

TVA Copay Plan  
2010 Benefits Summary



| Covered Services   | In-Network Benefits  | *Out-of-Network Benefits   |
|--|--|--|
| <b>Benefit Information</b>   |  |  |
| <b>Deductible</b>  |  |  |
| Individual – In- & Out-of-Network Combined   | None   | None   |
| Family – In- & Out-of-Network Combined   | None   | None   |
| <b>Out-of-Pocket Calendar Year Maximums</b>  |  |  |
| Individual – In- & Out-of-Network Combined   | \$1,500  | \$3,000  |
| Family – In- & Out-of-Network Combined   | \$3,000  | \$6,000  |
| <b>Lifetime Maximum</b>  | Unlimited  | Unlimited  |
| <b>Services Received at the Practitioner's Office</b>  |  |  |
| <b>Office Exams and Consultations</b>  |  |  |
| Diagnosis and treatment of illness and injury  | 100% after \$25 copay  | 70%  |
| Maternity office visits (if visits are billed separately from global delivery charges)   | 100% after \$25 copay<br>(copay applies to first visit only)   | 70%  |
| Preventive, including immunizations – Children under age 6   | 100%   | 100% of billed charges   |
|  | <small>Birth to 1 year – 4 exams per year<br/>Age 1 up to 2 – 2 exams per year<br/>Age 2 up to 6 – 1 exam per year</small> | <small>Birth to 1 year – 4 exams per year<br/>Age 1 up to 2 – 2 exams per year<br/>Age 2 up to 6 – 1 exam per year</small> |
| 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                        |
| <b>Diagnostic Services</b>   |  |  |
| Allergy Testing  | 100%   | 70%  |
| Non-Routine Diagnostic Services for illness or injury (includes MRIs, CAT Scans, Nuclear Medicine or other similar technologies)   | 100% after \$50 copay per procedure  | 70%  |
| All Other Diagnostic Services for illness or injury (i.e. EKGs, X-rays and Labs)   | 100%   | 70%  |
| Maternity care diagnostic services   | 100%   | 70%  |

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

\*\*Prescription Benefits administered through Medco.

| Covered Services            | In-Network Benefits  | *Out-of-Network Benefits                              |
|-----------------------------|--|---|
| <b>Mental Health</b>        |  |   |
| Inpatient Services          | 100% after \$500 copay per admission; 60-day calendar year maximum | 70%; 60-day calendar year maximum                     |
| Outpatient Services         | 100% after \$25 copay per visit; 60-visit calendar year maximum    | 70%; 60-visit calendar year maximum                   |
| <b>Substance Abuse</b>      |  |   |
| Inpatient Services          | 100% after \$500 copay per admission; 150-day lifetime maximum     | 70%; 150-day lifetime maximum                         |
| Outpatient Services         | 100% after \$25 copay per visit; 30-visit calendar year maximum    | 70%; 30-visit calendar year maximum                   |
| <b>**Prescription Drugs</b> |  |   |
| Generic                     |  | \$10 copay  |
| Preferred Brand             |  | \$24 copay  |
| Non-Preferred Brand         |  | \$39 copay  |
| Mail-Order Pharmacy         |  | 2x retail copay for up to a 90-day supply             |
| <b>Vision</b>               |  |   |
| Exam                        |  | \$10 copay every 12 months                            |
| Lenses                      |  | \$10 copay every 12 months                            |
| Frames (every 2 years)      |  | \$10 copay up to \$100, then 80% of amount over \$100 |
| Contacts                    |  | \$10 up to \$115 allowance per year                   |

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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](http://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](http://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](http://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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