# 2024 Health Plan Comparison of Member Costs — Local Education and Local Government

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

| HEALTHCARE OPTION | PREMIER PPO | | STANDARD PPO | | LIMITED PPO | | LOCAL CDHP/HSA | |
|---|---|---|---|---|---|---|---|---|
| COVERED SERVICES | IN-NETWORK [1] | OUT-OF-NETWORK [1] | 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** | | | | | | | | |
| • Well-baby, well-child visits as recommended<br>• Adult annual physical exam<br>• Annual well-woman exam<br>• Immunizations as recommended<br>• Annual hearing and non-refractive vision screening<br>• Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended | No charge | $45 | No charge | $50 | No charge | $50 | No charge | 50% |
| **OUTPATIENT SERVICES — SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA** | | | | | | | | |
| **Primary Care Office Visit**<br>• Family practice, general practice, internal medicine, OB/GYN and pediatrics<br>• Provider based telehealth<br>• Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider<br>• Including surgery in office setting and initial maternity visit | $25 | $45 | $30 | $50 | $35 | $55 | 30% | 50% |
| **Specialist Office Visit**<br>• Including surgery in office setting<br>• Provider based telehealth<br>• Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a specialist | $45 | $70 | $50 | $75 | $55 | $80 | 30% | 50% |
| **Behavioral Health and Substance Use** [2]<br>• Including virtual visits | $25 | $45 | $30 | $50 | $35 | $55 | 30% | 50% |
| **Telehealth Carrier Programs** (MDLive/ Teledoc) | $15 | N/A | $15 | N/A | $15 | N/A | 30% | N/A |
| **Allergy Injection Without an Office Visit**<br>• Allergy Serum has additional member cost | 100% covered | 100% covered up to MAC | 100% covered | 100% covered up to MAC | 100% covered | 100% covered up to MAC | 30% | 50% |
| **Chiropractic and Acupuncture**<br>• Limit of 50 visits of each per year | Visits 1-20: $25<br>Visits 21-50: $45 | Visits 1-20: $45<br>Visits 21-50: $70 | Visits 1-20: $30<br>Visits 21-50: $50 | Visits 1-20: $50<br>Visits 21-50: $75 | Visits 1-20: $35<br>Visits 21-50: $55 | Visits 1-20: $55<br>Visits 21-50: $80 | 30% | 50% |
| **Convenience Clinic** | $25 | $45 | $30 | $50 | $35 | $55 | 30% | 50% |
| **Urgent Care Facility** | $45 | $70 | $50 | $75 | $55 | $80 | 30% | 50% |
| **PHARMACY** | | | | | | | | |
| **30-Day Supply** | $7 generic;<br>$40 preferred brand;<br>$90 non-preferred | copay plus amount exceeding MAC | $14 generic;<br>$50 preferred brand;<br>$100 non-preferred | copay plus amount exceeding MAC | $14 generic;<br>$60 preferred brand;<br>$110 non-preferred | copay plus amount exceeding MAC | 30% | 50% plus amount exceeding MAC |
| **90-Day Supply** (90-day network pharmacy or mail order) | $14 generic;<br>$80 preferred brand;<br>$180 non-preferred | N/A - no network | $28 generic;<br>$100 preferred brand;<br>$200 non-preferred | N/A - no network | $28 generic;<br>$120 preferred brand;<br>$220 non-preferred | N/A - no network | 30% | N/A - no network |
| **Maintenance Medications** (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) [3] | $7 generic;<br>$40 preferred brand;<br>$160 non-preferred | N/A - no network | $14 generic;<br>$50 preferred brand;<br>$180 non-preferred | N/A - no network | $14 generic;<br>$60 preferred brand;<br>$200 non-preferred | 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%;<br>min $100; max $200 | N/A - no network | 20%;<br>min $100; max $200 | N/A - no network | 20%;<br>min $100; max $200 | N/A - no network | 30% | N/A - no network |
| **Specialty Medication Tier 2** (all brands; 30-day supply from a specialty network pharmacy) | 30%;<br>min $200; max $400 | | 30%;<br>min $200; max $400 | | 30%;<br>min $200; max $400 | | | |

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PPO services in this table ARE subject to a deductible unless noted with a [5]. Local CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care.

| HEALTHCARE OPTION | PREMIER PPO | | STANDARD PPO | | LIMITED PPO | | LOCAL CDHP/HSA | |
|---|---|---|---|---|---|---|---|---|
| **COVERED SERVICES** | **IN-NETWORK [1]** | **OUT-OF-NETWORK [1]** | **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, lung imaging and bone density scans | No charge [5] | 40% | No charge [5] | 40% | No charge [5] | 50% | No charge | 50% |
| **OTHER SERVICES** | | | | | | | | |
| **Hospital/Facility Services** [4]<br>• Inpatient care [7]; outpatient surgery [7]<br>• Inpatient behavioral health and substance use [2] [6] | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| • Emergency room services [7] | 15% | | 20% | | 30% | | 30% | |
| **Maternity**<br>• Global billing for labor and delivery and routine services beyond the initial office visit | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **Home Care** [4]<br>• Home health; home infusion therapy | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **Rehabilitation and Therapy Services**<br>• Inpatient and skilled nursing facility [4]<br>• Outpatient PT/ST/OT/ABA [5]; Other therapy | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **X-Ray, Lab and Diagnostics** (not including advanced x-rays, scans and imaging) [5] | 15% | | 20% | | 30% | | 30% | 50% |
| **Advanced X-Ray, Scans and Imaging**<br>• Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4] | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **Pathology and Radiology Reading, Interpretation and Results** [5] | 15% | | 20% | | 30% | | 30% | |
| **Ambulance** (medically necessary, air and ground) | 15% | | 20% | | 30% | | 30% | |
| **Equipment and Supplies** [4]<br>• Durable medical equipment and external prosthetics<br>• Other supplies (i.e., ostomy, bandages, dressings) | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **Allergy Serum** | 15% | 40% | 20% | 40% | 30% | 50% | 30% | 50% |
| **Also Covered** | Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered. See Member Handbook for coverage details. | | | | | | | |
| **DEDUCTIBLE — ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE** | | | | | | | | |
| Employee Only | $750 | $1,500 | $1,300 | $2,600 | $1,800 | $3,600 | $2,000 | $4,000 |
| Employee + Child(ren) | $1,125 | $2,250 | $1,950 | $3,900 | $2,500 | $4,800 | $4,000 | $8,000 |
| Employee + Spouse | $1,500 | $3,000 | $2,600 | $5,200 | $2,800 | $5,500 | $4,000 | $8,000 |
| Employee + Spouse + Child(ren) | $1,875 | $3,750 | $3,250 | $6,500 | $3,600 | $7,200 | $4,000 | $8,000 |
| **OUT-OF-POCKET MAXIMUM** – MEDICAL AND PHARMACY COMBINED – ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE, COUNT TOWARD THE OUT-OF-POCKET MAXIMUM | | | | | | | | |
| Employee Only | $3,600 | $7,200 | $4,400 | $8,800 | $6,800 | $13,600 | $5,000 | $10,000 |
| Employee + Child(ren) | $5,400 | $10,800 | $6,600 | $13,200 | $13,600 | $27,200 | $10,000 | $20,000 |
| Employee + Spouse | $7,200 | $14,400 | $8,800 | $17,600 | $13,600 | $27,200 | $10,000 | $20,000 |
| Employee + Spouse + Child(ren) | $9,000 | $18,000 | $11,000 | $22,000 | $13,600 | $27,200 | $10,000 | $20,000 |

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

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

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

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

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