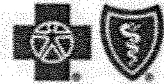
Benefits for 2018 Plan Year

Medical

Claiborne County Board of Education



BlueCross BlueShield of Tennessee

Blue Network P

Plan 1

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$3000/$6000	$6000/$12000
Annual Out-of-Pocket Maximum		
Individual/Family	$5000/$10000	$15000/$30000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services		
Well Child Care Services	Covered at 100%	40% after Deductible
Well Care Services	Covered at 100%	40% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits	20% after Deductible	40% after Deductible
Specialist Office Visits	20% after Deductible	40% after Deductible
Office Surgery	20% after Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray &	20% after Deductible	40% after Deductible
Advanced Radiological Imaging	20% after Deductible	40% after Deductible
Provider-Administered Specialty Drugs	$150 Copay	40% after Deductible
Services Received at a Facility (includes professional and facility		
Inpatient Services	20% after Deductible	40% after Deductible
Outpatient Surgery	20% after Deductible	40% after Deductible
Routine Diagnostic Services - Outpatient	20% after Deductible	40% after Deductible
Advanced Radiological Imaging - Outpatient	20% after Deductible	40% after Deductible
Other Outpatient Services	20% after Deductible	40% after Deductible
Emergency Care Services	20% after Deductible	20% after Deductible
Emergency Care Advanced Radiological Imaging	20% after Deductible	20% after Deductible
Medical Equipment		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics	20% after Deductible	40% after Deductible
Orthotic Appliances	20% after Deductible	40% after Deductible
Hearing Aids (under age 18)	20% after Deductible	40% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual	20% after Deductible	40% after Deductible
Outpatient: Unlimited visits per annual	20% after Deductible	40% after Deductible
Therapy Services **Limited to 30-36 visits per annual benefit period per therapy type**	20% after Deductible	40% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services **Limited to 60 days combined**	20% after Deductible	40% after Deductible
Home Health Care Services **Limited to 60 visits annually**	20% after Deductible	40% after Deductible
Hospice Services		
Inpatient	Covered at 100%	40% after Deductible
Outpatient	Covered at 100%	40% after Deductible
Ambulance Service	20% after Deductible	20% after Deductible
Prescription Drugs		
Prescription Contraceptives	Covered at 100%	40% after Deductible
Retail RX04 Network - up to 30 day		
Generic	$3.00	40% after Deductible
Preferred	$45.00	40% after Deductible
Non-Preferred	$75.00	40% after Deductible
Self-Administered Specialty Drugs Specialty Pharmacy Network - 30 day	$150.00	Not Covered

COVERAGE	COST PER MONTH
Employee Only	$40.00
Employee/Child(ren)	$402.94

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.