MyBenefits 2020 Health Plans At A Glance

This chart provides an overview of the health plan options, giving you a comparison to help you decide which **CDHP** fits you best. Network options vary based on where you live. Visit FirstNet Share to find out which network(s) are available to you.

Options	1500 CDHP	2200 CDHP
	P – Preferred Network (Option 812)	**P – Preferred Network (Option 822)**
Employee Only:	Annual: $2,611 ($100.42 Biweekly)	Annual: $2,131 ($81.96 Biweekly)
Employee + Child(ren):	Annual: $4,359 ($167.65 Biweekly)	Annual: $3,560 ($136.92 Biweekly)
Employee + Spouse:	Annual: $5,091 ($195.81 Biweekly)	Annual: $4,157 ($159.88 Biweekly)
Family:	Annual: $6,839 ($263.04 Biweekly)	Annual: $5,586 ($214.85 Biweekly)
	S – Select Network (Option 811)**	**S – Select Network** (Option 821)**
Employee Only:	Annual: $2,371 ($91.19 Biweekly)	Annual: $1,910 ($73.46 Biweekly)
Employee + Child(ren):	Annual: $3,958 ($152.23 Biweekly)	Annual: $3,190 ($122.69 Biweekly)
Employee + Spouse:	Annual: $4,622 ($177.77 Biweekly)	Annual: $3,724 ($143.23 Biweekly)
Family:	Annual: $6,209 ($238.81 Biweekly)	Annual: $5,004 ($192.46 Biweekly)

Plan Pays % After Deductible	1500 CDHP In-Network	1500 CDHP Out-of-Network (c)	2200 CDHP In-Network	2200 CDHP Out-of-Network (c)
Annual Deductible (a)	Single $1,500 Family $3,000	Single $3,000 Family $6,000	Single $2,200 Family $4,400	Single $4,400 Family $8,800
Annual Out-of-Pocket Max (a)	Single $5,000 Family $10,000	Single $8,000 Family $16,000	Single $6,600 Family $13,200	Single $12,200 Family $24,000
Preventive Care (e)	Covered 100%	Not-covered	Covered 100%	Not-covered
Physician Services (f)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospital Services (g)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Care	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Preventive Medications (e)	Covered 100%		Covered 100%	
Generic & Preferred Brands	80% after deductible		80% after deductible	
Non-Preferred Brands	60% after deductible		60% after deductible	
Dollar Maximum per prescription (after deductible)	Not-covered		Not-covered	
Generic & Preferred Brands	Up to 30-day: $100; Up to 90-day: $200		Up to 30-day: $100; Up to 90-day: $200	
Non-Preferred Brands	Up to 30-day: $150; Up to 90-day: $250		Up to 30-day: $150; Up to 90-day: $250	
	No Lifetime Maximum		No Lifetime Maximum	

a. In- and out-of-network deductibles and out-of-pocket maximums must be met separately. The out-of-pocket maximum is the most you could pay annually for covered services. It includes the deductible and coinsurance amounts. It does not include non-covered expenses.

b. Family plans have an individual and family out-of-pocket maximum for covered in-network expenses. An individual out-of-pocket maximum is the individual (Single) amount in a family plan.

c. If you use an out-of-network provider, expenses exceeding the maximum allowable charge will be your responsibility. The maximum allowable charge is based on the maximum amount that would be paid to an in-network provider for the same service. Use of out-of-network providers will substantially increase your expenses.

d. Prior Authorization (PA) is required for certain services including but not limited to inpatient admissions (maternity stays longer than 48 hours for vaginal delivery or 96 hours for cesarean section), certain outpatient services such injectible drugs (other than self-injectibles), speech therapy and durable medical equipment. The PA list is subject to change.

For Advanced Radiological Imaging services such as MRI's, PET Scans, etc. you should make sure your provider calls for PA for these services as well. If the service is not pre- authorized, your benefits may be reduced by $750 for failing to obtain the authorization in advance.

e. Certain preventive care and certain preventive medications are covered at 100%. If not specified under the Affordable Care Act, the plan follows established guidelines as determined by the carriers.

f. Physician Services include office visits, specialist visits, chiropractic care, diagnostic labs and x-rays, surgical services, and maternity care.

g. Hospital Services include inpatient and out-patient care.

* Cost is before Flexible Dollars.
** The "S" Network is only available to Tennessee residents.

Important! Some covered services have an annual visit/day maximum. Certain services, including infertility treatments, are excluded.

Searching for providers in the BlueCross BlueShield of Tennessee (BlueCross) Networks

Check the BlueCross website before you enroll to ensure your doctor, hospital and health care providers participate in the network you are electing. After enrolling, ***always*** check with the provider to confirm their participation in the network in which you have enrolled *before* receiving services.

1. **Click here** to visit the BlueCross Find-A-Doctor tool to start your search today.
2. **Tennessee Residents.** Hover your mouse over *"please select network"* and click for a drop down box to select "Blue Network P" or "Blue Network S" and click "Go". Network "S" is *only* available to Tennessee residents. If you are a Tennessee resident, check both available networks before enrolling.
3. **Residents of other states.** Hover your mouse over *"please select network"* and click for a drop down box to select "BlueCard PPO". If you reside outside the State of Tennessee, you will be able to enroll in Network "P" but essentially you will need to search for providers in the "BlueCard PPO" Network.
4. Double check your search by making sure the network you selected is next to the "My Health Plan" link in the top header. If needed, be sure to update your search by changing the City and State next to the "My Location" link in the top header. If you can't change your search, such as switch between "P" and "S", close or refresh your browser and start over again with a new search.
5. Click "Find Medical Care" and select an option to indicate how you want to search the network listing (i.e. primary care, specialist, hospitals, urgent and convenience care). To verify all the networks accepted by a provider, click on the individual search result (i.e., doctor's name).

BCBST Networks	Geographic Regions	Primary Hospitals in Network
Blue Network P in TN*	Reside or traveling in TN	In Memphis – Baptist, Methodist & Saint Francis
Blue Network S in TN*	Reside in TN	In Memphis – Baptist & Saint Francis
BlueCard PPO	Reside or traveling Outside TN	Nationwide Network

* If you are traveling outside your home state and need care while traveling, you still have access to more doctors and hospitals nationwide and in nearly every country and territory around the world with the BlueCard program. Use the Find a Doctor tool to see which doctors or hospitals are in the BlueCard PPO network. When you visit, just show them your member ID card. The provider will identify your benefits through this symbol: 

Important! Doctors, hospitals and other providers can join or leave a network at any time so the website directory is subject to change. Make sure the provider you choose is participating in your specific network. You'll find your network name on the front of your BCBST ID card. If you need a referral, remind your provider what coverage you have, and ask to refer you to a provider in your network. **Always check your provider's network status before receiving services, and also check the address. It's important to find out if all the providers involved in your care are in-network.** Know that providers may not be required to disclose before they provide a service whether they are in-network. You're ultimately responsible for checking if you're seeing an in-network provider.

In-Network	Out-of-Network
• These providers participate in your network and are called "network providers" or "in-network providers." • Providers offer discounts for their services per their contract with BCBST and will accept the discounted rate as payment. • Getting prior authorization for in-network services rendered in Tennessee is the responsibility of your doctor. You are responsible for getting prior authorization for in-network services rendered outside of the state of Tennessee. • After you meet the annual in-network deductible, you pay 20% of eligible expenses up to the out-of-pocket maximum. Your cost is less because covered expenses are subject to discounted prices.	• These providers do NOT participate in your network and are called "non-network providers" or "out-of-network providers." • Providers are NOT bound by a negotiated fee so they can charge whatever they like and may not accept any reductions. • When you use an out-of-network provider, you're ultimately responsible for filing your claim *and* for making sure *all* out-of-network services that require prior authorization get filed by your provider. • After you meet the annual out-of-network deductible, you pay 40% of eligible expenses up to the out-of-network out-of-pocket maximum, *plus* any expenses exceeding the Maximum Allowable Charge (MAC). Your cost is substantially higher when you use an out-of-network provider and you can be balance billed for all charges exceeding the MAC, *plus* your out-of-network benefits.

Important! Be sure to get prior authorization when required, *and* for any questionable coverage of a procedure or surgery such as procedures that may be considered unproven or expensive (or out-of-network), also get a predetermination *prior* to service. Predetermination is similar to prior authorization as it allows services or treatment to be reviewed for medical necessity. In the predetermination process, benefit coverage is predetermined *before* services are rendered and any limitation under a plan can be addressed *before* services are rendered. Predetermination is a voluntary process, whereas a prior authorization is a requirement.