

# BlueCross BlueShield PPO Blue Network P

## Summary of Benefits

Effective 01/01/12 for Metro Government of Nashville and Davidson County

| Description                                                                               | Blue Network P Provider (PPO)                                                                                                                                                                                                                                                                                                                                                                                                                                   | Non-Network Provider                                                                                                                                                            |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hospital Coverage</b><br>(semi-private room allowance, supplies, drugs, X-rays, tests) | 80% of maximum allowable charges by Plan<br>(100% coverage if out of pocket has been met)                                                                                                                                                                                                                                                                                                                                                                       | 60% of maximum allowable charges by Plan                                                                                                                                        |
| <b>Hospital</b><br>Emergency Room                                                         | 80% of maximum allowable charges by Plan.<br>You pay 20% + \$100 patient copay<br><br>\$100 will be waived for an accident or overnight admission                                                                                                                                                                                                                                                                                                               | 60% of maximum allowable charges by Plan.<br>You pay 40% + \$100 patient copay                                                                                                  |
| <b>Physicians</b>                                                                         | 80% of maximum allowable charges by Plan.<br>You pay 20% plus \$20 patient copay for PCPs and you pay 20% plus \$30 patient copay for Specialists.<br>No balance billing                                                                                                                                                                                                                                                                                        | 60% of maximum allowable charges by Plan.<br>You pay 40% plus \$20 patient copay for PCPs and you pay 40% plus \$30 patient copay for Specialists.<br>You may be balance billed |
| <b>Deductible</b>                                                                         | None                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$200 individual<br>\$600 family maximum<br><br><b>Deductible is required when services are provided by a non-network provider</b>                                              |
| <b>Out-of-Pocket Maximum</b>                                                              | \$1,000 individual<br>\$2,000 family maximum<br><br>When the Out-of-Pocket Maximum is reached, benefits are paid at 100% of maximum allowable charges for the remainder of the calendar year. Copays for physician expenses, emergency room and for drugs will still be required and are not included in the out-of-pocket maximum.                                                                                                                             | \$5,000 individual<br>\$10,000 family maximum                                                                                                                                   |
| <b>Annual Well Care Physical</b> (ages 7 and above)                                       | 100% up to \$750, then 80%.                                                                                                                                                                                                                                                                                                                                                                                                                                     | 60% of maximum allowable charges by Plan                                                                                                                                        |
|                                                                                           | Wellness screenings such as the annual well woman visit, mammogram, men's PSA screening and colonoscopy will continue to be covered at 80% for participating providers and are not considered part of the annual preventive benefit.                                                                                                                                                                                                                            |                                                                                                                                                                                 |
| <b>Well Baby Care</b><br>(ages 6 and under)                                               | 80% of maximum allowable charges by Plan                                                                                                                                                                                                                                                                                                                                                                                                                        | 60% of maximum allowable charges by Plan                                                                                                                                        |
| <b>BlueCard PPO* Out-of-Area Benefits</b>                                                 | 80% of maximum allowable charges by Plan                                                                                                                                                                                                                                                                                                                                                                                                                        | 60% of maximum allowable charges by Plan                                                                                                                                        |
| <b>Other Covered Services</b>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                 |
| Chiropractic Services                                                                     | 50% of maximum allowable charges with \$2,000 maximum benefit per year                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                 |
| Skilled Nursing Facility                                                                  | 80%, limited to 100 days, must immediately follow 3-day hospital confinement                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                 |
| Acupuncture                                                                               | 50% of maximum allowable charges with \$1,000 maximum benefit per year                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                 |
| TMJ                                                                                       | Surgical 80% of maximum allowable charge by Plan                                                                                                                                                                                                                                                                                                                                                                                                                | Surgical 60% of maximum allowable charge by Plan                                                                                                                                |
|                                                                                           | Non-Surgical 50% of maximum allowable charge by Plan up to \$2000 annually                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                 |
| <b>Prior Authorization</b>                                                                | Prior authorization is required for certain services. Have your physician contact BlueCross BlueShield of Tennessee before services are provided or your benefits may be reduced or denied. Examples of when prior authorization is required are: organ transplants, services outside of Tennessee, skilled nursing visits, all inpatient hospital care, 23-hour hospital observation, private duty nursing care, cardiac rehabilitation, endometrial ablation. |                                                                                                                                                                                 |

| Description                                       | Blue Network P Provider (PPO)                                                                                                                                                           | Non-Network Provider                                                                                               |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Mental Health and Substance Abuse Services</b> |                                                                                                                                                                                         |                                                                                                                    |
| Inpatient Care or Facility Based                  | <ul style="list-style-type: none"> <li>80% of maximum allowable charges</li> <li>must be pre-authorized</li> </ul>                                                                      | <ul style="list-style-type: none"> <li>60% of maximum allowable charges</li> <li>must be pre-authorized</li> </ul> |
| Outpatient Care                                   | <ul style="list-style-type: none"> <li>\$20 copay then 80%</li> </ul>                                                                                                                   | <ul style="list-style-type: none"> <li>\$20 copay then 60%</li> </ul>                                              |
| <b>Prescription Drug Coverage</b>                 | Prescription drug benefits are through BlueCross BlueShield of Tennessee in conjunction with CVS/Caremark. You pay a \$10 copay for generic drugs or a \$30 copay for brand name drugs. |                                                                                                                    |

**\*BlueCard PPO** – For medical services outside of Tennessee, the level of benefits (80% or 60%) will be based on if the service is provided by a provider in the network BlueCard PPO. The Web site **bcbst.com** has a listing of these participating providers. Or you may call **1-800-810-BLUE**. It is your responsibility to make sure your provider obtains all prior approvals required by the Plan.

**This is only a brief summary of the major benefits of this program. There are additional limitations, requirements and guidelines that will affect the coverage of this program. Check your Evidence of Coverage for complete details**

### Important Information

**You can have prescriptions filled one of three ways:**

- Up to a month’s supply
    - Through your **RX04 Retail Pharmacy Network** with over 60,000 participating retail stores nationwide and over 1,800 in Tennessee (visit [bcbst.com](http://bcbst.com) for a list of participating pharmacies)
  - Up to 102 days supply for 2 copays
    - Either through the **Home Delivery Retail Network** with over 30,000 participating retail stores nationwide (visit [bcbst.com](http://bcbst.com) for a list)
- OR
- Through Home Delivery services by CVS/Caremark. Call 1-866-443-9159 to start prescription delivery by mail to your door.

**The BlueCross BlueShield of Tennessee provider network for the Metro’s Medical Plan is Blue Network P.**

Always check the Blue Network provider directory to find or select doctors, hospitals or other providers who participate in Blue Network P. Because the Metro Government Plan provides a higher level of benefits when you use Blue Network P providers, you should always verify with the provider that he/she is a current participant of the network before you receive health care services. You can check the **Find a Doctor** online directory at the BlueCross BlueShield of Tennessee Web site, [bcbst.com](http://bcbst.com), for the most current listings and information on Blue Network P providers.

If services are provided by a non-network provider, you will be responsible for the additional coinsurance amount as well as any amount above the approved charges (balance billing.) The amount you owe may be substantial.

The Metro Government Plan is a self-insured medical plan whereby the premiums, benefits and enrollment guidelines are determined by the Metropolitan Employee Benefit Board (MEBB). The MEBB contracts with BlueCross BlueShield of Tennessee to administer this medical plan on behalf of its employees.

**If you have questions about this program,  
call BlueCross BlueShield of Tennessee at 1-800-367-7790.**



BlueCross BlueShield of Tennessee  
1 Cameron Hill Circle | Chattanooga, TN 37402  
[bcbst.com](http://bcbst.com)