

**City of Hendersonville
Comparison of Medical Plans**

Effective Date: 07/01/2008	OPTION 1 BASE PLAN		OPTION 2 BUY UP PLAN		OPTION 3 BUY DOWN PLAN with HRA	
Deductible	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
<i>Individual</i>	\$500	\$1,000	\$300	\$600	\$750 NET**	\$3,000
<i>Family</i>	An aggregate total of \$1,000 for the entire family, with no one individual having to satisfy more than \$500	An aggregate total of \$2,000 for the entire family, with no one individual having to satisfy more than \$1,000	An aggregate total of \$600 for the entire family, with no one individual having to satisfy more than \$300	An aggregate total of \$1,200 for the entire family, with no one individual having to satisfy more than \$600	An aggregate total of \$1,500 NET** for the entire family, with no one individual having to satisfy more than \$750 NET**	An aggregate total of \$6,000 for the entire family, with no one individual having to satisfy more than \$3,000
4th Quarter Carry Over Provision	Yes		Yes		Yes	
Coinsurance	80% paid by BCBST, 20% paid by the insured	50%* paid by BCBST, 50%* paid by the insured	90% paid by BCBST, 10% paid by the insured	70%* paid by BCBST, 30%* paid by the insured	80% paid by BCBST, 20% paid by the insured	50%* paid by BCBST, 50%* paid by the insured
Out of Pocket Stop Loss Maximum (includes deductible but not copays)						
<i>Individual</i>	\$2,000	\$6,000	\$1,200	\$3,600	\$2,250 NET**	\$7,500
<i>Family</i>	An aggregate total of \$4,000 for the entire family, with no one individual having to satisfy more than \$2,000	An aggregate total of \$12,000 for the entire family, with no one individual having to satisfy more than \$6,000	An aggregate total of \$2,400 for the entire family, with no one individual having to satisfy more than \$1,200	An aggregate total of \$7,200 for the entire family, with no one individual having to satisfy more than \$3,600	An aggregate total of \$4,500 NET** for the entire family, with no one individual having to satisfy more than \$2,250 NET**	An aggregate total of \$15,000 for the entire family, with no one individual having to satisfy more than \$7,500
Lifetime Maximum Benefit	\$5,000,000		\$5,000,000		\$5,000,000	

YOU ARE RESPONSIBLE FOR:

Office Visits						
<i>Primary Care Physician</i>	Subject to deductible & coinsurance		Subject to deductible & coinsurance		\$25 Co-Payment max 5 / visits a year per insured combined with specialist visits \$40 Co-Payment max 5 / visits a year per insured combined with primary care visits Subject to Deductible and Co-Insurance (30 visits per calendar year)	Subject to Deductible and Co-Insurance
<i>Specialist Physician</i>						
<i>Chiropractic Physician</i>						
<i>Extraction of impacted wisdom teeth</i>	Not covered		Not covered		Not covered	
Routine Diagnostic Procedures						
<i>X-Ray and Lab (In conjunction with physician office visit)</i>	Subject to deductible & coinsurance		Subject to deductible & coinsurance		No Additional Charge	Subject to Deductible and Co-Insurance
Wellness Benefits						
<i>Office visit</i>					\$25 Co-Payment does not apply to max 5 / visits a year per insured	Subject to Deductible and Co-Insurance
<i>Routine Well Child Care</i>					No Additional Charge	
<i>Routine Childhood Immunizations</i>	Subject to deductible & coinsurance		Subject to deductible & coinsurance		No Additional Charge	
<i>Routine Well Woman Exam</i>					No Additional Charge	
<i>Routine Mammography Screening</i>					No Additional Charge	
<i>Routine Adult Physical Exam</i>					No Additional Charge	
<i>Benefit max. per calendar year</i>	\$300 ages 6+ (excludes well child and well woman care)		\$300 ages 6+ (excludes well child and well woman care)		\$300 ages 6+ (excludes well child and well woman care)	
Allergy Services in a Physician's Office	Subject to deductible & coinsurance		Subject to deductible & coinsurance		Subject to PCP or Specialist Copay	Subject to Deductible and Co-Insurance
Maternity						
<i>Prenatal & Postnatal Care</i>	Subject to deductible & coinsurance		Subject to deductible & coinsurance		\$25 Co-Payment (first visit only) then Subject to Deductible and Co-Insurance	Subject to Deductible and Co-Insurance
<i>Delivery</i>					Subject to Deductible and Co-Insurance	
Prescription Drugs						
<i>Generic</i>	Subject to a \$10 copay that does NOT apply to max out of pocket.				Subject to a \$10 copay that does NOT apply to max out of pocket.	
<i>Brand Name Preferred</i>	Subject to a \$35 copay that does NOT apply to max out of pocket.		Subject to deductible & coinsurance		After a \$200 Brand ONLY calendar year deductible, subject to a \$35 copay. Neither apply to max out of pocket.	
<i>Brand Name Non-Preferred</i>	Subject to a \$50 copay that does NOT apply to max out of pocket.				After a \$200 Brand ONLY calendar year deductible, subject to a \$50 copay. Neither apply to max out of pocket.	
<i>Maintenance Medications</i>	Up to a 90 day supply for 2.5X normal copay, that does NOT apply to max out of pocket.		Subject to deductible & coinsurance		Up to a 90 day supply for 2.5X normal copay, that does NOT apply to max out of pocket.	

This is a communication piece ONLY. Benefits, limitations and exclusions are described in detail in the insurance carrier's contract and certificate booklet. In the event of a discrepancy, those plan documents shall govern.

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Deductible	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Hospital & Related Services	Subject to deductible & coinsurance		Subject to deductible & coinsurance		Subject to deductible & coinsurance	
Inpatient Hospital & Related Services						
Outpatient Surgery						
Non-Routine Diagnostic Services (MRI, Cat Scan, etc.)						
Emergency Room Services	\$100 Co-Payment (waived if admitted)		\$100 Co-Payment (waived if admitted)		\$100 Co-Payment (waived if admitted)	
Rehabilitation Services	Subject to deductible & coinsurance (Limited to 30 visits per calendar year, Cardiac limited to 36 visits per calendar year)		Subject to deductible & coinsurance (Limited to 30 visits per calendar year, Cardiac limited to 36 visits per calendar year)		Subject to deductible & coinsurance (Limited to 30 visits per calendar year, Cardiac limited to 36 visits per calendar year)	
Home Health Services	Subject to deductible & coinsurance (Limited to 60 visits per calendar year)		Subject to deductible & coinsurance (Limited to 60 visits per calendar year)		Subject to deductible & coinsurance (Limited to 60 visits per calendar year)	
Hospice Care	100%	Subject to deductible & coinsurance	100%	Subject to deductible & coinsurance	100%	Subject to deductible & coinsurance
Ambulance Services	Subject to deductible & coinsurance		Subject to deductible & coinsurance		Subject to deductible & coinsurance	
Durable Medical Equipment						
Outpatient Mental Health	Subject to deductible & coinsurance (limited to a maximum of 45 visits per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 45 visits per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 45 visits per calendar year)	
Outpatient Substance Abuse	Subject to deductible & coinsurance (limited to a maximum of 45 visits per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 45 visits per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 45 visits per calendar year)	
Inpatient Mental Health	Subject to deductible & coinsurance (limited to a maximum of 40 days per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 40 days per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 40 days per calendar year)	
Inpatient Substance Abuse	Subject to deductible & coinsurance (limited to a maximum of 40 days per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 40 days per calendar year)		Subject to deductible & coinsurance (limited to a maximum of 40 days per calendar year)	

* Non-Network coinsurance percentages are applied to PPO fee allowance. Non PPO Providers may bill the insured for amounts above the allowance. Any such amounts do not apply towards the patients deductible or out of pocket maximum.

** The NET amount includes the City of Hendersonville's reimbursement of \$751-\$1,000 of the individual deductible and \$1,501 - \$2,000 of the Family deductible.

All of the above-illustrated plans require pre-certification prior to all non-emergency high tech imaging. It is the responsibility of the employee to confirm that all providers are in the network to receive the maximum benefit. This document is only a summary of plan highlights. More detailed information including limitations and exclusions can be found in the BlueCross BlueShield of TN certificate booklet. In the event of any discrepancy, that document will supercede this one. All deductions illustrated as well as the HRA reimbursement for Plan 3 is contingent upon the Board of Mayor and Aldermen's final budget approval.

Option 1 Base Plan		Option 2 Buy Up Plan		Option 3 Buy Down Plan	
	Semi-Monthly		Semi-Monthly	Semi-Monthly	Annual Savings over Option 1
Employee Only	\$17.99	Annual Savings over Option 2		\$7.02	(\$1,034.64)
Employee & Family	\$189.20			\$157.36	(\$3,004.32)
Employee Only	\$50.13				(\$263.28)
Employee & Family	\$282.54				(\$764.16)