2026 ANNUAL ENROLLMENT FREQUENTLY ASKED QUESTIONS FOR 2027 BENEFITS

PARTNERS FOR HEALTH

What is Annual Enrollment?

Annual Enrollment is the time each fall when you can choose and/or change your benefit selections for the following calendar year.

What can I do during Annual Enrollment?

During Annual Enrollment, subject to eligibility, you can:

- Choose your health insurance option
- Choose or change your health insurance carrier and network
- Enroll in or cancel health insurance for yourself or your eligible dependents
- Enroll in, cancel or transfer between dental options (if offered by your agency)
- Enroll in, cancel or transfer between vision options (if offered by your agency)
- Enroll in or cancel voluntary accidental death and dismemberment coverage (state and higher education only)
- Apply for, cancel, increase or decrease voluntary term life coverage amounts (state and higher education only)
- Enroll in short-term disability insurance. State and higher education employees are automatically enrolled in long-term disability insurance
- Enroll in flexible benefits (State and higher education employees only)

When is Annual Enrollment for 2027 benefits?

Oct. 1-Oct. 16, 2026, for state and higher education employees

Oct. 1-Oct. 30, 2026, for local education and local government employees and all retirees

Do I have to make changes during Annual Enrollment?

No. If you don't want to change your benefits, you don't have to do anything during Annual Enrollment for most benefits. If you're enrolled now and don't make changes, you'll be enrolled in the same plan options that you're enrolled in now, and you'll pay 2027 employee premium amounts.

There is **one exception for state and higher education employees**. Flexible spending accounts require you to enroll each year, so you must act if you wish to participate.

Partners for Health recommends you review your benefits during Annual Enrollment each year, even if you don't think you want to make changes.

What are the health plan options for 2027?

- Premier Preferred Provider Organization
- Standard PPO
- Consumer-driven health plan with a health savings account, state and higher education only
- Limited PPO, local education and local government only
- Copay PPO, new plan for local education and local government only
- Local CDHP/HSA, local education and local government only

How do I enroll for 2027 benefits during Annual Enrollment?

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

Higher education employees may be able to access Edison through their employer's human resources system.

When do the benefits I choose during Annual Enrollment begin?

The benefits you choose during 2026 Annual Enrollment begin on Jan. 1, 2027, and remain through Dec. 31, 2027.

If I change my mind, can I change my benefits later?

Once Annual Enrollment has ended, active employees and eligible retirees have one opportunity to revise their elections if they submit their requests to Benefits Administration no later than 4:30 p.m. CT on Dec. 1 of the current plan year.

You may also be able to change your benefits after the annual enrollment period has closed if you experience a qualifying event, such as getting married or having a baby.

Where can I find the Annual Enrollment guide and other materials?

Annual Enrollment guides are available on the Partners for Health website under Enrollment Materials.

Are premiums increasing for 2027?

Yes. Health insurance premiums are increasing due to rising healthcare costs; however, they are lower than both the national and state averages.

- The State Insurance Committee approved an average health insurance premium increase of 7.9% for state and higher education employees and state plan retirees.
- The Local Education Insurance Committee approved an average health insurance premium increase of 8.7% for local education employees and retirees.
- The Local Government Insurance Committee approved an average health insurance premium increase of 10.5% for local government employees and retirees.

Vision and dental premiums are not increasing. State and higher education employees note that the state pays one-half of their dental insurance premiums.

Are there any vendor changes for 2027?

The only vendor change in 2027 is for The Tennessee Plan, which is the supplemental medical insurance for retirees with Medicare. This vendor will change to BlueCross BlueShield.

Are there any benefit changes for 2027?

HEALTH PLANS

State and higher education:

In 2027, you'll have the choice of the same three health plan options: Premier PPO, Standard PPO, and Consumer-driven Health Plan. **For the PPOs, there will be no increase in health plan copays, deductibles or coinsurance. For the CDHP, there will be an increase in deductibles** but no increase in coinsurance. These are your "cost shares" for the out-of-pocket costs you pay when you get care.

Local education and local government:

In 2027, you'll have the choice of five different health plan options, including the **new Copay Preferred Provider Organization:**

- With the Copay PPO, enrolled members will have lower premiums and no deductible.
- Copay PPO members will pay simple, predictable copay costs, so they'll know what care will cost ahead of time.
- Copay PPO members will use BlueCross BlueShield Network S providers. These providers will be in two different tiers—members will pay less when they choose providers in Tier 1 versus Tier 2.
- Copay PPO members will use the CVS Value Formulary for prescription drugs. This formulary is more selective in the medications it covers and only includes two tiers—generic drugs and most preferred brand-name drugs. Coinsurance for weight-loss and specialty drugs will apply with this plan.
- Copay PPO behavioral health and substance use services are covered and administered by Optum Behavioral Health.
- With the Copay PPO, there are out-of-pocket maximums to protect members from high costs.
- Details about the new Copay PPO are found on the *Health webpage*, and you can watch a video to learn more.
- More Copay PPO frequently asked questions are at the end of this document.

With the other four health plan options for local education and local government: Premier PPO, Standard PPO, Limited PPO and the Local Consumer-driven Health Plan, there will be **no increase in health plan copays, deductibles or coinsurance.**

Weight-loss surgery

- In 2027, weight-loss surgery will only be covered through the Carrum Health centers of excellence program. PPO members will have no cost share, and CDHP members will have no cost after meeting their deductible. Weight-loss surgery performed by any other provider will not be covered.

Networks

BlueCross BlueShield and Cigna will remain your health insurance carriers and offer the same four provider networks. If you are a local education or local government member who chooses the new Copay PPO, you will be in BCBS Network S.

BCBST Network S and Cigna LocalPlus: These are efficient networks, and you will save money with them. If your providers are in these networks, either one may be your best choice.

BCBST Network P and Cigna Open Access Plus: These are expanded networks, which include more hospitals and facilities than the efficient networks. However, the premiums are higher for the expanded networks, and you may pay more for services you receive from network providers. Visit the Premiums page > Health Insurance premiums to see the monthly premium charts and the increased cost if you select either of these networks.

Other benefits changes

Optum Behavioral Health: State and higher education employees and enrolled health plan members and eligible dependents will get up to eight short-term counseling visits, per problem, per year, per individual at no cost. This is up from five visits.

State and higher education employees: In the Sharecare **wellness program**, enrolled health plan members will be able to earn an incentive for participating in the Unwinding Anxiety program. Five wellness challenges will offer incentives instead of four.

State and higher education employees: Disability coverage will stay with MetLife; however, the short-term and long-term disability options will change. If you're enrolled in short-term disability now and you don't cancel your coverage during Annual Enrollment, you will be automatically enrolled in the only available plan. The state pays 100% of the monthly premium for long-term disability so you will be automatically enrolled in the only available plan.

How can I talk to someone if I need help with Annual Enrollment?

On the Partners for Health website, you'll find a Questions link to contact our help desk. You'll also find a Help button to chat during business hours. You can call Benefits Administration at 615.741.3590 or 800.253.9981, Monday through Friday, 8 a.m. to 4:30 p.m. CT.

What do I do if I miss the Annual Enrollment deadline?

Once the designated annual enrollment period has closed, employees have one opportunity to revise their Annual Enrollment elections, provided they submit the request to Benefits Administration no later than 4:30 p.m. CT on Dec. 1 of the current plan year. Timely submitted revisions will become effective on Jan. 1 of the upcoming plan year.

When will I get my ID cards or debit card?

Newly enrolled members and members who change their medical, dental or vision plans will receive new ID cards for 2027.

State and higher education members enrolled in the Consumer-driven Health Plan will get new medical ID cards.

If you do not change your medical, dental or vision plan, you will not get a new ID card.

Local education and local government employees and retirees: If you enroll in the new Copay PPO, you will get new medical, behavioral health and pharmacy ID cards.

Medical plan members: Those who are newly enrolled, members who change their last name and members who change plans will receive new medical, behavioral health and pharmacy ID cards.

Debit Cards

Current CDHP/health savings account members will use their same debit cards. Newly enrolled CDHP members will get a new debit card from TASC.

When Cards Will Mail

BlueCross BlueShield: ID cards will mail by Dec. 15, 2026.

Cigna (both medical and dental: ID cards will mail between Dec. 9-18, 2026.

CVS Caremark: ID cards will mail between Dec. 11-31, 2026.

MetLife Dental: ID cards will mail between Dec. 9-18, 2026.

EyeMed: ID cards will mail by Dec. 17, 2026.

Optum Behavioral Health: ID cards will mail by Dec. 15, 2026.

TASC: HSA debit cards will mail between Dec. 10-31, 2026. They'll arrive in an unmarked envelope.

Members can request additional cards by contacting their vendor(s) or by using a vendor's mobile app or online member portal. Find vendor contact information on the Benefits Contact Information webpage.

Local Education and Local Government Employees and Retirees ONLY:

Learn More About the Copay PPO

What is the Copay PPO plan?

The Copay PPO is a new health plan option being offered during this year's Annual Enrollment to eligible local education and local government employees and retirees, with benefits starting in 2027.

With the Copay PPO, enrolled members will have lower premiums and no deductible. This means members do not have to meet a deductible before the plan starts paying for covered care.

Copay PPO members will pay simple, predictable copays, so they'll know what their care will cost ahead of time. Go to the 2027 Health Options – Local Education and Local Government comparison chart to see the copays and other costs for this plan.

Why is the Copay PPO being offered?

This plan is being offered along with the other health plan options to provide a plan with lower monthly premiums and simple predictable costs.

Enrolled members will also have free preventive care; free telehealth options; and protection from very large costs with out-of-pocket maximums. The plan is designed to help members choose high-quality, affordable providers when possible, when they need care.

What network of providers do Copay PPO members use?

Members enrolled in the Copay PPO will use BlueCross BlueShield Network S providers only. These providers will be in two different tiers—members will pay less when they choose providers in Tier 1 than in Tier 2.

Members in the Copay PPO need to make sure their doctors, hospitals, clinics and other providers are in BCBST Network S.

What are Tier 1 and Tier 2 providers?

Some in-network providers are considered Tier 1 and some are Tier 2. All providers in BCBST Network S meet quality standards for care, but Tier 1 providers go a step further by delivering higher-quality, more cost-efficient care or using care more appropriately than their peers. Tier 2 providers don't meet the Tier 1 selection criteria, but that does not mean they don't provide good or quality care.

When members choose a Tier 1 provider, they'll pay a lower office visit copay. When members choose a Tier 2 provider, they'll pay a higher office visit copay. Members can choose Tier 2 providers, but they will pay more out of pocket.

Members can save money by checking the provider tier before making an appointment. This plan requires a little more planning. If the member does research ahead of time, it can help avoid surprises and they'll pay less for services.

How do the copays work?

With the Copay PPO, when you go to the doctor or get another type of care or service, you'll pay a set amount for the visit. This is called your copay. This amount depends on the type of care and provider you choose.

Why does the plan use different copays?

The different copays are designed to help guide members toward high-quality, affordable care. That means the plan encourages members to use providers and services that can help keep costs lower for both the member and the plan. The plan encourages members to use:

- Primary care when appropriate.
- Telemedicine when appropriate.
- Lower-cost provider locations when possible.
- High-quality providers that cost less.

This can help members save money while still getting the care they need.

What services with the Copay PPO are free?

Some services under the Copay PPO plan have a $0 copay. Members will pay nothing for these services when they are covered and used correctly.

- Preventive care is covered at 100% in-network. Preventive care includes services that help catch problems early or help prevent illness. Examples include annual checkups, certain screenings and recommended immunizations.
- Teladoc Health virtual care has a $0 copay. That means members can use virtual care for certain health needs without paying a copay.
- Talkspace virtual behavioral healthcare also has a $0 copay. This gives members another option for behavioral health support.

These free services make it easier for members to get care early, before a health issue becomes more serious or more expensive.

What are some of the copays with the Copay PPO?

Here are some examples of how costs may work for in-network services, found on the 2027 Health Options—Local Education and Local Government comparison chart.

- Primary care office visits: the copay may be $30 or $80, depending on the provider's tier.
- Specialist office visits: the copay may be $50 or $100, depending on the provider's tier.
- Teladoc Health virtual care is $0.
- Some facility-based services have larger copays. For example, inpatient hospital services have a $2,500 copay.
- Outpatient surgery may have different copays depending on where the surgery takes place. An ambulatory surgical center costs less than an outpatient hospital setting.
- Emergency care services have a $1,000 copay.
- Urgent care has an $80 copay.
- A convenience clinic has a $30 copay.

The type of care, the provider and the location can all affect what a member pays.

What about pharmacy benefits with the Copay PPO?

The Copay PPO plan uses the CVS Value Formulary for prescription drugs. A formulary is a list of covered medications. This formulary is more selective in the medications it covers and only includes two tiers—generic drugs and most preferred brand-name drugs. Under this plan, pharmacy costs may look different depending on the type of medication.

- A 30-day supply will have one cost for generic drugs and another cost for brand-name drugs.
- A 90-day supply will also have different costs for generics and brand-name drugs.
- Unlike the other PPO options, there is no non-preferred brand drug tier.

Medications prescribed for obesity and specialty pharmacy medications use coinsurance instead of a flat copay. However, there is no deductible. The member pays a percentage of the cost for those specific medications.

- Members will pay 25% coinsurance for medications prescribed for weight loss.
- Members will pay 30% coinsurance for specialty medications and a separate out-of-pocket maximum will apply.
- Specialty drugs and medications prescribed for weight loss are limited to a 30-day supply for each fill.

What about behavioral health services?

Behavioral health services are included in the plan and include care for mental health, emotional health and substance use needs.

- Inpatient behavioral health services have a $2,500 copay.
- Outpatient behavioral health visits have a $30 copay.
- Talkspace virtual behavioral healthcare is available with a $0 copay.

EAP, behavioral health and substance use services will continue to be managed by Optum Behavioral Health. Members should continue to use Optum Behavioral Health in-network providers for those services. Members will pay more if they use out-of-network providers.

What is an out-of-pocket maximum?

An out-of-pocket maximum is the most a member should have to pay for covered services during the plan year. With the Copay PPO, there are out-of-pocket maximums to protect members from high costs.

Once a member reaches the out-of-pocket maximum limit, the plan pays most of the covered costs for the rest of the year. This protects members from very high medical costs if they have a serious illness, injury, surgery or other expensive care.

For medical, behavioral health and non-specialty pharmacy expenses, the employee-only out-of-pocket maximum is $9,600.

For specialty pharmacy only, the employee-only out-of-pocket maximum is $2,400. This only applies to specialty pharmacy medications and does not impact other medical out-of-pocket expenses.