

2027 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 except for 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]		CDHP/HSA NETWORK STATUS & COST ^[4]	
COVERED SERVICES	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 - Annual exams - adult physical and well-woman - Routine prenatal and postnatal services - Immunizations - Annual hearing and non-refractive vision screening - Screenings, labs, nutritional guidance, & tobacco cessation counseling	\$0	\$45	\$0	\$50	\$0	40%
OUTPATIENT SERVICES — SERVICES SUBJECT TO COINSURANCE MAY BE EXTRA						
Primary Care Office Visit ^[8] - 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 - Allergy injections and serum	\$25	\$45	\$30	\$50	20%	40%
Specialist Office Visit ^[8] - Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) - Surgery in office setting - Provider-based telehealth - Allergy injections and serum	\$45	\$70	\$50	\$75	20%	40%
Behavioral Health and Substance Use ^{[2] [8]} Including provider-based virtual visits	\$25	\$45	\$30	\$50	20%	40%
Telehealth Programs (MDLive/Teladoc/Talkspace)	\$15	N/A	\$15	N/A	20%	N/A
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	20%	40%
Convenience Clinic	\$25	\$45	\$30	\$50	20%	40%
Urgent Care Facility	\$45	\$70	\$50	\$75	20%	40%
PHARMACY – GENERIC/PREFERRED/NON-PREFERRED						
30-Day Supply	\$7/\$40/\$90	copay + amount > MAC	\$14/\$50/\$100	copay + amount > MAC	20%	40% + 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	20%	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	10% before deductible	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25%	N/A - no network	25%	N/A - no network	25%	N/A - no network
SPECIALTY PHARMACY MEDICATIONS – 30-DAY SUPPLY						
Generic/Preferred/Non-Preferred	30%	N/A - no network	30%	N/A - no network	30%	N/A - no network

2027 State and Higher Education Comparison 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 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]		CDHP/HSA NETWORK STATUS & COST ^[1]	
COVERED SERVICES	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	40%
OTHER SERVICES						
Hospital/Facility Services ^[4] ^[8] • 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 Labor and Delivery services	15%	40%	20%	40%	20%	40%
Home Care ^[4] ^[8] 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 (Excludes advanced studies below) ^[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 (air and ground)	15%		20%		20%	
Durable Medical Equipment, External Prosthetics and Medical Supplies ^[4]	15%	40%	20%	40%	20%	40%
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	\$1,750	\$3,400
Employee + Child(ren)	\$1,125	\$2,250	\$1,950	\$3,900	\$3,500	\$6,800
Employee + Spouse	\$1,500	\$3,000	\$2,600	\$5,200	\$3,500	\$6,800
Employee + Spouse + Child(ren)	\$1,875	\$3,750	\$3,250	\$6,500	\$3,500	\$6,800
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES— MEDICAL, BEHAVIORAL AND NON-SPECIALTY PHARMACY, COMBINED, INCLUDING APPLICABLE DEDUCTIBLE EXPENSES						
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
OUT-OF-POCKET MAXIMUM — ELIGIBLE EXPENSES— SPECIALTY PHARMACY (ONLY), INCLUDING SPECIALTY PHARMACY CDHP DEDUCTIBLE EXPENSES						
Employee Only	\$2,400	N/A	\$2,400	N/A	\$2,400	N/A
Employee + Child(ren)	\$3,600	N/A	\$3,600	N/A	\$4,800	N/A
Employee + Spouse	\$4,800	N/A	\$4,800	N/A	\$4,800	N/A
Employee + Spouse + Child(ren)	\$6,000	N/A	\$6,000	N/A	\$4,800	N/A
CDHP STATE HEALTH SAVINGS ACCOUNT (HSA) CONTRIBUTION						
For individuals who enroll in the CDHP	N/A		N/A		\$500 employee only coverage level; \$1,000 all 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 or medication. For non-emergent care from an out-of-network provider or pharmacy 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 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.

[8] Member cost share for medications administered by a provider is determined by the place of service at the time of administration, i.e. provider office, infusion center, inpatient, or home.