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

PARTNERS FOR HEALTH

PPO services in this table ARE NOT subject to a deductible. CDHP/HSA services in this table ARE subject to a deductible and coinsurance with the exception of in-network preventive care and maintenance medications.
Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.

HEALTH PLAN OPTION	PREMIER PPO NETWORK STATUS & COST [1]		STANDARD PPO NETWORK STATUS & COST [1]		LIMITED PPO NETWORK STATUS & COST [1]		LOCAL CDHP/HSA NETWORK STATUS & COST [1]	
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
PREVENTIVE CARE — OFFICE VISITS – AS RECOMMENDED & MEDICALLY NECESSARY								
• Well-baby, well-child visits • Adult annual physical exam • Annual well-woman exam • Immunizations • Annual hearing and non-refractive vision screening • Screenings, labs, nutritional guidance, tobacco cessation counseling & other	$0	$45	$0	$50	$0	$50	$0	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA								
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Initial maternity visit • Surgery in office setting • Provider-based telehealth	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) • Surgery in office setting • Provider-based telehealth	$45	$70	$50	$75	$55	$80	30%	50%
Behavioral Health and Substance Use[2] • Including provider-based virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Programs (MDLive/Teledoc/Talkspace)	$15	N/A	$15	N/A	$15	NA	30%	N/A
Allergy Injection Without Office Visit Allergy serum – see page 2	$0	$0	$0	$0	$0	$0	30%	50%
Chiropractic and Acupuncture • Annual limit of 50 visits each	$25/visit 1-20 $45/visit 21-50	$45/visit 1-20 $70/visit 21-50	$30/visit 1-20 $50/visit 21-50	$50/visit 1-20 $75/visit 21-50	$35/visit 1-20 $55/visit 21-50	$55/visit 1-20 $80/visit 21-50	30%	50%
Convenience Clinic	$25	$45	$30	$50	$35	$55	30%	50%
Urgent Care Facility	$45	$70	$50	$75	$55	$80	30%	50%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED								
30-Day Supply	$7/$40/$90	copay + amount > MAC	$14/$50/$100	copay + amount > MAC	$14/$60/$110	copay + amount > MAC	30%	50% + amount >MAC
90-Day Supply 90-day pharmacy or mail order	$14/$80/$180	N/A - no network	$28/$100/$200	N/A - no network	$28/$120/$220	N/A - no network	30%	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order[3]	$7/$40/$160	N/A - no network	$14/$50/$180	N/A - no network	$14/$60/$200	N/A – no network	20% before deductible	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY								
Generics Tier 1	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A - no network	20%; min $100; max $200	N/A – no network	30%	N/A - no network
Preferred Brands Tier 2	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A - no network	30%; min $200; max $400	N/A – no network	30%	N/A - no network
Non-Preferred Brands Tier 3	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	40%; min $300; max $600	N/A - no network	30%	N/A – no network

2025 Local Education and Local Government Comparison. PPO services in this table ARE subject to a deductible unless noted with a [5]. Local CDHP/HSA services in this table ARE subject to a deductible and coinsurance except for in-network preventive care. **Coverage for ALL services is subject to medical necessity as determined by the Third Party Administrator.**

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

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

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

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

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

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

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

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

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