Plan Overview

State of Tennessee ● Department of Finance and Administration

Return Application of Health Coverage* to:

AccessTN c/o BCBST
1 Cameron Hill Circle
Chattanooga, TN 37402
Secure Fax: 1-866-636-0161
AccessTN is administered by BlueCross BlueShield of Tennessee, Inc.
- an Independent Licensee of the BlueCross BlueShield Association.

2011 Application* Tips, Benefit Plans, & Premium Tables

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

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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.

Forms and information about AccessTN can also be found on the web at www.AccessTN.gov if you need more. Help with the application* is available toll free at 1-866-636-0080. This is the Member Services line at BlueCross BlueShield of Tennessee (BCBST). BCBST is AccessTN's plan administrator. Forms and information are also available on their website at www.BCBST.com. You can find them under the "Plan Options - Cover Tennessee" tabs at the top of the www.BCBST.com webpage. Or you may request forms and information by calling 1-866-0080.

Our mailing address for completed applications* is:

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

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov.

****************IMPORTANT NOTICE****************

The AccessTN Board has **reopened enrollment in the program**. AccessTN is now available to those who meet the eligibility requirements. The premium assistance program has reached its maximum budget. Therefore, **premium assistance will not be available to new members**. Those who are eligible for AccessTN may also be eligible for the federal Pre-existing Condition Insurance Plan (PCIP). Information about PCIP is available at www.pcip.gov or by calling 1-866-717-5826.

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 pre-existing medical conditions. The program is part of the Cover Tennessee initiative and is one of 35 state high risk pools across the country 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 11.

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.

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.

Section A - Applicant Info

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.

Section B – Choose Your Benefit Plan

What is a PPO and what are my options?

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 by each benefit plan. More detailed information on covered services, their limits, and exceptions can be found in the Plan Document.

- Plan One has a $1,000 deductible. This plan offers the lowest deductible.
- Plan Two has a $3,000 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 $5,000 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 2011

These Plans are available for both Regular and Portability eligibility. Portability has no waiting period for pre-existing conditions. Regular coverage has a 6 month reduced benefit period for pre-existing conditions. Benefit Plans subject to change by AccessTN Board. Plan reimbursement based on the maximum allowable charge (MAC).

OUTLINE OF PPO MEDICAL BENEFITS These plans are offered for either Portability and Regular eligibility (see Plan Document for more detail)	Plan One "lowest deductible"	Plan Two "health savings account-eligible"	Plan Three "high deductible" Not HSA-eligible
DEDUCTIBLE per plan year: In-network Out-of-network	$1,000 $2,000	$3,000 $3,000	$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	$250,000 medical $100,000 pharmacy	No medical maximum $50,000 pharmacy	$250,000 medical $100,000 pharmacy
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

Benefit	Plan One	Plan Two	Plan Three
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

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov.

Section C – Info for Premium

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. Rates are the same whether you qualify for Portability or for Regular AccessTN coverage.

AccessTN will figure your premium. If you want, you can estimate what your monthly member share of premium will be using the tables on page 10.

There is no income or asset limitation to join AccessTN. It is open to people of all incomes. <u>Premium assistance is not available.</u>

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.

Section D – How Do You Qualify?

Do you qualify as a State uninsurable, State Portable, or HIPAA-eligible?

There are three ways to qualify for AccessTN:

- D1 – State Uninsurable – if you have a pre-existing medical condition which keeps you from getting insurance. We call this Regular Coverage.
- D2 – State Portability – if you are just coming off TennCare, CoverKids, or off certain other insurance with less than 18 months of continuous coverage.
- D3 – HIPAA-eligible – if you are just coming off of COBRA or other qualifying coverage with more than 18 months of continuous coverage.

All benefit plans (Plans One, Two, and Three) are available for each type of eligibility.

We offer health coverage to those who can't get other insurance because of their health status. The main difference between the three categories is whether you've had insurance in the last 3 months and whether your pre-existing conditions can be covered at full benefit when you join.

*Pre-existing Conditions - For eligibility categories D1 – State Uninsurable (Regular), or D2 – State Portability, you **<u>MUST SEND</u>** us proof that you are uninsurable. This means you cannot get insurance because you have a pre-existing health condition.*

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.

*You can prove a **pre-existing condition** with either one of these:*

- ***One denial of coverage letter from an insurance company**, based on **ANY** health condition or combination of conditions. It does NOT have to be one of the 55 listed pre-existing health conditions (listed on the next page).*

***Use the separate Attending Physician's Statement* (enclosed in your packet) or a letter from your doctor** showing that you have one of the 55 qualified pre-existing health conditions (listed on the next page)*

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov.

⇒ *If you use an insurance decline letter to show you are uninsurable, it can be for any condition or combination of conditions. It does not have to be one of the medical conditions listed below.*

⇒ *If you have one of these medical conditions, your doctor can sign the separate* ***Attending Physician's Statement**** *(in your packet or online at www.AccessTN.gov) or* ***your doctor can write a separate letter if it also tells us the diagnosis and billing code for your condition.***

Medical Conditions which can qualify you for AccessTN without being declined by an Insurer.					
Body System		*Medical Condition*	*Body System*		*Medical Condition*
1	Major	AIDS/HIV+	29	Nervous System	Cerebral Palsy, mod. to severe
2	Major	Transplants, completed or recommended, excl. donor or cornea	30	Nervous System	Friedrich's Ataxia
3	Cancers	Cancers, excluding skin cancers except melanoma	31	Nervous System	Guillain-Barre Syndrome, Presenting
4	Cancers	Hodgkin's Disease	32	Nervous System	Huntington's Chorea
5	Cancers	Leukemia	33	Nervous System	Myasthenia Gravis
6	Circulatory	Aplastic Anemia, chronic	34	Nervous System	Sturge-Weber syndrome
7	Circulatory	Cerebral Embolism, Pulmonary Embolism	35	Nervous System	Tabes Dorsallis (Locomotor Ataxia)
8	Circulatory	Cerebral Vascular Accident (CVA) [Stroke] other than Transient Ischemic Attack	36	Nervous System	Hydrocephalus
9	Circulatory	Congestive Heart Failure, including Cardiomyopathy	37	Nervous System	Lead Poisoning (Cerebral)
10	Circulatory	Heart Attack (Myocardial Infarction) within 5 years	38	Nervous System	Multiple Sclerosis, Post-lateral Sclerosis
11	Circulatory	Heart Bypass Surgery within 5 years	39	Nervous System	Muscular Dystrophy
12	Circulatory	Hepatitis B, C, D or G acute or chronic moderate or severe with Rx	40	Nervous System	Parkinson's Disease
13	Circulatory	Sickle Cell Anemia	41	Nervous System	Syringomyelia
14	Circulatory	Thalassemia with present symptoms	42	Nervous System	Topectomy and Lobotomy
15	Circulatory	Arteritis, necrotizing	43	Nervous System	Tumors, Brain or Pituitary
16	Circulatory	Hemophilia	44	Nervous System	Paralysis, including quadriplegia and paraplegia
17	Digestive	Crohn's Disease, with current symptoms and requiring surgery	45	Other	Autistic Disorders
18	Digestive	Ulcerative Colitis, present	46	Other	Cystic Fibrosis
19	Digestive	Cirrhosis of the Liver	47	Other	Systemic Lupus Erythematosus
20	Digestive	Pancreatis, chronic	48	Other	Wilson's Disease
21	Endocrine	Diabetes, Type I or Type II uncontrolled, or diabetes with complications (eyes, kidneys, feet, etc.)	49	Psychiatric	Psychotic Disorders, including Schizophrenia & Delusional Disorders
22	Musculo Skeletal	Arthritis, Rheumatoid	50	Respiratory	Pulmonary Emphysema, moderate to severe
23	Musculo Skeletal	Cleft Palate, requiring surgery, excluding microform cleft	51	Respiratory	Pulmonary Fibrosis
24	Musculo Skeletal	Still's Disease	52	Respiratory	Silicosis (Black Lung)
25	Musculo Skeletal	Legge-Perthes Disease	53	Urinary	Kidney, Polycystic
26	Nervous System	Alzheimer's	54	Urinary	Kidney, Chronic Renal Failure, including those receiving dialysis
27	Nervous System	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	55	Urinary	Hypertensive Renal Disease
28	Nervous System	Brain injury, traumatic			

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov.

*For **D1 – State Uninsurable (Regular)** eligibility**,** you must meet the rules (a) through (f) below:*

(a) Be a Tennessee resident for 6 months and a U.S. citizen or qualified legal alien
(b) Have a pre-existing health condition which makes you uninsurable
(c) Not be eligible for employer coverage where you work, Medicare or Medicaid and not have other health insurance
(d) Must show you are **uninsurable** as we describe on the previous pages**.** Uninsurable means you cannot get insurance because you have pre-existing health reasons.
(e) Have been uninsured for the past 3 months before applying for coverage (or meet any approved exception to this requirement)
(f) Send proof of prior insurance

D1 – State Uninsurable, or Regular coverage, is the eligibility category for those who 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.

Effective date: Forms for Regular coverage approved by the 15th of any month will have coverage starting the 1st of the next month.

(The Application for Health Coverage* has additional detail on the requirements of D1.)

*For **D2 – State Portability** eligibility**,** you must meet the rules (a) through (f) below:*

(a) Be a Tennessee resident for 6 months and a U.S. citizen or qualified legal alien
(b) You are applying within 63 days of prior coverage with TennCare (Medicaid), CoverKids or other specified coverage
(c) Have a pre-existing health condition which makes you uninsurable
(d) Not eligible for a group health plan, Medicare or Medicaid, and you do not have other health insurance coverage
(e) Must show you are **uninsurable** as we describe on the previous pages**.** Uninsurable means you cannot get insurance because you have pre-existing health reasons
(f) Send proof of prior insurance

D2 – State Portability coverage is the eligibility category for those who are just coming off of TennCare or Medicaid or who are losing certain other group coverage with less than 18 months coverage and no option for COBRA or continuation coverage. There is no "go-bare" requirement.

Effective date: State Portability coverage starts the day after the end of your prior coverage. You can apply before your prior coverage ends. You will have to pay all back premiums.

(The Application for Health Coverage* has additional detail on the requirements of D2.)

*For **D3 – HIPAA** eligibility **–** you do **NOT** have to show you are **uninsurable.** You must be a Tennessee resident and meet **ALL** the rules (a) through (f) below:*

(a) Be a Tennessee resident and U.S. citizen or qualified legal alien
(b) Have 18 or more months of combined health coverage with no break in coverage of more than 63 days
(b) Coverage through an employer-sponsored GROUP health plan as your most recent coverage
(c) Not eligible for employer coverage, Medicare or Medicaid and you do not have other health coverage
(d) Have not terminated for nonpayment of premiums or fraud under your most recent coverage
(e) Have taken and completed your full COBRA eligibility if COBRA or group continuation available
(f) Send proof of prior insurance

Effective date: If you qualify as a HIPAA-eligible person, then you will check that box at Section D3. Your AccessTN coverage will start the day after your previous coverage ended, if you pay the premium due for all months due. This type of eligibility has no reduction in coverage for pre-existing medical conditions during the first six months.

(The Application for Health Coverage* has additional detail on the requirements of D3.)

Call 1-866-636-0080 toll-free with questions or for help with these papers.

*Enclosed in application packet and available at BCBST.com or AccessTN.gov.

The different types of eligibility (D1, D2 or D3) are also different in how we pay services for pre-existing conditions in the first six months of coverage.

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.

The D2 – State Portability category and the D3 – HIPAA-eligible category pay the full benefit (usually 80%) for pre-existing conditions from Day One of coverage. This is true whether you choose Plan One, Plan Two, or Plan Three.

The D1 – State Uninsurable eligibility category, which we call Regular AccessTN coverage, offers a reduced benefit for Pre-existing Conditions for the first six months of enrollment. Plans One, Two and Three for this "Regular AccessTN" category all have a 6 month "pre-existing conditions" waiting 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 (D1 – State Uninsurable eligibility), 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.

Exceptions to the pre-existing conditions limitation: 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. Both Regular and Portability 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 rules for plans used with a health savings account (HSA), these benefits must be subject to the deductible for both Regular and Portability Plan Two.

D1 – State Uninsurable eligibility (Regular) Plans One, Two and Three also have a 12 month waiting period before maternity is covered.

Section E – Other Insurance Coverage

What other insurance is permitted?

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 details.

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.

Section F - Health History

Why does AccessTN need my health history?

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 for Health Coverage*. Medical conditions are listed to help identify more of your needs for care management. Yes and No answers and what you remember are okay for this purpose.

Sections G – Applicant Signature

What does my signature on the application* mean?

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

Section H – Fill Out This Section If Someone Helped You or Can Help Us With This Form

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

This tells us if someone helped you fill out the application*. You can also give us permission in this section to talk to those you name about your health facts.

Section I – Protected Health Information and Authorization

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

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

- claims records
- correspondence
- laboratory reports
- medical records
- hospital 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, 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 (Medicaid) program.

Sections J – Statement of Understanding and Affirmation

Please read this information carefully. Ask us any questions you have. When you sign the application* in Section G, you are stating that you have read this Section J and you understand its terms. You are also agreeing to our terms of coverage and that the information you have submitted in the application* is true.

MONTHLY PREMIUMS FOR ACCESSTN PLANS

Plan ONE: $1,000 deductible

	Target Weight or Below		Above Target Weight	
Age	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

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

	Target Weight or Below		Above Target Weight	
Age	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)

	Target Weight or Below		Above Target Weight	
Age	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 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.

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.

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

INSURANCE TERMS AND DEFINITIONS

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 $1,000 or $5,000, 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 in 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.

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. serves 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.