2027 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.
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 • Annual exams - adult physical and well-woman • Immunizations • Annual hearing and non-refractive vision screening • Routine prenatal and postnatal services • Screenings, labs, nutritional guidance, & tobacco cessation counseling	$0	$45	$0	$50	$0	$50	$0	50%
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	$35	$55	30%	50%
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	$55	$80	30%	50%
Behavioral Health and Substance Use [2] [8] • Including provider-based virtual visits	$25	$45	$30	$50	$35	$55	30%	50%
Telehealth Programs (MDLive/Teladoc/Talkspace)	$15	N/A	$15	N/A	$15	NA	30%	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	$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
30-Day Supply Medications Prescribed for Obesity	25%	N/A - no network	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	30%	N/A - no network

2027 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] [8] • 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 • Labor and delivery services	15%	40%	20%	40%	30%	50%	30%	50%
Home Care [4] [8] • 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%
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— MEDICAL, BEHAVIORAL, AND NON-SPECIALTY PHARMACY, COMBINED, INCLUDING APPLICABLE DEDUCTIBLE EXPENSES								
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
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	$2,400	N/A
Employee + Child(ren)	$3,600	N/A	$3,600	N/A	$4,800	N/A	$4,800	N/A
Employee + Spouse	$4,800	N/A	$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	$4,800	N/A

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. 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 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.

HEALTH PLAN OPTION	Copay PPO Plan	
BENEFIT PLAN FEATURES:	BlueCross BlueShield Network S	
	Your Cost In-Network [14]	Your Cost Out-of-Network [1]
COVERED SERVICES		
Preventive Care Services [17]	Covered at 100%	50% after deductible
PRACTITIONER OFFICE SERVICES	**Tier 1 Provider/ Tier 2 Provider**	
Primary Care Office Visits [12] [13]	$30 / $80 copay	50% after deductible
Specialist Office Visits [13]	$50 / $100 copay	50% after deductible
Office Surgery [3] [4] [6] [12] [13]	$30 / $80 copay (PCP); $50 / $100 copay (Specialist)	50% after deductible
Allergy Injections and Allergy Serum [13]	$30 / $80 copay (PCP); $50 / $100 copay (Specialist)	50% after deductible
Allergy Testing	$250 copay	50% after deductible
Routine Diagnostic Lab, X-Ray, Supplies & Injections [16]	$50 copay	50% after deductible
Physical, Occupational, and Speech Therapeutic Services	$30 copay	50% after deductible
Chiropractic and Acupuncture Services (annual limit 50 visits each)	$30 copay	50% after deductible
Teladoc Health® Virtual Care	$0 copay	Not Covered
SERVICES RECEIVED AT A FACILITY (INCLUDES PROFESSIONAL AND FACILITY CHARGES) [2] [7]		
Inpatient Services [2] [4]	$2,500 copay	50% after deductible
Outpatient Surgery [3] [4] [6]	$1,000 Ambulatory Surgical Center / $2,500 Outpatient Hospital	50% after deductible
Advanced Radiological Imaging - Outpatient [2] [4] [7] [16]	$750 copay	50% after deductible
Other Outpatient Services (per day, per service type) [8]	$250 copay ($2,500 copay maximum per service type)	50% after deductible
Convenience Clinic Services	$30 copay	50% after deductible
Urgent Care Center Services	$80 copay	50% after deductible
Emergency Care Services [9]	$1,000 copay	$1,000 copay
Emergency Care Advanced Radiological Imaging [7] [16]	$750 copay	$750 copay
Ambulance Services [3] [4]	$1,000 copay	$1,000 copay
Provider-Administered Specialty Drugs [3] [11]	$200 copay	Not Covered
BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES [5]		
Inpatient [2] [4]	$2,500 copay	50% after deductible
Other Outpatient Services (per day, per service type) [2] [8]	$250 copay ($2,500 copay maximum per service type)	50% after deductible
Outpatient Office Visits	$30 copay	50% after deductible
Applied Behavioral Analysis [2]	$30 copay	50% after deductible
Talkspace® Virtual Behavioral Healthcare	$0 copay	Not Covered
MEDICAL EQUIPMENT SERVICES [3] [4]		
Durable Medical Equipment, Prosthetic or Orthotics, Hearing Aids (under age 18)	$250 copay	50% after deductible
SKILLED NURSING & REHABILITATION FACILITY SERVICES		
Inpatient [2] [4]	$2,500 copay	50% after deductible
Cardiac and Pulmonary Rehabilitative Therapies (outside of a facility admission)	$30 copay	50% after deductible
Home Health Care Services (per day) [3] [4]	$50 copay	50% after deductible
HOSPICE SERVICES		
Inpatient [2] [4]; Outpatient [3] [4]	$0 copay	50% after deductible

HEALTH PLAN OPTION	Copay PPO Plan	
BENEFIT PLAN FEATURES:	BLUECROSS BLUESHIELD NETWORK S	
	Your Cost In-Network [14]	Your Cost Out-of-Network [1]
PHARMACY – GENERIC/BRAND *(CVS Value Formulary)*		
30-Day Supply	$14 generics /$50 brand	copay + amount > MAC
90-Day Supply 90-day pharmacy or mail order	$28 generics /$100 brand	N/A - no network
90-Day Supply Certain Maintenance Medications 90-day pharmacy or mail order	$14 generics /$50 brand	N/A - no network
30-Day Supply Medications Prescribed for Obesity	25% Coinsurance	N/A - no network
Specialty Pharmacy Medications – 30-Day Supply	30% Coinsurance	N/A - no network
ANNUAL DEDUCTIBLE		
Employee Only	$0	$9,600
Employee + Child(ren)	$0	$19,200
Employee + Spouse	$0	$19,200
Employee + Spouse + Child(ren)	$0	$19,200
OUT-OF-POCKET MAXIMUM [10] — Eligible Expenses — Medical, Behavioral, and Non-Specialty Pharmacy, Combined		
Employee Only	$9,600	$19,200
Employee + Child(ren)	$19,200	$38,400
Employee + Spouse	$19,200	$38,400
Employee + Spouse + Child(ren)	$19,200	$38,400
OUT-OF-POCKET MAXIMUM [10] — Eligible Expenses— Specialty Pharmacy Only		
Employee Only	$2,400	N/A
Employee + Child(ren)	$4,800	N/A
Employee + Spouse	$4,800	N/A
Employee + Spouse + Child(ren)	$4,800	N/A

[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] Prior authorization is required.

[3] Certain procedures, services, medication and equipment may require prior authorization.

[4] 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 and based upon out of network coinsurance. If services are not medically necessary, no benefits will be provided.

[5] The following behavioral health services are treated as "facility based care" for the purpose of determining member cost-sharing: residential (inpatient) treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to facility based care, 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.

[6] Surgeries include incisions, excisions, biopsies, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).

[7] Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.

[8] Includes services such as radiation therapy, chemotherapy, renal dialysis, infusion administration, sleep studies, wound care, observation stays, BH partial hospitalization/day treatment programs, and BH intensive outpatient therapy.

[9] Copay, if applicable, waived if admitted to hospital.

[10] No single family member will be subject to an out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total out-of- pocket maximum, it will be met by all covered family members.

[11] To receive benefits for provider-administered specialty drugs, you must use a BCBS Specialty Pharmacy Network provider. Cost share listed is for the medication only; providers may bill additional charges for the administering of the drug under your medical benefit.

[12] The primary care copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health and Health Department services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.

[13] Tiered Copay PPO plans offer lower copays for certain practitioner services when those services are provided by a Tier 1 network provider, compared to the same services rendered by a Tier 2 network provider.

[14] Member is responsible for the lesser of the allowable charges or the listed copay.

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

[16] Reading and Interpretation included with applicable service copay.

[17] Well-baby, well-child, adult annual physical exam, well-woman exam, routine prenatal and postnatal services, immunizations, annual hearing and non-refractive vision screening, screenings, labs, nutritional guidance, tobacco cessation counseling, colonoscopy, mammogram, colorectal, lung imaging, and bone density scans.