2020 Health Plan Comparison— Local Education and Local Government

PPO services in this table ARE NOT subject to a deductible. Local CDHP/HSA services in this table ARE subject to a deductible with the exception of in-network preventive care and 90-day supply maintenance medications. In the table, $ = your copayment amount; % = your coinsurance; and 100% covered = you pay $0 in-network.

HEALTHCARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs		LIMITED PPO Member Costs		LOCAL CDHP/HSA Member Costs	
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 • 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	No charge	50%
OUTPATIENT SERVICES — SERVICES SUBJECT TO A 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 healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$25	$45	$30	$50	$35	$55	30%	50%
Specialist Office Visit • Including surgery in office setting • 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] • Including virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth (approved carrier programs only)	$15	N/A	$15	N/A	$15	N/A	30%	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	30%	50%
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	Visits 1-20: $35 Visits 21-50: $55	Visits 1-20: $55 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%
Emergency Room Visit	$150		$175		$200		30%	
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	$14 generic; $60 preferred brand; $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; $80 preferred brand; $180 non-preferred	N/A - no network	$28 generic; $100 preferred brand; $200 non-preferred	N/A - no network	$28 generic; $120 preferred brand; $220 non-preferred	N/A - no network	30%	N/A - no network
90-Day Supply (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	$14 generic; $60 preferred brand; $200 non-preferred	N/A - no network	20% without first having to meet deductible	N/A - no network
Specialty Medications (30-day supply from a specialty network pharmacy)	10%; min $50; max $150	N/A - no network	10%; min $50; max $150	N/A - no network	10%; min $50; max $150	N/A - no network	30%	N/A - no network

2020 Health Plan Comparison— Local Education and Local Government

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 with the exception of in-network preventive care. In the table, % = your coinsurance.

HEALTHCARE OPTION	PREMIER PPO Member Costs		STANDARD PPO Member Costs		LIMITED PPO Member Costs		LOCAL CDHP/HSA Member Costs	
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								
• Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No charge [5]	40%	No charge [5]	40%	No charge [5]	50%	No charge	50%
OTHER SERVICES								
Hospital/Facility Services [4] • Inpatient care; outpatient surgery • Inpatient behavioral health and substance use [2] [6]	10%	40%	20%	40%	30%	50%	30%	50%
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	10%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] • Home health; home infusion therapy	10%	40%	20%	40%	30%	50%	30%	50%
Rehabilitation and Therapy Services • Inpatient and skilled nursing facility [4]; outpatient • Outpatient IN-NETWORK physical, occupational and speech therapy [5]	10%	40%	20%	40%	30%	50%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced x-rays, scans and imaging) [5]	10%		20%		30%		30%	50%
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies [4]	10%	40%	20%	40%	30%	50%	30%	50%
All Reading, Interpretation and Results [5]	10%		20%		30%		30%	
Ambulance (air and ground)	10%		20%		30%		30%	
Equipment and Supplies [4] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	10%	40%	20%	40%	30%	50%	30%	50%
Also Covered	Certain limited Dental benefits, Hospice Care and Out-of-Country Charges are also covered subject to applicable deductible and coinsurance. See separate sections in the Member Handbook for details.							
DEDUCTIBLE								
Employee Only	$500	$1,000	$1,000	$2,000	$1,800	$3,600	$2,000	$4,000
Employee + Child(ren)	$750	$1,500	$1,500	$3,000	$2,500	$4,800	$4,000	$8,000
Employee + Spouse	$1,000	$2,000	$2,000	$4,000	$2,800	$5,500	$4,000	$8,000
Employee + Spouse + Child(ren)	$1,250	$2,500	$2,500	$5,000	$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	$4,000	$4,000	$4,500	$6,800	$10,400	$5,000	$8,000
Employee + Child(ren)	$5,400	$6,000	$6,000	$6,750	$13,600	$20,800	$10,000	$16,000
Employee + Spouse	$7,200	$8,000	$8,000	$9,000	$13,600	$20,800	$10,000	$16,000
Employee + Spouse + Child(ren)	$9,000	$10,000	$10,000	$11,250	$13,600	$20,800	$10,000	$16,000

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge (MAC) will not be counted. 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 $8,150 to the in-network family out-of-pocket maximum total. See the "Out of Pocket Maximums" section in the Member Handbook for more details. For Local CDHP Plan, coinsurance is after deductible is met unless otherwise noted.

[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.

[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] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization (PA) required. When using out-of-network providers, benefits for 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.

[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.