2026 Health Plan Comparison of Member Costs — State and Higher Education

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 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 [1]	
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 • Adult annual physical exam • Annual well-woman exam • 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

2026 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 Global billing after first visit; Routine services & labor and delivery	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	$1,700	$3,400
Employee + Child(ren)	$1,125	$2,250	$1,950	$3,900	$3,400	$6,800
Employee + Spouse	$1,500	$3,000	$2,600	$5,200	$3,400	$6,800
Employee + Spouse + Child(ren)	$1,875	$3,750	$3,250	$6,500	$3,400	$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 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. 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.

[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.

Partners for Health 2026 Dental Insurance

PARTNERS FOR HEALTH

TWO OPTIONS ARE AVAILABLE

1. **Dental health maintenance organization** - prepaid provider administered by Cigna
2. **Dental preferred provider organization** administered by MetLife

DHMO

- There is no deductible to meet, no annual maximum for services and no waiting periods.
- You pay copays for services, which are found in the Patient Charge Schedule. You will also be responsible for paying lab fees for certain services.

Teledentistry is available to members at a $0 copay with no frequency limit.

Routine exams and cleanings

- Oral evaluations are limited to a combined total of 4 of the following during a 12 consecutive month period
  - periodic oral evaluations,
  - comprehensive oral evaluations, and
  - comprehensive periodontal evaluations
- Cleaning – limit 2 per calendar year; can add 2 additional per year at copay of $45

Orthodontics

- $3,360 maximum ($140 x 24 months) for treatment fee only. Member pays full charge after 24 months
- No age limit

Waiting periods

- There are no waiting periods.

Providers/Network

- You must select and use a Cigna network general dentist from the DHMO list for the state's dental plan and let Cigna know of your choice. You may select a network pediatric dentist for your child under age 13; the dentist will be considered a specialist.
- Before enrolling, carefully check the network for your location. You may be able to cancel this coverage if you enroll and later there are no network general dentists within a 25-mile driving-distance of your home address.
- Providers can be found here: *hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC060*

DPPO

Deductible

- In-network: $50 single; $150 family, per plan year
- Out of network: $100 single; $300 family, per plan year
- $1,500 plan benefit maximum per person per calendar year

Costs

- You pay deductible and coinsurance for services
- Provider negotiated fee, or maximum plan allowance, is the highest dollar amount of reimbursement for specific dental procedures provided by MetLife DPPO in-network providers. The in-network dentists have agreed to not charge members or the plan more than the PNF.

Member coinsurance breakdown for in-network

- Diagnostic and preventive services: 0%
- Basic services: 20%
- Major services: 50%
- Orthodontic services: 50%

Routine exams & cleanings

- 2 routine office exams per calendar year
- 2 problem-focused exams (office or teledentistry) per calendar year

Orthodontics

- $1,500 lifetime plan benefit maximum per person

Waiting periods

- There are no waiting periods.

Providers/Network

- You can use any dentist, but you'll save money and receive maximum benefits when visiting an in-network MetLife PDP Plus provider for the Partners for Health DPPO dental plan.
- Providers can be found here: *metlife.com/StateOfTN*

Visit *tn.gov/partnersforhealth/other-benefits/dental* for details.

Review the member handbooks and certificates of coverage for details at *tn.gov/partnersforhealth/publications/publications*. Request pre-treatment estimates to understand costs prior to receiving service.

2026 Covered Vision Services

Here is a comparison of discounts, copays and allowed amounts for 2026 under the vision options. Copays represent what the member pays. Allowances and percentage discounts represent the cost the carrier will cover. Actual costs and benefits may vary based upon the plan design selected. Exclusions and limitations may apply. Out-of-network member costs can be found in the EyeMed Handbook at https://www.tn.gov/partnersforhealth/publications/publications.html.

SERVICE	BASIC PLAN IN-NETWORK COSTS [1]	EXPANDED PLAN IN-NETWORK COSTS [1]
Eye Exam With Dilation as Necessary	$10 copay	$0 copay
Retinal Imaging	Up to $39 copay	$0 copay
Contact Lens fit and Follow up (standard/premium)	$40/$50 copay	$35/$45 copay
Low Vision Evaluation	$300 allowance	$300 allowance
Low Vision Supplemental Aids	$300 allowance	$300 allowance
Eyeglass Benefit—Frame		
Retail Frame	$105 allowance	$150 allowance
Eyeglass Benefit—Spectacle Lenses		
Single Vision, Bifocal, Trifocal & Lenticular Lenses	$20 copay	$15 copay
Standard Progressive Lenses	$90 copay	$50 copay
Premium Progressive Lenses (Tier 1|Tier 2|Tier 3|Tier4)	Copay amount of: ($110/$140/$155/$225)	Copay amount of: ($85/$110/$150/$175)
UV Treatment	$15 copay	$15 copay
Tint (solid or gradient)	$15 copay	$15 copay
Standard Polycarbonate (adults/children[4])	$40/$0 copay	$40 copay/$0 copay
Standard Anti-reflective Coating	$45 copay	$45 copay
Premium Anti-reflective Coating (Tier 1|Tier 2|Tier 3)	$57/$68/$85 copay	$57/$68/$85 copay
Polarized	$90 copay	$75 copay
Plastic Photochromic Lenses	$75 copay	$50 copay
Standard Plastic Scratch Coating	$15 copay	$15 copay
Contact Lenses		
Conventional and Disposable	$105 allowance	$150 allowance
Medically Necessary	$155 allowance	$0 copay
Frequency of Vision Benefits		
Vision Exam	Once every calendar year	Once every calendar year
Eyeglass Lenses	Once every calendar year (in lieu of contact lenses)	Once every calendar year (in lieu of contact lenses)
Frames	Once every two calendar years	Once every calendar year
Contact Lenses	Once every calendar year (in lieu of eyeglass lenses)	Once every calendar year (in lieu of eyeglasses)
Contact Lens Fit and Two Follow-ups	Once every calendar year	Once every calendar year
Retinal Imaging	Once every calendar year	Once every calendar year
Low Vision Evaluation	Once every two calendar years	Once every two calendar years
Low Vision Aids	Once every two calendar years	Once every two calendar years

[1] Member pay will not be greater than the copay, but could be less based upon the actual charge.

Discounts

- Member receives a 40% discount on additional complete pairs of eyeglasses once the funded benefit has been used.
- Member receives a 20% discount on the amount over the frame allowance.
- Member receives a 15% discount on the amount over the contact lens allowance for conventional contact lenses.
- Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations.

Note: Discounts may not be available with all providers.

Some exclusions and limitations apply. See the EyeMed Handbook at https://www.tn.gov/partnersforhealth/publications/publications.html.

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