

**2009 Medical Plan Options
Rutherford County Employee Benefit Plan**

Employee Classification	Option 1 Employee Monthly Premium Amount	
	Individual Coverage	Family Coverage
County General	\$53.11	\$197.32
*Certified	\$76.97	\$178.49
*Classified	\$60.70	\$225.51

Employee Classification	Option 2 Employee Monthly Premium Amount	
	Individual Coverage	Family Coverage
County General	\$34.97	\$129.92
*Certified	\$55.46	\$101.49
*Classified	\$39.19	\$148.48

Option 3 (HRA) Premium Amount		
Individual Coverage	Family Coverage	
\$	-	\$ -
\$	-	\$ -
\$	-	\$ -

*Annual premiums are collected over a 10-month pay period

Benefit	Option 1	
	In-network	Out-of-network
Annual Deductible	\$300 per individual \$600 per family	\$500 per individual \$1,000 per family
Fund	N/A	N/A
Out of Pocket Maximum	\$1,750 per individual \$3,500 per family	\$3,250 per individual \$6,500 per family
Physician Office Visit	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Lab Work at Physician Office	100% of eligible expenses	60% of eligible expenses after deductible
Preventive Care	\$20 copay per visit physician or facility for preventive care. Not subject to deductible, no annual maximum	Not covered
CareHere Clinic	100% coverage for all services, supplies and drugs provided by CareHere	Not covered
Prescription Drugs	Generics (participating pharmacy) \$5.00 Copay Generics (CareHere) - 0% Preferred Drugs - 20% Non-Preferred Preferred Drugs - 35%	Generics (participating pharmacy) \$5.00 Copay Generics (CareHere) - 0% Preferred Drugs - 20% Non-Preferred Preferred Drugs - 35%
Hospital Care	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Emergency Room	\$100 per visit. The copay does not apply to your annual deductible. The copay is waived if admitted	
Ambulance Service	80% of eligible expenses after deductible	
Mental Health Inpatient	80% of eligible expenses after deductible, limited to 60 days per calendar year	Not covered

Benefit	Option 2	
	In-network	Out-of-network
Annual Deductible	\$500 per individual \$1,000 per family	\$900 per individual \$1,800 per family
Fund	N/A	N/A
Out of Pocket Maximum	\$2,300 per individual \$4,600 per family	\$4,600 per individual \$9,200 per family
Physician Office Visit	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Lab Work at Physician Office	100% of eligible expenses	60% of eligible expenses after deductible
Preventive Care	\$20 copay per visit physician or facility for preventive care. Not subject to deductible, no annual maximum	Not covered
CareHere Clinic	100% coverage for all services, supplies and drugs provided by CareHere	Not covered
Prescription Drugs	Generics (participating pharmacy) \$5.00 Copay Generics (CareHere) - 0% Preferred Drugs - 20% Non-Preferred Preferred Drugs - 35%	Generics (participating pharmacy) \$5.00 Copay Generics (CareHere) - 0% Preferred Drugs - 20% Non-Preferred Preferred Drugs - 35%
Hospital Care	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Emergency Room	\$100 per visit. The copay does not apply to your annual deductible. The copay is waived if admitted	
Ambulance Service	80% of eligible expenses after deductible	
Mental Health Inpatient	80% of eligible expenses after deductible, limited to 60 days per calendar year	Not covered

Benefit	Option 3 (HRA)	
	In-network	Out-of-network
Annual Deductible	\$1,500 single \$3,000 family (collective)	\$2,500 single \$5,000 family (collective)
Fund	\$750 single \$1,500 family Fund applies to both in and out-of-network	
Out of Pocket Maximum	\$5,000 single \$10,000 family (collective)	\$10,000 single \$20,000 family (collective)
Physician Office Visit	90% of eligible expenses after deductible	60% of eligible expenses after deductible
Lab Work at Physician Office	90% of eligible expenses after deductible	60% of eligible expenses after deductible
Preventive Care	100% of eligible expenses, no annual maximum	Not covered
CareHere Clinic	100% coverage for preventive services, \$50 copay for non-preventive services	Not Covered
Prescription Drugs	Generics (participating pharmacy) 30% Generics (CareHere) - 0% Preferred Preferred Drugs - 40% Non-Preferred Drugs - 50% Fund and Deductibles Apply	
Hospital Care	90% of eligible expenses after deductible	60% of eligible expenses after deductible
Emergency Room	90% of eligible expenses after deductible	
Ambulance Service	90% of eligible expenses after deductible	
Mental Health Inpatient	90% of eligible expenses after deductible, limited to 60 days per calendar year	Not Covered

Benefit	Option 1	
	In-network	Out-of-network
Mental Health Outpatient	80% of eligible expenses after deductible, limited to 50 visits per calendar year	Not covered
Sustance Abuse Outpatient	80% of eligible expenses after deductible, maximum 2 programs per lifetime, limited to \$10,000 per calendar year	Not covered
Physical, Speech, & Occupational Therapy	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Chiropractic Care	Limited to 26 visits per year. Maximum payment of \$17.50 per visit. Subject to an annual deductible of \$150	
Maternity Care	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Lifetime Maximum	\$2,000,000	\$2,000,000
Pre-Admission Testing	100% of eligible expenses after deductible	60% of eligible expenses after deductible
Second Surgical Opinion	100% of eligible expenses after deductible	60% of eligible expenses after deductible
Home Health	100% of eligible expenses after deductible	60% of eligible expenses after deductible
Skilled Nursing Facility	100% of eligible expenses after deductible, limited to 100 days	60% of eligible expenses after deductible, limited to 100 days
Diabetes Training	100% of eligible expenses after deductible, limited to \$125 per session, limited to 2 sessions per lifetime	
Pre-Existing Condition	6 months pre-existing condition exclusion for new enrollees not previously covered under another group immediately prior to joining the County Health Plan. Late enrollees have an 18-month pre-existing condition exclusion.	

Benefit	Option 2	
	In-network	Out-of-network
Mental Health Outpatient	80% of eligible expenses after deductible, limited to 50 visits per calendar year	Not covered
Sustance Abuse Outpatient	80% of eligible expenses after deductible, maximum 2 programs per lifetime, limited to \$10,000 per calendar year	Not covered
Physical, Speech, & Occupational Therapy	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Chiropractic Care	Limited to 26 visits per year. Maximum payment of \$17.50 per visit. Subject to an annual deductible of \$150	
Maternity Care	80% of eligible expenses after deductible	60% of eligible expenses after deductible
Lifetime Maximum	\$2,000,000	\$2,000,000
Pre-Admission Testing	100% of eligible expenses after deductible	60% of eligible expenses after deductible
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Skilled Nursing Facility	100% of eligible expenses after deductible, limited to 100 days	60% of eligible expenses after deductible, limited to 100 days
Diabetes Training	100% of eligible expenses after deductible, limited to \$125 per session, limited to 2 sessions per lifetime	
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Sustance Abuse Outpatient	90% of eligible expenses after deductible Maximum of 2 programs per lifetime, limited to \$10,000 per calendar year.	Not Covered
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Skilled Nursing Facility	90% of eligible expenses after deductible, limited to 60 days	60% of eligible expenses after deductible, limited to 60 days
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Pre-Existing Condition	6 months pre-existing condition exclusion for new enrollees not previously covered under another group immediately prior to joining the County Health Plan. Late enrollees have an 18-month pre-existing condition exclusion.	