2024 Health Plan Comparison of Member Costs — State and Higher Education

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.

HEALTH PLAN OPTION	PREMIER PPO		STANDARD PPO		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]
PREVENTIVE CARE OFFICE VISITS						
• 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	40%
OUTPATIENT SERVICES SERVICES SUBJECT TO A COINSURANCE MAY BE EXTRA						
Primary Care Office Visit • 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 • Including surgery in office setting and initial maternity visit	$25	$45	$30	$50	20%	40%
Specialist Office Visit • 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	$45	$70	$50	$75	20%	40%
Behavioral Health and Substance Use [2] • Including virtual visits	$25	$45	$30	$50	20%	40%
Telehealth Carrier Programs (MDLive/Teledoc)	$15	N/A	$15	N/A	20%	N/A
Allergy Injection Without an Office Visit • Allergy serum has additional member cost	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	20%	40%
Chiropractic and Acupuncture • Limit of 50 visits of each per year	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	20%	40%
Convenience Clinic	$25	$45	$30	$50	20%	40%
Urgent Care Facility	$45	$70	$50	$75	20%	40%
PHARMACY						
30-Day Supply	$7 generic; $40 preferred brand; $90 non-preferred	copay plus amount exceeding MAC	$14 generic; $50 preferred brand; $100 non-preferred	copay plus amount exceeding MAC	20%	40% plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail order)	$14 generic; $80 preferred brand; $180 non-preferred	N/A - no network	$28 generic; $100 preferred brand; $200 non-preferred	N/A - no network	20%	N/A - no network
Maintenance Medications (90-day supply of certain maintenance medications from 90-day network pharmacy or mail order) [3]	$7 generic; $40 preferred brand; $160 non-preferred	N/A - no network	$14 generic; $50 preferred brand; $180 non-preferred	N/A - no network	10% without first having to meet deductible	N/A - no network
Specialty Medication Tier 1 (generics; 30-day supply from a specialty network pharmacy)	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	20%	N/A - no network
Specialty Medication Tier 2 (all brands; 30-day supply from a specialty network pharmacy)	30%; min $200; max $400		30%; min $200; max $400			

2024 Health Plan Comparison of Member Costs — State and Higher Education

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

HEALTH PLAN OPTION	PREMIER PPO		STANDARD PPO		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]**
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	40%
OTHER SERVICES						
Hospital/Facility Services [4] • Inpatient care [7]; outpatient surgery [7] • Inpatient behavioral health and substance use [2] [6]	15%	40%	20%	40%	20%	40%
• Emergency room services [7]	15%		20%		20%	
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	15%	40%	20%	40%	20%	40%
Home Care [4] • Home health; home infusion therapy	15%	40%	20%	40%	20%	40%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4] • Outpatient PT/ST/OT/ABA [5]; Other therapy	15%	40%	20%	40%	20%	40%
X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging) [5]	15%		20%		20%	40%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	15%	40%	20%	40%	20%	40%
Pathology and Radiology Reading, Interpretation and Results [5]	15%		20%		20%	
Ambulance (medically necessary, air and ground)	15%		20%		20%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	15%	40%	20%	40%	20%	40%
Allergy Serum	15%	40%	20%	40%	20%	40%
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	$1,700	$3,400
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900	$3,400	$6,800
Employee + Spouse	$1,500	$3,000	$2,600	$5,200	$3,400	$6,800
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500	$3,400	$6,800
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	$2,800	$5,600
Employee + Child(ren)	$5,400	$10,800	$6,600	$13,200	$5,600	$11,200
Employee + Spouse	$7,200	$14,400	$8,800	$17,600	$5,600	$11,200
Employee + Spouse + Child(ren)	$9,000	$18,000	$11,000	$22,000	$5,600	$11,200
CDHP STATE HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION						
For individuals who enroll in the CDHP	N/A		N/A		$500 for employee only; $1,000 for other coverage levels	

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

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

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