Provider Organization (PPO), Standard PPO, Limited PPO, Consumer-Driven Health Plan/Health Savings Account and Local CDHP/HSA.

Make sure you know the name of the plan you've chosen, and pay special attention when that plan is mentioned. Much of the information in this handbook applies to all plans. Some of the information, like what services will cost you, is specific to the plan you've chosen. You'll see plan names mentioned when information is plan-specific.

The ParTNers for Health website (www.tn.gov/partnersforhealth) contains an electronic version of this handbook and many other important publications including Summaries of Benefits and Coverage (SBC) and Plan Documents. The Plan Documents are the official legal publications that define eligibility, enrollment, covered and excluded services, benefits and administrative rules of the State Group Insurance Program.

Want a coverage summary you can hold in the palm of your hand? Take a look at your member ID card. It has the name of your plan, your cost for common services, your plan's network and important phone numbers. See a sample member ID card on page v.

Need help with a bill? If you receive a bill for medical services that is more than you expected to pay, call Cigna Member Services at **800.997.1617**. Ask us to look at your claim and discuss the bill you received from your provider. Have your Cigna explanation of benefits (EOB) and the bill from your provider in front of you so that we can review them together. No worries if you don't have a printed copy of your EOB. You can find it by signing in to your secure and personal myCigna account at <https://my.cigna.com/>.

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**.



WELCOME TO CIGNA

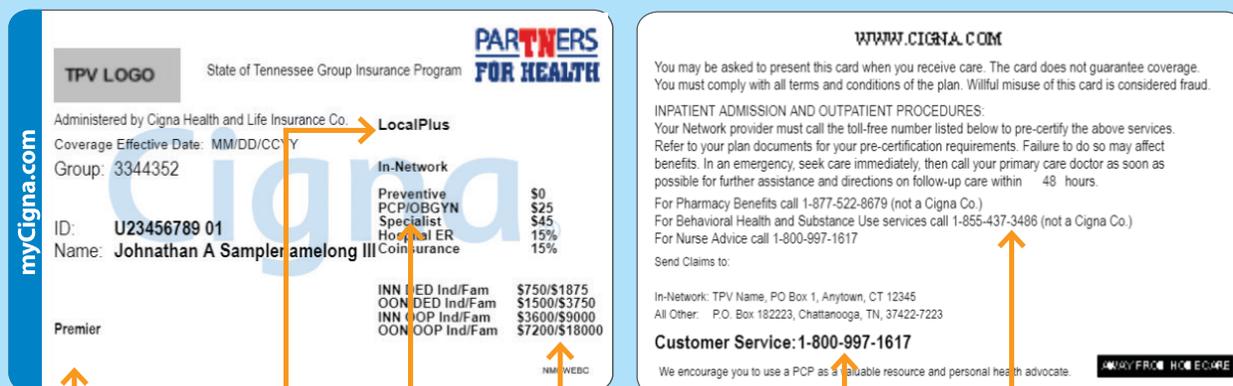
State, higher education, local education and local government members:

Cigna is pleased to administer networks and plans to help you and your family access cost-effective health care services to get and stay healthy. Your plan provides access to quality care, close to where you live and work. You have the freedom to choose your doctor—either in or out of network—and convenient, no-referral access to specialists. We encourage you to use our online tools and resources to help you get the most out of your plan and to stay healthy. We stand ready to help, so just call the dedicated toll-free number on your Cigna ID card if you have questions or concerns.

ID Cards

You have ID cards for yourself and each of your covered dependents. Each covered person gets a card with their name on it. The cards show your health plan and network. Your network is either **LocalPlus** or **Open Access Plus**. Review this information carefully and call if you have any questions.

See your actual ID card.



The name of your plan will appear here. You will see one of the following:
Premier
Standard
Limited
CDHP/HSA
Local CDHP/HSA

In-network amounts (copayment or coinsurance for various health care services)

Annual deductible and out-of-pocket maximum amounts

The name of the network for your plan will appear in this field. Note whether your card says LocalPlus (LP) or Open Access Plus (OAP). Be sure to schedule services with providers specific to your plan's network to receive maximum in-network benefits

Your main number for questions and assistance; providers should call this number for prior authorization.

Other important numbers

Where's My Member ID Card?

- You will receive new ID cards for 2023 if you are a continuing Cigna customer
- You will also receive ID cards if you are a new Cigna customer, if you add dependents or if you elect a different medical plan design option
- You can print temporary cards and request replacement cards at <https://my.cigna.com/>
- Access your card on the MYCIGNA APP®

Network Choices

Cigna offers two network options for plan members. Your choice of network affects your monthly premium cost.

- ▶ The LocalPlus network has many providers and facilities across Tennessee. There is no additional premium charge when you select this network. If your plan network is LocalPlus, but you are outside of a LocalPlus service area, you have access to Cigna's national "Open Access Plus" network of providers.
- ▶ Open Access Plus is a larger network with more doctors and facilities than the LocalPlus network. A higher monthly premium applies if you select this network.

Your health coverage is effective Jan. 1, 2023 through Dec. 31, 2023, subject to eligibility.

You won't be able to change plans or networks for 2023. You may be able to make changes allowed by the plan if you have a qualifying event. **A provider or hospital leaving a network is not a qualifying event.**

Plan Administration and Claims Administration

Benefits Administration, a division of the Department of Finance and Administration, is the plan administrator, and Cigna is the claims administrator. This program uses the benefit structure approved by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund made up of your premiums and any employer contributions. Cigna is contracted by the state to process claims, establish and maintain adequate provider networks and conduct utilization management reviews.

Claims paid in error for any reason may be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting Benefits Administration.

If You Have Questions:

- ▶ about eligibility or enrollment (e.g., becoming insured, adding dependents, when your coverage starts, transferring between plans, ending coverage), contact your agency benefits coordinator. They will work with Benefits Administration to help you.

- ▶ about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your health care provider or Cigna), contact Cigna member services at **800.997.1617**. See also, information at the end of this handbook about your appeal rights.

Adding Dependents

If you want to add dependents to your coverage you must provide documentation verifying the dependent's eligibility to Benefits Administration. A list of acceptable documents is available from your agency benefits coordinator or the ParTNers for Health **website**.

Important Contact Information

Please call member services for information about specific health care claims. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting member services, you will be asked to verify your identity and give information from your identification card.

Cigna

Cigna Member Services
800.997.1617

Cigna Medical Claims

PO Box 182223
Chattanooga, TN 37422-7223

Behavioral Health, Substance Use, and Employee Assistance Program

Optum Behavioral Health
1.855.Here4TN (1.855.437.3486)

Here4TN.com

Pharmacy

CVS Caremark
877.522.8679

info.caremark.com/stateoftn

HSA/FSA

Optum Financial
1.866.600.4984

optumbank.com/Tennessee

ParTNers for Health Wellness Program

888.741.3390

<http://goactivehealth.com/wellnesstn>

Website

For general information about Cigna, visit **Cigna.com** and see what we are all about.

Once you enroll, myCigna.com is your personalized, convenient and secure website.

On myCigna.com you can:

- Locate doctors, hospitals and other health care providers.
- Verify plan details such as coverage, copays and deductibles.
- View and keep track of claims.
- Find information and estimate costs for medical procedures and treatments.
- Learn about health conditions, treatments, etc.

Cost Sharing

The term “cost sharing” means your share of costs, or what you must pay out of your own pocket, for services covered by your health plan. Sometimes these costs are called “out-of-pocket” costs.

Some examples of cost sharing are copayments, deductibles and coinsurance. Other costs, including your premiums or the cost of care not covered by your plan, aren’t considered cost sharing.

Your cost sharing is less for in-network care. You have separate out-of-network cost-sharing amounts for eligible services from out-of-network providers.

A **copayment** (or copay) is a fixed amount you pay for a covered health care service, usually when you receive the service. An example of a copayment is \$25.

Coinsurance is your share of the cost of a covered health care service, calculated as a percentage. An example of coinsurance is 20% of the allowed amount for a service. Generally, if coinsurance applies to a health care service, you will have to “meet” or “satisfy” a deductible first. In other words, you will pay your deductible plus coinsurance.

A **deductible** is the amount you pay each plan year for certain covered health care services before your plan pays for those services. Eligible medical, pharmacy and behavioral health expenses count toward your deductible. Ineligible expenses, including amounts that exceed the maximum allowable charge, are not applied to the deductible. A deductible applies to some services under the state-sponsored PPO plans and almost all services under the state-sponsored CDHP/HSA plans.

There are in-network and out-of-network deductibles. The two deductibles add up separately. In-network

charges cannot be applied to an out-of-network deductible, and out-of-network charges cannot be applied to an in-network deductible.

For PPO plans, members in a family plan DO have an individual deductible equal to the “employee only” amount.

For CDHP plans, members in a family plan DO NOT have an individual deductible limit. Each family member will contribute to the overall family deductible which must be met before the plan pays for any family member’s claims subject to a deductible.

Copayment, coinsurance and deductible amounts vary depending on the plan you’ve chosen and the type of services you receive. See the benefit grids in this handbook for more details and look for information specific to your plan.

An **out-of-pocket maximum** limits how much you pay in any year. If your spending reaches the out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the year. Your eligible cost-sharing amounts, including your deductible, count toward your annual out-of-pocket maximum.

For PPO plans, members in a family plan DO have an individual out-of-pocket maximum amount equal to the “employee only” amount.

For the CDHP/HSA plan, state and higher education members in a family plan DO NOT have an individual out-of-pocket limit. Each family member will contribute to the overall family out-of-pocket amount which must be met before the plan covers the family’s eligible in-network expenses at 100% for the remainder of the plan year.

For the Local CDHP/HSA plan, local education and local government members in a family plan DO have an individual out-of-pocket limit FOR IN-NETWORK EXPENSES. No one family member will pay more than \$8,700 toward their in-network out-of-pocket limit. Once a family member has eligible in-network out-of-pocket costs totaling \$8,700, the plan will cover that family member’s eligible in-network expenses at 100% for the remainder of the plan year. All other family members will contribute to the remaining overall family out-of-pocket limit which must be met before the plan covers the family’s eligible in-network expenses at 100% for the remainder of the plan year.

See the Benefit Grids in this handbook for out-of-pocket limits.

Note: There are separate out-of-pocket maximums for in-network and out-of-network expenses. As with the deductible, in-network charges cannot be applied to an out-of-network out-of-pocket maximum, and out-of-network charges cannot be applied to an in-network out-of-pocket maximum. Charges in excess of the maximum allowable charge and non-covered expenses do not count toward the out-of-pocket maximum.

PPO Plans

A PPO plan is a preferred provider organization plan. It requires that you pay either a copayment or a deductible and coinsurance for covered services.

Whether you're enrolled in the Premier PPO, the Standard PPO or the Limited PPO:

- › In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.

You pay copays for other covered services like:

- › office visits to primary care providers and specialists,
- › outpatient behavioral health and substance use services,
- › telehealth,
- › visits to convenience clinics,
- › urgent care facilities, and
- › most prescription medications

You pay deductible and coinsurance for things like:

- › emergency rooms,
- › ambulance services,
- › inpatient hospital care,
- › outpatient surgery,
- › advanced imaging, and
- › durable medical equipment

CDHP Plans

A CDHP includes a tax-free health savings account, which you own and can use to pay for qualified medical expenses. Qualified expenses include things that may not be covered by your health insurance plan, like vision and dental expenses, hearing aids, contact lens supplies, and more. More information follows in the HSA section of this handbook.

Whether you're enrolled in the CDHP/HSA or the Local CDHP/HSA:

- › In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- › You pay coinsurance for ALL other covered services.
- › You must meet your deductible before the plan pays for covered expenses, EXCEPT for in-network preventive care and 90-day supply maintenance medications (e.g., certain medications to treat high blood pressure, diabetes, depression, high cholesterol, etc.).
- › Your cost for prescription medications is the discounted network rate for the prescriptions until the deductible is met. Then you pay your coinsurance, which is a percentage of the discounted network rate.
- › If you buy your prescriptions by mail order and want to use your HSA funds to pay, you must provide CVS Caremark with your HSA debit card number before the prescription is filled and shipped. Otherwise, CVS Caremark will charge the order to the credit card they have on file.

Health Savings Account

When you enroll in a CDHP, a HSA will be opened for you automatically. The HSA is managed by **Optum Financial**. Contact information is under the "Important Contact Information" section of this handbook. You own your HSA account, and it is your responsibility to register for your online account access at optumbank.com/Tennessee. The state will pay the monthly fee for your HSA while you are enrolled in the state's CDHP. You must pay standard banking fees such as an ATM fee each time you use your HSA debit card at an ATM. If you leave your job, move to COBRA or choose a PPO option in the future and keep funds in your HSA, you must pay the monthly HSA fees. These fees will be taken from your HSA automatically.

You and your employer may put money into your HSA. The money saved in your HSA (both yours and any employer contributions, if offered) rolls over each year and collects interest. You don't lose it at

the end of the year. The money is yours! You take your HSA with you if you leave or retire.

- ▶ You can put money into your HSA through online bank transfer, by mailing a check, or your employer may offer payroll deduction.
- ▶ In 2023, IRS guidelines allow total annual tax-free contributions up to \$3,850 for those with single coverage and \$7,750 for those with any other coverage. At age 55 and older, you can make an additional \$1,000/year contribution (\$4,850 for individuals or \$8,750 for families) The maximum includes any employer contribution.
- ▶ If you have questions about employer contributions, contact your human resources office or your agency benefits coordinator.
- ▶ Your full HSA contribution is not available upfront at the beginning of the year or after you enroll. Your pledged amount is taken out of each paycheck each pay period (if payroll deduction is offered by your employer). You may only spend the money that is available in your HSA at the time of service or care.

You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses. Once funds are in your HSA, it is easy to pay for your eligible expenses.

- ▶ Use the Optum Bank Card®, your account debit card. It's a convenient way to pay for eligible expenses. Expenses are paid automatically, as long as funds are available. If you have family coverage, additional debit cards may be ordered online or by phone.

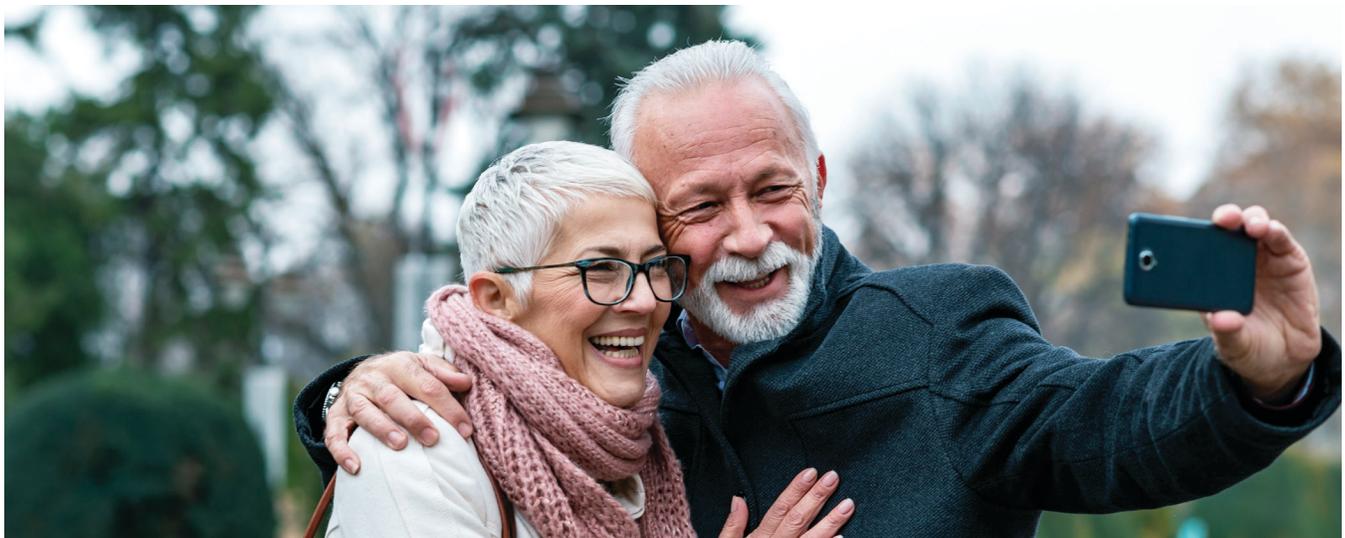
- ▶ Use Optum Bank's online feature to pay your provider directly from your account.
- ▶ Pay yourself back: Pay for eligible expenses with cash, check or your personal credit card. Then withdraw funds from your HSA to pay yourself back. You can even have your payment deposited directly into your linked checking or savings account.

Optum Bank Free Mobile App

- ▶ This app makes it easy for you to manage your account virtually 24/7. It's available for iPhone® and iPad® mobile digital devices, Android® and BlackBerry® smartphones. It will give you access to your online account to transfer funds, make payments or view a list of qualified medical expenses. It even lets you upload photos of your receipts for qualified expenses to keep for tax purposes.
- ▶ Both employee and employer contributions (if offered) are tax free. Withdrawals for qualified medical expenses are tax free. Interest accrued on your HSA balance is tax free.

Note: Payroll deductions are made before tax. Contributions made directly from employees' bank accounts need to be recorded as a tax deduction.

Go to www.tn.gov/partnersforhealth under Health Options and CDHP/HSA Insurance Options to learn more.



Benefit Grid – PPO Plans

TABLE 1 Member Costs: Services in this table **ARE NOT** subject to a deductible. The Limited is open to Local Education and Local Government members only.

PPO HEALTH CARE OPTION	PREMIER		STANDARD		LIMITED	
COVERED SERVICES	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹
PREVENTIVE CARE – office visits						
<ul style="list-style-type: none"> ▶ Well-baby, well-child visits as recommended ▶ Adult annual physical exam ▶ Annual well-woman exam ▶ Immunizations as recommended ▶ Annual hearing and non-refractive vision screening ▶ Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended 	No charge	\$45	No charge	\$50	No charge	\$50
OUTPATIENT SERVICES – services subject to a coinsurance may be extra						
Primary Care Office Visit	\$25	\$45	\$30	\$50	\$35	\$55
<ul style="list-style-type: none"> ▶ Family practice, general practice, internal medicine, OB/GYN and pediatrics ▶ Provider based telehealth ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider ▶ Inc surgery in office setting and initial maternity visit 						
Specialist Office Visit	\$45	\$70	\$50	\$75	\$55	\$80
<ul style="list-style-type: none"> ▶ Including surgery in office setting ▶ Provider based telehealth ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist 						
Behavioral Health and Substance Use Treatment² including virtual visits	\$25	\$45	\$30	\$50	\$35	\$55
Telehealth Carrier Program (MDLive)	\$15	N/A	\$15	N/A	\$15	N/A
Allergy Injection without an Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
<ul style="list-style-type: none"> ▶ Allergy Serum has additional member cost 						
Chiropractic and Acupuncture	Visits 1-20: \$25 Visits 21-50: \$45	Visits 1-20: \$45 Visits 21-50: \$70	Visits 1-20: \$30 Visits 21-50: \$50	Visits 1-20: \$50 Visits 21-50: \$75	Visits 1-20: \$35 Visits 21-50: \$55	Visits 1-20: \$55 Visits 21-50: \$80
<ul style="list-style-type: none"> ▶ Limit of 50 visits of each per year 						
Convenience Clinic	\$25	\$45	\$30	\$50	\$35	\$55
Urgent Care Facility	\$45	\$70	\$50	\$75	\$55	\$80
PHARMACY						
30-Day Supply generic preferred brand non-preferred	\$7 \$40 \$90	copay plus amount exceeding MAC	\$14 \$50 \$100	copay plus amount exceeding MAC	\$14 \$60 \$110	copay plus amount exceeding MAC
90-Day Supply generic preferred brand non-preferred (90-day network pharmacy or mail order)	\$14 \$80 \$180	N/A – no network	\$28 \$100 \$200	NA – no network	\$28 \$120 \$220	N/A – no network
Maintenance Medications generic preferred brand non-preferred (90-day supply of certain maintenance medications from 90-day network 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
Specialty Medication Tier 1 (generics; 30-day supply from a specialty network pharmacy)	In-Network for all plans = 20%; minimum \$100; maximum \$200 Out-of-Network for all plans = NA – no network					
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	In-Network for all plans = 30%; minimum \$200; maximum \$400 Out-of-Network = NA – no network					

TABLE 2 Member Costs: Services in this table **ARE** subject to a deductible unless noted with a [5]. The Limited is open to Local Education and Local Government members only.

PPO HEALTH CARE OPTION	PREMIER		STANDARD		LIMITED	
COVERED SERVICES	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹
PREVENTIVE CARE – outpatient facilities						
▶ Recommended screenings such as colonoscopy, mammogram, colorectal, and bone density scans	No charge ⁵	40%	No charge ⁵	40%	No charge ⁵	50%
OTHER SERVICES						
Hospital/Facility Services⁴	15%	40%	20%	40%	30%	50%
▶ Inpatient care ⁷ ; outpatient surgery ⁷						
▶ Inpatient behavioral health and substance use ^{2,6}						
▶ Emergency room services ⁷	15%		20%		30%	
Maternity Global billing for labor and delivery and routine services beyond initial office visit	15%	40%	20%	40%	30%	50%
Home Care⁴	15%	40%	20%	40%	30%	50%
▶ Home health; home infusion therapy						
Rehabilitation and Therapy Services	15%	40%	20%	40%	30%	50%
▶ Inpatient and skilled nursing facility; ⁴						
▶ Outpatient PT/ST/OT/ABA ⁵ ; Other therapy						
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) ⁵	15%		20%		30%	
Advanced X-Ray, Scans and Imaging	15%	40%	20%	40%	30%	50%
▶ Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ⁴						
Pathology and Radiology Reading, Interpretation and Results⁵	15%		20%		30%	
Ambulance (medically necessary air and ground)	15%		20%		30%	
Equipment and Supplies⁴	15%	40%	20%	40%	30%	50%
▶ Durable medical equipment and external prosthetics						
▶ Other supplies (i.e., ostomy, bandages, dressings)						
Allergy Serum	15%	40%	20%	40%	30%	50%
Also covered	Certain limited dental benefits, hospice care and out-of-country charges See separate sections in this handbook for details.					
DEDUCTIBLE – ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE						
Employee Only	\$750	\$1,500	\$1,300	\$2,600	\$1,800	\$3,600
Employee + Child(ren)	\$1,125	\$2,250	\$1,950	\$3,900	\$2,500	\$4,800
Employee + Spouse	\$1,500	\$3,000	\$2,600	\$5,200	\$2,800	\$5,500
Employee + Spouse + Child(ren)	\$1,875	\$3,750	\$3,250	\$6,500	\$3,600	\$7,200
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE COUNT						
Employee Only	\$3,600	\$7,200	\$4,400	\$8,800	\$6,800	\$13,600
Employee + Child(ren)	\$5,400	\$10,800	\$6,600	\$13,200	\$13,600	\$27,200
Employee + Spouse	\$7,200	\$14,400	\$8,800	\$17,600	\$13,600	\$27,200
Employee + Spouse + Child(ren)	\$9,000	\$18,000	\$11,000	\$22,000	\$13,600	\$27,200

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.

¹ Subject to maximum allowable charge (MAC). 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 (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor’s clinical staff.

³ List of eligible medication classes and a list of participating Retail-90 pharmacies can be found at <https://www.tn.gov/partnersforhealth/health-options/pharmacy.html>.

⁴ Prior authorization (PA) 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 Deductible DOES NOT apply.

⁶ Select Substance Use Treatment Facilities are preferred with an enhanced benefit – members won’t have to pay a deductible or coinsurance for facility-based substance use treatment; Copays 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.

Benefit Grid – CDHP Plans

TABLE 1 Member Costs: Services in this table **ARE** subject to a deductible with the exception of in-network preventive care and 90-day supply maintenance medications.

CDHP/HSA HEALTH CARE OPTION	CDHP/HSA State and Higher Education		LOCAL CDHP/HSA Local Education and Local Government	
	In-Network ¹	Out-of- Network ¹	In-Network ¹	Out-of- Network ¹
PREVENTIVE CARE OFFICE VISITS				
<ul style="list-style-type: none"> ▶ Well-baby, well-child visits as recommended ▶ Adult annual physical exam ▶ Annual well-woman exam ▶ Immunizations as recommended ▶ Annual hearing and non-refractive vision screening ▶ Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended 	No charge	40%	No charge	50%
OUTPATIENT SERVICES				
Primary Care Office Visit <ul style="list-style-type: none"> ▶ Family practice, general practice, internal medicine, OB/GYN and pediatrics ▶ Provider based telehealth ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider ▶ Inc surgery in office setting and initial maternity visit 	20%	40%	30%	50%
Specialist Office Visit <ul style="list-style-type: none"> ▶ Including surgery in office setting ▶ Provider based telehealth ▶ Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist 	20%	40%	30%	50%
Behavioral Health and Substance Use Treatment² including virtual visits	20%	40%	30%	50%
Telehealth Carrier Program (MDLive)	20%	40%	30%	50%
Allergy Injection without an Office Visit <ul style="list-style-type: none"> ▶ Allergy Serum has additional member cost 	20%	N/A	30%	N/A
Chiropractic and Acupuncture <ul style="list-style-type: none"> ▶ Limit of 50 visits of each per year 	20%	40%	30%	50%
Convenience Clinic	20%	40%	30%	50%
Urgent Care Facility	20%	40%	30%	50%
PHARMACY				
30-Day Supply generic preferred brand non-preferred	20%	40% plus amount exceeding MAC	30%	50% plus amount exceeding MAC
90-Day Supply generic preferred brand non-preferred (90-day network pharmacy or mail order)	20%	N/A – no network	30%	NA – no network
Maintenance Medications generic preferred brand non-preferred (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) ³	10% without first having to meet deductible	N/A – no network	20% without first having to meet deductible	N/A – no network
Specialty Medication Tier 1 (generics; 30-day supply from a specialty network pharmacy)	20%	N/A – no network	30%	N/A – no network
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	20%	N/A – no network	30%	N/A – no network

TABLE 2 Member Costs: Services in this table **ARE** subject to a deductible with the exception of in-network preventive care.

CDHP/HSA HEALTH CARE OPTION	CDHP/HSA State and Higher Education		LOCAL CDHP/HSA Local Education and Local Government	
	In-Network ¹	Out-of-Network ¹	In-Network ¹	Out-of-Network ¹
PREVENTIVE CARE – outpatient facilities				
▶ Recommended screenings such as colonoscopy, mammogram, colorectal, and bone density scans	No charge	40%	No charge	50%
OTHER SERVICES				
Hospital/Facility Services⁴	20%	40%	30%	50%
▶ Inpatient care ⁶ ; outpatient surgery ⁶				
▶ Inpatient behavioral health and substance use ^{2,5}				
▶ Emergency room services ⁶	20%		30%	
Maternity Global billing for labor and delivery and routine services beyond initial office visit	20%	40%	30%	50%
Home Care⁴	20%	40%	30%	50%
▶ Home health; home infusion therapy				
Rehabilitation and Therapy Services	20%	40%	30%	50%
▶ Inpatient and skilled nursing facility; ⁴ Outpatient PT/ST/OT/ABA; Other therapy				
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging)	20%	40%	30%	50%
Advanced X-Ray, Scans and Imaging	20%	40%	30%	50%
▶ Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies ⁴				
Pathology and Radiology Reading, Interpretation and Results⁵	20%		30%	
Ambulance (medically necessary air and ground)	20%		30%	
Equipment and Supplies⁴	20%	40%	30%	50%
▶ Durable medical equipment and external prosthetics				
▶ Other supplies (i.e., ostomy, bandages, dressings)				
Allergy Serum	20%	40%	30%	50%
Also covered	Certain limited dental benefits, hospice care and out-of-country charges See separate sections in this handbook for details.			
DEDUCTIBLE – ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE				
Employee Only	\$1,700	\$3,400	\$2,000	\$4,000
Employee + Child(ren)	\$3,400	\$6,800	\$4,000	\$8,000
Employee + Spouse	\$3,400	\$6,800	\$4,000	\$8,000
Employee + Spouse + Child(ren)	\$3,400	\$6,800	\$4,000	\$8,000
OUT-OF-POCKET MAXIMUM – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE COUNT				
Employee Only	\$2,800	\$5,600	\$5,000	\$10,000
Employee + Child(ren)	\$5,600	\$11,200	\$10,000	\$20,000
Employee + Spouse	\$5,600	\$11,200	\$10,000	\$20,000
Employee + Spouse + Child(ren)	\$5,600	\$11,200	\$10,000	\$20,000
CDHP HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION				
State contribution made to HSA for individuals enrolled in the CDHP/HSA - State and Higher Education only	\$500 for employee only \$1,000 for all other coverage levels		N/A	

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 for the family. No one family member may contribute more than \$8,700 to the in-network family out-of-pocket maximum total.

¹ Subject to maximum allowable charge (MAC). 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 (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

³ CDHP list of eligible medications and a list of participating Retail-90 pharmacies can be found at <https://www.tn.gov/partnersforhealth/health-options/pharmacy.html>.

⁴ Prior authorization (PA) 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 Select Substance Use Treatment Facilities are preferred with an enhanced benefit - members must meet their deductible first, then coinsurance is waived. Deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

⁶ In-network benefits apply to certain out-of-network professional services at certain in-network facilities.

Engaging in Your Health care

Choosing a new doctor is an important decision that can feel overwhelming. Quality varies so it is critical to do your homework and choose someone who will meet your needs and provide quality care. But how do you know which providers are of the highest quality or which have the best outcomes? Fortunately, Cigna offers provider designations to help you make an informed choice. Read on for some of the decision making tools available to you.

Cigna - Quality Ratings & Recognitions

The online directories on www.Cigna.com or www.myCigna.com include information about a physician's Quality Ratings & Recognitions, including Board Certification, compliance with Evidence-based Medicine criteria and National Committee for Quality Assurance credentialing.

Cigna Care Designation

The Cigna Care Designation is assigned to physicians that are ranked in the top 34% for both quality and cost efficiency results as compared to their physician peers in the market. Cigna Care Designated physicians are identified by the symbol  in the online directory at www.Cigna.com and on www.myCigna.com.

Cost-Efficiency Performance

Information regarding a physician's Cost-Efficiency Performance is displayed on www.myCigna.com. Cost efficiency measures the effectiveness of the doctor in treating the most common conditions within their specialty. Star ratings communicate cost-efficiency results when compared to other physicians of like specialty type within the geographic market.

- ★★★ Results in top 34% for cost-efficiency
- ★★ Results in middle 33% for cost-efficiency
- ★ Results in the bottom 33% for cost-efficiency

Quality and Safety in Health care

Think about the last time you purchased a car or a major appliance. Did you do your homework? Did you compare features, warranties, costs? Now think about the last time you or a family member went to the hospital or had a medical procedure or service. You probably didn't even know you might have a choice. And it's unlikely that you compared services or quality of your health care.

Quality and safety vary widely in health care. The resources below can help you and your family find the best place to receive high quality care and also offer suggestions about:

- › Questions to ask your doctor
- › How to talk with your doctor about choosing the health care you need, and
- › Which medical tests and treatments you may or may not need
- › **Know Your Health** - A campaign by ParTners for Health to educate members on how to engage in their health care and to empower you to become a smarter health care consumer. Includes resources to help you and your family talk with your doctors about choosing the health care you need, what you may not need and the best place to receive care. www.tn.gov/partnersforhealth/know-your-health
- › **Leapfrog Hospital Safety Grade** - A consumer-friendly letter grade rating of hospitals on their records of patient safety. www.hospitalafetygrade.org

Tennessee Hospital and Surgery Center Ratings and Safety Grades

- ▶ **Compare Hospitals** - Interactive tool that helps you choose the best hospital for you. www.leapfroggroup.org/compare-hospitals
- ▶ **www.hospitalsafetygrade.org**. Grades are updated twice annually, in the fall and spring.
- ▶ **Choosing Wisely** - Promoting conversations between patients and clinicians. An initiative of the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding unnecessary medical tests treatments and procedures. www.choosingwisely.org

www.hospitalsafetygrade.org



Covered Medical Expenses

The State, Local Education and Local Government Medical Plan Documents at www.tn.gov/partnersforhealth/publications/publications.html contain details about covered medical expenses. Services, treatments, and expenses will be considered covered expenses if:

- They are not listed in the Excluded Services and Procedures section of the Plan Documents; and
- They are consistent with plan policies and guidelines; and
- They are determined to be medically necessary and/or clinically necessary by the claims administrator, or
- Coverage is required by applicable state or federal law

Medical Benefit Reminders:

- **In-Network Preventive Care** – There is no charge to you but you will be responsible for your share of the cost if your provider bills for something other than preventive care.
- **Emergency Room Services** – Cost sharing for all plan members is deductible and coinsurance. There are no longer any copayments for these benefits. See benefit grids in this handbook for PPO and CDHP cost-sharing amounts.
- **Allergy Serum** – Cost sharing for all plan members is deductible and coinsurance. The benefit for injection of the serum depends on the plan option the member is enrolled in. See benefit grids in this handbook for PPO and CDHP cost-sharing amounts.
- **Physical, Occupational, Speech and ABA Therapies** – PPO members only pay coinsurance for in-network, outpatient physical, occupational, speech and ABA therapies; CDHP/HSA members pay deductible and coinsurance.
- **Cardiac Rehab** – PPO members pay no deductible or coinsurance for in-network, outpatient services; CDHP/HSA members pay deductible, but no coinsurance.
- **If you have scheduled a visit for a colonoscopy or a mammogram** – It is very important that you talk to your health care provider about the type of service you will have. There is no charge for in-network preventive services. However, you will be charged for services scheduled for diagnostic purposes or billed as anything other than preventive care.
- **Ask Early If You Don't Know** – If you are unsure about whether a procedure, type of facility, equipment or any other expense is covered, ask your physician to submit a pre-determination request form to Cigna describing the condition and planned treatment. Pre-determination requests may take up to three weeks to review.

Excluded Services and Procedures

The State, Local Education and Local Government Medical Plan Documents at www.tn.gov/partnersforhealth/publications/publications.html contain details about excluded expenses. Benefits required by applicable state or federal law, or regulations are not excluded. Services, treatments, and expenses will be considered excluded expenses if:

- They are not listed in the Covered Expenses section of the Plan Document; or
- They are inconsistent with plan policies and guidelines; or
- They are determined not to be medically necessary and/or clinically necessary by the claims administrator.

How the Plan Works

Choice of Doctors

Your plan doesn't make you choose a primary care physician or get a referral for specialist services. Your network is made up of physicians, hospitals and other health care providers who have contracted with Cigna to provide discounts for care. You will save money and get the most from your benefits if you use these in-network providers.

While you don't have to choose a primary care provider, you should get routine care from the same primary-type provider whenever possible.

A primary care provider can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician assistants and nurse midwives may also be considered primary-type providers when working under the supervision of a primary care provider.

You may sometimes need to see a specialist for a medical condition. Simply choose an in-network specialist and schedule an appointment. If an in-network specialist determines you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it's a good idea for you to contact Cigna to confirm your benefits for hospital admissions or other services that require prior authorization.

If you need help finding and scheduling an appointment with an in-network provider, who is accepting new patients or has reasonable availability (i.e., urgent visit in 24 hours, wellness visit in two months, routine medical visit in 14 days, specialist visit in 30 days or routine mental health visit in four days), you can call either Cigna or Optum.

Telehealth

MDLive telehealth services let you get care through phone or video. You can talk to a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents anywhere, anytime. Register for MDLive ahead of time so you can use telehealth services quickly when you need them. Call member services if you have any questions or need help signing up.

- › **For PPO plans**, you pay \$15 per telehealth visit.
- › **For CDHP/HSA plans**, you pay the negotiated rate until you reach your deductible, then your primary care office coinsurance applies. These costs don't apply to health services you get from a different program or provider.
- › Learn more and schedule your appointment today at cigna.com/MDLIVE, or call **888.726.3171**.

Yearly Benefits

The Plan Year begins on January 1 and ends on December 31. Benefits reset each year. This means if your doctor recommends you have a certain service every year, that service will be covered once, anytime within the plan year. Services must be considered medically necessary, and are subject to any plan limits.

Maternity Benefits

Coverage for maternity benefits involves an initial office visit cost to verify the pregnancy. Later visits for routine care are covered under what is called "global billing." These charges are included in the cost of labor and delivery. Should complications arise that require additional services of a specialist, additional charges will apply.

Hospice Benefits

Your plan covers approved hospice programs designed to provide terminally ill patients with more dignified, comfortable and less costly care during the six months before death. Prior authorization is required.

Plan	Coverage
Premier PPO	100% covered
Standard PPO	100% covered
Limited PPO	100% covered
CDHP/HSA	100% covered after deductible
Local CDHP/HSA	100% covered after deductible

Dental Treatment

Your medical plan covers certain limited benefits for dental treatment – orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function, extraction of impacted wisdom teeth, excision of solid-based oral tumors, eligible expenses for temporomandibular joint malfunction, and accidental injury or damage to sound natural teeth and/or jaw (other than by eating or chewing). Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person’s ability to masticate and maintain a healthy weight. Charges for the facility and related medical services are also covered when hospitalization for dental services is determined to be medically necessary by the claims administrator.

Member Costs by Plan:

All benefits are after plan deductible.

Plan	Oral Surgeons		Non-Contracted Providers (i.e., dentists, orthodontists)
	In-Network	Out-of-Network	
Premier PPO	15%	40%	15%
Standard PPO	20%	40%	20%
Limited PPO	30%	50%	30%
CDHP/HSA	20%	40%	20%
Local CDHP/HSA	30%	50%	30%

Cost Savings Programs

Transplants

Prior authorization is required for ALL transplants. Your plan provides extra cost savings if you have an approved transplant at:

- › a Cigna LifeSource facility; or
- › an in-network approved facility if there is no Cigna LifeSource facility for the type of transplant you need

Orthopedic Surgeries

Your plan provides extra cost savings if you have approved, medically necessary procedures with

providers and facilities in Cigna’s Bone and Joint Health Benefit Program.

- › Hip replacement
- › Knee replacement
- › Shoulder replacement
- › Hip arthroplasty
- › Knee arthroplasty
- › Laminectomy without fusion
- › Low back disk surgery
- › Lumbar spinal fusion

The program includes personalized member support to help you make health care decisions.

Travel benefits are also available – up to \$600 per procedure – if you must travel more than 60 miles for your surgery.

If you elect to have covered transplant or orthopedic services with other providers or facilities when there is a cost-savings option available, you will pay the usual member cost share. The chart below shows the difference between the cost-savings benefit and other in-network benefits. Call **855.678.0042** between the hours of 8:00 am–5:00pm ET, M–F or visit **Cigna.com/stateoftn** for more information, including help in locating a cost-savings program provider.

Plan	Cost Savings	Usual In-Network Member Share
Premier PPO	100% covered	Deductible plus 15% coinsurance
Standard PPO	100% covered	Deductible plus 20% coinsurance
Limited PPO	100% covered	Deductible plus 30% coinsurance
CDHP/HSA	100% covered after deductible	Deductible plus 20% coinsurance
Local CDHP/HSA	100% covered after deductible	Deductible plus 30% coinsurance

Benefits: In-Network or Out-of-Network

Check your insurance card to verify whether you have the **LocalPlus Network** or the **OAP Network**. In-network benefits apply when you receive care from doctors and hospitals participating in your plan’s network. Receiving in-network care allows the highest level of benefits.

You can receive care from providers who do not participate in the network, but in most cases, reduced out-of-network benefits will apply, and you will be required to pay the difference between the maximum allowable charge (MAC) and the actual charge.

Reminder: Your health care coverage does not allow payment if Cigna determines a service is not, or was not, medically necessary for your condition.

Maximum Allowable Charge Defined

The MAC is the maximum amount the plan will pay to a particular provider for a particular service. Providers who have contracted with Cigna to provide in-network services have agreed to accept that amount as payment in full. This means they write off the rest of the charge after any applicable cost is paid by the member. Out-of-network providers have not agreed to the contracted rate and may balance bill you for the amount above the MAC.

SEE ALSO: Sections on emergency care and out-of-network providers at certain in-network facilities.

Convenient Care and Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. Convenient Care and Urgent Care is care that is important, but does not result from a life-threatening condition. You can search for a provider online or refer to a provider directory to find in-network facilities.

Convenient care clinics can help with common conditions like burns and sprains, sinus infections, sore throats, skin rashes and upset stomachs. These types of clinics are often located in grocery or drug stores. Your cost for a convenient care clinic visit is the same as a primary care visit.

Urgent care centers treat more serious injuries or illnesses like urinary tract infections, broken bones or deep cuts that may require x-rays or more complicated lab tests. They are often near a hospital but can also be free standing. Your cost for an urgent care center visit is the same as a specialist visit.

Your Rights and Protections Against Surprise Medical Bills

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care, like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. For more information, see the important notice about surprise medical bills at https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/surprise_billing_model_notice.pdf.

Emergency Care

If you have a medical emergency, seek treatment at the nearest medical facility. Follow the instructions provided by the emergency room provider for any recommended follow up care. If you require assistance with follow up instructions call your doctor or Cigna member services.

The emergency room should be used only in the case of an emergency or for urgent care as directed by your doctor. The highest level of benefits is available for any emergency room visit that meets the definition of an emergency explained below. You will be responsible for those amounts if it is determined the situation was not an emergency or not medically necessary.

If you receive a bill for emergency services asking you to pay more than you expected to pay, call Cigna customer service. Be prepared to provide a copy of the bill you received, and ask for a review of your claim to see if insurance can pay anything more.

An “emergency” medical condition is an illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you don’t get medical attention right away. If you don’t get medical attention you could reasonably expect one of the following:

- ▶ Your health would be put in serious danger (or, with respect to pregnant women, the health of the woman or her unborn child)
- ▶ You would have serious problems with your bodily functions
- ▶ You would have serious damage to any part or organ of your body

For each covered emergency room visit, you will pay your portion of the emergency room cost. If you are admitted for more than 23 hours, the emergency room visit is considered part of your inpatient services. If the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room, the visit is included in your original emergency room costs. **If you also receive services such as an MRI or CT, you will be charged for those services in addition to your emergency room visit.** Should an out-of-network ER require you to pay in full, file the billing statement along with a claim form with Cigna, and you will be reimbursed subject to the terms and conditions of the plan.

Out-of-Network Providers at In-Network Facilities

Some providers are not employed by the hospital, ambulatory surgery center or other facility but may provide medical services and care for you. Sometimes these providers are out-of-network even at an in-network facility. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

You are eligible for in-network benefits for covered services received from these providers.

Claims for these types of services may not process to apply in-network benefits the first time. If you receive a bill from one of these out-of-network providers that you saw at an in-network facility, and you are asked to pay more than you expected to pay, call Cigna member services. Cigna will provide you with assistance to make sure you are not responsible for those amounts. You may be asked to provide a copy of the bill you received from the provider. Also, see the “Your Rights and Protections Against Surprise Medical Bills” section of this handbook.

Utilization Management

Utilization management programs review requirements and determine authorization for payment of benefits. Programs include:

- › Pre-admission certification
- › Post-certification of emergency admissions
- › Weekend admissions
- › Optional second surgical opinions

- › Certain outpatient procedures
- › Home health
- › Case management
- › Private duty nursing
- › Durable medical equipment
- › Provider Administered Specialty Pharmacy program

These programs are not meant to supersede the physician/patient relationship. The level and duration of medical care is always the patient’s decision in conjunction with their physician.

UM decisions are based only on medical appropriateness of care/service and coverage eligibility. The UM organization does not reward practitioners or other individuals for issuing denials of coverage or care.

Prior Authorization

Prior authorization is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with the medical needs of the member and with patterns of care in an established managed care environment for treatment of a particular illness, injury or medical condition.

PA is required for certain services including some of the more common specific services listed below. Other specific services are included in broader categories that appear on the list, like inpatient hospital services and same-day surgery procedures. You can find a full list of services that require PA under the preferred column by visiting <https://www.cigna.com/static/www-cigna-com/docs/individuals-families/master-precertification-list-for-providers.pdf>. See items marked with an X in the preferred column. Contact Cigna member services before receiving services if you have a question about benefits requiring prior authorization.

- › Inpatient hospital services
- › Skilled nursing facility stays
- › Home health care
- › Inpatient rehabilitation services
- › 23 hour or less observation room stays
- › Hospice
- › Inpatient cardiac rehabilitation
- › Home infusion therapy (certain drugs)
- › Private duty nursing

- › Advanced X-rays, scans and imaging
- › Durable medical equipment
- › Same-day surgery procedures, including procedures at an ambulatory surgical center (does not apply to screening colonoscopy)
- › Chemotherapy and radiation therapy
- › Non-emergent ambulance transport (air and ground)
- › External Prosthetic Appliances

All providers for the above services should request these authorizations prior to delivering services.

If a network provider fails to obtain required authorization, no benefits will be paid, and both the plan and the covered person shall be held harmless.

Out-of-network providers are not contracted. If you receive medically necessary care from an out-of-network provider, you are responsible for verifying with Cigna that prior authorization has been requested and approved before receiving care.

When PA is required but not obtained, benefits for medically necessary services received out-of-network will be reduced by half, subject to the maximum allowable charge.

PA is not required for maternity admissions or emergency care.

Cigna does not manage PA for pharmacy benefits or behavioral health and substance use treatment. Contact information for those programs is provided under the “Important Contact Information” section of this handbook.

Hospitalization

If you need to be hospitalized, your doctor should make the necessary arrangements at an in-network facility. Be sure to ask if the facility is in-network or call us to confirm. Your doctor should also coordinate your care and prior authorization with Cigna. If you are admitted to a hospital (in-network or out-of-network) without prior authorization, your benefits will be greatly reduced.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should follow the discharge instructions for follow up care. If you require assistance with obtaining recommended follow up care, contact your doctor or Cigna member services.

Advanced Radiological Imaging

PA is required for certain non-routine diagnostic services and the setting for such services. Cigna will coordinate review for medical appropriateness and necessity before the services are performed. Services subject to such review include Magnetic Resonance Imaging, Magnetic Resonance Angiography, Magnetic Resonance Spectroscopy, Computerized Tomography, Computerized Tomography Angiography, Positron Emission Tomography scans and nuclear cardiac imaging studies.

Durable Medical Equipment

The plan covers certain durable medical equipment determined to be medically necessary on the basis of an individual’s medical and physical condition.

Some equipment requires prior authorization (PA). Generally, PA only applies to items with high risk and high utilization. Providers should request PA, if needed, before providing equipment to you. You can also contact Cigna to see if the equipment you need requires PA and if any necessary PA has been approved.

Depending on the type of equipment needed, DME may be furnished on a rental basis or purchased. Types of equipment include blood glucose monitors and breathing equipment such as oxygen tanks, tents, regulators and flow meters. DME is not for comfort or convenience. Items are typically prescribed by a physician when recognized as therapeutic for a patient’s diagnosis.

EviCore and Accredo are the in-network providers for Home Health (HH)/Durable Medical Equipment (DME)/Home Infusion (HIT) services and Sleep Programs.

Your provider will work with Cigna to coordinate care for the following services:

- › Durable medical equipment (e.g., beds, wheelchairs, walkers)
- › Respiratory equipment (e.g., oxygen, CPAP, ventilators)
- › Enteral nutrition (e.g., pumps and nutritional support)
- › Home health care (e.g., nursing, therapies, social work and home health aides)
- › Home infusion products

- › Other specialty services (e.g., insulin pumps and supplies, CPM machines and supplies, wound vacuums and supplies)
- › Through its network of credentialed providers, Cigna will now coordinate and manage the full range of home health, infusion and respiratory services. The benefit to you is access to one-stop service which includes:
 - A single call coordinating care for complete home health care, infusion and DME services
 - 24/7 availability of service

If you have questions about DME, you can call Cigna at 800-997-1617.

Hearing Aids (for children under 18)

Hearing aids for children under the age of 18 are covered at one per ear, every three years, at the applicable deductible and coinsurance level. Amplifon Hearing Health Care, one of the largest distributors of hearing aids and services in the world, is Cigna's exclusive in-network national supplier of digital and digitally programmable analog hearing aids and supplies.

Customers can choose the participating health care professional most convenient for them, including ENTs, Audiologists and free standing hearing centers that are directly-contracted (in-network) with Cigna, as well as Amplifon subcontracted health care professionals. If a customer chooses an out-of-network health care professional, or obtains a hearing aid from a supplier other than Amplifon, claims will be paid according to the plan's coverage for out-of-network services. The cost to customers could be substantial.

Using Amplifon to provide hearing aids to our customers ensures they receive quality devices at a more consistent and cost-effective expense. By using Amplifon customers will have:

- › A single source for ordering hearing aids from multiple manufacturers at discounted prices;
- › Increased benefit transparency;
- › More accurate claims processing; and
- › Quick delivery

How getting hearing aids and supplies from Amplifon works

- › Health care professionals will verify patient benefit and eligibility information and order hearing aids and supplies directly from Amplifon.
- › After verifying patient benefit and eligibility information, the health care professional will provide the customer with a completed disclosure form showing the patient's benefit level and cost share, if any.
- › The health care professional will order devices directly from Amplifon.
- › Health care professionals will submit claims to Cigna for processing and claims will be paid according to benefit coverage.

Coordination of Benefits with Other Insurance Plans

Once a year you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments. The completed form letter must be received before any further claims processing can take place. You may also update this information on-line using the personalized and secure member website **myCigna.com**. A response is necessary even if there is no other coverage or there have been no changes in coverage.

If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100% of allowable charges. At no time should reimbursement be more than 100% of actual expenses.

COB will be applied to your claims so that:

- › If you have other primary medical coverage, and secondary medical coverage with this plan, you will pay any cost share required by this plan.
- › If you have primary and secondary coverage with this plan, you will pay the cost share required by this plan's secondary coverage.

If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document.

Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g. active, retired, COBRA).

If your spouse has coverage through their employer and has you covered, that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits.

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. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to Cigna.

If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time. For example, if a married dependent child under the age of 26 is covered by a parent under this plan and also has coverage under their spouse's plan, the primary plan will be the plan which has covered the dependent child for the longer period of time.

Claims Subrogation

The medical plan has the right to subrogate claims. This means the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third party or insurer of a third-party. This would include automobile or homeowners insurance, whether yours or another's.

You are required to assist in this process and should not settle any claim without written consent from Cigna's subrogation department. Failure to respond to the plan's requests for information, and to reimburse the plan for any money received for medical expenses, may result in the covered person's disenrollment from the plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person.

Benefit Level Exceptions

Three types of exceptions — Unique Care, Transition of Care and Continuity of Care — may be granted. These exceptions allow benefits to be paid at the in-network level to an out-of-network provider or facility. **Any charges above the maximum allowable charge are the patient's responsibility.** All requests for exceptions are reviewed by Cigna. Exceptions will be granted only for medical necessity, not for convenience.

Unique Care/Network Adequacy

An exception can be granted for treatment not routinely available from an in-network provider in a member's geographic area. This exception is based on the patient's condition or need for a particular physician and must be requested before receiving care. Cigna will determine whether an in-network provider is available to provide treatment for the illness or injury.

If an exception is granted, benefits are paid at the in-network level. If out-of-state travel is required, reimbursement will be at 80% of commercial coach airfare or ground travel at the state approved mileage rate or for actual fuel.

When exceptions are granted, a time frame for this approval is given. If more time for an exception is needed beyond the stated time frame, then another request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required. The review of this unique care approval extension request will include a review of the available network to determine if the required care can now be accessed within the network.

To apply you should call Customer Service. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all information can be gathered.

- ▶ Patient name and ID number
- ▶ Name and type of provider you are requesting
- ▶ Diagnosis and treatment plan, date(s) of service
- ▶ A statement explaining why this treatment cannot be received at an in-network facility or provided by an in-network physician

Transition of Care

With Transition of Care, you may be able to continue to receive services for specified medical conditions with health care providers who are not in the Cigna network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 30 days after the effective date of your coverage. To apply, complete the **Medical Transition of Care request form** found on the Cigna member web page, or call Cigna for assistance.

Continuity of Care

With Continuity of Care, you can receive services at in-network coverage levels for specified medical conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe. This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care provider's termination date. This is the date that they are leaving your plan's network. To apply, complete the **Medical Transition of Care request form** found on the Cigna member web page, or call Cigna for assistance.

Coverage for Second Surgical Opinion Charges

In some instances, you have the option to receive a second surgical opinion. Second surgical opinions are not required. The second surgical opinion must be obtained from a surgeon qualified to perform the surgical procedure, but who is not in the same medical group as the physician who originally recommended surgery.

For PPO plan members, charges for the second surgical opinion and any tests performed in obtaining the second surgical opinion will be paid at 100% of the maximum allowable charge if an in-network provider is used. **CDHP plan members** must first meet the annual deductible requirement.

If you wish to obtain a second surgical opinion about a procedure not included on the list below, normal plan benefits and rules apply. Any surgeries

(including those listed) must be medically necessary to be approved.

- › Bone and joint surgery of the foot
- › Cataract extraction with and without implant
- › Cholecystectomy
- › Elective C-section
- › Hysterectomy
- › Knee surgery
- › Mastectomy
- › Prostatectomy
- › Septoplasty/sub-mucous resection
- › Spinal and disc surgery
- › Tonsillectomy and adenoidectomy



Virtual expert medical second opinion services are available for all plan members at no cost to you through ConsumerMedical.

- › **Connect with ConsumerMedical:**
1-888-361-3944
Monday–Friday, 8:30 a.m.–11 p.m. EST
myconsumermedical.com

To register, enter company code **Cigna State of TN**

Case Management

Case management is a program that promotes quality and cost-effective coordination of care for members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing regarding alternative treatment plans. Members or providers may also contact member services if they believe they would benefit from case management.

Filing Claims

Cigna is responsible for all medical plan claims processing. When you visit an in-network doctor or facility, be sure to show your identification card. The provider will file your claim directly. These in-network providers must file your claim within six months of the date of service. All questions regarding claims, including requests for claim forms, should be addressed to member services.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims yourself. Out-of-network providers may also require

payment in full at the time of service. The correct form must be used and a separate claim form must be completed for each individual who received services. The medical claim form can be found at <https://stateoftn.cigna.com/> within the footer under “Find a Form.” More than one bill can be submitted on a claim form. For out-of-network providers, you have 13 months from the date of service to file claims and be eligible for reimbursement.

Cigna is not responsible for processing claims for pharmacy or behavioral health and substance use treatment. Contact information for those programs is provided under the “Important Contact Information” section of this handbook.

Out-of-State Providers

Members who live outside of Tennessee still have access to in-network providers through our national network.

You can locate providers anywhere in the nation using the general Cigna website at [Cigna.com](https://www.cigna.com). You will then select **Find a Doctor** and indicate what type of provider you are looking for. Your network name is either LocalPlus or Open Access Plus. See your ID card to determine the network you selected.

You can also contact Cigna at the toll-free member service number on your ID card. We will be happy to assist you with locating a network provider in your area.

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses for medically necessary emergency and urgent care services are covered at the in-network level. Other medically necessary care will be covered at the out-of-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Claims from a non-English speaking country should be translated to standard English at the covered person’s expense. Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

Out-of-Country Benefits – non-emergency and non-urgent care Out-of-Network benefits only; Out-of-Network deductible applies

Plan	Coinsurance
Premier PPO	40%
Standard PPO	40%
Limited PPO	50%
CDHP/HSA	40%
Local CDHP/HSA	50%

Healthy Rewards Program^{®*}

Cigna Healthy Rewards provides access to a range of health and wellness programs and services not covered by many traditional plans including, but not limited to, Weight Watchers[®], Jenny Craig, tobacco cessation programs, fitness club memberships, laser vision care, massage therapy, health & wellness products and discounts on popular magazines. This program can save you money by providing discounts on these services when you use Healthy Rewards participating providers. There are no referrals, no claim forms, and no catch! To locate participating providers, call 800.870.3470 or visit [myCigna.com](https://www.myCigna.com).

*Some Healthy Rewards programs are not available in all states. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of, your plan coverage. A discount program is NOT insurance, and you must pay the entire discounted charge.

Cigna Healthy Babies[®]

The Cigna Healthy Babies program gives mothers-to-be the information and support they need to make the best choices for mom and baby.

When you enroll in Healthy Babies you’ll get valuable educational materials, including:

- ▶ Guidelines for a healthy pregnancy and baby.
- ▶ Information on health issues that can impact pregnant women and their babies, including stress, depression and gum disease.
- ▶ A guide to pregnancy-related topics available through the Cigna 24-Hour Health Information Line.
- ▶ A list of informative online and telephone resources.
- ▶ Information on prenatal care from the March of Dimes[®] – a recognized source of information on pregnancy and babies.

You may also be eligible for support from a registered nurse case manager if you or your baby has special health care needs.

To enroll, just call the toll-free number on your Cigna ID card, any time during your pregnancy.

Please note: The Healthy Babies program is offered in addition to the services covered as part of a Cigna medical benefit plan. Covered services depend on the Cigna plan offered by your employer.

Pharmacy Benefits

Pharmacy benefits are administered by CVS Caremark and not Cigna. Please call 877.522.8679 for further information or visit info.caremark.com/stateoftn. Once there, you can view the State of Tennessee Group Insurance Program Prescription Drug List, Specialty Drug List, Vaccine Network Pharmacy List, Medications Requiring Prior Authorization for Medical Necessity, and the Retail-90 Network Pharmacy List. Any medication classified as a specialty medication can only be filled for a 30-day supply and must be filled through a pharmacy in the CVS Caremark Specialty Network. Three levels of benefits are available for prescription drugs, and your choice determines the amount you pay each time you have your drugs dispensed by a pharmacy.

- › **Generic drugs** are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand name drugs, and are available in many instances.
- › **Preferred brands** are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list. This list includes many popular brand-name drugs.
- › **Non-preferred brands** are in the third tier and will cost you more.

When a generic is available and the member's physician has indicated "may substitute" but the pharmacy dispenses the brand name **based on the member's request**, the member will pay the difference between the brand name drug and the generic drug plus the brand copay or coinsurance.

Specialty Drugs

Certain chronic or genetic conditions require specialty pharmacy products, typically in the form

of injected or infused medications. Specialty drugs are limited to a 30-day supply and must be filled through a pharmacy in the CVS Caremark Specialty Network. A specialty pharmacy drug list is available at info.caremark.com/stateoftn > Drug Lists > Specialty Drug List. **PPO plan members** will pay a different coinsurance percentage for specialty drugs, depending on whether the drug is Tier 1 (generics) or Tier 2 (all brands). **CDHP plan members** must first pay their deductible and then coinsurance for specialty drugs (regardless of whether generic or brand). See the Benefit Grids in this handbook for member cost.

Medication Assisted Treatment

Medication assisted treatment combines behavioral therapy and medications to treat substance use disorders. Members do not have to pay for specific medications used to treat opioid dependency.

Maintenance Medications

When you fill a prescription for certain chronic maintenance medications, you can save money by paying a lower copay or coinsurance when you have your doctor write a prescription for a 90-day supply and you fill it through mail order or from a participating Retail-90 pharmacy. A CDHP list of eligible medications, a PPO list of eligible medication classes and a list of participating Retail-90 pharmacies can be found at <https://www.tn.gov/partnersforhealth/health-options/pharmacy.html>.

Med Sync for Maintenance Medications

You can request that refills of your maintenance medications be synchronized so that you can have them all filled on the same day. If you're enrolled in a PPO, you will pay pro-rated copays for any maintenance drugs being synchronized. Persons enrolled in a CDHP will pay the plan discounted drug cost. If you want to sync your maintenance drugs, you will need to work with your retail pharmacy or mail order pharmacy to coordinate synchronization of your refills.

Compound Drugs

Any and all compound drugs (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound drugs require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Statin Drugs

Eligible members may receive certain low-dose statins in-network at zero cost share. These drugs are primarily used to treat high cholesterol. No high dose or brand statins are included.

Weight Management

Some obesity medications are available for members who meet certain requirements. This gives members a less costly, non-surgical option for losing weight. Go to the caremark website at info.caremark.com/stateoftn to look for covered medications. They are found under “Antiobesity” on the State of Tennessee Preferred Drug List with Advanced Control Specialty Formulary.

Tobacco Cessation Products

Members who want to stop using tobacco products can get free tobacco quit aids. Varenicline (generic Chantix), Bupropion (Generic Zyban), over-the-counter generic nicotine replacement products (including gum, patches and lozenges), and Nicotrol oral and nasal inhalers are FREE under the pharmacy benefit. Members may receive up to two, 12-week courses of treatment per calendar year (up to 168 days of treatment) with no lifetime maximum. A licensed clinician is required to write a prescription to get any tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your CVS Caremark card at the pharmacy counter (not at the check-out registers) to fill at \$0 copay. The plan only covers generic over-the-counter tobacco cessation products, not brand names.

Copay Installment Program

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

Flu and Pneumonia Vaccines

Each year, members can get free flu and pneumonia vaccines (if eligible) through certain pharmacies or at a participating doctor’s office. Contact CVS Caremark (pharmacy benefits) or Cigna (medical benefits) for more information, or go to tn.gov/partnersforhealth and click on Health Options/Pharmacy.

Behavioral Health, Substance Use and Employee Assistance Program – “Here4TN”**RESOURCES:**

- › **Sanvello**, an on-demand mobile app to help with stress, anxiety and depression
- › **Talkspace**, online therapy including text, audio, and video within a secure app. Learn more at Here4TN.com

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Behavioral Health. Optum can be reached toll-free at 855-Here4TN (855.437.3486) any time, day or night, to speak confidentially with a trained professional for a referral. Services generally include the following:

- › Outpatient assessment and treatment
- › Virtual visits – visits with a provider through private, secure video conferencing
- › Inpatient assessment and treatment
- › Enhanced benefit for facility-based substance use treatment at select facilities – call 855-Here4TN for assistance
- › Partial hospitalization
- › Residential treatment
- › Intensive outpatient treatment
- › Treatment follow-up and aftercare

Certain services are specifically excluded under the terms and conditions of the State Group Insurance Program. For more information, contact Optum.

To receive maximum benefit coverage, participants must use an in-network provider and obtain prior authorization for inpatient services as well as some outpatient services including psychological testing, electro-convulsive treatment, applied behavior analysis, and transcranial magnetic stimulation. Out-of-network behavioral health benefits are available; however, your cost will be higher. You are also subject to balance billing by the out-of-network provider, meaning you will pay the difference between the maximum allowable charge and the actual charge. You are also at risk of having inpatient benefits denied.

You also have access to an Employee Assistance Program, or EAP. EAP counseling sessions are issued and authorized on a per-problem-per-year-per-person basis. For example, the member receives five counseling sessions for each problem. Should a different unrelated problem arise within the same plan year, the member would receive an additional five sessions to address the new problem. A different problem is either: 1) a new issue for which the member has received no previous counseling, or 2) an existing issue that has not been treated in that plan year. Examples of different problems (not an exhaustive list): relationship issues, job stress, parenting issues, caregiving of a loved one and death of a loved one.

EAP counseling is now available through virtual visits as well. Go to www.Here4TN.com for more information.

In addition to counseling support, your EAP provides a variety of consulting services including financial, legal, childcare and eldercare.

Prior authorization is required to see an EAP provider and can be obtained by either logging on to www.Here4TN.com or calling 855-Here4TN (855.437.3486). The website provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, online trainings, search for providers, access a map of your provider's location and get driving directions. You may set up your own unique account number and password for confidential and anonymous access to a wide variety of information and resources. This includes viewing claims information online.

Optum also has its own policies and procedures to protect your privacy. These policies guide Optum staff, providers and visitors on how to keep information private. By signing Optum's Authorization to Use or Disclose Protected Health Information Form, you permit Optum to disclose your personal information. If you have a guardian or someone selected by the court, they can sign the form for you. Optum can only give your information to you or the designated person. To get the form, please call 855.437.3486.

ParTNers for Health Wellness Program

The ParTNers for Health Wellness Program is voluntary and members are not required to complete any wellness program activities. ActiveHealth Management, the wellness vendor, will send more information directly to members about the programs, tools and resources that are available in 2023. Go to <http://go.activehealth.com/wellnesstn> for updates.

- ▶ State and higher education members and enrolled spouses can earn money by completing certain wellness activities. The money will be deposited into the head of contract's paycheck. Members choose activities from an approved list. Each activity will have a dollar value, and you can earn up to \$250 each. That is \$500 for the employee and spouse.
- ▶ Local education and local government employees, retirees, COBRA participants and enrolled spouses will have access to a health assessment and coaching support (online personal or group coaching, or by phone) for disease management programs such as asthma, diabetes, congestive heart failure, coronary artery disease and chronic obstructive pulmonary disease. You will get emails about coaching support that's available to you. It is completely voluntary and won't cost you anything. In addition you will have access to the web portal and mobile app where you can get access to your coaches, the health assessment and tips and trackers.
- ▶ There is also a Diabetes Prevention Program (DPP) for those with prediabetes who qualify for the program. Cigna is partnering with Omada to offer an online DPP that can help members lose weight, feel good and develop long term health habits. The program is free to eligible plan members and their dependents. To see if you are eligible go to omadahealth.com/partnersforhealth or call 888.409.8687.

Member Rights and Responsibilities

Member Rights

You have the right to:

- › Be treated with respect and dignity.
- › Expect that any information you give will be treated in a confidential manner.
- › Information about policies and services of the plan.
- › Information regarding in-network providers.
- › Medically necessary and appropriate medical care.
- › Information about your health.
- › Make decisions about your health care with practitioners.
- › Voice complaints about your health care providers, the care given to you, or the plan. You can expect an answer within a reasonable time. You also have the right to formally appeal answers if you do not agree.
- › A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage.

Confidentiality and Privacy

Your health is your own private business. Be assured that we will treat your medical records and claims payment history in a confidential manner. When you enroll in the plan, you give routine consent for certain matters. That allows the company to release information without your prior written consent for these purposes:

- › Claim processing.
- › Performing peer review, utilization review, and medical audits.
- › Administration of programs established by us for quality health care and control of health care costs.
- › Medical research and education.

Important steps are taken to protect your privacy.

- › Employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out the established policies.
- › Contracted practitioners and providers follow confidentiality guidelines set forth by the state in which they practice.

- › Vendors must sign confidentiality agreements if they receive personal health information for purposes of plan administration such as measurement of data to improve quality.
- › It is the policy not to release member-specific health information to employers unless allowed by law.
- › Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

Members can take comfort in knowing that confidentiality is important. You are encouraged to call Cigna if you have questions about privacy policies and practices.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses and physical complications during any stage of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same cost sharing as other services.

Member Responsibilities

Members are responsible for:

- › Reading the member materials in their entirety and complying with the rules and limitations as stated.
- › Contacting providers to arrange for medical appointments as necessary.
- › Notifying providers in a timely manner of any cancellations of appointments.
- › Paying the cost sharing as stated in the benefit plan documents at the time service is provided.
- › Receiving prior authorization for services when required, and complying with the limits of the prior authorization.
- › Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.

- › Using in-network providers consistent with the applicable benefit plan.
- › Providing, to the extent possible, information needed by professional staff in order to care for the member.
- › Following instructions and guidelines given by those providing health care services.

APPEALS

Information in this section does not apply to any complaint alleging possible professional liability, commonly known as malpractice, or for any complaint concerning benefits provided by any other plan. In the event of a conflict between information in this handbook and applicable state or federal law, the applicable law shall control.

The appeals process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations. **For more information** see the State, Local Education or Local Government Plan Documents at www.tn.gov/partnersforhealth. Look under the Publications tab and Medical Plan Documents.

You may submit any appeals described in the sections that follow with or without the help of an authorized person or personal representative.

The plan does not provide an appeal process for providers, does not review disputes under a provider contract with a claims administrator and does not permit covered persons to assign appeal rights to a provider. A provider may help you prepare an appeal but shall not become a party to the appeal. Providers may appeal to claims administrators on their own behalf if permitted by an agreement between the provider and the claims administrator or state or federal law. Such appeals are outside of appeal or administrative remedies provided under this plan.

Call First

You can call with or without help from an authorized person or personal representative. A telephone call does not constitute an appeal, but a call should be made as soon as possible upon learning of any enrollment or premium issue or denial of payment or medical services. **Call as soon as possible for faster resolution and to avoid missing deadlines.**

Enrollment or Premium Issues – call Benefits Administration at 1-800-253-9981 or visit <https://tn.gov/partnersforhealth>.

Medical Services or Payment Issues – call the telephone number listed on your insurance card. The separate phone numbers for behavioral health and substance use, pharmacy and medical can also be found at the front of this handbook under **“Important Contact Information” on page 1.**

Deadline to File Appeals

If an issue is not resolved and you want to start an appeal, **you have 180 calendar days** after you receive notice of an adverse determination.

Enrollment and Premium Appeals

Contact Benefits Administration at Benefits.Administration@tn.gov, or write to:

**State of Tennessee,
Department of Finance and Administration,
Benefits Administration**
312 Rosa L. Parks Avenue, Suite 1900
William R. Snodgrass Tennessee Tower
Nashville, TN 37243-1102

- › Enrollment and premium appeals are submitted to and decided by the Benefits Administration Review Team
- › No external administrative appeal is provided
- › An enrollment appeal cannot be utilized to make mid-year benefit election changes not otherwise permitted by the plan
- › A retroactive termination of enrollment that meets the definition of “rescission” under 45 CFR147.128 is appealable and shall be resolved in accordance with federal law

Behavioral Health and Substance Use Appeals

Contact Optum at 855.437.3486 for EAP, behavioral health and substance use appeals or write to:

Optum Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 855-312-1470

Pharmacy Appeals

Contact CVS Caremark at 877.522.8679 for pharmacy appeals or write to:

CVS Caremark

Appeals Department MC109

P.O. Box 52084

Phoenix, AZ 85072-2084

Please include your name and member ID number, doctor's name and telephone number, name of medication, information relevant to your appeal.

Medical Service Appeals

If you disagree with a coverage decision or the way a claim has been paid or processed, you should **first call Cigna member service at 800.997.1617 to discuss the issue.**

First Internal Appeal – If the issue cannot be resolved through member service, you may file an appeal/member grievance. **You will have 180 days to start an internal appeal with Cigna following notice of an adverse determination.** The appeals/grievance form can be found on the Cigna Member Resources Page under forms at **Cigna.com/sites/stateoftn**. Once a determination is made, you will be notified in writing and advised of any further appeal options and timeframes for filing additional appeals. All requests must be filed within the specified timeframes.

Second Internal Appeal – In addition to the initial internal appeal, you may initiate a second internal appeal within 180 calendar days from receipt of an adverse determination of the initial appeal.

External Review – When an appeal decision made by Cigna is unfavorable and the appeal qualifies for external review, Cigna will advise you of the right to initiate an external appeal. External appeals are considered by an Independent Review Organization. If you choose to pursue an external appeal, you must submit a request within four months of the notice of the appeal decision you receive from Cigna.

Expedited Reconsideration – If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., emergency or life-threatening procedures), then you may request an expedited reconsideration. If your treating provider fails to request the reconsideration and decides not to provide urgently needed services, then you may request the expedited reconsideration. If Cigna agrees it is appropriate to conduct an expedited reconsideration, they will inform you of their decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

Please Note: The expedited reconsideration process only applies in situations where a benefit determination or a prior authorization denial has been made prior to services being received.

Notification of decisions will be made within the following time frames and all decision notices shall advise of any further appeal options:

- ▶ No later than 72 hours after receipt of the appeal for urgently needed services
- ▶ 30 days for denials of non-urgent care not yet received
- ▶ 60 days for denials of services already received

Q&A

Q. Is my child who is attending college out of state covered at the in-network level?

A. Yes, Cigna offers a broad national network of providers. You can locate a network provider in your child's specific area by visiting **Cigna.com** and selecting Find a Doctor or contacting the toll-free member services number. We will be happy to assist you with locating a network provider in the area.

Q. Other than the benefit level, are there other differences if I use out-of-network providers?

A. Out-of-network providers can bill you for any difference between actual charges and the maximum "allowable charge" plus any services deemed not medically necessary or not authorized. When you use an out-of-network provider, the charges for which you are responsible may be substantial.

Q. Do I have a choice of hospitals?

A. We have contracted with certain hospitals to provide in-network care to you. If specialty care is not available at the contracted in-network hospital(s), arrangements will be made with the appropriate out-of-network hospital. A unique care exception benefits request is required and may be approved but is not guaranteed.

Q. I received a bill from an out-of-network provider that I wasn't expecting. What can I do?

A. Call Cigna. We will review your claim and explanation of benefits with you to determine and explain your cost share. You may be asked to provide a copy of the bill from the provider. In some cases you may not be responsible for expenses which exceed the maximum allowable charge. See page 18 for more information on emergency care and page 19 for more information on out-of-network providers at in-network facilities.

Q. What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?

A. A provider appeals process is available for this situation.

Q. What if I must reach my physician after regular office hours or my doctor is out of the office?

A. Doctors "cover" for each other on a rotating schedule. This means you may not always be able to talk with your doctor. Most physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk with a representative from the answering service. The on-call nurse or doctor will be able to help you. They may ask for some identifying information and will need a general description of your urgent medical need.

Another option is telehealth, which allows you to receive care through virtual visits. You can contact a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents for anywhere, at any time. **For PPO plans**, The cost is only \$15 per telehealth visit. **For CDHP plans**, you pay the negotiated rate until you reach your deductible, then the primary care office visit coinsurance applies.

Pre-registration is very important so you can access telehealth services when you need them.

Call member services if you have any questions or need assistance with the registration process.

Q. How do I receive services covered by the Barry Brady Act?

A. If you are a firefighter who qualifies for additional health screenings under the Barry Brady Act and your related claims process with unexpected member cost share, call Cigna customer service and request a reconsideration of your claims.

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).





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Insurance Company
PO Box 182223
Chattanooga, TN 37422



State of Tennessee
Group Insurance Program



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