

<b>Covered Services</b>	In-Network Benefits for Covered Services received from Network Providers	*Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
<b>Benefit Information</b>		
Individual Deductible	\$250	\$500
Family Deductible	\$750	\$1,500
Individual Out-of-Pocket**	\$2,000	\$4,000
Family Out-of-Pocket**	\$2,000 per individual	\$4,000 per individual
Lifetime Maximum	Unlimited	Unlimited
Coordination of Benefits – Retirees	Retiree benefits are calculated so that the sum of Medicare and the Teacher Plan benefits equal the amounts shown in this document.	
Coordination of Benefits – Active Employees Standard COB guidelines will be followed.		
<b>Services Received at the Practitioner’s Office</b>		
<b>Office Exams and Consultations</b>		
Primary Care Physician office services Primary Care Physicians include Family Practitioners, General Practitioners, Internal Medicine Practitioners, Pediatricians and OB/GYN Practitioners.	\$25 copay then 100%	70% subject to deductible
Specialist office services	\$35 copay then 100%	\$35 copay only for initial visit related to an accident. Additional visits 70% subject to deductible.
Well Child Care Program: 11 visits between birth and age 6	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist	70% subject to deductible
Preventive Health Services include: one routine physical exam per calendar year, mammograms, Pap smears, prostate exams and screening colonoscopies.	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist	70% subject to deductible
<b>Diagnostic Services and Other Office Procedures</b>		
Allergy Services with office visit	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist *Injections - 100% *Allergy testing - 90%	70% subject to deductible

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

\*\* Out-of-Pocket does not include deductible, penalties, copay, non-covered expenses, charges over MAC, or psychiatric care

## 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 (continued)

Mammogram *1 baseline (35-40), 1 annual (40 and above)	If filed with an office visit pay at 100%, Facility charges paid at 100% after \$25 copay, then 100% – PCP \$35 copay, then 100% – specialist, and physicians that read the mammogram will be paid at 100%	70% subject to deductible
Chiropractic Services *Limited to 24 visits per calendar year	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist	No Out-of-Network benefits available
Covered Dental Services	90% subject to deductible	70% subject to deductible
TMJ Covered Services	90% subject to deductible	70% subject to deductible
Vision Services due to illness or injury	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist	70% subject to deductible
One set of eyeglasses or contacts following cataract surgery is covered under the DME benefit as a supply item.	90% subject to deductible	70% subject to deductible
Hearing Services due to illness or injury	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist	70% subject to deductible
Obesity/Weight Reduction *Lifetime max of \$1,650 does not include surgery	90% subject to deductible	70% subject to deductible

### Services Received at a Facility

#### Inpatient Hospital & 23-Hour Observation

Hospital Services (Medical and Surgical) *Prior Authorization Required	90% subject to deductible	70% subject to deductible
Physician Services (Medical and Surgical)	90% subject to deductible	70% subject to deductible
Blood	Blood and blood plasma, including components and derivatives, when provided by a hospital and not donated or replaced.	

#### Dialysis Clinics

Dialysis Services	90% subject to deductible	70% subject to deductible
-------------------	---------------------------	---------------------------

#### Skilled Nursing or Rehabilitation Facilities

Skilled Nursing Facility *Prior Authorization Required Convalescent care must begin 30 days after a covered hospital confinement of at least three (3) days.	90% subject to deductible	70% subject to deductible
Approved/Accredited Rehabilitation Facility Inpatient* or Outpatient Care	90% subject to deductible	70% 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

## Services Received at a Facility (continued)

### Outpatient Hospital and Emergency Care

Outpatient Hospital Services	90% subject to deductible	70% subject to deductible
Emergency Room Services *In-network benefits for Out-of-Network Provider for only the initial treatment of an accident	\$75 copay, then 90% subject to deductible	\$75 copay, then *70% 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	90% after Network deductible; Network OOP applies	90% of Transplant MAC after Network deductible; Network OOP applies, Amounts over TMAC do not apply to the OOP max and are not covered.	70% of TMAC, after Out-of-Network deductible; Out-of-Network OOP applies. Amounts over TMAC do not apply to the OOP and are not covered.
Organ Transplant Services, Kidney Transplants	90% after Network deductible; Network OOP applies		70% of MAC, after Out-of-Network deductible; Out-of-Network OOP applies.
<b>In-Transplant Network providers</b> = Blue Distinction Transplant facilities <b>Network Providers</b> = Blue Network P and BlueCard PPO providers <b>Non-Network Providers</b> = 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) *Prior Authorization Required	90% subject to deductible	70% subject to deductible
All other Diagnostic Services for illness or injury (including EKGs, Routine X-Rays and Labs)	90% subject to deductible	70% subject to deductible

## Services Received in the Home

Home Health Agency *Prior Authorization Required	90% subject to deductible	70% subject to deductible
Home Infusion Therapy *Prior Authorization Required	90% subject to deductible	70% subject to deductible
Hospice Care *Prior Authorization Required for Inpatient	90% subject to deductible	70% subject to deductible

## Ambulance Services

Ambulance	Independently Operated or In-Network Facility	Out-of-Network Facility
	90% subject to deductible	70% subject to deductible

## Maternity Services

Inpatient Facility	90% subject to deductible	70% subject to deductible
Inpatient Physician	90% subject to deductible	70% subject to deductible
Physician Office Visit	\$25 copay, then 100% – PCP \$35 copay, then 100% – specialist	70% 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

## Therapeutic Services

Inpatient Physical, Occupational & Speech Therapy	90% subject to deductible	70% subject to deductible
Outpatient Physical, Occupational & Speech Therapy	90% subject to deductible	70% subject to deductible
Pulmonary Rehabilitation (see benefits summary) <i>*Prior Authorization Required</i>	90% subject to deductible	70% subject to deductible
Cardiac Rehabilitation <i>*Prior Authorization Required</i>	90% subject to deductible	70% subject to deductible

## Other Services

BlueCard PPO – Out-of-State	90% subject to deductible	70% subject to deductible
DME (including DME supplies), Orthotics and Prosthetics. Arch supports or shoe inserts are eligible except for running, limit one pair per lifetime except as required by law for diabetic patients or as part of a leg brace.	90% subject to deductible	70% subject to deductible
Medical Suppliers (e.g. ostomy supplies, dressings, bandages and diabetic supplies)	90% subject to deductible	70% subject to deductible

Out of the Country Benefits

BlueCard Worldwide Benefits Apply

### Prescription Drugs 2010

Includes lancets, swabs, test strips, syringes and monitors.

Retail pharmacy networks:

1. RX04 (Network). This is the same pharmacy network you use today where you can purchase a one-month prescription (up to a 30 day supply). You will continue to use this same pharmacy network in 2010.
2. Home Delivery Retail Network. This is the new pharmacy network where you may purchase a 30- to 90-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 Teachers at [www.bcbst.com/member/metro-teachers](http://www.bcbst.com/member/metro-teachers) or call 1-800-376-4695.

If a member's pharmacy copayments total \$1,500 in the calendar year, covered drugs will be paid at 100% for the remainder of the year. Pharmacy out-of-pocket expenses do not apply to the medical out-of-pocket expense amount.

Up to 30-day supply:

- Generic \$5;
- Preferred brand \$20;
- Non-preferred brand \$50

>30-day supply:

- Generic \$10;
- Preferred Brand \$40;
- Non-preferred Brand \$100

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.

Mental Health & Substance Abuse Inpatient and Outpatient Services	90% subject to deductible	70% subject to deductible
--	---------------------------	---------------------------

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



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