Medical

Claiborne County Board of Education

BlueCross BlueShield of Tennessee

Blue Network P

Plan 2

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network
Annual Deductible		
Individual/Family	$1000/$2000	$2000/$4000
Annual Out-of-Pocket Maximum		
Individual/Family	$4000/$8000	$12000/$24000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services		
Well Child Care Services	Covered at 100%	50% after Deductible
Well Care Services [2]	Covered at 100%	50% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	50% after Deductible
Practitioner Office Services		
Primary Care Office Visits	$30 Copay	50% after Deductible
Specialist Office Visits	$50 Copay	50% after Deductible
Office Surgery	$30/$50 Copay	50% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	50% after Deductible
Advanced Radiological Imaging	30% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs	$150 Copay	50% after Deductible
Services Received at a Facility (includes professional and facility		
Inpatient Services	30% after Deductible	50% after Deductible
Outpatient Surgery	30% after Deductible	50% after Deductible
Routine Diagnostic Services - Outpatient	100% (no Deductible)	50% after Deductible
Advanced Radiological Imaging - Outpatient	30% after Deductible	50% after Deductible
Other Outpatient Services	30% after Deductible	50% after Deductible
Emergency Care Services	30% after Deductible	30% after Deductible
Emergency Care Advanced Radiological Imaging	30% after Deductible	30% after Deductible
Medical Equipment		
Durable Medical Equipment	30% after Deductible	50% after Deductible
Prosthetics	30% after Deductible	50% after Deductible
Orthotic Appliances	30% after Deductible	50% after Deductible
Hearing Aids (under age 18)	30% after Deductible	50% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual	30% after Deductible	50% after Deductible
Outpatient: Unlimited visits per annual	$30 Copay	50% after Deductible
Therapy Services Limited to 30-36 visits per annual benefit period per therapy type	30% after Deductible	50% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services		
Limited to 60 days combined	30% after Deductible	50% after Deductible
Home Health Care Services	30% after Deductible	50% after Deductible
Limited to 60 visits annually		
Hospice Services		
Inpatient	Covered at 100%	50% after Deductible
Outpatient	Covered at 100%	50% after Deductible
Ambulance Service	30% after Deductible	30% after Deductible
Prescription Drugs		
Prescription Contraceptives	Covered at 100%	50% after Deductible
Retail RX04 Network up to 30 day		
Generic	$7.00	50% after Deductible
Preferred	$40.00	50% after Deductible
Non-Preferred	$60.00	50% after Deductible
Self-Administered Specialty Drugs	$150.00	Not Covered
Specialty Pharmacy Network - 30 day		

COVERAGE	COST PER MONTH
Employee Only	$200.00
Employee/Child(ren)	$950.00