

Metro Government PPO
2010 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 injury or illness	After your \$20 copay for primary care physician, plan pays 80% After your \$30 copay for specialist, then plan pays 80%	After your \$20 copay, plan pays 80% for only the initial visit of an accident. Additional visits at \$20 copay, then plan pays 60% subject to deductible; \$30 copay for specialists, then plan pays 60%.
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)	\$20 copay, then plan pays 60% (\$750 annual max); \$30 copay for specialists, then plan pays 60%
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 2010!	After your \$20 copay for primary care physician if billed with an office visit, plan pays 80% After your \$30 copay for specialist, plan pays 80%	After your \$20 copay if billed with an office visit, plan pays 60% subject to deductible

* Unless otherwise noted, all payments based on maximum allowable charges.

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

Diagnostic Services and Other Office Procedures

Allergy Services	After your \$20 copay when applicable, plan pays 80% After your \$30 copay for specialist, plan pays 80%	After your \$20 copay when applicable, plan pays 60% subject to deductible After your \$30 copay for specialist, plan pays 60%
Acupuncture *\$1,000 max per calendar year	50%	50% Not subject to deductible
Chiropractic Services \$2,000 max per calendar year	50%	50% not subject to deductible
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)	After your \$20 copay if billed with an office visit, plan pays 80% After your \$30 copay for specialist, plan pays 80%	After your \$20 copay if billed with an office visit, plan pays 60% After your \$30 copay for specialist, plan pays 60%
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%	80%

* Unless otherwise noted, all payments based on maximum allowable charges.

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

Outpatient Hospital & Emergency Care

Outpatient Hospital Services	80%	60% subject to deductible
Emergency Room Services *Copay will be waived for an accident or overnight admission **In-network benefits for OON Provider for only the initial treatment of an accident	*\$100 copay then 80%	*\$100 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%, Network OOP max applies	80% of Transplant MAC, 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%; Network OOP max applies	60%, after Non-network deductible, Non-network OOP max applies.

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

* Unless otherwise noted, all payments based on maximum allowable charges.

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

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	After your \$20 copay, plan pays 80% After your \$30 copay if specialist used, plan pays 80%	\$20 copay, then 60% subject to deductible After your \$30 copay if specialist used, plan pays 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 <i>*Prior Authorization Required</i>	80%	60% subject to deductible
Cardiac Rehabilitation <i>*Prior Authorization Required</i>	80%	60% subject to deductible

* Unless otherwise noted, all payments based on maximum allowable charges.

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

Other Services

BlueCard PPO – Out of State	After your \$20 copay for office services, plan pays 80% After your \$30 copay for specialist, then plan pays 80%	60% subject to deductible, \$20 copay for office services, \$30 copay for specialists
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	
<p>Prescription Drugs 2010 Includes lancets, swabs, test strips, syringes and monitors.</p> <p>1. RX04 (Network). This is the <u>same</u> pharmacy network you use today where you can purchase a one-month prescription (up to a 34-day supply). You will continue to use this same pharmacy network in 2010.</p> <p>2. Home Delivery Retail Network. This is the <u>new</u> pharmacy network where you may purchase a 35- to 102-day supply for most drugs. This network includes Walgreens, as well as CVS, Krogers, Publix and Walmart retail stores. To find which retail pharmacies participate in this network, please go to the dedicated Web page for Metro Government at www.bcbst.com/members/metro-gov or call 1-800-367-7790.</p>	<p>Up to 34-day supply:</p> <ul style="list-style-type: none"> • Generic \$5; • Preferred brand \$20; • Non-preferred brand \$50 <p>35-102 day supply:</p> <ul style="list-style-type: none"> • Generic \$10; • Preferred Brand \$40; • Non-preferred Brand \$100 	<p>If filled at a non-network pharmacy, 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 or coinsurance, and excess charges over MAC.</p>
Mental Health <i>*Prior Authorization Required</i>	80%	60% subject to deductible
Substance Abuse <i>*Prior Authorization Required</i>	80%	60% subject to deductible



BlueCross BlueShield of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402
bcbst.com