of Tennessee

Metro Teachers Coinsurance 2009 Policy Benefit 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	$250	$325
Family Deductible	$750	$975
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.		
Services Received at the Practitioner's Office		
Office Exams and Consultations		
Office services due to an illness	90% subject to deductible	70% subject to deductible
Office services due to an injury	90% subject to deductible	90% subject to deductible for only the initial visit of an accident. Additional visits 70% subject to deductible.
Well Child Care Program: 11 visits between birth and age 6	90% subject to deductible	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 for Primary Care Physicians (PCP), PCPs include Family Practitioners, General Practitioners, Internal Medicine Practitioners, Pediatricians and OB/GYN Practitioners. $35 copayment for Specialist Providers.	$25 copay, then 100% – PCP $35 copay, then 100% – specialist	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

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	90% subject to deductible	70% subject to deductible
Mammogram *1 baseline (35-40), 1 annual (40 and above)	90% subject to deductible	70% subject to deductible
Chiropractic Services *Limited to 24 visits per calendar year	90% subject to deductible	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	90% subject to deductible	70% subject to deductible
One set of eyeglasses or contacts following cataract surgery	90% subject to deductible	70% subject to deductible
Hearing Services due to illness or injury	90% subject to deductible	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 Auth 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 **Prior Authorization Required*	90% subject to deductible	70% subject to deductible
Outpatient Hospital & 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

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Covered Services

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

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 TMAC, after Out-of-Network deductible; Out-of-Network OOP 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

Service	In-Network	Out-of-Network
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

Service	In-Network	Out-of-Network
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

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

Maternity Services

Service	In-Network	Out-of-Network
Inpatient Facility	90% subject to deductible	70% subject to deductible
Inpatient Physician	90% subject to deductible	70% subject to deductible
Office Services	90% subject to deductible	70% subject to deductible

Therapeutic Services

Service	In-Network	Out-of-Network
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 **Prior Authorization Required*	90% subject to deductible	70% subject to deductible
Cardiac Rehabilitation **Prior Authorization Required*	90% subject to deductible	70% subject to deductible

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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 2009 Administered through Caremark including lancets, swabs, test strips, syringes and monitors. Limited to 30-calendar day supply, 90-day supply of maintenance drugs or 90 days for mail order if over 30-day supply. Effective 3/1/09, 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.	**Effective 3/1/09** 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 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 or coinsurance, and excess charges over MAC.
Mental Health & Substance Abuse Inpatient: limited to 50 days Outpatient: limited to 30 visits (medication management not included)	90% subject to deductible	70% subject to deductible

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09-441 Teachers Coins (3/09)