TGMC
Terrebonne General Medical Center

GROUP HEALTH BENEFIT SUMMARY

Effective April 1, 2018

	PLAN 1	PLAN 2
DEDUCTIBLE (Per person, per calendar year)		
Tier 1 – TGMC Facility & TQHN Providers	$500 ($1,500 per family maximum)	$2,000 ($4,000 per family maximum)
Tier 2 – PPO Providers	$750 ($2,250 per family maximum)	$2,500 ($5,000 per family maximum)
Tier 3 – Non-Network	$1,000 ($3,000 per family maximum)	$3,000 ($6,000 per family maximum)
CO-INSURANCE	Plan pays / Employee pays	Plan pays / Employee pays
Tier 1 – TGMC Facility & TQHN Providers	90% / 10%	90% / 10%
Tier 2 – PPO Providers	70% / 30%	70% / 30%
Tier 3 – Non-Network	30% / 70%	30% / 70%
Deductible per confinement or outpatient surgery in a facility other than TGMC - farther than 30 mile radius from TGMC (one per confinement deductible per calendar year)	Tier 2 – PPO Provider is $1,000 Tier 3 – Non-Network is $1,500	Tier 2 – PPO Provider is $1,000 Tier 3 – Non-Network is $1,500
Deductible per confinement or outpatient surgery in a facility other than TGMC - within 30 mile radius from TGMC (deductible applies for each confinement and each outpatient surgery)	Tier 2 – PPO Provider is $1,500 Tier 3 – Non-Network is $2,000	Tier 2 – PPO Provider is $1,500 Tier 3 – Non-Network is $2,000
OUT OF POCKET EXPENSE (including deductible)		
Tier 1 – TGMC Facility & TQHN Providers	$2,500 ($7,500 per family maximum)	$5,000 ($10,000 per family maximum)*
Tier 2 – PPO Providers	$3,000 ($9,000 per family maximum)	$6,000 ($12,000 per family maximum)*
Tier 3 – Non-Network	Unlimited	Unlimited *Includes prescription drug out-of-pocket
PHYSICIAN SERVICES		
Tier 1 – TQHN Providers	Deductible, then 10% co-insurance	Deductible, then 10% co-insurance
Tier 2 – PPO Providers	Deductible, then 30% co-insurance	Deductible, then 30% co-insurance
Tier 3 – Non-Network	Deductible, then 70% co-insurance	Deductible, then 70% co-insurance
DIAGNOSTIC TESTING - OUTPATIENT		
Facility		
Tier 1 – TGMC Facility	0% (no deductible, no co-insurance)	0% (no deductible, no co-insurance)
Tier 1 – TQHN Providers	Deductible, then 10% co-insurance	Deductible, then 10% co-insurance
Tier 2 – PPO Providers	Deductible, then 30% co-insurance	Deductible, then 30% co-insurance
Tier 3 – Non-Network	Deductible, then 70% co-insurance	Deductible, then 70% co-insurance
Physician		
Tier 1 – TQHN Providers	Deductible, then 10% co-insurance	Deductible, then 10% co-insurance
Tier 2 – PPO Providers	Deductible, then 30% co-insurance	Deductible, then 30% co-insurance
Tier 3 – Non-Network	Deductible, then 70% co-insurance	Deductible, then 70% co-insurance

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	PLAN 1	PLAN 2
PRESCRIPTION DRUGS		
Calendar Year Deductible	$150 ($450 per family maximum)	$150 ($450 per family maximum)
Retail Pharmacy - Acute Prescriptions		
Generic Drugs	Deductible waived $10 co-pay or 20% of cost, whichever is greater	Deductible waived $10 co-pay or 20% of cost, whichever is greater
Formulary Drugs	$25 co-pay or 30% of cost, whichever is greater	$25 co-pay or 30% of cost, whichever is greater
Non-Formulary Drugs	$50 co-pay or 50% of cost, whichever is greater	$50 co-pay or 50% of cost, whichever is greater
Prescribed Preventive Medications and Contraceptives as required by federal law	No cost	No cost
Mail Order - Maintenance Prescriptions		
Generic Drugs	Deductible waived $25 co-pay or 20% of cost, whichever is greater	Deductible waived $25 co-pay or 20% of cost, whichever is greater
Formulary Drugs	$62.50 co-pay or 30% of cost, whichever is greater	$62.50 co-pay or 30% of cost, whichever is greater
Non-Formulary Drugs	$125 co-pay or 50% of cost, whichever is greater	$125 co-pay or 50% of cost, whichever is greater
Prescribed Preventive Generic Medications and Contraceptives as required by federal law	No cost	No cost
Out of Pocket Expense		
Per person, per calendar year Per family, per calendar year	$2,750 $5,500	Applies to medical Out of Pocket expenses
	Under Plan 1, prescription drug out-of-pocket amount is separate from the medical out-of-pocket amount.	*Prescription drug expenses apply to the medical out-of pocket amount.
PAYROLL DEDUCTIONS (24 pay periods per year)		
Employee Employee+1 Family (Employee+2 or more)	$56.57 per pay period $240.72 per pay period $360.72 per pay period	$18.33 per pay period $127.24 per pay period $191.10 per pay period

REMINDERS

- Preventive Care benefit is covered at 100% for both plan options. Covers preventive care recommended by the U.S. Preventive Task Force and immunizations recommended by the CDC.
- Pre-certification is required for all inpatient admissions.
- For Behavioral/Mental Health and Substance Use Disorder services, New Directions is an additional PPO option. Please call 1-800-624-5544.

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