

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	\$3,000 \$3,000
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	\$50,000 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).