

RESOLUTION NO. 22-2024

**A RESOLUTION APPROVING CONTRACTS WITH BLUECROSS/BLUESHIELD,
PRINCIPAL, AND ONE AMERICA FOR GROUP HEALTH INSURANCE FOR
EMPLOYEES AND OFFICIALS OF THE CITY OF MANCHESTER**

WHEREAS T.C.A. 8-27-602 specifically sets forth the procedure for municipalities desiring to purchase group insurance; and

WHEREAS the Finance Committee or its designee of the City of Manchester is a committee of Aldermen, as contemplated by T.C.A. 8-27-602; and

WHEREAS the Board of Mayor and Aldermen hereby designated the Finance Committee or its designee to serve as the committee to carry out the intent of Part 27 of Title 8 of Tennessee Code; and

WHEREAS the committee, at its meeting May 6, 2024, considered various bids and options and, pursuant to the statutory mandate, recommends approval of the attached bids for group insurance.


NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF MAYOR AND ALDERMEN OF THE CITY OF MANCHESTER, TENNESSEE that the City of Manchester, Tennessee enter into a contract for insurance coverage with the recommended insurance carriers according to the terms included in the attached bids.

BE IT FURTHER RESOLVED BY THE BOARD OF MAYOR AND ALDERMEN OF THE CITY OF MANCHESTER, TENNESSEE that the Mayor and Finance Director are authorized to execute the necessary documents to effect the intent of this resolution.

Resolved this 7 day of May 2024.



Anthony Burrows, Finance Director



Marilyn Howard, Mayor



INSURANCE

BENEFITS ASSOCIATES, INC.

Executive Summary

Group Medical Plan

Currently the City of Manchester provides a group medical plan that is based on a two ID card system. This plan design has not worked well for the employees because a major healthcare provider in the area does not work with two ID card plans. This has caused employees to pay for services and apply for reimbursement from the plan provider. As part of the bid process for Plan Year 2024, the bid required a one card/one provider plan. The plan design requested is attached as Exhibit A-1. The benefit structure is based on the 2023 benefit plan structure currently provided to the employees.

Two carriers/TPA's submitted bids for the 2024 benefit plan. Blue Cross Blue Shield and Lucent. The Blue Cross plan is fully insured and utilizes a Health Reimbursement Account (HRA) administered by BCBS to meet the bid specs for the 2024 benefit plan. Lucent bid a plan design that matched the bid specs.

After reviewing the bids from the carriers and reviewing the terms and conditions of the bids it was determined by the Manchester Insurance Committee to contract with Blue Cross Blue Shield of Tennessee for the plan year 2024. The recommendation is based on past years' experience with the two-card system and the comfort level employees have with Blue Cross Blue Shield. It is recommended

that Plan number 790 is the selected plan with the addition of an HRA to maintain the benefit structure of the requested plan bid as outlined in Exhibit A-1. The rate structure for the 2023 plan year and the proposed 2024 plan year are outlined below:

Total premium by plan tier:

	2023	2024
Employee	\$ 550.31	\$ 650.95
Employee/Spouse	\$ 1,195.13	\$ 1,367.00
Employee/Child(ren)	\$ 793.64	\$ 1,191.23
Family	\$ 1,387.33	\$ 1,975.64

Manchester currently contributes 90% of the premium for Employee only coverage and 80% of the premium for dependent coverage. The 2024 coverage breakdown is as follows:

2024 projected premium sharing excluding HRA (funded by City)

	Employer Monthly	Employee Monthly
Employee	\$ 585.86	\$ 65.09
Employee/Spouse	\$ 1,093.60	\$ 273.40
Employee/Child	\$ 952.98	\$ 238.25
Family	\$ 1,580.51	\$ 395.13

The Blue Cross Bid includes an HRA to fund the difference from the actual BCBS plan outline to the 2024 Manchester Employee plan design. It is estimated that the HRA funding will average \$ 25,000 a month. The Insurance Committee

recommends the City incur the expense of funding the HRA. The HRA is funded on an expense incurred basis only. Funds would only be paid to BCBS if the employee and or dependent has a valid HRA expense. Expenses that fall under the HRA are claims that are applied to the medical deductible and out of pocket limits under the plan.

The City is currently paying an estimated \$ 130,000 a month for the current 2023 plan. As we have noted, this plan design is not working for either the city or the city employees. The recommended plan has an estimated monthly expense of \$ 182,728.56. This amount includes both the medical premium and the projected HRA expense. The HRA is projected to be 30% of the total HRA liability. The total liability is the funding limit times the number of covered lives in the plan.

It is our recommendation and that of the Insurance Committee to contract with Blue Cross Blue Shield for the medical coverage and the HRA administration which provides for a one ID card system and seamless coverage.

As part of our review process, we determined that the City is deducting the employees share of the insurance premium a month in advance. For example, employee premium for June billing is deducted in the month of May. This causes issues for both the city and the employees. If the city hires a new employee in the last two weeks of the month, then the next month the city will have to take a double deduction for the employee share of premium. If an employee terminates coverage, the city owes the employee back one month of premium already collected. Collecting the employee share of premium a month in advance is a rare occurrence. The normal practice for an employer is to collect the premium the month of coverage. Example, deducting the employee share of the premium in June for June coverage.

Executive Summary

Group and Voluntary Benefits

The City of Manchester currently offers the following benefits through the associated Provider.

<u>Line of Coverage</u>	<u>Current 2023</u>	<u>Recommend 2024</u>
Group Life Insurance	OneAmerica	OneAmerica
Dependent Life Insurance	OneAmerica	OneAmerica
Voluntary Life Insurance	OneAmerica	OneAmerica
Dental Insurance	BCBS TN	Principal
Vision	BCBS TN	Principal
Accident	Colonial	Principal
Short Term Disability	Colonial	OneAmerica
Long Term Disability	OneAmerica Vol.	OneAmerica
Critical Illness	Colonial	Paid by City
Whole Life	Colonial	Principal
		Term Coverage



Summary of Recommendations:

Life Insurance and Voluntary Life

- Group Life Insurance- Employer paid.
- Group Voluntary Life Insurance- Employee paid.

- *Recommend OneAmerica - Current carrier and most competitive rates.*

Disability Insurance

Short Term (STD) – Employee paid.

Long Term (LTD) – Currently 5 year benefit, Employee paid.

- *Recommend STD with OneAmerica, currently with Colonial*
 - *Rates lower for group with slight savings for employees below age 55 and slight increases for those above age 55.*
 - *Match carrier with LTD for seamless claim handling.*
- *Recommend LTD with OneAmerica – current provider.*
 - *Change from 5yr benefit to a plan that pays until social security retirement age.*
 - *Change to Employer paid benefit at a monthly cost of \$3,296.00.*

Dental Insurance

Individual and family plans – Employee paid.

- *Recommend move Principal from BCBS*
 - *Increase benefit to remove 12 month waiting period for major services.*
 - *25.7% of employees have a tenure less than 12 months.*
 - *Plan pricing increases from \$2 - \$8 per month depending on plan tier.*

Vision Insurance

Individual and family plans – Employee paid.

- *Recommend moving from BCBS direct to VSP through Principal.*
 - *Benefits stay the same.*
 - *Pricing is the same.*
 - *Adds back local providers not accessible through BCBS.*

Accident and Critical Illness

Individual and family options – Employee paid.

- *Recommend moving both to Principal.*
 - *Rates are competitive*
 - *Benefits are higher on guaranteed issued coverage.*
 - *Children included in Critical illness rates. Not currently included.*



INSURANCE

BENEFITS ASSOCIATES, INC.

Upon a comprehensive review of the benefits and discussions with the City of Manchester Insurance Committee as to the administration, benefits, and any issues with the current plan offerings, we would like to make the following recommendations for the 2024 plan year.

Life Insurance and Voluntary Life

Group Life Insurance- Employer Paid

Group Voluntary Life Insurance- Employee Paid

We recommend OneAmerica for the Group Life Insurance, Dependent Life and Voluntary Life offered by the City. This recommendation is based on OneAmerica offering the most competitive rates and having a business focus on the Government marketplace. OneAmerica has been the current provider of these benefits for several years. There were two other bidders for these benefits. Four additional carriers were sent bid packets and declined to quote due to being uncompetitive. The City pays for \$ 30,000 Life Insurance and ADD for all full time employees. The projected cost for the city is \$ 373.86 per month based on the current 134 employees. The rate is the same as for plan year 2023.

Disability Currently Voluntary STD and LTD - Employee Paid

Recommend Voluntary Short Term- Employee Paid

Long Term Disability- Employer Paid

The City currently offers Long-Term Disability through OneAmerica and Short-Term Disability through Colonial. The recommendation is to maintain the Long-Term Disability with OneAmerica for two main reasons. The first is the service and rates are competitive in the voluntary market. The second is OneAmerica is the only bidder for the line of coverage. Five other carriers declined to quote due to the ratio of Fire and Police to the total number of employees.

We would also recommend changing the Short-Term Disability to OneAmerica due to improved claims service and overall competitive rates as compared to the current provider. The rates with OneAmerica are greater than Colonial for employees over the age of 55. There are 8 employees that would be affected by an average \$ 6.96 increase per month on their short-term deduction rates. Forty one employees would see a reduction in their rates with an average of \$ 1.84 per month. The net premium difference is a savings for the overall group.

It is also our recommendation for the City to provide the Long-Term Disability as an employer paid benefit. This change would allow the city to be more competitive in the marketplace for recruiting and retaining employees. It is our recommendation for the City to provide a plan that will cover the employees to their Social Security retirement age. If an employee was disabled they would receive 60% of their gross income. The estimated cost is based on a rate of \$.550 per \$ 100 of covered

monthly earnings. Based on the current monthly payroll the estimated cost is \$ 3,296.00 per month to cover all full time employees.

Dental- Voluntary- Employee Paid

Two carriers bid on the dental benefits. Five carriers declined to quote due to not being competitive. The current carrier is Blue Cross Blue Shield. The other carrier is Principal. We are recommending Principal for several reasons. The rates are slightly higher than Blue Cross, however, the benefits are improved. Currently Blue Cross has a waiting period for major services of 12 months. The Principal bid does not have a waiting period. The network is larger than the Blue Cross network. Principal also provided a bid to cover out of network claims are usual and customary. The current Blue Cross coverage covers out of network on a MAC rate basis. Currently the city has 35 new hires which account for 25.7% of covered employees. Changing the Dental to Principal will improve the benefits for major procedures for all current and future new hires. The projected increase in monthly cost for all covered employees is \$ 476.79 a month. However, if 5 employees and or dependents utilized major services in their first year of coverage then the overall employee benefit savings is greater than the overall increase in the premium. The difference is rates are as follows:

	Current BCBS	Principal
Employee	\$ 22.55	\$ 24.66
Emp/Sp	\$ 49.62	\$ 54.27
Emp/Child	\$ 53.08	\$ 58.05
Family	\$ 86.44	\$ 94.54

Vision- Voluntary- Employee Paid

Three carriers provided a bid on the vision coverage. The current vision is provided through Blue Cross Blue Shield. The benefits of the plans are the same. The difference is both Principal and VSP are using the VSP network. The VSP network is larger than the current Eyemed network provided by Blue Cross. The recommendation would be to provide the benefit through Principal.

Accident- Voluntary- Employee Paid

The Voluntary accident plan is currently provided through Colonial. it is recommended to move the Accident plan to Principal. The rates and benefits offered by Principal are competitive with the current Colonial plan. Principal has a wellness benefit that if the employee or covered dependent have a Preventive care checkup then Principal will pay the employee \$ 150.00. This benefit offsets a large portion of the cost of the Accident plan.

Critical Illness- Voluntary- Employee Paid

The critical illness plan is currently provided through Colonial. The rates and benefits offered by Principal are competitive with the current Colonial plan. The Principal plan covers children for critical illness coverage at no additional cost. Colonial charges additional premium for child coverage.

Summary

We recommend OneAmerica for the Group Life, Voluntary Life, and both Short Term and Long Term Disability. As part of the recommendation we recommend the City paying for Long Term Disability for all full time employees. The Short Term Disability would continue to be a Voluntary benefit paid for by the employees who select the coverage.

We recommend Principal for the additional lines of Voluntary Employee paid coverages which includes Dental, Vision, Accident, and Critical Illness.

The recommendations outlined allow the city to work with two carriers for the Group and Voluntary benefits. Currently the City works with 3 different carriers for the supplemental benefits. The claims process for disability claims would be improved due to a single carrier providing both the LTD and STD coverage. The dental and vision provider networks would be larger which provides the employees with a greater selection of providers.

Exhibit A-1
CITY OF MANCHESTER
EMPLOYEE BENEFIT PLAN
SUMMARY OF BENEFITS –RFP Quote Request
EFFECTIVE JULY 1, 2024

The following is a summary of benefits to be quoted for 2024. Eligible Expenses under this plan are charges that have first been applied to the deductible and/or coinsurance of your fully-insured high deductible health plan. All Benefits shown below are subject to precertification requirements, limitations and exclusions as outlined in your fully-insured high deductible health plan, unless otherwise stated.

For a detailed explanation of how your employer helps share a portion of your costs of your fully-insured high deductible plan, see the section called "HOW THIS PLAN WORKS!"

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

PPO Plan

Type of Expense	In-Network Amounts	Out-of-Network Amounts
Embedded Deductible, per Calendar Year		
Employee Only	\$2,000	\$4,000
Employee + Spouse	\$2,500	\$8,000
Employee + Children	\$2,500	\$8,000
Family Unit	\$3,000	\$8,000
Payment Level (unless otherwise stated)	70%	50%
Maximum Out-of-Pocket, per Calendar Year		
Employee Only	\$4,500	\$13,500
Employee + Spouse	\$9,000	\$27,000
Employee + Children	\$9,000	\$27,000
Family Unit	\$9,000	\$27,000

- The Deductible and Coinsurance are applied to and included in the maximum out-of-pocket amount. Any penalties or non-covered services do not apply towards the maximum-out-pocket amount.
- The In-Network and Out-of-Network Deductible and out-of-pocket amounts do not credit or reduce each other.
- This is an embedded plan.
 - Individual Deductibles are tracked and applied to the individual and the family when an embedded plan is utilized. Once an individual has met the individual Deductible, their claims will be paid at the next level of benefits even though the family Deductible has not been met. Other individuals in the family must continue to pay their individual Deductible amount until either their own individual Deductible is met, or the family Deductible is met, whichever occurs first.
 - Out-of-Pocket amounts are tracked and applied to the individual and the family. Once an individual has met the individual maximum out-of-pocket, their claims will be paid at 100% even though the family maximum out-of-pocket as not been met. Other individuals in the family continue to pay toward their individual maximum out-of-pocket until either their individual maximum is met, or the family maximum is met, whichever occurs first.

PPO Copay Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	In-Network Amounts	Out-of-Network Amounts	Limits
Acupuncture	Visits 1 – 20: \$30 copay then 100% deductible waived Visits 21 – 50: \$50 copay then 100% deductible waived	Visits 1 – 20: \$55 copay then 100% deductible waived Visits 21 – 50: \$80 copay then 100% deductible waived	Limited to 50 visits per Calendar Year
Advanced Imaging – Includes, but not limited to, MRI/MRA/CT/PET	70% after deductible	50% after deductible	
Allergy Services			
Office Visit	\$30 PCP or \$50 Specialist copay then 100% deductible waived	\$55 PCP or \$80 Specialist copay then 100% deductible waived	
Testing/Injections	100%, deductible waived	100%, deductible waived	
Ambulance	70% after deductible	70% after in-network deductible	
Ambulatory Surgical Center	70% after deductible	50% after deductible	
Anesthesia	Office Services: 100% deductible waived Other: 70% after deductible	Office Services: 100% deductible waived Other: 70% after deductible	
Chiropractic Care (Spinal Manipulations)	Visits 1 – 20: \$30 copay then 100% deductible waived Visits 21 – 50: \$50 copay then 100% deductible waived	Visits 1 – 20: \$55 copay then 100% deductible waived Visits 21 – 50: \$80 copay then 100% deductible waived	Limited to 50 visits per Calendar Year
Telehealth Services	Covered 100% under your Plan	Covered 100^ under your Plan	
Dialysis (Outpatient)	70% after deductible	50% after deductible	
Durable Medical Equipment	70% after deductible	50% after deductible	
Hearing Aids	70% after deductible	50% after deductible	
Home Health Care	70% after deductible	50% after deductible	

PPO CopayPlan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	In-Network Amounts	Out-of-Network Amounts	Limits
Hospice Care Inpatient/Outpatient Treatment Family Bereavement Counseling	70% after deductible	50% after deductible	
	70% after deductible	50% after deductible	
Hospital Inpatient Outpatient	70% after deductible	50% after deductible	
	70% after deductible	50% after deductible	
Mental Health/Substance Abuse Residential Treatment Inpatient Treatment Partial Day Program Outpatient Physician	70% after deductible	50% after deductible	
	70% after deductible	50% after deductible	
	70% after deductible	50% after deductible	
	\$30 copay then 100%, deductible waived	\$55 copay then 100%, deductible waived	
Newborn Care	70% after deductible	50% after deductible	
Outpatient Diagnostic X-ray and Lab Services	70%, deductible waived	70%, deductible waived	
Outpatient Emergency Services Physician/Facility	\$300 copay then 100%, deductible waived	\$300 copay then 100%, deductible waived	Copay waived if admitted
	\$30 copay then 100%, deductible waived	\$55 copay then 100%, deductible waived	
Physician Services Primary Care Office Visit Specialist Office Visit Lab, X-rays Surgery	\$50 copay then 100%, deductible waived	\$80 copay then 100%, deductible waived	
	100%, deductible waived	100%, deductible waived	
	\$30 PCP or \$50 Specialist copay then 100%, deductible waived	\$55 PCP or \$80 Specialist copay then 100%, deductible waived	
• Primary Care Providers include: Family Practitioners, General Practitioners, Internists, OBGYNs and Pediatricians. Benefits for Nurse Practitioners and Physician's Assistants are considered PCPs or Specialists based on the Provider they are working under.			
Preventive Care as defined under the Patient Protection and Affordable Care Act of 2010	100% deductible waived	Office Services: \$50 copay then 100%, deductible waived Outpatient Services: 50% after deductible	

PPO Copay Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	In-Network Amounts	Out-of-Network Amounts	Limits
Prosthetics and Orthotics	70% after deductible	50% after deductible	
Skilled Nursing Facility	70% after deductible	50% after deductible	
Temporomandibular Joint Disorder (TMJ)	70% after deductible	50% after deductible	
Therapy (Outpatient) – Rehabilitative & Habilitative			
Autism Therapy	Benefit Based Upon Service Rendered	Benefit Based Upon Service Rendered	
Cognitive Therapy	70% after deductible	50% after deductible	
Cardiac Therapy	70% after deductible	50% after deductible	
Massage Therapy	70% after deductible	50% after deductible	
Occupational Therapy	70%, deductible waived	50% after deductible	
Physical Therapy	70%, deductible waived	50% after deductible	
Pulmonary Therapy	70% after deductible	50% after deductible	
Speech Therapy	70%, deductible waived	50% after deductible	
Vision Therapy	70% after deductible	50% after deductible	
Transplants	70% after deductible	50% after deductible	
Travel & Lodging	70% after deductible	50% after deductible	
Urgent Care	\$55 copay then 100%, deductible waived	\$80 copay then 100%, deductible waived	
Wigs	70% after deductible	50% after deductible	
All Other Covered Services	70% after deductible	50% after deductible	

PPO Prescription Drug Benefits		
Covered Prescription Drug Expenses	Participating Pharmacy	
	30-day supply	90-day supply
Pharmacy Option: 90-day maximum		
Copayment, per prescription or refill, for generic:	\$15 copay	\$30 copay
Copayment, per prescription or refill, for preferred name brands:	\$50 copay	\$100 copay
Copayment, per prescription or refill, for non-preferred name brands:	\$90 copay	\$180 copay
Maintenance Medications: 90-day maximum	90-day supply	
Copayment, per prescription or refill, for generic:	\$15 copay	
Copayment, per prescription or refill, for preferred name brands:	\$50 copay	
Copayment, per prescription or refill, for non-preferred name brands:	\$180 copay	
Mail Order Option: 90-day maximum	90-day supply	
Copayment, per prescription or refill, for generic:	30 copay	
Copayment, per prescription or refill, for preferred name brands:	\$100 copay	
Copayment, per prescription or refill, for non-preferred name brands:	\$180 copay	
Specialty Drug Option: 30-day maximum	30-day supply	
Coinsurance, per prescription or refill, for generic:	10% coinsurance after deductible; Minimum \$50; Maximum \$150	
Coinsurance, per prescription or refill, for preferred name brands:	10% coinsurance after deductible; Minimum \$50; Maximum \$150	
Coinsurance, per prescription or refill, for non-preferred name brands:	10% coinsurance after deductible; Minimum \$50; Maximum \$150	

**CITY OF MANCHESTER
EMPLOYEE BENEFIT PLAN
SUMMARY OF BENEFITS – LOCAL CDHP PLAN
EFFECTIVE JULY 1, 2024**

The following is a summary of benefits under this plan. Eligible Expenses under this plan are charges that have first been applied to the deductible and/or coinsurance of your fully-insured high deductible health plan. All Benefits shown below are subject to precertification requirements, limitations and exclusions as outlined in your fully-insured high deductible health plan, unless otherwise stated.

For a detailed explanation of how your employer helps share a portion of your costs of your fully-insured high deductible plan, see the section called "HOW THIS PLAN WORKS!"

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

CDHP Plan		
Type of Expense	In-Network Amounts	Out-of-Network Amounts
Embedded Deductible, per Calendar Year		
Individual	\$2,000	\$4,000
Family Unit	\$4,000	\$8,000
Payment Level (unless otherwise stated)	70%	50%
Maximum Out-of-Pocket, per Calendar Year		
Individual	\$4,500	\$10,000
Family Unit	\$9,000	\$20,000

- The Deductible and Coinsurance are applied to and included in the maximum out-of-pocket amount. Any penalties or non-covered services do not apply towards the maximum-out-pocket amount.
- The In-Network and Out-of-Network Deductible and out-of-pocket amounts do not credit or reduce each other.
- This is an embedded plan.
 - Individual Deductibles are tracked and applied to the individual and the family when an embedded plan is utilized. Once an individual has met the individual Deductible, their claims will be paid at the next level of benefits even though the family Deductible has not been met. Other individuals in the family must continue to pay their individual Deductible amount until either their own individual Deductible is met, or the family Deductible is met, whichever occurs first.
 - Out-of-Pocket amounts are tracked and applied to the individual and the family. Once an individual has met the individual maximum out-of-pocket, their claims will be paid at 100% even though the family maximum out-of-pocket as not been met. Other individuals in the family continue to pay toward their individual maximum out-of-pocket until either their individual maximum is met, or the family maximum is met, whichever occurs first.

CDHP Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	In-Network Amounts	Out-of-Network Amounts	Limits
Acupuncture	70% after deductible	50% after deductible	Limited to 50 visits per Calendar Year
Advanced Imaging – Includes, but not limited to, MR/MRA/CT/PET	70% after deductible	50% after deductible	
Allergy Services Office Visit	70% after deductible	50% after deductible	
Testing/Injections	70% after deductible	50% after deductible	
Ambulance	70% after deductible	70% after in-network deductible	
Ambulatory Surgical Center	70% after deductible	50% after deductible	
Anesthesia	70% after deductible	50% after deductible	
Chiropractic Care (Spinal Manipulations)	70% after deductible	50% after deductible	Limited to 50 visits per Calendar Year
COVID-19 Testing	Covered under your Fully-Insured Plan	Covered under your Fully-Insured Plan	
Dialysis (Outpatient)	70% after deductible	50% after deductible	
Durable Medical Equipment	70% after deductible	50% after deductible	
Hearing Aids	70% after deductible	50% after deductible	
Home Health Care	70% after deductible	50% after deductible	
Hospice Care Inpatient/Outpatient Treatment	Covered under your Fully-Insured Plan	50% after deductible	
Family Bereavement Counseling	Covered under your Fully-Insured Plan	50% after deductible	
Hospital Inpatient	70% after deductible	50% after deductible	
Outpatient	70% after deductible	50% after deductible	

CDHP Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	In-Network Amounts	Out-of-Network Amounts	Limits
Mental Health/Substance Abuse Residential Treatment Inpatient Treatment Partial Day Program Outpatient Physician	70% after deductible 70% after deductible 70% after deductible 70% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible	
Newborn Care	70% after deductible	50% after deductible	
Outpatient Diagnostic X-ray and Lab Services	70% after deductible	50% after deductible	
Outpatient Emergency Services			
Physician/Facility	70% after deductible	70% after in-network deductible	
Physician Services			
Primary Care Office Visit	70% after deductible	50% after deductible	
Specialist Office Visit	70% after deductible	50% after deductible	
Lab, X-rays	70% after deductible	50% after deductible	
Surgery	70% after deductible	50% after deductible	
• Primary Care Providers include: Family Practitioners, General Practitioners, Internists, OBGYNs and Pediatricians. Benefits for Nurse Practitioners and Physician's Assistants are considered PCPs or Specialists based on the Provider they are working under.			
Preventive Care as defined under the Patient Protection and Affordable Care Act of 2010	Covered 100% deductible waived	50% after deductible	
Prosthetics and Orthotics	70% after deductible	50% after deductible	
Skilled Nursing Facility	70% after deductible	50% after deductible	
Temporomandibular Joint Disorder (TMJ)	70% after deductible	50% after deductible	
Therapy (Outpatient) – Rehabilitative & Habilitative			
Autism Therapy	Benefit Based Upon Service Rendered	Benefit Based Upon Service Rendered	
Cognitive Therapy	70% after deductible	50% after deductible	

CDHP Plan			
Covered Medical Expenses (Subject to Fully-Insured Plan Precertification Requirements, Limitations and Exclusions, unless otherwise stated)	In-Network Amounts	Out-of-Network Amounts	Limits
Cardiac Therapy	70% after deductible	50% after deductible	
Massage Therapy	70% after deductible	50% after deductible	
Occupational Therapy	70% after deductible	50% after deductible	
Physical Therapy	70% after deductible	50% after deductible	
Pulmonary Therapy	70% after deductible	50% after deductible	
Speech Therapy	70% after deductible	50% after deductible	
Vision Therapy	70% after deductible	50% after deductible	
Transplants			
Travel & Lodging	70% after deductible	50% after deductible	
Urgent Care			
Wigs	70% after deductible	50% after deductible	
All Other Covered Services	70% after deductible	50% after deductible	

Prescription Drug Benefits		
Covered Prescription Drug Expenses	Participating Pharmacy	
Pharmacy Option: 90-day maximum	30-day supply	90-day supply
Coinsurance, per prescription or refill, for generic:	30% coinsurance after deductible	30% coinsurance after deductible
Coinsurance, per prescription or refill, for preferred name brands:	30% coinsurance after deductible	30% coinsurance after deductible
Coinsurance, per prescription or refill, for non-preferred name brands:	30% coinsurance after deductible	30% coinsurance after deductible
Maintenance Medications: 90-day maximum	90-day supply	
Coinsurance, per prescription or refill, for generic:	20% coinsurance, deductible waived	
Coinsurance, per prescription or refill, for preferred name brands:	20% coinsurance, deductible waived	
Coinsurance, per prescription or refill, for non-preferred name brands:	20% coinsurance, deductible waived	
Mail Order Option: 90-day maximum	90-day supply	
Coinsurance, per prescription or refill, for generic:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for preferred name brands:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for non-preferred name brands:	30% coinsurance after deductible	
Specialty Drug Option: 30-day maximum	30-day supply	
Coinsurance, per prescription or refill, for generic:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for preferred name brands:	30% coinsurance after deductible	
Coinsurance, per prescription or refill, for non-preferred name brands:	30% coinsurance after deductible	