

Metro Government PPO
2009 Policy Benefits Grid



Covered Services

In-Network Benefits for
Covered Services
received from
Network Providers

*Out-of-Network
Benefits for Covered
Services received
from Out-of-Network
Providers

Benefit Information

Individual Deductible (4 th quarter carryover)	None	\$200
Family Deductible	None	\$600
Individual Out-of-Pocket**	\$1000	\$5000
Family Out-of-Pocket** **Copays do not apply to the OOP Maximum	\$2000	\$10,000
Lifetime Maximum	Unlimited	\$1,000,000
Coordination of Benefits	Carve out for Medicare retirees and their dependents only, standard COB for all others	

Services Received at the Practitioner's Office

Office Exams and Consultations

Office services due to an illness	\$10 copay then 80%	\$10 copay then 60% subject to deductible
Office services due to an injury	\$10 copay then 80%	\$10 copay then 80% for only the initial visit of an accident. Additional visits \$10 copay then 60% subject to deductible
Well Baby Program: Birth to age 6 Under age 1: 4 exams in addition to hospital services; Age 1: 2 exams; Ages 2-6: 1 exam per year; and Immunizations	80%	60% subject to deductible
Preventive Health Services including: Routine Physical Exam – maximum of \$750 per member for physical examination and associated services.	100% (\$750 annual max)	\$10 copay then 60% (\$750 annual max)
Preventive Health Services including: gynecological exam with Pap smear, Mammogram, prostate screening and one Colorectal Exam every 5 years (after age 50) These services DO NOT apply to the \$750 max for 2009!	\$10 copay if billed with an office visit then 80%	\$10 copay if billed with an office visit then 60% subject to deductible

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Diagnostic Services and Other Office Procedures

Allergy Services	\$10 copay when applicable then 80%	\$10 copay when applicable then 60% subject to deductible
Acupuncture *\$1,000 max per calendar year	50% Not subject to deductible	50% Not subject to deductible
Chiropractic Services \$2,000 max per calendar year	50%	50%
Covered Dental Services only include: Removal of Impacted Wisdom Teeth and Accidental Injury to the natural teeth, jaw, face or mouth	80% of billed for DDS or 80% of MAC for Oral Surgeons	80% of billed for DDS or 60% of MAC for Oral Surgeons subject to deductible
Mammogram *1 baseline (35-40), 1 annual (40 and above)	\$10 copay if billed with an office visit then 80%	\$10 copay if billed with an office visit then 60% subject to deductible
TMJ Covered Services Annual max \$2,000* Lifetime max \$4,000* *The dollar maximums only apply to non-surgical care.	Surgical: 80% Non-Surgical: 50%	Surgical: 60% subject to deductible Non-Surgical: 50% subject to deductible
Diabetic treatment, education, and nutrition services	80%	60% subject to deductible

Services Received at a Facility

Inpatient Hospital & 23-Hour Observation

Hospital Services (Medical and Surgical) *Prior Authorization Required	80%	60% subject to deductible
Physician Services (Medical and Surgical)	80%	60% subject to deductible
Blood	Covered if blood or blood plasma is not donated or replaced.	

Skilled Nursing or Rehabilitation Facilities

Skilled Nursing Facility *Prior Auth Required Limited to 100 days per year immediately following 3 days of inpatient confinement	80%	80%
Approved/Accredited Rehabilitation Facility Inpatient* or Outpatient Care *Prior Authorization Required	80%	60%

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Outpatient Hospital & Emergency Care

Outpatient Hospital Services	80%	60% subject to deductible
Emergency Room Services *Copay waived if admitted **In-network benefits for OON Provider for only the initial treatment of an accident	*\$50 copay then 80%	*\$50 copay then **60% subject to deductible

Organ Transplant

Transplant Type	In-Transplant Network Benefits	Network Providers not in our Transplant Network	Non-Network Providers
Organ Transplant Services, all transplants except Kidney	80% after Network deductible, Network OOP max applies	80% of Transplant MAC after Network deductible, Network OOP applies; amounts over TMAC do not apply to the OOP max and are not covered.	60% of TMAC, after Non-network deductible, Non-network OOP max applies; amounts over TMAC do not apply to the OOP and are not covered.
Organ Transplant Services, Kidney Transplants	Network Providers – 80% after Network deductible; Network OOP max applies		60% of TMAC, after Non-network deductible, Non-network OOP max applies; amounts over TMAC do not apply to the OOP and are not covered.

In-Transplant Network providers = Blue Distinction Transplant facilities

Network Providers = Blue Network P and BlueCard PPO providers

Non-Network Providers = Not with any BlueCross BlueShield of Tennessee network

Outpatient Diagnostic Services

Non-Routine Diagnostic Services for illness or injury (includes MRIs, Cat Scans, Nuclear Medicine and other similar technologies)	80%	60% subject to deductible
All other Diagnostic Services for illness or injury (including EKGs, Routine X-Rays and Labs)	80%	60% subject to deductible

Services Received in the Home

Home Health Agency * Prior Auth Required for Medical Social Worker, Private Duty Nursing & Skilled Nursing visits	80%	60% subject to deductible
Home Infusion Therapy *Prior Authorization Required	80%	60% subject to deductible
Hospice Care *Prior Authorization Required for Inpatient	80%	60% subject to deductible

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Ambulance Services

Ambulance

Independently operated or In-Network Facility
80%

Out-of-Network Facility
60% subject to deductible

Maternity Services

Inpatient Facility

80%

60% subject to deductible

Inpatient Physician

80%

60% subject to deductible

Office Services

\$10 copay then 80%

\$10 copay then 60% subject to deductible

Therapeutic Services

Inpatient Physical, Occupational & Speech Therapy

80%

60% subject to deductible

Outpatient Physical, Occupational & Speech Therapy

80%

60% subject to deductible

Pulmonary Rehabilitation
**Prior Authorization Required*

80%

60% subject to deductible

Cardiac Rehabilitation
**Prior Authorization Required*

80%

60% subject to deductible

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Other Services		
BlueCard PPO – Out of State	80% \$10 copay for office services	60% subject to deductible, \$10 copay for office services
DME (including DME and Diabetic supplies), Orthotics and Prosthetics *\$1,500 lifetime max on Custom-Built Shoes	80%	60% subject to deductible
Medical Suppliers (e.g. ostomy supplies, dressings, bandages and diabetic supplies)	80%	60% subject to deductible
Out of the Country Benefits	BlueCard Worldwide Benefits Apply	
Prescription Drugs 2009 Administered through Caremark including lancets, swabs, test strips, syringes and monitors. You can purchase up to a 102-day supply of prescription drugs for two copayments through the Caremark Retail-90 network or the Caremark Home Delivery Program.	Up to 34-day supply: Generic \$10 Brand \$20	If filled at a pharmacy that does not use Caremark, the member will pay up front and file the claim to BlueCross. Benefits will be allowed at the maximum allowable charge. Member will be responsible for copay and excess charges over MAC.
Mental Health <i>*Prior Authorization Required</i> Annual inpatient max 45 days, outpatient max 50 days for mental health and substance abuse combined (not including outpatient visits for medication management)	80%	60% subject to deductible
Substance Abuse <i>*Prior Authorization Required</i> *Annual outpatient max 50 days for mental health and substance abuse combined (not including outpatient visits for medication management); Substance abuse inpatient benefits are limited to a 30-day annual maximum; Lifetime max \$50,000	80%	60% subject to deductible



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One Cameron Hill Circle
Chattanooga, TN 37402