

BLOUNT COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN

SCHEDULE OF BENEFITS

Effective January 1, 2008

Benefits	Tier I Blount Preferred*	Tier II PPO**	Tier III Out-of-Network
Supplemental Accident Benefit	First \$300 paid at 100%		
Lifetime Maximum Benefit Per Covered Person	\$2,000,000		
Inpatient Mental or Nervous Disorders Treatment	30 days per calendar year; 80% after the deductible		30 days per calendar year; 50% after the deductible
Outpatient Mental or Nervous Disorders Treatment	20 visits per calendar year; 80% after deductible		20 visits per calendar year; 50% after deductible
Inpatient Alcoholism or Chemical Dependency Treatment	30 days per calendar year; 80% after the deductible		30 days per calendar year; 50% after the deductible
Outpatient Alcoholism or Chemical Dependency Treatment	20 visits per calendar year; 80% after deductible		20 visits per calendar year; 50% after deductible
Calendar Year Deductible			
Per Covered Person	\$250		\$500
Per Family (Aggregate)	\$500		\$1,000
<ul style="list-style-type: none"> • The Calendar Year Deductible Applies to all covered expenses unless otherwise stated. The Calendar Year Deductible does not apply to the first \$300 of any covered expense resulting from an accidental injury. • Charges attributable to the Calendar Year Deductibles of participating family members will be combined to meet the Family Deductible. However, when the husband and wife are both employees of Blount County and only one carries family coverage and the other does not, the Per Family Deductible amount will not exceed the Family Deductible maximums listed above for all covered family members combined. • If a charge toward a Deductible is incurred during the last quarter of the calendar year, that charge will carry over and be applied to the following year's deductible. 			
Percentage Payable	90%	80%	50%
<ul style="list-style-type: none"> • The Percentage Payable applies to all Covered Expenses unless otherwise stated. 			
Out-of-Pocket Maximums*	\$1,500 Per Covered Person *No Family Out-of-Pocket Maximum		\$5,000 Per Covered Person *No Family Out-of-Pocket Maximum
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum excludes Deductibles, Treatment of Mental or Nervous Disorders and Alcoholism or Chemical Dependency Treatment charges, and Cost Containment Penalties. 			
COST CONTAINMENT PROVISIONS:			
Outpatient Pre-Admission Testing within 5 days of scheduled admission	90%, deductible waived	80%, deductible waived	50% after deductible
Second Surgical Opinion Benefit	100% up to \$100 per opinion		
The Calendar Year Deductible is waived for the initial \$100 benefit. Any expenses exceeding \$100 are subject to the Calendar Year Deductible and applicable percentage payable.			
Room & Board Benefit Semi-Private.....up to Hospital's Actual Charge Intensive Care.....3 times the Hospital's Most Common Semi-Private Room Rate Private.....up to Hospital's Most Common Semi-Private Room Rate plus \$4* *When the Hospital only has Private Room accommodations and does not have a Most Common Semi-Private Room Rate, the room and board benefit will be 3 times the Most Common Semi-Private Room Rate for that geographic area.			
Pre-Admission Certification – If Pre-Admission Certification is NOT obtained for a Hospital confinement, all eligible Hospital expense benefits will be reduced by 20%. The additional reduction will NOT apply towards satisfying any other plan Deductibles or the Out-of-Pocket Maximum. For example, if a Covered Person does not obtain pre-admission certification for an Inpatient Hospital confinement, benefits for covered expenses will be reimbursed at 70% after Deductible for a Tier I provider instead of 90% after Deductible. The 20% difference that the Covered Person would have to pay for the penalty would not apply toward their Deductible or Out-of-Pocket Maximum.			
Weekend Hospital Admission: Admissions for Inpatient Hospital Confinement are not eligible for reimbursement under the Plan when admission takes place after twelve (12) noon on Friday or before twelve (12) noon on Sunday. This provision does not apply to admissions for a Medical Emergency or if surgery is performed within twenty-four (24) hours of the admission.			

*Blount Preferred - PPO/Cariten Providers in Blount County and East Tennessee Children's Hospital

**PPO – Cariten Providers outside of Blount County

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OTHER PLAN PROVISIONS:			
Physician Expenses – Office Visit Charges & Hospital Inpatient Surgery	90% after deductible	80% after deductible	50% after deductible
Outpatient Surgery Expenses – Physician Expenses for Hospital or Physician's Office	90%, deductible waived	80%, deductible waived	50% after deductible
Outpatient Surgery Expenses – Hospital Expenses	90%, deductible waived	80%, deductible waived	50% after deductible
Outpatient Surgery Expenses – Ambulatory Surgical Facility	90%, deductible waived	80%, deductible waived	50% after deductible
Hospital Expenses – Emergency Room Services	\$50 copay* per visit (waived if admitted); then 90% after deductible	\$50 copay* per visit (waived if admitted); then 80% after deductible	\$50 copay* per visit (waived if admitted); then 50% after deductible
*Emergency Room Copay will be waived for medical emergencies that include chest pains, severe bleeding, broken bones, breathing problems, or if referred to the emergency room by a physician.			
Hospital Expenses – Inpatient Expenses**	90% after deductible	80% after deductible	50% after deductible
**Any services not available with a Tier I Hospital provider, but are available with a Tier II Hospital provider will be paid at the Tier I level of benefits.			
Pregnancy/Maternity (Coverage for Employee or Spouse Only)	90% after deductible	80% after deductible	50% after deductible
Chiropractic Care (All Services)	80% after deductible; \$50 maximum benefit per visit (excluding 1 st visit); limited to a maximum of 25 visits per calendar year		
NOTE: Only the in-network Deductible applies. X-rays are covered for the initial visit only.			
Physical Therapy	Must obtain authorization after 20 visits.		
	90% after deductible	80% after deductible	50% after deductible
Breast Forms & Prosthetic Bra	80% after deductible; \$300 allowable in 24 consecutive month period; limited to 2 forms in a 24 consecutive month period		
Artificial Limb (Prosthetic Device)	80% after deductible; covers initial purchase and replacement if medically necessary & pre-authorized		
A wig following Chemotherapy or Radiation Treatment	\$100 Lifetime Maximum		
Non-Surgical TMJ	\$600 Lifetime Maximum		
Hospice Care	\$50,000 Lifetime Maximum; \$150 maximum benefit per day; 90%, deductible waived	\$50,000 Lifetime Maximum; \$150 maximum benefit per day; 80%, deductible waived	\$50,000 Lifetime Maximum; \$150 maximum benefit per day; 50%, after deductible
Home Health Care	80 visit calendar year maximum; 90%, deductible waived	80 visit calendar year maximum; 80%, deductible waived	80 visit calendar year maximum; 50%, deductible waived
Skilled Nursing Facility	28 days calendar year maximum; 90% after deductible	28 days calendar year maximum; 80% after deductible	28 days calendar year maximum; 50% after deductible

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Preventive Care	100%, no deductible	100%, no deductible	No coverage
Exam Frequency <i>No coverage out-of-network</i>	<ul style="list-style-type: none"> • Under Age 6 years: <i>Exams are not limited</i> • Age 6 years to age 30: <i>1 Exam every 3 Calendar Years</i> • Age 30 to age 40: <i>1 Exam every 2 Calendar Years</i> • Age 40 and Over: <i>1 Exam per Calendar Year</i> <p>Routine preventive care services are those services for routine medical care for which there is no diagnosis due to an illness or injury. A routine physical exam can include office visit and eligible charges incurred on the same day as the office visit, such as routine immunizations, booster shots, and vaccinations.</p> <p>In the event an employee or eligible family member cannot complete their routine physical examination under the care of one Physician, the plan will allow one additional visit to a health care specialist.</p> <p>The following routine benefits will be paid at 100%, deductible waived, regardless of the above frequency limits: (a) all routine childhood immunizations required by the health department for dependent children to attend schools; and (b) flu shots for both adults and children.</p>		
Mammogram Frequency <i>No coverage out-of-network</i>	<ul style="list-style-type: none"> • Between Age 35 and 40: <i>1 Baseline</i> • Age 40 to age 50: <i>1 Screening Mammogram every 2 years or more frequently based on recommendation of the Physician</i> • Age 50 and Over: <i>One Screening Mammogram Per Calendar Year</i> 		
Well Woman Exam Frequency <i>No coverage out-of-network</i>	1 visit per calendar year which includes: <ul style="list-style-type: none"> • Exam • Pap Smear • Lab Work 		
Prostate Screening Frequency <i>No coverage out-of-network</i>	<ul style="list-style-type: none"> • Age 40 and Over: <i>1 Exam per Calendar Year</i> 		
Colonoscopy Frequency <i>No coverage out-of-network</i>	<ul style="list-style-type: none"> • Age 50 and Over: <i>1 Exam per every 10 years or more frequently, based on the recommendation of the Physician</i> 		
Prescription Drug Benefit	Retail	Mail Order	
Generic	\$5 copay	\$10 copay	
Brand	\$25 copay	\$50 copay	
<p>*The co-payment for prescriptions will apply only to the out-of-pocket annual maximum if the covered participant files the applicable copayment amounts with the TPA within six (6) months of purchase date (retail or mail order). If you have other prescription drug coverage that is primary, please see the coordination with other prescription drug plans provision under COORDINATION OF BENEFITS.</p> <p>*If the Covered Person requests a Brand name drug when a Generic drug is available, the Covered Person must pay the price difference between the Brand name and the Generic drug.</p>			

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MISCELLANEOUS PROVISIONS:

- When a covered person receives treatment or services as a result of a Medical Emergency, eligible expenses will be paid on the basis of a Tier II provider, whether or not such services were performed by a Tier II provider.
- When covered services are rendered in a Tier I or II Hospital by an anesthesiologist, radiologist or pathologist who is a Tier III Provider, the benefit percentage will be the same as that for services rendered by a Tier I or II Provider dependent upon the Hospital where the services are rendered.
- When covered services are rendered within the PPO Service Area by a Tier III Provider and such services are not available from a Tier I or II Provider, the benefit percentage will be the same as that for services rendered by a Tier I Provider.
- When covered services are received: (1) outside the geographic Service Area of the Tier I or II provider network; (2) by a dependent child who lives in another state with a divorced parent; or (3) by a retiree, the percentage payable for eligible charges will be the same as that stated in the Schedule of Benefits for Tier II Providers. However, if the covered person travels outside the geographic Service Area for the purpose of obtaining medical care, which is available from a Tier I or II provider, the percentage payable by the Plan will be the same as that for a Tier III provider as stated in the Schedule of Benefits.

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WEEKLY ACCIDENT AND SICKNESS BENEFITS

Class 1 Plan Outline:

- Description of Eligible Classes
 - All full-time active Highway Department Employees, and
 - Full-time active Board of Education employees classified: Cafeteria Employees
- Maximums
 - Amount of Weekly Benefits..... \$60
 - Maximum Period of Benefits..... 52 weeks
- Waiting Period for Disability due to accidental bodily injury: The greater of any accumulated sick days plus a 0 day waiting period.
- Waiting Period for Disability due to a sickness: The greater of any accumulated sick days plus a 7 day waiting period.

Class 2 Plan Outline:

- Description of Eligible Classes
 - All full-time, active Courthouse Employees, and
 - Full-time, active Board of Education employees except: Cafeteria Employees
- Maximums
 - Amount of Weekly Benefits..... \$60
 - Maximum Period of Benefits..... 52 weeks
- Waiting Period for Disability due to accidental bodily injury: The greater of any accumulated sick days plus a 30 day waiting period.
- Waiting Period for Disability due to a sickness: The greater of any accumulated sick days plus a 30 day waiting period.

LIFE INSURANCE

- Class:** All Full-Time Eligible Employees
- Coverage:** Life Insurance:
- 1 x salary to maximum of \$50,000 minimum \$6,000
- Accidental Death & Dismemberment (AD&D):
- 1 x salary if due to accident
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- Class:** All Retired Eligible Employees
- Coverage:** Life Insurance:
- \$10,000
- Accidental Death & Dismemberment (AD&D):
- \$10,000 if due to accident

**This is a brief outline of benefits.
Always consult your booklet for actual details concerning coverage.**

Blount County Government

Summary of Benefits	Dental Blue	
Deductible Calendar Year Applies to Coverage B and C only	<u>Individual</u> \$50	<u>Family</u> \$150
Benefit Maximums Applies to Coverage A, B, and C (per Calendar Year) Coverage D (per Lifetime)	\$1,000 \$1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	Benefit Percentages
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%
Coverage C Major Restorative and Prosthodontics	50%
Coverage D Orthodontics-Child to age 18	50%
Preferred Network Option	Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule
DenteMax National Network	Included**
BluePerks	Discounts on routine vision care, Lasik surgery, weight loss and fitness centers, complementary/alternative medicine and more

This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions From Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. We have contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because we have no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

**DenteMax National Network: We have partnered with DenteMax to provide access to their nationwide network of more than 80,000 dentists. Members may access the DenteMax network via www.bcbst.com.