AccessTN Outline of PPO Medical Benefits

For Plan Year April 1, 2007, through December 31, 2007

This listing is for illustration only; plan documents shall control. Benefits are subject to change by the AccessTN Board of Directors.

	Plan 1000 "Medium"	Plan 2500 "HSA-eligible"	Plan 5000 "Catastrophic"
Preventive Care (first dollar prior to deductible)	$300	$300	$300
Deductibles: individual maximum deductible per plan year In-Network Out-of-Network	 $1,000 $2,000	 $2,500 $2,500	 $5,000 $10,000
Covered Expenses, as specified plan document, subject to maximum allowable charge	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Pre-existing Conditions Period, except as stated for specific benefits, to be determined by Board of Directors	Underwritten based on 12 months	Underwritten based on 12 months	Underwritten based on 12 months
Prescription Drugs - pharmacy does not apply to out-of-pocket maximum except for Plan 2500-HSA	No deductible for outpatient drugs	Deductible applies to drugs	No deductible for outpatient drugs
(In addition to retail prices below, mail order program may offer incentive pricing, also to include willing network retail providers who contract to supply on same terms)	Copayment or coinsurance to be determined	Copayment or coinsurance to be determined	Copayment or coinsurance to be determined
Generic	$10 copayment (or cost if less)	Covered under deductible, coinsurance and out-of-pocket limit to meet federal guidelines for an HSA eligible plan. (annual pharmacy maximum for this plan pending)	$15 copayment (or cost if less)
Preferred Brand Drugs	25% coinsurance subject to a min. of $25, max. of $50		30% coinsurance subject to a min. of $30, max. of $75
Non-preferred Brand	50% coinsurance subject to a min. of $50, max. of $100	Non-preferred brands are not covered	60% coinsurance subject to a min. of $60, max. of $150
Non-covered Drugs	as identified by formulary	as identified by formulary	as identified by formulary
Maximum Out-of-Pocket Expense (see criteria)	$5,000	$5,000	$10,000
Maximum Annual Benefits, except for supplemental organ transplants as below	$120,000	N/A	$100,000
Supplemental Maximum Benefit for Transplants	$100,000	$100,000	$100,000
Maximum Lifetime Benefits: subject to prior benefits incurred in another state high risk pool(s)	$1,000,000	$1,000,000	$1,000,000
Maximum Out-of-Pocket Expense No out-of-pocket max for out-of-network services No out-of-pocket max for pharmacy, except for Plan 2500, according to HSA regulations No out-of-pocket max for copays-emergency room visits	$5,000	$5,000	$10,000
Covered Services Include			
Inpatient services — non-emergent service must be preauthorized	80% in-network 60% out-of-network	80% in-network 60% out-of-network Limited to 45 days per year	80% in-network 60% out-of-network
Surgical procedures Diagnostic lab and imaging services Physician office visits Preventive care after first dollar allowance above Chemotherapy and radiation therapy Organ transplant (designated procedures)	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Maternity benefits — covered only under optional rider	Not Covered	Not Covered	Not Covered

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Approved/Accredited Rehabilitation Facility			
Covered services listed below	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Inpatient rehabilitation facility		Limited to 45 days per year	
Outpatient rehabilitation facility	Limited to 45 days per year	Limited to 45 days per year	Limited to 45 days per year
Skilled nursing facility (following approved hospitalization, prior authorization required)	Limited to 45 days per year	Limited to 45 days per year	Limited to 45 days per year
Home health care	30 visits per year	30 visits per year	30 visits per year
Non-Hospital and Non-Physician Services			
Independently practicing physical therapists, speech therapists, occupational therapists, dialysis clinics, oral surgeons or audiologists	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Non-Contracted Providers (varies based on the network/ services area outside of Tennessee)			
Emergency Services (in-state or out-of-state)			
Emergency services (in-network or out-of-network) Note: Out-of-network benefits will be reduced to non-PPO levels if the claims administrators determines the situation was not an emergency.	80% of reasonable charges	80% of reasonable charges	80% of reasonable charges
Emergency room visit copayment (waived if admitted: note: copayment required even if out-of-pocket expenses have been met, except HSA)	$50 copayment per use	$75 copayment per use	$75 copayment per use
Non-Emergent Care			
Urgent care received at a walk-in clinic	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Urgent care received through hospital emergency room (in addition to ER copay)	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Appliances and Equipment (durable medical equipment)	80% in-network 60% out-of-network $3,000 annual max	80% in-network 60% out-of-network $3,000 annual max	80% in-network 60% out-of-network $3,000 annual max
Exclusions (this is a partial list, includes any services not medically necessary, etc.; see plan document for complete listing of exclusions)	Cosmetic procedure; Human growth hormone; Hearing aids; Eyeglasses, contacts, etc.; Dental services; Routine foot care; Maternity coverage, including routine newborn care; Assisted reproductive technology, including fertility drugs; Services or supplies related to obesity, including surgical or other treatment for morbid obesity		
Mental Health and Substance Abuse Benefits			
Deductibles (no separate mental health deductible)	Outpatient services not subject to plan deductible	All services subject to health plan deductible	Outpatient services not subject to plan deductible
Coinsurance (for mental health/substance abuse)	See below	After $2,500 plan deductible	See below
Inpatient — Including Intermediate Care (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 80/60% levels)	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days
Outpatient (outpatient therapy sessions are not subject to plan deductible; inpatient above and intermediate levels below are subject to deductible)	80% in-network 60% out-of-network 30 sessions	80% in-network 60% out-of-network 30 sessions	80% in-network 60% out-of-network 30 sessions
Expenses determined not to be medically necessary by the utilization review organization	$0	$0	$0

Intermediate Care

All intermediate levels of care will be counted as inpatient for purposes of plan limitations.

- Residential Treatment: defined as a 24-hour level of residential care that is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services.
  1.5 residential treatment days = 1 inpatient day
- Partial Hospitalization: defined as structured and medically supervised day, evening and/or night treatment programs where program services are provided to patients at least 4 hours/day and are available at least 3 days/week, although some patients may need to attend less often.
  2 partial hospitalization days = 1 inpatient day
- Intensive Outpatient: defined as an intensive outpatient program, usually comprised of coordinated and integrated multidisciplinary services, having the capacity for a planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often.
  5 structured outpatient days = 1 inpatient day

Substance Abuse Limitations

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay. A stay is any substance treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 28 inpatient days.
- Lifetime maximum: Two inpatient stays for detoxification – maximum of 5 days per stay. A stay is any detox treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 5 inpatient days.

Additional Mental Health Limitations (See Section 12.06)

- Inpatient care limit of 30 days per plan year (intermediate levels of care will be considered inpatient treatment for purposes of this limitation).
- Outpatient care limit of 30 visits per plan year is for mental health/substance abuse combined.

Payment is based on the MAC. Covered persons will be responsible for the deductible and any applicable copayment or coinsurance amounts. If non-network providers are used, covered persons will also be responsible for payment of charges above the MAC.