2025 TMFPD HEALTH BENEFIT COMPARISON

	PROMINENCE HIGH DEDUCTIBLE PPO HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA) *		PROMINENCE PPO HEALTH PLAN *	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$3,300/$6,600	$6,600/$13,200	$500 / $1,000	$2,000 / $4,000
Out-of-Pocket Limit	$4,000/$8,000	$8,000/$16,000	$3,000 / $6,000	$6,000 / $12,000
Health Savings Account (HSA) * District provided funds Employee only/Employee +1 or more**	$2,356/$4,688	Not Applicable	Not applicable	Not applicable
HEALTH CARE PROVIDER OFFICE OR CLINIC VISIT				
Primary care visit to treat an injury or illness	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	$15 copay per visit	CYD/30% coinsurance per visit
Specialist visit	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	$30 copay per visit	CYD/30% coinsurance per visit
Preventive care/screening/ immunization	No Charge	CYD/30% coinsurance per visit	No Charge	CYD/30% coinsurance per visit
TESTING IMAGING, DIAGNOSTIC, LABS				
Diagnostic test (x-ray, blood work)	CYD/0% coinsurance per test Blood work (Laboratory) -CYD/0% coinsurance per visit	CYD/30% coinsurance per test CYD/30% coinsurance per test	$15 copay per test Blood work (Laboratory) – $0 copay per test	CYD/30% coinsurance per test CYD/30% coinsurance per test
Imaging (CT/PET scans, MRIs)	CYD/0% coinsurance per test	CYD/30% coinsurance per test	$100 copay per test	CYD/30% coinsurance per test
PRESCRIPTION DRUGS				
Generic drugs	CYD/$15 copay per prescription (retail)	Not Covered	$10 copay per prescription (retail)	Not Covered
Preferred brand drugs	CYD/$40 copay per prescription (retail)	Not Covered	$30 copay per prescription (retail)	Not Covered
Non-preferred brand drugs	CYD/$60 copay per prescription (retail)	Not Covered	$50 copay per prescription (retail)	Not Covered
Specialty drugs	CYD/20% coinsurance per prescription	Not Covered	20% coinsurance per prescription	Not Covered
OUTPATIENT SURGERY				
Facility fee (e.g., ambulatory surgery center)	CYD/0% coinsurance per surgery	CYD/30% coinsurance per surgery	CYD/10% coinsurance per surgery	CYD/30% coinsurance per surgery
Physician/surgeon fees	Included in above	Included in above	Included in above	Included in above
IMMEDIATE MEDICAL ATTENTION				
Emergency room care	CYD/0% coinsurance per visit	CYD/0% coinsurance per visit	$100 copay per visit	$100 copay per visit
Emergency medical transportation	CYD/0% coinsurance per trip	CYD/0% coinsurance per trip	$200 copay per trip – Air $100 copay per trip -- ground	$200 copay per trip – Air $100 copay per trip -- ground
Urgent care	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	$35 copay per visit	CYD/30% coinsurance per visit
Facility fee (e.g., hospital room)	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	CYD/10% coinsurance per admit	CYD/30% coinsurance per admit
Physician/surgeon fees	Included in facility fee above	Included in facility fee above	Included in facility fee above	Included in facility fee above
Outpatient services	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	CYD/10% coinsurance per visit	CYD/30% coinsurance per visit
Inpatient services	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	CYD/10% coinsurance per admit	CYD/30% coinsurance per admit
PREGNANCY				
Office visits	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	$30 copay per visit	CYD/30% coinsurance per visit
Childbirth/delivery professional services	CYD/0% coinsurance per delivery	CYD/30% coinsurance per delivery	$30 copay per visit	CYD/30% coinsurance per delivery
Childbirth/delivery facility services	CYD/0% coinsurance per admit	CYD/30% coinsurance per admit	CYD/10% coinsurance per admit	CYD/30% coinsurance per admit
ADDITIONAL SERVICES				
Home health care	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	CYD/10% coinsurance per visit	CYD/30% coinsurance per visit
Skilled nursing care	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	CYD/10% coinsurance per visit	CYD/30% coinsurance per visit
Durable medical equipment	CYD/0% coinsurance per device	CYD/30% coinsurance per device	CYD/10% coinsurance per device	CYD/30% coinsurance per device
Hospice services	CYD/0% coinsurance per visit	CYD/30% coinsurance per visit	$30 copay per visit	CYD/30% coinsurance per visit
DENTAL	**GUARDIAN**		**GUARDIAN**	

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	PROMINENCE HIGH DEDUCTIBLE PPO HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA) *		PROMINENCE PPO HEALTH PLAN *	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$0	$50	$0	$50
Charges covered for care **	Preventative 100% Basic 80% Major 50% Orthodontia 50% *Lifetime Orthodontia $1500* *(Dependent Children to 18 Only orthodontia)* *Annual Maximum Benefit $2000*	Preventative 100% Basic 80% Major 50% Orthodontia 50% *Lifetime Orthodontia $1500* *(Dependent Children to 18 Only orthodontia)* *Annual Maximum Benefit $2000*	Preventative 100% Basic 80% Major 50% Orthodontia 50% *Lifetime Orthodontia $1500* *(Dependent Children under 18 Only orthodontia)* *Annual Maximum Benefit $2000*	Preventative 100% Basic 80% Major 50% Orthodontia 50% *Lifetime Orthodontia $1500* *(Dependent Children under 18 Only orthodontia)Annual Maximum Benefit $2000*
VISION	**VSP**		**VSP**	
	Copay	**Frequency**	**Copay**	**Frequency**
Copay WellVision Exam	$10	Every 12 Mo	$10	Every 12 Mo
Primary Eyecare (medical and urgent eyecare)	$20	As needed	$20	As needed
Prescription Glasses	$25	See Below	$25	See Below
Frame	Included in Prescription Glasses $200 allowance frames $220 allowance featured frame brands 20% savings on the amount over your allowance	Every 24 Mo	Included in Prescription Glasses $200 allowance frames $220 allowance featured frame brands 20% savings on the amount over your allowance	Every 24 Mo
Elective Contact Lenses	$120 allowance contacts	Every 12 Mo	$120 allowance contacts	Every 12 Mo
Lenses	Included in Prescription Glasses	Every 12 Mo	Included in Prescription Glasses	Every 12 Mo
VSP LightCare	$200 allowance for ready-made non-prescription sunglasses, blue light filtering glasses instead of prescription glasses or contacts	Every 24 Mo	$200 allowance for ready-made non-prescription sunglasses, blue light filtering glasses instead of prescription glasses or contacts	Every 24 Mo
Lens Enhancements	Standard progressive lenses $0 Premium progressive lenses $80 - $90 Custom progressive lenses $120 - $160	Every 12 Mo	Standard progressive lenses $0 Premium progressive lenses $80 - $90 Custom progressive lenses $120 - $160	Every 12 Mo
LIFE INSURANCE	**THE STANDARD**		**THE STANDARD**	
Full time employees - District provided	Benefit Amount $25,000 Benefit Reduces at 65 to 65% Benefit Reduces at 70 to 50%		Benefit Amount $25,000 Benefit Reduces at 65 to 65% Benefit Reduces at 70 to 50%	

* See Summary of Benefits and Coverage (SBC) for each plan for more detailed information.

** See provider packet for each plan for more detailed information.

*** Prorate - new hires as needed per hire date and/or changes to dependents going from EE only to EE + 1 or more

This list of services is not all inclusive