

TVA Consumer-Directed
Health Plan (CDHP)
2010 Benefits Summary



Covered Services	In-Network Benefits	*Out-of-Network Benefits
Benefit Information		
Deductible		
Individual – In- & Out-of-Network Combined	\$1,200	\$2,000
Family – In- & Out-of-Network Combined	\$2,400	\$4,000
Out-of-Pocket Calendar Year Maximums		
Individual – In- & Out-of-Network Combined	\$4,500	\$9,000
Family – In- & Out-of-Network Combined	\$9,000	\$18,000
Lifetime Maximum	Unlimited	Unlimited
Health Savings Account (HSA)	TVA Contribution: Individual \$600, Family \$1,200	

Services Received at the Practitioner's Office

Office Exams and Consultations		
Diagnosis and treatment of illness and injury	80% after deductible	60% after deductible
Maternity office visits (if visits are billed separately from global delivery charges)	80% after deductible	60% after deductible
Preventive, including immunizations – Children under age 6	100% Birth to 1 year – 4 exams per year Age 1 up to 2 – 2 exams per year Age 2 up to 6 – 1 exam per year	100% of billed charges Birth to 1 year – 4 exams per year Age 1 up to 2 – 2 exams per year Age 2 up to 6 – 1 exam per year
Preventive Care – Services include but are not limited to: GYN exam, annual routine exam, mammogram screenings, pap smears, prostate screening, audiology screenings, flu and pneumonia shots and related routine diagnostic services. Does not include colonoscopies, as these are considered medical.	100% up to \$500 annual limit per covered member; not covered after limit reached	100% of billed charges up to \$500 annual limit per covered member; not covered after limit reached

Diagnostic Services

Allergy Testing	80% after deductible	60% after deductible
Non-Routine Diagnostic Services for illness or injury (includes MRIs, CAT Scans, Nuclear Medicine or other similar technologies)	80% after deductible	60% after deductible
All Other Diagnostic Services for illness or injury (i.e. EKGs, X-rays and Labs)	80% after deductible	60% after deductible
Maternity care diagnostic services	80% after deductible	60% after deductible

* Unless otherwise noted, all payments based on maximum allowable charge.

**Prescription Benefits administered through Medco.

Covered Services	In-Network Benefits	*Out-of-Network Benefits
Mental Health		
Inpatient Services	80% subject to deductible; 60-day calendar year maximum	60% subject to deductible; 60-day calendar year maximum
Outpatient Services	80% subject to deductible; 60-visit calendar year maximum	60% subject to deductible; 60-visit calendar year maximum
Substance Abuse		
Inpatient Services	80% subject to deductible; 150-day lifetime maximum	60% subject to deductible; 150-day lifetime maximum
Outpatient Services	80% subject to deductible; 30-visit calendar year maximum	60% subject to deductible; 30-visit calendar year maximum
**Prescription Drugs		
Generic	80% after deductible; \$10 minimum; \$100 maximum	
Preferred Brand	80% after deductible; \$24 minimum; \$100 maximum	
Non-Preferred Brand	80% after deductible; \$39 minimum; \$100 maximum	
Mail-Order Pharmacy	80% after deductible; 2x retail minimums and maximums for a 90-day supply	
Vision		
Vision care benefits are not available.		

How CDHP/HSA Works

The CDHP is a high-deductible health plan. Once your deductible is met, benefits for covered services are paid at 80% (in-network) and 60% (out-of-network) for the remainder of the year, until the out-of-pocket maximum is met.

Participants in the CDHP may be eligible for an HSA, a tax-exempt trust account. TVA will make a contribution of \$600/individual or \$1,200/family to your HSA once your account is opened. You choose whether or not to make additional contributions. The maximum contribution from all sources is \$3,050/individual or \$6,150/family. Any unused HSA balance can carry over to future years with no limits. You decide whether or not to use your HSA money now for qualified medical expenses, including your deductible, or to save it for future use.

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BlueCard PPO Network – Access the PPO network throughout the country using the Blue Network P. To locate providers go to www.bcbst.com and click on Find a Doctor.

Claims Filing – In-network providers will file claims and handle any necessary prior approvals. You are responsible for filing your out-of-network claims and complying with any prior approval requirements. Instructions for getting prior approval are printed on your ID Card.

In-network/Out-of-network – You can receive services from both in-network and out-of-network providers. A higher benefit will be paid for using providers in your network.

Member Self-Service – Member Self-Service available through BlueAccess, the secure area of www.bcbst.com, allows you to access your EOBs as well as claim, eligibility, benefit and authorization information. Member Self-Service also allows you to order replacement ID cards and update your COB information.

Customer Service – Customer Service can be reached at 1-800-245-7942 from 8 am – 5:15 pm EST, Monday – Friday.

Prior Authorization – Prior approval may be necessary for inpatient admissions and certain outpatient procedures. Providers that are in your network will take care of this process for you. You are responsible for complying with any prior approval requirements when seeing out-of-network providers. Instructions for getting prior approval are printed on your ID Card.

TVA Account page – A host of health tools are available to you through the TVA Account page on www.bcbst.com. Tools such as the Health Plan Comparison, Hospital Quality, Treatment Cost Estimator, Hospital Cost, etc. give you the ability to make more informed health care decisions.

Worldwide Coverage – Provides coverage for inpatient hospital care at participating hospitals at the same level of benefits you receive in the U.S.



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