



Plan Overview

2010 Application Notes, Benefit Plans, & Premium Tables

This booklet is about AccessTN. We hope it will help you as you fill out an application. It is arranged by sections in the same order as the Application for Health Coverage:

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Forms are also available on the web at www.AccessTN.gov if you need more. But remember – help with the application is available toll free at 1-866-636-0080.

In these and other AccessTN papers, we’ll use plural words like “we” or “our” or “us” to mean AccessTN. We’ll use individual words like “you” or “I” for the applicant, a person applying for coverage. We may also use “member” to refer to a person enrolled in AccessTN. When we say “Plan Document”, we mean the collection of papers, especially the member handbook, which provide the formal description controlling plan benefits, policies and definitions, as approved by the AccessTN Board.

Anytime we say that something is available at www.AccessTN.gov, you can also get that information by calling toll-free 1-866-636-0080. That is the customer service line for the AccessTN plan administrator, BlueCross BlueShield of Tennessee, Inc. Information is also available on their website. You can find AccessTN information under the “Plan Options - Cover Tennessee” tabs at the top of the www.bcbst.com webpage.

Call 1-866-636-0080 toll free if you have questions or need help with the application.

Our mailing address for completed applications is:

AccessTN
c/o BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga TN 37402

AccessTN is a program of the State of Tennessee. The health plans are administered by BlueCross BlueShield of Tennessee, Inc. – an Independent Licensee of the BlueCross BlueShield Association.



AccessTN Health Coverage

State of Tennessee • Department of Finance and Administration

Keep this booklet but return applications to:

1 Cameron Hill Circle, Chattanooga TN 37402

AccessTN is administered by BlueCrossBlueShield of Tennessee, Inc.
- an Independent Licensee of the BlueCrossBlueShield Association

What is AccessTN?

AccessTN is a program sponsored by the State of Tennessee for people who can't get other health coverage because of their medical conditions. The program is part of the Cover Tennessee initiative and is one of thirty-five state high risk pools that provide this type of coverage. When we say "coverage," we mean payments for medical services and drug costs as health insurance does. We may use "Pool" as short for AccessTN, including those companies we use to administer services such as enrollment, claims payment, or premium assistance.

AccessTN is health coverage that works like individual insurance.

Insurance is a term we will use a lot. First, AccessTN is NOT TennCare, a medical assistance program regulated by federal Medicaid guidelines. It is not Medicare either. Insurance is rule-based, which can make it complicated. This booklet will tell you about some of our guidelines.

Insurance is an arrangement in which you pay a set fee (a premium) to receive coverage for a set schedule of medical and health services (benefit plan). The premium is based on the professional estimate of what those services will cost. "Covered services" are simply those the plan covers, or pays for. Please take some time to review page 4 showing the different benefit plan options. The meanings of some commonly used insurance terms are on page 13.

Insurance will NOT pay for other health services, called "non-covered services." If you have these services done, you will have to pay these claims yourself, even if a doctor prescribes them. That's why it's important to choose your benefit plan carefully and know what services we will and will not cover.

Who pays for AccessTN?

Our members may have serious health conditions and tend to have more medical claims. That makes our premiums higher than commercial rates but still may not cover actual Pool costs. State funds and contributions from other health plans in the state will help pay part of the losses of AccessTN. State funds have also been provided to help members pay premiums, based on family income.

We are part of the Cover Tennessee family of state programs to help Tennesseans improve their access to health insurance and to medical care, and we hope AccessTN can be an option for you. But we will enroll only the number of members we think the Pool can pay for. Please apply as early as you can if you think you may be eligible.

Separate optional forms and applications available at www.AccessTN.gov or 1-866-636-0080.

Application for Premium Assistance – To apply for premium assistance, you should send in the separate Application for Premium Assistance with your Application for Health Coverage. If you do not send them in together, your premium assistance may not start at the same time.

Attending Physician's Statement – your doctor can use this paper, or write a different letter, to report diagnosis, medical billing codes, and treatment history. A doctor's statement is only necessary if you are using any of the 50+ listed medical conditions to show that you are uninsurable.

Qualified Legal Alien Statement – if you are not a U.S. citizen, you may qualify if you meet one of the specific criteria shown on the form.

Information you provide in Section A of the Application for Health Coverage gives us details about who you are and where you live. We need it to know how to contact you, to confirm that you qualify for the program, and to assist you in managing your health conditions. We realize this is your personal health information (PHI) and must be handled carefully. We call this information your “health facts” but it also includes other information that identifies you, like your date of birth, or street address. We and those companies that provide AccessTN services will only use your health facts as state laws and privacy rules permit. Sections G and I of the Application for Health Coverage will tell you more.

What is a PPO and what are my options?**Section B**

Our current benefit plan options are all based on a PPO (preferred provider organization) design. This means that the Plan contracts with a “network” of doctors, hospitals and other health providers. They agree to be paid a set amount called the “maximum allowed charge” (MAC) for each covered service. They will not collect more from you than a pre-set share of the claim, called “co-insurance.” This member share is frequently 20% in our benefit plans. Look at the provider directory on www.bcbst.com or call 1-866-636-0080 to see if your current doctors are “in-network,” or to look for other “in-network” doctors where you live.

You can also use other non-listed doctors and hospitals, called “out-of-network” providers. But if you do, you will pay a higher member share, frequently 40%. Those out-of-network providers can also charge you more than the Plan’s maximum allowed charge, the set amount which we pay “in-network”.

AccessTN has three different benefit plans - One, Two, and Three. Page 4 shows a general listing of services covered for each benefit plan. More detailed information on covered services, their limits, and exceptions can be found in the Plan Document. The name of each plan has been based on its “deductible”, the dollar amount of covered services you pay for before the Plan begins paying claims. For example, Plan One was called Plan 1000 because of its \$1000 deductible. Now they are called:

- Plan One has a \$1000 deductible and is the only benefit plan offering premium assistance, if you qualify and funds are available.
- Plan Two has a \$3000 deductible and is the only plan eligible for use with a health savings account (HSA). There’s more information on HSAs below.
- Plan Three has a \$5000 deductible. This is a high deductible health plan NOT eligible for use with an HSA. It might be a good choice for those who plan to pay most medical expenses on their own, but want coverage for pharmacy or high medical expenses from a disease or injury.

What makes Plan Two compatible with a health savings account?

We will not offer the “health savings account” (HSA) itself. You can start the HSA at banks or credit unions. An HSA is an individual savings account for current and future medical expenses which is given special federal tax treatment. See www.ustreas.gov or IRS Publication 969 for more information on HSAs. We cannot give you tax advice, so talk to a tax adviser about your choice.

AccessTN offers one high deductible health plan – Plan Two (\$3000 deductible) – that can be used with an HSA. HSAs have special rules and can only be used with a qualified high-deductible insurance plan like Plan Two. High-deductible plans used with HSAs require that ALL services except preventive care apply to the deductible. This means that, except for your annual physical, you will pay the full cost of all medical and pharmacy costs until you have paid \$3000 in qualifying expenses for the plan year.

Plan Two benefits are very different than Plans One and Three. See the benefit schedule on page 4. Notice that the maximum pharmacy benefit is lower than Plans One and Three. See www.bcbst.com or call 1-866-636-0080 if you have questions. Weigh these differences and the tax benefits of using an HSA in choosing your benefit plan.

AVAILABLE BENEFIT PLANS FOR 2010

Regular AccessTN category has a 6 months reduced benefit period for pre-existing conditions, see rates page 9

Portability has no waiting period for pre-existing conditions but has a higher premium for Plan One, see page 11

OUTLINE OF PPO MEDICAL BENEFITS	Plan One “premium assistance-eligible”	Plan Two “health savings account-eligible”	Plan Three “high deductible” Not HSA-eligible
These plans are offered for either Portability and Regular eligibility (see Plan Document for more detail)			
DEDUCTIBLE per plan year:	In-network Out-of-network	\$1,000 \$2,000	\$5,000 \$10,000
PREVENTIVE CARE- specific services only	100% In-Network	100% In-Network	100% In-Network
Preventive care is first dollar coverage for specific wellness services such as an annual well woman exam, preventive screenings and an annual physical. Preventive care is not subject to the in-network deductible above or to co-insurance.			
SPECIALIST ALLOWANCE - a \$200 allowance toward the first claim(s) for specialist care services received each plan year; Not subject to deductible or co-insurance	100% up to \$200 in-network only	Not available due to federal HSA rules	100% up to \$200 in-network only
PRESCRIPTION DRUGS - subject to additional limits; Pharmacy not subject to deductible in Plans One & Three	No deductible for outpatient drugs	Deductible applies to drugs	No deductible for outpatient drugs
Generic Drugs	\$10 co-pay (cost if less)	\$10 co-pay (cost if less)	\$10 co-pay (cost if less)
Preferred Brand Drugs	25% co-payment to a maximum of \$50	25% co-payment to a maximum of \$50	25% co-payment to a maximum of \$50
Non-Preferred Brand Drugs	50% co-payment to a maximum of \$100	50% co-payment to a maximum of \$100	50% co-payment to a maximum of \$100
COVERED EXPENSES , as specified in Plan Document subject to maximum allowable charge (MAC)	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
PRE-EXISTING CONDITIONS- reduced benefit for 6 months in Regular plans – limitation does not apply to preventive care, prescription drugs, or outpatient mental health counseling; does <u>not</u> apply to Portability plans	50% in-network 50% out-of-network during first 6 months of coverage only	50% in-network 50% out-of-network during first 6 months of coverage only	50% in-network 50% out-of-network during first 6 months of coverage only
Maternity benefits in Regular Plans	Excluded during 12 month waiting period	Excluded during 12 month waiting period	Excluded during 12 month waiting period
Maternity benefits in Portable Plans from Day One and in Regular Plans after first 12 months	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Chiropractic benefits	Subject to guidelines	Subject to guidelines	Subject to guidelines
Emergency services (in-network or out-of-network)	80% of reasonable charges	80% of reasonable charges	80% of reasonable charges
Emergency Room (ER) co-payment per visit – waived if admitted (Note: co-payment required even if out-of-pocket expenses have been met, except HSA)	\$50 co-payment per visit in addition to co-insurance	subject to deductible and co-insurance requirements	\$75 co-payment per visit in addition to co-insurance
Maximum Annual Out-of-Pocket Expense	\$5,000	\$5,950	\$10,000
Note: The Maximum Annual Out-of-Pocket Expense does not apply to pre-existing conditions during first 6 months; does not apply to out-of-network services or ER co-payments; and does not apply to pharmacy co-payments except for Plan Two			
Maximum Annual Benefits , except organ transplant	\$300,000	No aggregate maximum	\$300,000
Supplemental Organ Transplant benefit (Plans One & Three only)	\$100,000	\$100,000 maximum Not supplemental	\$100,000
Maximum Lifetime Benefits	\$1,000,000	\$1,000,000	\$1,000,000
Substance Abuse Treatment Limitations	Lifetime maximums: Two inpatient stays – maximum of 28 days per stay. Two inpatient stays for detoxification – maximum of 5 days per stay.		

ANNUAL LIMITS FOR SPECIFIC BENEFITS

Pharmacy (may be additional limits for specific drugs)	\$100,000 maximum	\$30,000 maximum	\$100,000 maximum
Plans One and Three provide supplemental outpatient pharmacy coverage for anti-hemophilic factor which extends the max to \$180,000.			
Inpatient Rehabilitation Facility	No separate limit	45 days	No separate limit
Outpatient Rehabilitation Facility	45 days	45 days	45 days
Outpatient Physical Therapy, Occupational Therapy, Speech Therapy	45 sessions subject to Plan guidelines	45 sessions subject to Plan guidelines	45 sessions subject to Plan guidelines
Skilled Nursing Facility (Following approved hospitalization.	45 days	45 days	45 days
Home Health Care	30 visits	30 visits	30 visits
Durable Medical Equipment	\$3,000 Max	\$3,000 Max	\$3,000 Max
Inpatient Mental Health/ Substance Abuse	30 days	30 days	30 days
Outpatient Mental Health/ Substance Abuse	45 sessions	45 sessions	45 sessions

Benefit Plans subject to change by AccessTN Board. Plan reimbursement based on the maximum allowable charge (MAC).

We will calculate your premium. Premiums are different for Plans One, Two, and Three. Section C of the application requires information about your weight and whether you smoke. Premium tables for AccessTN Regular coverage begin on page 9 and those for Portability eligibility begin on page 11.

AccessTN will figure your premium and, if you qualify, your premium assistance. If you want to estimate your member share, you must first decide whether you will have a Regular or a Portable Plan, which we'll talk about in Section E. Then you can estimate what your monthly member share of premium will be using the tables on page 9 -10 for Regular Plans and pages 11-12 for Portability Plans.

Financial help is available for Plan One. Premium assistance can help pay for Plan One (\$1000 in-network deductible). If you have a family income of \$75,000 or less, you can apply for help paying your premiums. You will still have to pay your member share of the premium each month.

Individuals may qualify for 20%, 40%, or 60% premium assistance, based on income. An illustration may help. If we assume that the premium for Plan One, based on your age, and your smoking and weight status would normally be \$1000, and you qualify for the maximum 60% assistance, the State would pay \$600 of your premium. Your monthly member share each month would be \$400.

To use an actual example from the rate tables for Regular Plan One, the premium for a 52 year old person who was below the target weight for their height and a non-smoker would be \$688 per month. If that person qualified for 60% assistance, his or her member share of premium would be 40% or \$275 each month.

To apply for assistance, send in the separate Application for Premium Assistance with your Application for Health Coverage. If you do not send both applications in together, your premium assistance may not start at the same time as your health coverage. You will also need to send in pages 1 and 2 of your most recent IRS tax filing or, if you do not file taxes, other papers which show your family income. Income assistance tables are on page 10 and page 12. Here are some of the guidelines we use.

“Family” or **“Household”** means you and all of your children at home or anyone you live with that the IRS lets you count as a dependent on yours and your spouse's tax return.

“Income”, means money you have to pay federal taxes on, before taking standard and itemized deductions on your tax form. IRS calls it “Adjusted Gross Income” (AGI). We use IRS rules which can be found at www.irs.gov. This income number includes wages, bonuses and other earnings. Income includes interest, pensions, unemployment compensation, alimony you get, business income, or social security payments (to the extent they are included in AGI on your tax return) but does not include alimony you pay or supplemental security income (SSI) payments. **If you use Form 1040 to pay taxes, the income number we will use is at the top of page 2 (line 38) of your taxes.** If you do not file income taxes, we can use other proof of income to determine premium assistance.

Who can pay your premium for you? Pool rules require that you tell us if you get help paying your share of the premium from anyone other than family and friends. But the rules allow a church or foundation to help if you let us know. Doctors, hospitals, or drug companies are not allowed to pay your premium. Neither can your employer.

Anyone can help with costs other than premiums. Pool rules do not restrict who can help you with co-insurance, deductibles, or payments for services not covered by your benefit plan.

Do you qualify as a HIPAA eligible person or a state eligible “uninsurable”? Section D

All benefit plans (Plans One, Two, and Three) are available for each type of eligibility - HIPAA Portability, and State Uninsurable (either Portability or Regular). Portability means coverage that allows you to move from certain health plans to new health coverage without any waiting period and without any pre-existing conditions limitation.

We have two different kinds of eligibility - HIPAA eligibility and state uninsurable eligibility. HIPAA stands for the Health Insurance Portability and Accountability Act, which has rules on insurance plan portability and on privacy.

For **HIPAA eligibility** you do **NOT** have to show you are **uninsurable**. You must be a Tennessee resident and meet **ALL** the rules (a) thru (e) below:

- (a) you have eighteen (18) or more months of combined health coverage with no break in coverage of more than 63 days;
- (b) your most recent coverage was under an employer-sponsored GROUP health plan;
- (c) you are not eligible for employer coverage where you work, Medicare or Medicaid, and you do not have other health coverage;
- (d) your most recent coverage was not terminated for nonpayment of premiums or fraud; and,
- (e) if eligible for COBRA or group continuation, you must have taken and completed your full COBRA eligibility.

If you qualify as a HIPAA eligible person, then you will check “Yes” to question D1 in Section D and you will also check box E3 for HIPAA Portability in Section E. Your AccessTN coverage will start the day after your previous coverage ended, if you pay the premium due for all months since the start date. This type of eligibility has no reduction in coverage for pre-existing medical conditions during the first six months, but has a higher premium for those in Plan One.

If you do not qualify for HIPAA eligibility, you can still join AccessTN if you qualify as a state eligible person.

For **state eligibility** (either State Portability or Regular) you must meet the rules (a) thru (c) below:

- (a) you must be a Tennessee resident for 6 months;
- (b) you are not eligible for a group health plan, Medicare, Medicaid, and you do not have other health insurance coverage;
- (c) AND you must show you are **uninsurable**. Uninsurable means you cannot get insurance because of health reasons.

In state eligibility, you must show that you are uninsurable to qualify for either the Regular category or the Portability category described in Section E. You can show you are uninsurable in either of the ways listed below:

- Denial of coverage due to health reasons by a health insurer; OR
- A doctor’s statement that you have one of the 55 medical conditions on the Attending Physician’s Statement. See www.accessn.com/web/access_physicianstatement.pdf. You can use the copy in your packet or your doctor can write us a separate letter. The letter **must** tell us the diagnosis code. We only accept specific codes for each medical condition.

(The Application for Health Coverage has additional detail on the requirements of each method.)

Start Date of Coverage. All AccessTN coverage begins according to our enrollment schedule. For Regular Plans One, Two, or Three, your application must be processed prior to the 15th of the month for coverage to begin the first of the next month. For Portability Plans One, Two, or Three, if you apply within 63 days of your prior qualifying coverage ending, your AccessTN coverage will begin the day following the end of the prior insurance. You can apply prior to the end of your other coverage.

Pre-existing conditions are those for which you got or had reason to get medical care or treatment during a six-month period immediately before you enrolled in AccessTN. We offer two types of coverage - Regular or Portability, based on how the plans pay for pre-existing conditions. Plans One, Two, and Three, as described on Page 4, are offered for both Regular and Portability coverage.

Portability is a rule that allows you to move from a prior health plan to new coverage without any waiting period and without any pre-existing conditions limitation in the new plan. Portability category plans may be offered for either State or HIPAA eligible individuals, depending on your prior coverage. You must apply within 63 days. You can apply before the end of your other coverage. Portability Plan One premiums are higher than rates for the Regular category Plan One

- **HIPAA Portability – if you are applying without a significant break since your most recent qualifying employer-sponsored group coverage. To qualify for Portability coverage:**
 - Apply within 63 days of finishing your COBRA or other group continuation coverage OR
 - Apply within 63 days of the end of qualifying group coverage if no COBRA available
 - Meet all five criteria for HIPAA Portability listed in Section D.
- **State Portability – if you do not qualify for HIPAA Portability, certain types of prior coverage allow you to come directly into AccessTN.** You can join without a 3-month waiting period and without any pre-existing conditions limitation if you are coming from certain kinds of coverage. This includes TennCare, CoverKids, and certain small group or other Board-approved plans not eligible for HIPAA portability. You must apply within 63 days of the prior coverage and must not have been terminated for fraud, misrepresentation, or non-payment.

Note: State Portability requires you to show that you are uninsurable as described in Section D.

- **Regular AccessTN – if you will have been uninsured 3 months when your AccessTN begins.** All Regular plans are based on state eligibility and require proof of uninsurability. Regular plans are for those who have had a significant break in coverage (more than 63 days). You must have been without other health insurance for 3 months prior to AccessTN (some exceptions apply). This time without insurance is called a “go-bare” requirement.

Plans One, Two, and Three for this Regular AccessTN category all have a 6 month “pre-existing conditions” period before we will pay the full benefit (usually 80%) of claims for any medical conditions you had at the time you enroll.

How the 6 month reduced benefit period for pre-existing conditions works. In Regular plans, we will pay 50% of the Maximum Allowable Charge (MAC) for services for pre-existing conditions during the first 6 months, subject to your deductible. You will be responsible for paying the remaining 50% of the MAC. The 50% you pay during this 6 months does NOT count toward your out-of-pocket maximum, so you may want to wait on some non-essential services until after you have been covered 6 months. Regular Plans One, Two, and Three also have a 12 month waiting period for maternity coverage.

Exceptions to the pre-existing conditions limitation in Regular Plans. The pre-existing conditions limitation does NOT apply to specific preventive care services related to an annual well woman exam, preventive screenings and an annual physical. Regular Plans also provide the full benefit from day one for outpatient pharmacy, outpatient chemotherapy and radiation drugs, outpatient counseling services, and a new \$200 annual specialist allowance. None of these services will be subject to the Plan One or Plan Three deductible. However, because of the special IRS rules for plans used with a health savings account (HSA), all benefits except preventive care must be subject to the deductible for both Regular and Portability Plan Two.

What Other Insurance is Permitted?

Section F

AccessTN is health coverage for those who cannot get health insurance elsewhere. We cannot cover those who are able to get insurance through an employer. Availability of group coverage at your work or being enrolled in an individual major medical policy may disqualify you for immediate enrollment in AccessTN. Plan rules require that you let us know if you have other coverage or are able to get other coverage after you qualify for AccessTN. **Not all types of health insurance will disqualify you for AccessTN.** Tell us what you can about any other coverage. We may ask you for additional detail.

Long term care, cancer-only and indemnity policies are examples of coverage that does not count as other insurance for purposes of AccessTN eligibility. This means you can have these policies during any “go-bare” requirement without disqualifying you and that you may keep them while in AccessTN.

Individual coverage that excludes a major body system like the heart may not disqualify you in some cases. The exclusion must be based on your personal medical history and must be a permanent exclusion of a body system. See the first column of the Attending Physician’s Statement for examples.

What is Protected Health Information and how are my health facts used?

Section G

Protected Health Information (PHI) means facts and records about your health, including:

- claims records
- laboratory reports
- hospital records
- correspondence
- medical records
- your address and birthday

Federal and state laws protect the privacy of your health facts. Privacy rules say AccessTN or your health providers can’t give others information about you unless you give permission. These rules permit us to use this information for your health care, including AccessTN operations such as eligibility and enrollment. When you sign your application, you are giving your authorization for your providers or employers or others you name in the application to provide AccessTN information about you. And for us to talk to them. This includes TennCare if you were ever enrolled in TennCare.

Why does AccessTN need my Health History?

Section H

This information will help AccessTN assist you in managing your health conditions, including the possibility of disease management if you have asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, or diabetes. Please provide brief answers to the questions listed on pages 5 and 6 of the application. Your answers will help us identify how we can help with care management. Yes and No answers and what you remember are OK for this purpose.

What does my signature on the application mean?

Sections I & J

By signing the application in Section J, you are stating that you have read the required sections and that the information you have submitted in the application is true. Please take the time to read this information carefully.

Tell us who helped you with your application and if we can talk to people you name.

Section K

This section is for the applicant to provide the information we need if a friend, family member or other person helped to complete the application. If you choose to, you can also give us permission in this section to talk about your health facts with that helper or your relatives or others you name.

Monthly Premiums for Regular AccessTN Plans

Plan ONE: \$1,000 deductible – premium assistance is available for this plan

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	\$410	\$472	\$456	\$524
30-39	\$477	\$548	\$530	\$608
40-49	\$579	\$666	\$643	\$740
50-59	\$688	\$792	\$765	\$880
60-64	\$812	\$934	\$902	\$1,038
65+	\$958	\$1,102	\$1,065	\$1,225

To determine your monthly premium, first find your height and weight on the chart below.

Next, go to the tables on the left side of this page for the benefit plan you have chosen (Plans One, Two, or Three) and find the row for your age group.

Then move across the row for your age to find the column that fits you:

- If your weight is equal to or less than what is listed in the chart, use the “Target Weight or Below” columns. If your weight is more than what is listed in the chart, use the “Above Target Weight” side.
- Finally, are you a tobacco user (cigarettes, chewing tobacco, pipe or cigars) or not?

This will be the monthly premium for your beginning coverage, unless you qualify for premium assistance. If you qualify, you can use the tables on page 10 in the same way as is described here.

Note: Plan One has 20% to 60% premium help available for applicants with incomes up to \$75,000, Assistance is subject to funding. See Page 10.

Plan TWO: \$3,000 deductible (Health Savings Account eligible)

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	\$318	\$366	\$353	\$406
30-39	\$369	\$425	\$410	\$472
40-49	\$449	\$516	\$498	\$573
50-59	\$534	\$614	\$593	\$682
60-64	\$630	\$724	\$699	\$804
65+	\$743	\$855	\$826	\$950

Plan THREE: \$5,000 deductible (not HSA compatible)

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	\$284	\$326	\$315	\$362
30-39	\$330	\$379	\$366	\$420
40-49	\$399	\$460	\$444	\$511
50-59	\$475	\$547	\$528	\$607
60-64	\$561	\$645	\$623	\$717
65+	\$662	\$761	\$736	\$847

Target Weight defined as having a Body Mass Index (BMI) of 30

Height	Target Weight
4' 10"	142
4' 11"	147
5' 0"	152
5' 1"	157
5' 2"	163
5' 3"	168
5' 4"	173
5' 5"	179
5' 6"	185
5' 7"	190
5' 8"	196
5' 9"	202
6' 0"	220
6' 1"	226
6' 2"	232
6' 3"	239
6' 4"	245
6' 5"	252

Note-

- 1) All Regular AccessTN benefit plans above subject to 6 months pre-existing conditions waiting period and 12 month waiting period for maternity coverage.
- 2) You are eligible for AccessTN coverage over the age of 64 ONLY if you are NOT eligible for Medicare.
- 3) AccessTN is not a Medicare supplement policy.

Premium Assistance for Regular AccessTN Plan One

(for those who will have been without insurance for 3 months when they join AccessTN)

Available for Plan One (\$1000 in-network deductible)

Income Guidelines for Premium Assistance*

Persons in Household	Incomes up to 200% FPL	Incomes up to 250% FPL	Incomes up to 350% FPL
1	\$ 21,660	\$ 27,075	\$ 37,905
2	\$ 29,140	\$ 36,425	\$ 50,995
3	\$ 36,620	\$ 45,775	\$ 64,085
4	\$ 44,100	\$ 55,125	up to \$75,000
5	\$ 51,580	\$ 64,475	up to \$75,000
6	\$ 59,060	\$ 73,825	up to \$75,000
7	\$ 66,540	up to \$75,000	up to \$75,000
8	\$ 74,020	up to \$75,000	up to \$75,000
State Premium Assistance	Program pays 60%	Program pays 40%	Program pays 20%
Member Share of Premium	Member pays 40%	Member pays 60%	Member pays 80%
	See Table D below	See Table C below	See Table B below

*Based on 2009 Federal Poverty Level (FPL). AccessTN will update these incomes each year as the federal government revises its poverty level guidelines.

Payment amounts listed in the tables below are per member per month (pmpm)

A) No State Premium Assistance - Member Pays 100%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$410	\$472	\$456	\$524
30-39	\$477	\$548	\$530	\$608
40-49	\$579	\$666	\$643	\$740
50-59	\$688	\$792	\$765	\$880
60-64	\$812	\$934	\$902	\$1,038
65+	\$958	\$1,102	\$1,065	\$1,225

B) 20% State Premium Assistance – Member Pays 80%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$328	\$378	\$365	\$419
30-39	\$382	\$438	\$424	\$486
40-49	\$463	\$533	\$514	\$592
50-59	\$550	\$634	\$612	\$704
60-64	\$650	\$747	\$722	\$830
65+	\$766	\$882	\$852	\$980

C) 40% State Premium Assistance – Member Pays 60%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$246	\$283	\$274	\$314
30-39	\$286	\$329	\$318	\$365
40-49	\$347	\$400	\$386	\$444
50-59	\$413	\$475	\$459	\$528
60-64	\$487	\$560	\$541	\$623
65+	\$575	\$661	\$639	\$735

D) 60% State Premium Assistance - Member Pays 40%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$164	\$189	\$182	\$210
30-39	\$191	\$219	\$212	\$243
40-49	\$232	\$266	\$257	\$296
50-59	\$275	\$317	\$306	\$352
60-64	\$325	\$374	\$361	\$415
65+	\$383	\$441	\$426	\$490

Monthly Premiums for Portability Plans

Plan ONE: \$1,000 deductible – premium assistance is available for this plan.

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	\$496	\$571	\$551	\$634
30-39	\$576	\$661	\$640	\$737
40-49	\$700	\$805	\$777	\$894
50-59	\$833	\$958	\$925	\$1,064
60-64	\$984	\$1,131	\$1,093	\$1,256
65+	\$1,160	\$1,335	\$1,289	\$1,482

Note: Plan One has 20% to 60% premium help available for applicants with incomes up to \$75,000. Assistance is subject to funding. See Page 12.

Plan TWO: \$3,000 deductible (Health Savings Account eligible)

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	\$318	\$366	\$353	\$406
30-39	\$369	\$425	\$410	\$472
40-49	\$449	\$516	\$498	\$573
50-59	\$534	\$614	\$593	\$682
60-64	\$630	\$724	\$699	\$804
65+	\$743	\$855	\$826	\$950

Plan THREE: \$5,000 deductible (not HSA compatible)

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco User	Tobacco User	Non Tobacco User	Tobacco User
<30	\$284	\$326	\$315	\$362
30-39	\$330	\$379	\$366	\$420
40-49	\$399	\$460	\$444	\$511
50-59	\$475	\$547	\$528	\$607
60-64	\$561	\$645	\$623	\$717
65+	\$662	\$761	\$736	\$847

Note-

- 1) All Portability benefit plans above are NOT subject to any pre-existing conditions waiting period but are subject to 12 month waiting period for maternity coverage.
- 2) You are eligible for AccessTN coverage over the age of 64 ONLY if you are NOT eligible for Medicare.
- 3) AccessTN is not a Medicare supplement policy.

To determine your monthly premium, first find your height and weight on the chart below.

Next, go to the tables on the left side of this page for the benefit plan you have chosen (Plans One, Two, or Three) and find the row for your age group.

Then move across the row for your age to find the column that fits you:

- If your weight is equal to or less than what is listed in the chart, use the “Target Weight or Below” columns. If your weight is more than what is listed in the chart, use the “Above Target Weight” side.
- Finally, are you a tobacco user (cigarettes, chewing tobacco, pipe or cigars) or not?

This will be the monthly premium for your beginning coverage, unless you qualify for premium assistance. If you qualify, you can use the tables on page 12 in the same way as is described here.

Target Weight defined as having a Body Mass Index (BMI) of 30

Height	Target Weight
4' 10"	142
4' 11"	147
5' 0"	152
5' 1"	157
5' 2"	163
5' 3"	168
5' 4"	173
5' 5"	179
5' 6"	185
5' 7"	190
5' 8"	196
5' 9"	202
5' 10"	208
5' 11"	214
6' 0"	220
6' 1"	226
6' 2"	232
6' 3"	239
6' 4"	245
6' 5"	252

Premium Assistance for Portability Plan One

(for those finishing COBRA plans or other coverage that allows them to join without waiting 3 months)

Available for Plan One (\$1000 in-network deductible)

Income Guidelines for Premium Assistance*

Persons in Household	Incomes up to 200% FPL	Incomes up to 250% FPL	Incomes up to 350% FPL
1	\$ 21,660	\$ 27,075	\$ 37,905
2	\$ 29,140	\$ 36,425	\$ 50,995
3	\$ 36,620	\$ 45,775	\$ 64,085
4	\$ 44,100	\$ 55,125	up to \$75,000
5	\$ 51,580	\$ 64,475	up to \$75,000
6	\$ 59,060	\$ 73,825	up to \$75,000
7	\$ 66,540	up to \$75,000	up to \$75,000
8	\$ 74,020	up to \$75,000	up to \$75,000
State Premium Assistance	Program pays 60%	Program pays 40%	Program pays 20%
Member Share of Premium	Member pays 40%	Member pays 60%	Member pays 80%
	See Table D below	See Table C below	See Table B below

*Based on 2009 Federal Poverty Level (FPL). AccessTN will update these incomes each year as the federal government revises its poverty level guidelines.

Payment amounts in tables below are per member per month (pmpm)

A) No State Premium Assistance - Member Pays 100%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$496	\$571	\$551	\$634
30-39	\$576	\$661	\$640	\$737
40-49	\$700	\$805	\$777	\$894
50-59	\$833	\$958	\$925	\$1,064
60-64	\$984	\$1,131	\$1,093	\$1,256
65+	\$1,160	\$1,335	\$1,289	\$1,482

B) 20% State Premium Assistance - Member Pays 80%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$397	\$457	\$441	\$507
30-39	\$461	\$529	\$512	\$590
40-49	\$560	\$644	\$622	\$715
50-59	\$666	\$766	\$740	\$851
60-64	\$787	\$905	\$874	\$1,005
65+	\$928	\$1,068	\$1,031	\$1,186

C) 40% State Premium Assistance - Member Pays 60%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$298	\$343	\$331	\$380
30-39	\$346	\$397	\$384	\$442
40-49	\$420	\$483	\$466	\$536
50-59	\$500	\$575	\$555	\$638
60-64	\$590	\$679	\$656	\$754
65+	\$696	\$801	\$773	\$889

D) 60% State Premium Assistance - Member Pays 40%

Age	Target Weight or Below		Above Target Weight	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco
	User	User	User	User
< 30	\$198	\$228	\$220	\$254
30-39	\$230	\$264	\$256	\$295
40-49	\$280	\$322	\$311	\$358
50-59	\$333	\$383	\$370	\$426
60-64	\$394	\$452	\$437	\$502
65+	\$464	\$534	\$516	\$593

Some insurance terms we've used (see your Plan Document for more complete information):

"Board" means the AccessTN Board of Directors, the body that the Tennessee State Legislature has made responsible for setting the rules, benefit plans, and premiums for AccessTN.

"Care Management" is all the activities the Plan does to coordinate your health care with you and your medical providers. Sometimes called "case management" or "utilization review" for medical events like going into a hospital, most of these services are done by the Plan Administrator's medical and nursing staff.

"Claims" are the requests for payment sent to AccessTN by doctors and other medical providers for health care they provide to you. We will only pay for "covered services." Payment to network providers is based on fees they have agreed to accept from the Plan.

"Co-insurance" is the portion of the claim you are responsible to pay, usually a percentage, such as 20%. This is listed in your benefit plan. It is sometimes called a "co-payment" if the member pays a set dollar amount, like \$20.

"Deductible," such as \$1000 or \$5000, is the dollar amount a member must pay before the Plan starts paying for covered services. Some services, such as covered prescription medicines, are not subject to the deductible for Plans One and Three.

"Disease management" is a targeted type of care management to assist you caring for specific medical conditions like diabetes or asthma.

"Drug Formulary" is a list showing generic drugs and brand drugs that are preferred with lower member payments.

"HIPAA" is the Health Insurance Portability Accountability Act of 1996, which has many rules affecting privacy of personal information and which govern pre-existing conditions provisions of health insurance policies. As we use it with the Portability eligibility category, a HIPAA plan is a certain type of individual health insurance policy for which you can't be turned down if you apply for it in less than 63 days after losing certain other coverage.

"Maximum allowed charge" (MAC) is a set dollar fee that network providers agree to accept in full payment of a covered service they provide to you.

"Medical Underwriting" is an insurance term referring to a requirement of a medical background check to qualify for health coverage. We will do this for those who request it and who pay the \$75.00 nonrefundable fee.

"Out-of-pocket maximum" is the maximum amount of your share (deductibles, co-insurance, and co-payments) of claims on covered services in a benefit plan before the Plan starts paying 100% of claims for certain benefits.

"Plan Administrator" is the company that has been selected to administer the daily operation of AccessTN, including enrollment, customer service eligibility verification, claims payment, and care management. BlueCross and Blue Shield of Tennessee, Inc. will be serving as Plan Administrator for AccessTN.

"Plan Document" is the collected series of documents, especially the member handbook, which provide the formal description controlling plan benefits, policies and definitions, as approved by the AccessTN Board of Directors.

"Pre-authorization" refers to a Plan rule that certain services, such as hospitalization or surgery, must be pre-approved by the Plan to be fully covered.

"Pre-existing conditions" are those for which you received or had reason to receive medical care or treatment during a six-month period immediately before you enrolled in AccessTN.

"Resident" means a person who is legally domiciled in Tennessee (makes his or her home here). One can be staying in several places, but you can only have one domicile, or legal residence. We may ask for periodic proof.

"Network" refers to all the health providers who are contracted with the Plan. Non-contracted providers are referred to as "out-of-network."

"Waiting period" is a set period of time you must wait before a benefit plan pays or pays a full benefit for services for a particular condition, such as maternity, or a pre-existing condition.