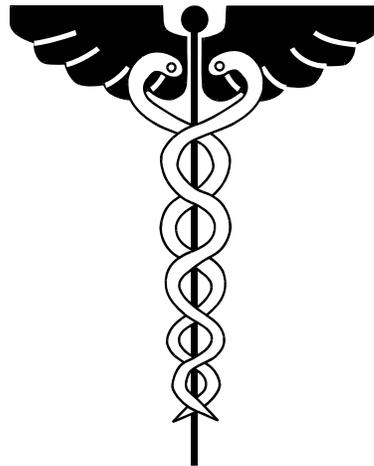


**EXHIBIT A to the Administrative Services Agreement
EVIDENCE OF COVERAGE (EOC)**

**THE TENNESSEE VALLEY
AUTHORITY**

**Health Benefit Plan
Evidence of Coverage**



NOTICE

PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR BENEFITS AS ADMINISTERED BY BLUECROSS BLUESHIELD OF TENNESSEE, INC. IF YOU HAVE ANY QUESTIONS ABOUT THIS EVIDENCE OF COVERAGE OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

**CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.,
ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402
(800) 245-7942**

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INTRODUCTION

This Evidence of Health Coverage (this “EOC”) is included in the Summary Plan Description document (SPD) created by the Employer (listed on the cover of this EOC) as part of its employee welfare benefit plan (the “Plan”). References in this EOC to “administrator,” “We,” “Us,” “Our,” or “BCBST” mean BlueCross BlueShield of Tennessee, Inc. The Employer has entered into an Administrative Services Agreement (ASA) with BCBST for it to administer the claims Payments under the terms of the SPD, and to provide other services. BCBST does not assume any financial risk or obligation with respect to Plan claims. BCBST is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. These ERISA terms are used in this EOC to clarify their meaning, **even though the Plan is not subject to ERISA.** Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

This EOC describes the terms and conditions of Your Coverage through the Plan. It replaces and supersedes any EOC or other description of benefits You have previously received from the Plan.

PLEASE READ THIS EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND DUTIES OF MEMBERS. IT IS IMPORTANT TO READ THE ENTIRE EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE LIMITED. THE PLAN WILL NOT PAY FOR ANY SERVICE NOT SPECIFICALLY LISTED AS A COVERED SERVICE, EVEN IF A HEALTH CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE. (SEE ATTACHMENTS A-D.)

While the Employer has delegated discretionary authority to make any benefit or eligibility determinations to the administrator, the Employer also has the authority to make any final Plan determination. The Employer, as the Plan

Administrator, and BCBST also have the authority to construe the terms of Your Coverage. The Plan and BCBST shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Employer’s benefit plan is subject to ERISA.

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS EOC SHALL BE RESOLVED IN ACCORDANCE WITH THE "GRIEVANCE PROCEDURE" SECTION OF THIS EOC.

- adoption;
- birth of additional dependents; or
- termination of employment.

In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the "DEFINITIONS" section of this EOC.

Please contact one of the administrator's consumer advisors, at the number listed on the Subscriber's membership ID card, if You have any questions when reading this EOC. The consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

BENEFIT ADMINISTRATION ERROR

If the administrator makes an error in administering the benefits under this EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this EOC.

NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under the Plan. To make sure the Plan works correctly, please notify the TVA Service Center at 865-632-8800, 423-751-8800, or 888-275-8094 when You change:

- name;
- address;
- telephone number;
- employment

Notify the customer service department at the number listed on the Subscriber's membership ID card when You have a change in the status of any other health coverage You have.

Subscribers must notify the TVA Service Center of any eligibility or status changes for themselves or Covered Dependents, including:

- the marriage or death of a family member;
- divorce;

ELIGIBILITY

Any Employee of the Employer and his or her family dependents who meet the eligibility requirements of this Section will be eligible for Coverage if properly enrolled for Coverage, and upon payment of the required Payment for such Coverage. If there is any question about whether a person is eligible for Coverage, TVA shall make final eligibility determinations.

A. Subscriber

To be eligible to enroll as a Subscriber must be:

An annual full-time TVA employee, or part-time employee regularly scheduled to work 16 hours or per week.

OR

An employee of a union directly representing TVA salary policy employees

OR

A retiree not eligible for Medicare hospital insurance who meets the criteria for retiree medical coverage as determined by TVA.

OR

A retired employee of a union directly representing TVA salary policy employees.

Eligible employees and retirees must enroll in the Plan in accordance with the enrollment processes and timeframes established by TVA.

B. Covered Dependents

Dependents eligible for coverage include the Subscriber's:

Spouse. (Common-law spouses may be recognized as eligible for plan coverage if the employee resides in a state that recognizes common-law marriage and

provides evidence satisfactory to TVA to document the common-law relationship.)

Natural child, adopted child, foster child, stepchild, or child for whom the Subscriber is legal guardian or for whom the Subscriber has legal custody who is under the age of 26.

Coverage for dependent children may be continued past the age limit if the child is certified as disabled due to physical handicap or mental illness, through receipt of Social Security Disability or other private disability benefits, or as determined by the administrator. The disabling condition must have begun before reaching the dependent age limit and the dependent must be currently enrolled in the health plan. TVA must receive this certification at least thirty-one (31) days prior to the date of coverage termination. Certification of disability may be required on an annual basis.

A child is considered a foster child if:

1. TVA receives the application to cover the child within thirty-one (31) days prior to the placement or date the child established residency, whichever is earlier;
2. The placement is for a minimum of twenty-five (25) days per month and expected to exceed one year; and
3. The medical expenses of the child are not covered by any other group coverage or by the agency through which the child was placed.

Notarized statements of custody, guardianship, adoption, foster care, or legitimacy are not acceptable documentation. Copies of the actual legal papers as issued with the final decree from the respective court or legal placement papers issued by the authorized agency are required.

An employee or retiree cannot be covered as an employee or retiree and as the spouse or dependent of an employee or retiree. A dependent child can be covered under only one TVA-sponsored medical plan.

TVA's determination of eligibility under the terms of this provision shall be final.

The Plan reserves the right to require proof of eligibility including--but not limited to--marriage certificates, birth certificates, and certified copies of qualified medical child support orders.

ENROLLMENT IN THE PLAN

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section.

A. Initial Enrollment Period

Eligible employees and retirees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. They must enroll in the Plan in accordance with the enrollment processes and timeframes established by TVA.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the TVA Open Enrollment Period. The eligible Employee must enroll in accordance with the open-enrollment processes and timeframes established by TVA.

There is not an open-enrollment period for retirees.

C. Adding Dependents

A Subscriber may add a dependent who became eligible after the Subscriber enrolled as follows:

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth, and a legally adopted child, or a child for whom the Subscriber has been appointed legal guardian by a court of competent jurisdiction, will be Covered effective on the date the child is placed in the Subscriber's physical custody. The Subscriber must enroll that child within 31 days of the date that the Subscriber acquires the child.

However, the Plan cannot add the newborn or newly acquired child to the Subscriber's Coverage until

notified. This may delay claims processing.

2. Any other new dependent, (e.g., if the Subscriber marries) may be added as a Covered Dependent if the Subscriber enrolls such dependent within 31 days of the date that person first becomes eligible for Coverage.

Employees and retirees must contact the TVA Service Center to add eligible dependents. Dependents cannot be added by contacting administrator.

D. Late Enrollment for Employees

Employees or their dependents who do not enroll when becoming eligible for Coverage under (A), (B) or (C), above may enroll:

1. During a subsequent Open Enrollment Period for employees; or
2. If the Employee acquires a new dependent, and he or she applies for Coverage within 31 days.

E. Late Enrollment for Retirees

A retiree who does not enroll within 31 days of retirement will not have another opportunity to enroll in a TVA-sponsored retiree medical plan.

A retiree who signed a form provided by TVA prior to July 1993 to defer enrollment for the retiree (or dependents) because of medical coverage in another group plan may be eligible to enroll in a TVA retiree medical plan within 31 days of the date such other coverage ended. Questions about the possibility of enrolling in a TVA plan should be directed to the TVA Service Center.

F. Change in Status for Employees

If You have a change in status, You may be eligible to change Your Coverage other than during the Open Enrollment Period. Subscribers must, within the

time-frame set forth below, submit a change form to the Group representative to notify the Plan of any changes in status for themselves or for a Covered Dependent. Any change in Your elections must be consistent with the change in status.

You must request the change within 31 days of the change in status for the following events: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee or acquisition of an eligible dependent through legal custody or legal guardianship; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse; (9) taking an unpaid leave of absence by the Employee or the Employee's spouse, or returning from unpaid leave of absence; (10) significant change in the health coverage of the Employee or the Employee's spouse attributable to the spouse's employment.

You must request the change within 60 days of the change in status for the following events: (1) loss of eligibility for Medicaid or CHIP coverage, or (2) becoming eligible to receive a subsidy for Medicaid or CHIP coverage.

G. Change in Status for Retirees

If a retiree that is covered under a TVA plan gets married and is eligible to enroll the new spouse, he/she must enroll that new spouse within 30 days of the date of marriage. If he/she fails to add the new spouse within 30

days of marriage, the new spouse can only be added by providing (without expense to the plan or the Administrator) evidence of good health of the new spouse. Eligible coverage will begin on the first day of the calendar month following the date the Administrator determines such evidence to be acceptable. If a retiree that is covered under a TVA plan has an eligible dependent child that is not enrolled in the TVA plan, the retiree can add such eligible dependent child only if the child loses current medical coverage. The child may be added within 30 days of the date he/she loses current coverage. If the retiree fails to add the dependent within 30 days of the loss of other coverage, the dependent can only be added by providing (without expense to the plan or the Administrator) evidence of good health of the dependent. Eligible coverage will begin on the first day of the calendar month following the date the Administrator determines such evidence to be acceptable.

H. Restoration of Coverage for Employees

1. An active employee restored with restoration rights following service in the Armed Forces or the Public Health Service is entitled to reinstatement hereunder at the time of restoration. To exercise this right, the employee must apply for coverage within 31 days of restoration. Coverage will begin on the date of restoration. There is no waiting period for pre-existing conditions in this case.

If the employee so restored wants coverage restored retroactive to the date of discharge, it may be done by

making payment for total premiums for all full calendar months from the date of discharge to the beginning of the first full month following restoration.

Questions regarding status changes must be directed to the TVA Service Center at 865-632-8800, 423-751-8800, or 888-275-8094.

2. An active employee who is otherwise restored and entitled to restoration of medical plan coverage may elect to be covered retroactive to the date medical coverage terminated after termination of employment and must pay the employee contributions to cover that period. If the employee elects not to be retroactive covered under the medical plan, medical coverage is handled as for a new employee, including any applicable waiting period for pre-existing conditions, and coverage would become effective the date the employee returns to active employment. Where TVA determines that the time period was not missed due to the fault of the employee and failure to grant a waiver would be against equity and good science, a waiver may be granted by TVA.

I. Death of Active Employee

When an active employee with coverage for self and dependent(s) dies, coverage for the dependent(s) is continued through the end of the month. Additionally, the dependent coverage is continued under the active employee plan for two (2) more months. The surviving dependent(s) must then apply for coverage to be continued under the retiree plan by submitting the appropriate retiree medical plan enrollment form within 31 days of the date the active coverage ends. Such retiree coverage shall become effective on the day following the termination of the active employee dependent(s) coverage.

WHEN COVERAGE BEGINS

If You are eligible, have enrolled and have paid or had the Payment for Coverage paid on Your behalf, Coverage under this EOC shall become effective on the earliest of the following dates:

A. Effective Date of ASA

Coverage shall be effective on the effective date of the ASA, if all eligibility requirements are met as of that date; or

B. Enrollment During an Open Enrollment Period

Coverage shall be effective on January 1st of the calendar year following the Open Enrollment Period.

C. Newly Eligible Employees

Coverage shall be effective on the date of eligibility as specified in the ASA; or

D. Newly Eligible Dependents

Dependents acquired as the result of Employee's marriage – Coverage will be effective on the day of the marriage.

Newborn children of the Employee or Employee's spouse- Coverage will be effective as of the date of birth;

Dependents adopted or placed for adoption with Employee – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

Dependents acquired through legal custody or legal guardianship – Coverage will be effective the date of the court order awarding custody or guardianship to the Employee.

Eligible employees and retirees must enroll newly eligible dependents in accordance with the enrollment processes and timeframes established by TVA.

WHEN COVERAGE ENDS

A. Termination or Modification of Coverage by BCBST or the Employer

BCBST or the Employer may modify or terminate the ASA. Notice to the Employer of the termination or modification of the ASA is deemed to be notice to all Members Covered under the Plan. The Employer is responsible for notifying You of such a termination or modification of Your Coverage.

All Members' Coverage through the ASA will change or terminate at 12:00 midnight on the date of such modification or termination. The Employer's failure to notify You of the modification or termination of Your Coverage does not continue or extend Your Coverage beyond the date that the ASA is modified or terminated. You have no vested right to Coverage under this EOC following the date of the termination of the ASA.

B. Termination of Coverage Due to Loss of Eligibility

Employment Ends - If Your employment ends, Your Coverage will terminate at 12:00 midnight on the last day of the month in which your employment ends. When Your coverage ends, coverage for your dependents will end at the same time.

Divorce or Legal Separation - Coverage for a spouse ends on the date of legal separation or divorce.

Dependent Loses Eligibility - Coverage for a dependent ends on the date the dependent becomes ineligible.

Becoming Eligible for Medicare - Coverage for a retiree or a retiree's dependent will end at the end of the month before the retiree or dependent becomes eligible for Medicare hospital insurance. However, employees and their dependents otherwise eligible for Medicare hospital insurance may

continue coverage in this plan in accordance with Federal laws regarding older workers, unless they choose to end their active employee coverage in this plan.

C. Payment For Services Rendered After Termination of Coverage

If You receive Covered Services after the termination of Your Coverage, the Plan may recover the amount paid for such Services from You, plus any costs of recovering such Charges, including its attorneys' fees.

eligible for similar group coverage within 31 days following termination of coverage under this Plan.

D. BENEFITS AFTER COVERAGE ENDS

Benefits will be provided for six months after a member's coverage terminates for any condition which had been diagnosed and for which treatment had begun prior to termination of coverage. This does not apply to dental surgery.

These extended benefits will not be continued if the group contract terminates, unless the former member is hospitalized on the date group coverage terminates, in which case benefits will be provided until maximum benefits are provided or until he or she is discharged, whichever occurs first.

These extended benefits will be coordinated with any other benefits available to the member in accordance with the provisions of the Coordination of Benefits section.

E. CONVERSION TO NON-GROUP CONTRACT

If a person's coverage under this Plan ends while this contract is in effect, that person may apply for coverage under a non-group plan available through the administrator if the person lives in Tennessee or through the BlueCross BlueShield plan that covers the area in which the person lives if other than Tennessee.

The person must apply for the new contract within 31 days after coverage is this Plan ends or otherwise as provided for by the administrator or the BlueCross BlueShield plan in that area.

This conversion is not available if coverage terminated under this Plan because the person became eligible for Medicare hospital insurance or became

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

BlueCross BlueShield of Tennessee provides services to help manage Your care including, performing Prior Authorization of certain services to ensure they are Medically Necessary, Concurrent Review of hospitalization, discharge planning, lifestyle and health counseling, low-risk case management, catastrophic medical and transplant case management and the development and publishing of medical policy.

BCBST does not make medical treatment decisions under any circumstances. You may always elect to receive services that do not comply with BCBST's Care Management requirements or medical policy, but doing so may affect the Coverage of such services.

Prior Authorization

BCBST must Authorize some Covered Services in advance in order for those Covered Services to be paid at the Maximum Allowable Charge without Penalty. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the EOC must be satisfied before Coverage for services will be provided.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital stays (except maternity admissions)
- Skilled nursing facility and rehabilitation facility admissions
- Certain Specialty Drugs

Refer to Attachment C: Schedule of Benefits for details on benefit penalties for failure to obtain Prior Authorization.

Network Providers in Tennessee will request Prior Authorization for You.

You are responsible for requesting Prior Authorization when using Providers outside Tennessee and Out-of-Network Providers, or benefits will be reduced or denied.

For the most current list of services that require Prior Authorization, call customer service or visit our Web site at www.bcbst.com.

BCBST may authorize some services for a limited time. BCBST must review any request for additional days or services.

Network Providers in Tennessee are required to comply with all of BCBST's medical management programs. You are held harmless (not responsible for Penalties) if a Network Provider in Tennessee fails to comply with Care Management program and Prior Authorization requirements, unless You agreed that the Provider should not comply with such requirements.

The Member is not held harmless if:

A Network Provider outside Tennessee (known as a BlueCard PPO Participating Provider) fails to comply with Care Management program and Prior Authorization requirements, or

An Out-of-Network Provider fails to comply with Care Management program and Prior Authorization requirements.

If You use an Out-of-Network Provider, or a Provider outside Tennessee, such as a Blue Card PPO Participating Provider, You are responsible for ensuring that the Provider obtains the appropriate Authorization prior to treatment. Failure to obtain the necessary Authorization may result in additional Member Payments and reduced Plan payment. Contact Our customer service department for a list of Covered Services that require Prior Authorization.

Care Management

A number of Care Management programs are available to Members, including those with low-risk health conditions, potentially complicated medical needs, chronic illness and/or catastrophic illnesses or injuries.

Lifestyle and Health Education --

Lifestyle and health education is for healthy Members and those with low-risk health conditions that can be self-managed with educational materials and tools. The program includes a toll-free number for obtaining information on more than 1,200 health-related topics.

Low Risk Case Management -- Low risk case management is performed for Members with conditions that require a daily regimen of care. Registered nurses work with health care Providers, the Member, and primary care givers to coordinate care. Specific programs include: (1) Emergency services management program; (2) transition of care program; and (3) condition-specific care coordination program.

Catastrophic Medical and Transplant Case Management -- Members with terminal illness, severe injury, major trauma, cognitive or physical disability, or Members who are transplant candidates may be served by the catastrophic medical and transplant case management program. Registered nurses work with health care Providers, the Member, and primary caregivers to coordinate the most appropriate, cost-efficient care settings. Case managers maintain regular contact with Members throughout treatment, coordinate clinical and health plan Coverage issues, and help families utilize available community resources.

After evaluation of the Member’s condition, it may be determined that alternative treatment is Medically Necessary and Appropriate.

In that event, alternative benefits for services not otherwise specified as Covered Services in Attachment A may be offered to the Member. Such benefits will be offered only in accordance with a written case management or alternative treatment plan agreed to by the Member’s attending physician and BCBST.

Emerging Health Care Programs --

Care Management is continually evaluating emerging health care

programs. These are services or technologies that demonstrate reasonable potential improvement in access, quality, health care costs, efficiency, and Member satisfaction. When We approve

Care Management services, emerging health care programs and alternative treatment plans may be offered to eligible Members on a case-by-case basis to address their unique needs. Under no circumstances does a Member acquire a vested interest in continued receipt of a particular level of benefits. Offer or confirmation of Care Management services, emerging health care programs or alternative treatment plans to address a Member’s unique needs in one instance shall not obligate the Plan to provide the same or similar benefits for any other Member.

an emerging health care program, services provided through that program are Covered, even though they may normally be excluded under the EOC.

Medical Policy

Medical Policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value.

Medical policies are based on an evidence-based research process that seeks to determine the scientific merit of a particular medical technology.

Determinations with respect to technologies are made using technology evaluation criteria. “Technologies” means devices, procedures, medications and other emerging medical services.

Medical policies state whether or not a technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members’ needs change, We may reevaluate and change medical policies without formal notice. You may check Our medical policies at www.bcbst.com. Enter “medical policy” in the Search field.

BCBST’s Medical Policies are made a part of this EOC by reference.

Medical policies sometimes define certain terms. If the definition of a term defined in a medical policy differs from a definition in this EOC, the medical policy definition controls.

Patient Safety

If You have a concern with the safety or quality of care You received from a Network Provider, please call Us at the number on the membership ID card.

Your concern will be noted and investigated by Our Clinical Risk Management department.

BLUECARD/BLUECARD PPO PROGRAM

When You are in an area where Our Network Providers are not available and You need health care services or information about a BlueCross BlueShield PPO physician or hospital, just call the BlueCard/BlueCard PPO Participating Doctor and Hospital Information Line at 1-800-810-BLUE (2583.)

We will help You locate the nearest BlueCard/BlueCard PPO Participating Provider.

If You call 1-800-810-BLUE (2583), **and** go to a BlueCard/BlueCard PPO Participating Physician or Hospital, Your benefits will be Covered as In-network benefits, and Your out-of-pocket expenses will be less than if You go to a non- BlueCard/BlueCard PPO Participating Provider or Hospital.

In the BlueCard/BlueCard PPO Program, the term “Host Plan” means the BlueCross BlueShield Plan that provides access to service in the location where You need health care services.

Show Your membership ID card (that has the “PPO in a suitcase” logo) to any BlueCard/BlueCard PPO Participating Provider. The BlueCard/BlueCard PPO Participating Provider can verify Your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard/BlueCard PPO Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any.) If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

The calculation of Your liability for claims incurred outside Our service area that are processed through the BlueCard/BlueCard PPO Program will typically be at the lower of the Provider's Billed Charges or the negotiated price We pay the Host Plan.

The negotiated price We pay to the Host Plan for health care services provided through the BlueCard/BlueCard PPO Program may

represent either: (a) the actual price paid by the Host Plan on such claims; (b) an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the Host Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if You receive Covered Services in these states, Your liability for Covered Services will be calculated using these states' statutory methods.

REMEMBER: YOU ARE RESPONSIBLE FOR RECEIVING PRIOR AUTHORIZATION FROM US. IF PRIOR AUTHORIZATION IS NOT RECEIVED, YOUR BENEFITS MAY BE REDUCED OR DENIED. CALL THE 1-800 NUMBER ON YOUR MEMBERSHIP ID CARD FOR PRIOR AUTHORIZATION. IN CASE OF AN EMERGENCY, YOU SHOULD SEEK IMMEDIATE CARE FROM THE CLOSEST HEALTH CARE PROVIDER.

BLUECARD

If You don't have BLUECARD PPO (Your membership card doesn't have the “PPO in a suitcase” logo), You can go to any BlueCard Participating Provider, and receive the same level of benefits.

BLUECARD WORLDWIDE

Through the BlueCard Worldwide Program, You also have access to a participating hospital network and referrals to doctors in major travel destinations

throughout the world. When You need to locate a hospital or doctor, You can call the BlueCard Worldwide Service Center at 1.800.810.BLUE, or call collect at 1.804.673.1177, 24 hours a day, 7 days a week. You can also visit the web site <https://international.worldaccess.com/bcbsa/index.asp?page=login>, or You can call BCBST. When You need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer You to a participating hospital. You will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-Covered expenses, Deductible, Copayment and/or Coinsurance). In an Emergency, You should go to the nearest hospital and call the BlueCard Worldwide Service Center if You are admitted. You still have the choice of using non-BlueCard Worldwide hospitals; however, You may have to pay the hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but You will have to pay the Provider and then file the claim for reimbursement.

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Provider must submit a claim form to Us. We will review the claim, and let You or the Provider know if We need more information before We pay or deny the claim. We follow Our internal administration procedures when We adjudicate claims.

A. Claims.

Federal regulations use several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.

A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to You. Only post-service claims can be billed to the Plan, or You.

Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

Claims Billing.

You should not be billed or charged for Covered Services rendered by

Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.

You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including obtaining Prior Authorization of such Services, when necessary).

If You are charged or receive a bill, You must submit a claim to Us.

To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim within the 1 year and 90 day time period, it will not be paid. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.

Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in sections 2. a. and b. above. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).

You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:

You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.

You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

Providers may bill or charge for Covered Services differently. Network Providers are reimbursed based on Our agreement with them. Different Network Providers have different reimbursement rates for different services. Your Out-of-Pocket expenses can be different from Provider to Provider.

Payment.

If You received Covered Services from a Network Provider, the Plan will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the In-Network Benefit level.

If You received Covered Services from an Out-of-Network Provider, You must submit a completed claim form for Covered Services within two years of the date of service. If the claim does not require further investigation, the Plan will reimburse You. The Plan may make payment for Covered Services either to the Provider or to You, at its discretion. The Plan's payment fully discharges its obligation related to that claim.

Non-Contracted Providers may or may not file Your claims for You. Either way, the In-Network Benefit level shown in Attachment C: Schedule of Benefits will apply to claims for Covered Services received from Non-Contracted Providers. However, You are responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. The Plan's payment fully discharges its obligation related to that claim.

If the ASA is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year and 90 days from the date the Covered Services were received.

We will pay benefits according to the Plan within 30 days after We receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form. Neither the Plan nor We are responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.

Mail all claim forms to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

When a claim is paid or denied, in whole or part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The administrator will make the EOB available to You at www.bcbst.com, or by calling the customer service department at the number listed on Your membership ID card.

You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

Complete Information.

Whenever You need to file a claim Yourself, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Providers will have claim forms or You can request them from Us by calling Our customer service department at the number listed on the membership ID card.

COORDINATION OF BENEFITS

This EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "Plan." Rules of this Section determine whether the benefits available under this EOC are determined before or after those of another Plan. In no event, however, will benefits under this EOC be increased because of this provision.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the Plan's benefits are determined before or after those of another Plan.

1. Definitions

The following terms apply to this provision:

"Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:

group, blanket, or franchise insurance;

a group BlueCross Plan, BlueShield Plan;

group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;

coverage under labor management trust Plans or employee benefit organization Plans;

coverage under government programs to which an employer contributes or makes payroll deductions;

coverage under a governmental Plan or coverage required or provided by law;

medical benefits coverage in group, group-type, and individual

automobile "no-fault" and traditional automobile "fault" type coverages;

coverage under Medicare and other governmental benefits; and

any other arrangement of health coverage for individuals in a group.

"Plan" does not include individual or family:

Insurance contracts;

Subscriber contracts;

Coverage through Health Maintenance (HMO) organizations;

Coverage under other prepayment, group practice and individual practice plans;

Public medical assistance programs (such as TennCaresm);

Group or group-type hospital indemnity benefits of \$100 per day or less;

School accident-type coverages.

Each Contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

- c. "This Plan" refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

The term "Other Plan" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other contracts when benefits are determined.

- d. Primary Plan/Secondary Plan.

The order of benefit determination rules state whether This Plan is a "Primary Plan" or "Secondary Plan" as to another plan covering You.

When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- e. "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private hospital room is Medically Necessary, either in terms of

generally accepted medical practice, or as specifically defined in the Plan.

We will determine only the benefits available under This Plan.

You are responsible for supplying Us with information about Other Plans so We can act on this provision.

- f. "Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which You have no coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules that applies:

- a. Non-Dependent/Dependent

The benefits of the Plan that covers the person as an Employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that:

if the person is also a Medicare beneficiary and,

if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

- benefits of the Plan of an active Employee covering the person as a Dependent;
- Medicare;
- benefits of the Plan covering the person as an Employee, Member, or Subscriber.

Dependent Child/Parents Not Separated or Divorced

Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called “parents”:

The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

If both parents have the same birthday, the benefits of the Plan that has covered one parent longer are determined before those of the Plan that has covered the other parent for a shorter period of time.

However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

Dependent Child/Separated or Divorced Parents

If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

First, the Plan of the parent with custody of the child;

Then, the Plan of the spouse of the parent with the custody of the child; and

Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for

the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2(b), Dependent Child/Parents Not Separated or Divorced.

Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan that has covered an Employee, Member, or Subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

To determine the length of time a person has been covered under a Plan, two Plans shall

be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

The start of the new Plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity that pays, provides, or administers the Plan's benefits; or
- A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan.)

The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a Member of the Group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

Rules. This Plan coordinates its benefits with a Non-complying Plan as follows:

If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

If:

The Non-complying Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to You or on Your behalf an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated

to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

Plan will be determined after those of This Plan; and

the order of benefit determination rules requires Us to determine benefits before those of the Other Plan.

Effect on the Benefits of this Plan

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

- a. Benefits of This Plan will be reduced when the sum of:

the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.

The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

Facility of Payment

A payment under Another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term "Payment Made" includes providing benefits in the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Are You Also Covered by Medicare?

If You are also Covered by Medicare, We follow the Medicare Secondary Payor (MSP) rules to determine Your benefits. If Your Employer has 20 or fewer employees, the MSP rules might not apply. Please contact customer service at the toll free number on Your membership ID card if You have any questions.

GRIEVANCE PROCEDURE

I. INTRODUCTION

Our Grievance procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the customer service department at the number listed on the membership ID card: (1) to file a Claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g., an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.

The Procedure can only resolve Disputes that are subject to Our control.

You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.

This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and

(3) pre-service and post-service claims (“Claims”), that are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to Us to obtain a determination concerning whether the Plan will cover that service.

Providers may also appeal an Adverse Benefit Determination through Our Provider dispute resolution procedure.

A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until a final Adverse Benefit Determination has been rendered in a matter being appealed through the Provider dispute resolution procedure.

You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.

We, the Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.

Any Dispute will be resolved in accordance with applicable

Tennessee or Federal laws and regulations, the ASA and this EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact the customer service department if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

First Level Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute.

Contact the customer service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory. BCBST is a limited fiduciary for the first level Grievance.

Grievance Process

After We have received and reviewed Your Grievance, Our

first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Plan is not otherwise governed by ERISA.

Written Decision

The committee or reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance as follows:

For a pre-service claim, within 30 days of receipt of Your request for review;

For a post-service claim, within 60 days of receipt of Your request for review; and

For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

The decision of the Committee will be sent to You in writing and will contain:

A statement of the committee's understanding of Your Grievance;

The basis of the committee's decision; and

Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information,

without charge, upon written request.

Second Level Appeal

You may file a written request for reconsideration with the Employer within ninety (90) days after We issue the first level Grievance committee's decision. This is called a second level appeal. Information on how to submit a second level appeal will be provided to You in the decision letter following the first level Grievance review.

The Plan may require You to exhaust each step of this Procedure in any Dispute that is not an ERISA Action:

Your decision concerning whether to file a second level appeal has no effect on Your rights to any other benefits under the Plan.

Decisions and determinations under this Plan shall be made within the sound discretion of the administrator for the initial determination and grievance process. Second level appeals are reviewed by the appropriate health care committee responsible for the plan under which the patient is covered. Decisions and determinations of the health care committee are final unless they are determined to be arbitrary and capricious. In matters that are appealed to the health care committee, the health care committee shall have authority to waive recovery of any amounts paid incorrectly to or on behalf of the patient if the incorrect payment was made with respect to an individual who is without fault and where the health care committee determines that recovery would be against equity and good conscience. Such waivers shall be without prejudice to the Plan and shall not be viewed as having precedential effect.

Questions about filing a second-level appeal can be directed to the TVA Service Center.

DEFINITIONS

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section.

Acute – An illness or injury that is both severe and of short duration.

Administrative Services Agreement or ASA – The arrangements between the administrator and the Employer, including any amendments, and any attachments to the ASA or this EOC.

Advanced Radiological Imaging – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

Behavioral Health Services – Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.

Billed Charges – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Maximum Allowable Charge for services.

BlueCard PPO Participating Provider – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Association (BlueCard PPO) Plans and/or Authorized by the Plan to provide Covered Services to Members.

Calendar Year – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st.

Care Management – A program that promotes quality and cost effective coordination of care for Members with

complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.

CHIP – The State Children’s Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.)

Coinsurance – The amount, stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the Member’s responsibility during the Calendar Year after any Deductible is satisfied. The Coinsurance percentage is calculated as 100%, minus the percentage Payment of the Maximum Allowable Charge as specified in Attachment C, Schedule of Benefits.

In addition to the Coinsurance percentage, You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of a Non-Contracted Provider or an Out-of-Network Provider are more than the Maximum Allowable Charge for such Services.

Complications of Pregnancy – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarian section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period

of pregnancy; morning sickness; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Concurrent Review – The process of evaluating care during the period when Covered Services are being rendered.

Copayment – The dollar amount specified in Attachment C, Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.

Cosmetic Service – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem. Our Medical Policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.

Covered Dependent – A Subscriber’s family member who: (1) meets the eligibility requirements of this EOC; (2) has been enrolled for Coverage; and (3) for whom the Plan has received the applicable Payment for Coverage.

Covered Family Members – A Subscriber and his or her Covered Dependents.

Covered Services, Coverage or Covered – Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this EOC.

Creditable Coverage – Credit for Your individual or group health coverage prior to Your Enrollment Date that may be applied to reduce Your Pre-existing

Condition Waiting Period, if any, stated in this EOC. Creditable Coverage also includes coverage under: (1) a group health plan; (2) health insurance coverage; (3) health maintenance organization (HMO); (4) Medicare; (5) Medicaid (including TennCareSM and TennCare SelectSM); (6) COBRA continuation and state continuation; (7) the Federal Employee Health Benefit Plan; (8) a public, government, military or Indian Health Service health benefit program; and/or (9) State Children’s Health Insurance Program (S-CHIP).

Up to 18 months of Creditable Coverage may be applied to reduce Your applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for purposes of reducing Your Pre-existing Condition Waiting Period if there is a break in such coverage of 63 days or more during which You were not Covered under any Creditable Coverage.

Custodial Care – Any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan including but not limited to eating, bathing, dressing or other self-care activities.

Deductible – The dollar amount, specified in Attachment C, Schedule of Benefits, that You must incur and pay for Covered Services during a Calendar Year before the Plan provides benefits for services. There is one Deductible amount for Network Providers and Out-of-Network Providers combined. The Deductible will apply to the Individual Out-of-Pocket and Family Out-of-Pocket Maximum(s).

Copayments and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) are not considered when determining if You have satisfied a Deductible.

Eligible Providers - All services must be rendered by a Practitioner or Provider type listed in the administrator's Provider Directory of Network Providers, or as otherwise specified in this plan. . The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner or Provider, or the delegate actually billing for the Practitioner or Provider, and be within the scope of his or her licensure.

Emergency – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:

serious impairment of bodily functions;
or

serious dysfunction of any bodily organ
or part; or

placing a prudent layperson's health in
serious jeopardy.

Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.

Emergency Care Services – Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.

Employee – A person who fulfills all eligibility requirements established by the Employer and the administrator.

Employer – A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws; and that enters into an Agreement with the administrator to provide Coverage to its Employees and their Eligible Dependents.

ERISA – The Employee Retirement Income Security Act of 1974, as amended. Note: The TVA-sponsored medical plan is not governed by ERISA.

Hospital Confinement – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.

Hospital Services – Covered Services that are Medically Appropriate to be provided by an Acute care Hospital.

In-Network Benefit – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C, Schedule of Benefits.

In-Transplant Network Institution – A facility or hospital that has contracted with the administrator (or with an entity on behalf of the administrator) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this EOC. For example, some hospitals might contract to perform heart transplants, but not liver transplants. An In-Transplant Network Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this EOC.

Incapacitated Child – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of mental illness or physical handicap as certified through receipt of Social Security disability or other private disability benefits or as determined by administrator; and (2) chiefly dependent upon the Subscriber for economic support and maintenance.

If the child reaches this Plan's limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of

when the child reaches the limiting age.

Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan, and have less than a 63 day break in coverage from the prior plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment.

You may be asked for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

Investigational Services – A drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") when such approval has not been granted at that time of its use or proposed use, or
- is the subject of a current Investigational new drug or new device application on file with the FDA, or
- is being provided according to Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial), or
- is being provided according to a written protocol that describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives, or
- is being delivered or should be delivered subject to the approval and supervision

of an Institutional Review Board ("IRB") as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS,") or

in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or

in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives, or

the service or supply is required to treat a complication of an experimental or Investigational Service.

The Medical Director has discretionary authority, in accordance with applicable ERISA standards even though Employer's Plan is not subject to ERISA, to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not Authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

- (1) Your medical records, or**
- (2) the protocol(s) under which proposed service or supply is to be delivered, or**
- (3) any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or**
- (4) the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of**

injuries or illnesses such as those experienced by You, or

- (5) regulations and other official publications issued by the FDA and HHS, or**
- (6) the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services, or**
- (7) the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.**

The Medical Director's decision may be appealed to the Employer, which has final authority on any decision affecting the Plan.

Late Enrollee – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 31 days after such person first became eligible for Coverage under this EOC; or (2) a subsequent Open Enrollment Period.

Lifetime Maximum – The maximum amount of benefits for Covered Services rendered to You during Your lifetime while covered under this EOC.

Maintenance Care – Skilled services including skilled nursing visits, skilled nursing facility care, physical therapy, occupational therapy and/or speech therapy for chronic, static or progressive medical conditions where the services: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature.

Maximum Allowable Charge – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the administrator's contract with a Network

Provider or the amount payable based on the administrator's fee schedule for the Covered Services.

Medicaid – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq.)

Medical Director – The physician designated by the administrator, or that physician's designee, who is responsible for the administration of the administrator's medical management programs, including its Authorization/Prior Authorization programs.

Medically Appropriate – Services that have been determined by the Medical Director to be of value in the care of a specific Member. To be Medically Appropriate, a service must:

be Medically Necessary;

be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation;

be consistent with current standards of good medical practice for the Member's medical condition;

be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;

on an ongoing basis, have a reasonable probability of:

(1) correcting a significant congenital malformation or disfigurement caused by disease or injury.

(2) preventing significant malformation or disease.

(3) substantially improving a life sustaining bodily function impaired by disease or injury;

not be provided solely to improve a Member's condition beyond normal

variations in individual development and aging including:

comfort measures in the absence of disease or injury.

Cosmetic Surgery; and

not be for the sole convenience of the Provider, Member or Member's family.

Medically Necessary or Medical Necessity

– "Medically Necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Medicare – Title XVIII of the Social Security Act, as amended.

Member, You, Your – Any person enrolled as a Subscriber or Covered Dependent under the Plan.

Member Payment – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C, Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The administrator may require proof that You have made any required Member Payment.

Network Provider – A Provider who has contracted with the administrator to provide access to benefits to Members at specified rates. Such Providers may be referred to as BlueCard PPO Participating Providers, Network hospitals, In-Transplant Network, etc.

Non-Contracted Provider – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider type to provide those Covered Services. These Providers can change, as We contract with different Providers. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.

Open Enrollment Period – Those periods of time established by the Plan during which eligible Employees and their dependents may enroll as Members.

Oral Appliance – a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal

splint, which is used to treat malocclusion or misalignment of teeth.

Out-of-Network Provider – Any Provider who is an eligible Provider type but who does not hold a contract with the administrator to provide Covered Services.

Out-of-Pocket Maximum – The total dollar amount, as stated in Attachment C, Schedule of Benefits, that a Member must incur and pay for Covered Services during the Calendar Year, including Deductible and Coinsurance.

Copayments, Penalties and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) are not considered when determining if the Out-of-Pocket Maximum has been satisfied.

When the Out-of-Pocket Maximum is satisfied, 100% of available benefits is payable for other Covered Services incurred by the Member during the remainder of that Calendar Year, excluding applicable Copayments and Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

Payment – The total payment for Coverage under the Plan, including amounts paid by You and the Employer for such Coverage.

Payor(s) – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for a Member's health care benefits.

Penalty/Penalties – Additional Member payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in Attachment C, Schedule of Benefits, as requiring such Prior Authorization. The

Penalty will be a reduction in the Plan payment for Covered Services.

Periodic Health Screening – An assessment of patient's health status at intervals set forth in the administrator's Medical Policy for the purpose of maintaining health and detecting disease in its early state. This assessment should include:

a complete history or interval update of the patient's history and a review of systems; and

a physical examination of all major organ systems, and screening tests per the administrator's Medical Policy.

Practitioner – A person licensed by the State to provide medical services.

Pre-existing Condition – Any physical or mental condition, regardless of cause, that was present during the six month period immediately before the earlier of when Your Coverage became effective under this EOC, or the first day of any Pre-Existing Condition Waiting Period, for which medical advice, diagnosis, care or treatment was recommended or received from a Provider of health care services.

The following are not Pre-Existing Conditions:

Genetic information in the absence of a diagnosis of the condition related to the genetic information; and

Pregnancy.

Anyone under the age of 19 is not considered to have a Pre-Existing Condition.

Pre-existing Condition Waiting Period – A 6-month period that begins on the date Your Coverage became effective, and during which benefits are not available for services received in connection with

a Pre-existing Condition. The Employer decides the length of the Plan's Pre-Existing Condition Waiting Period. The Pre-Existing Condition Waiting Period is shown in Attachment C: Schedule of Benefits.

The Pre-Existing Condition Waiting Period will be reduced by the period of Creditable Coverage occurring within 18 months before the date Coverage becomes effective (provided there is no break of 63 days or more during which You were not Covered under any Creditable Coverage).

Prescription Drug – A medication containing at least one Legend Drug that may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.

Prior Authorization, Authorization – A review conducted by the administrator, prior to the delivery of certain services, to determine if such services will be considered Covered Services.

Provider – A person or entity engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.

The following professional providers may provide services covered under the contract. In order to be covered, all services rendered must fall within a specialty (as defined below) and be those normally provided by a Provider within this specialty or degree. All services or supplies must be rendered by the Provider actually billing them and be within the scope of his or her licensure.

- a. Physician (M.D.)
- b. Doctor of Osteopathy (DO)
- c. Doctor of Dental Surgery(DDS)

- d. Doctor of Dental Medicine (DMD)
- e. Doctor of Optometry (OD)
- f. Doctor of Pediatric Medicine (DPM)
- g. Licensed Clinical, Counseling, or School Psychologist
- h. Registered Nurse (RN)
- i. Registered Nurse Anesthetist (RNA)
- j. Licensed Practical Nurse (LPN)
- k. Nurse Practitioner (Certified by national recognized accrediting body)
- l. Licensed Pharmacist (D. Pharm)
- m. Licensed registered nurse midwife when services are provided in a State Approved birthing center
- n. Registered occupational therapist (only cases indicated)
- o. Registered speech therapist (only for cases indicated)
- p. Licensed clinical social worker
- q. Licensed Professional Counselor – Mental health service providers (LPC-MHSP)
- r. Certified registered nurse anesthetist (CRNA)
- s. Physician Assistant
- t. Physical therapist and Physical therapist assistant
- u. Chiropractors

The following other Providers may also provide services covered under this contract:

- a. Suppliers of durable medical equipment, appliances and prosthesis

- b. Suppliers of oxygen
- c. Certified ambulance service
- d. Hospice
- e. Pharmacy
- f. Freestanding diagnostic laboratory
- g. Home Health Care Agency

Qualified Medical Child Support Order –

A medical child support order, issued by a court of competent jurisdiction or state administrative agency that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Plan. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.

Specialty Drugs – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the administrator's Specialty Drugs list. Specialty Drugs are categorized as provider-administered or self-administered.

Subscriber – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and who has submitted the applicable Payment for Coverage.

Surgery or Surgical Procedure - Medically Necessary and Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

Totally Disabled or Total Disability –
Either:

An Employee who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or

A Covered Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.

Transplant Maximum Allowable Charge (TMAC) –

The amount that the administrator, in its sole discretion, has determined to be the maximum amount payable for covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC.

Transplant Network – A network of hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some hospitals might contract to perform heart transplants, but not liver transplants.

Transplant Services – Medically Necessary and Appropriate Services listed as Covered under the Transplant Services section in Attachment A of this EOC.

Waiting Period – The time that must pass before an Employee or Dependent is eligible to be Covered for benefits under the Plan.

Well Child Care – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health

Screenings, immunizations and injections for children through age 5.

Well Woman Exam – A routine visit every Calendar Year to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

**ATTACHMENT A:
COVERED SERVICES AND EXCLUSIONS**

EVIDENCE OF COVERAGE

The Plan will pay the Maximum Allowable Charge for Medically Necessary and Appropriate services and supplies described below and provided in accordance with the reimbursement schedules set forth in Attachment C: Schedule of Benefits of this EOC, which is incorporated herein by reference. Charges in excess of the reimbursement rates set forth in the Schedule of Benefits are not eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with the administrator's medical policies and procedures. (See the Prior Authorization, Care Management, Medical Policy and Patient Safety section.)

This Attachment sets forth Covered Services and exclusions (services not Covered) arranged according to type of services.

Please also read Attachment B: Other Exclusions.

Your benefits are greater when You use Network Providers. BCBST contracts with Network Providers. Network Providers have agreed to accept the Maximum Allowable Charge as basis for payment to the Provider for Covered Services. (See the Definitions section for an explanation of Maximum Allowable Charge and Covered Services.) Network Providers have also agreed not to bill You for amounts above the Maximum Allowable Charge.

Out-of-Network Providers do not have a contract with BCBST. This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by the administrator in its contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You will be responsible for any difference between what the Plan pays and what the Out-of-Network Provider charges. This means that You may owe

the Out-of-Network Provider a large amount of money.

Obtaining services not listed as a Covered Service in this Attachment or not in accordance with the administrator's health care management policies and procedures may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the EOC must be satisfied before benefits for Covered Services will be provided. The administrator's Medical Policies can help Your Provider determine if a proposed service will be Covered.

When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.

Practitioner Office Services

Medically Necessary and Appropriate Covered Services in a Practitioner's office.

1. Covered Services

- a. Diagnosis and treatment of illness or injury.
- b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See Provider Administered Specialty Drugs section for information on Coverage).
- c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended the Surgery.
- d. Well Child Care for children through age 5, including appropriate immunizations, screenings and diagnostics, subject to limits defined in this document. Once the Member reaches age 6, well care services are provided as described below.
- e. Preventive/Well Care Services. Services and screenings Covered under this provision include, but are not limited to:
 - i. **Annual preventive health exam for adults and children age six and older, including screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam.**
 - ii. **Preventive health exam for children through age 5, including screenings with an A**

or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam ("Well Child Care").

- iii. **Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC).**
- iv. **Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).**
- v. **Colorectal cancer screening (age 50-75).**
- vi. **Prostate cancer screening for men age 50 and older.**
- vii. **Screening and counseling in the primary care setting for alcohol misuse and tobacco use.**
- viii. **Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.**

Coverage may be limited as indicated in Attachment C: Schedule of Benefits.

Exclusions

Office visits, physical exams and related immunizations and tests when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.

Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain.

Foot orthotics, shoe inserts and custom made shoes, except as required for the care of diabetic patients or as a part of a leg brace.

Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit.

Dental procedures, except as otherwise indicated in this EOC.

Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies in a hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of disease and injury; and (4) has a staff of physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

Covered Services

Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units.

Attending Practitioner's services for professional care.

Maternity and delivery services, including routine nursery care and Complications of Pregnancy. If the hospital or physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.

Exclusions

Inpatient stays primarily for therapy (such as physical or occupational therapy).

Services that could be provided in a less intensive setting.

Private room when not Authorized by the administrator and room and board charges are in excess of semi-private room.

Blood or plasma that is provided at no charge to the patient.

Hospital Emergency Care Services

Medically Necessary and Appropriate health care services and supplies furnished in a hospital emergency department that are required to determine, evaluate and/or treat an Emergency Medical Condition until such condition is stabilized, as directed or ordered by the Practitioner or hospital protocol.

1. Covered Services

Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition.

Practitioner services.

Exclusions

Treatment of a chronic, non-Emergency condition where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.

Services rendered for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the

administrator within 24 hours or the next working day.

Ambulance Services

Medically Necessary and Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the patient.

1. Covered Services

Medically Necessary and Appropriate land or air transportation: (1) from a Member's home to the nearest hospital; (2) from the scene of an accident or medical Emergency to the nearest appropriate hospital; (3) between hospitals; (4) between hospital and skilled nursing facility; or (5) from hospital to Member's home.

The Plan pays benefits for all charges related to Medically Necessary and Appropriate emergency services provided by ambulance personnel when subsequent transportation is not required.

Exclusions

Transportation for Your convenience.

Transportation that is not essential to reduce the probability of harm to the patient.

Outpatient Facility Services

Medically Necessary and Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes outpatient Surgery centers, the outpatient center of a hospital, outpatient diagnostic centers, and certain surgical suites in a Practitioner's office. Prior Authorization is required for certain outpatient services must be obtained from the administrator, or benefits will be reduced or denied.

Covered Services

Practitioner services.

Outpatient diagnostics (such as x-rays and laboratory services).

Outpatient treatments (such as medications and injections.)

Outpatient Surgery and supplies.

Observation stays less than 24 hours.

Exclusions

Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative benefit.

Services that could be provided in a less intensive setting.

Family Planning and Reproductive Services

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility.

Covered Services

Benefits for family planning, history, physical examination, diagnostic testing and genetic testing.

Sterilization procedures.

Services or supplies for the evaluation of infertility.

Medically Necessary and Appropriate termination of a pregnancy.

Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion, and removal.

Services for the diagnosis of infertility.

Exclusions

Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments.

Services or supplies for the reversals of sterilizations.

Reconstructive Surgery

Medically Necessary and Appropriate Surgical Procedures intended to restore normal form or function.

Covered Services

Surgery to correct significant defects from congenital causes (except where specifically excluded), accidents or disfigurement from a disease state.

Reconstructive breast Surgery as a result of a mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

Exclusions

Services, supplies or prosthetics primarily to improve appearance.

Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior Surgical Procedure, even if that

prior procedure was a Covered Service.

Surgeries and related services to change gender (transsexual Surgery).

Skilled Nursing/Rehabilitative Facility Services

Medically Necessary and Appropriate Inpatient care provided to Members requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home. Prior Authorization for Covered Services must be obtained from the administrator, or benefits will be reduced or denied.

Covered Services

- a. Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units.
- b. The attending Practitioner's services for professional care.
- c. Coverage is limited as indicated in Attachment C: Schedule of Benefits.

Exclusions

Custodial, domiciliary or private duty nursing services.

Skilled Nursing services not received in a Medicare certified skilled nursing facility.

Services for cognitive rehabilitation.

Therapeutic/Rehabilitative Services

Medically Necessary and Appropriate therapeutic and rehabilitative services performed in a Practitioner's office, outpatient facility or home health setting and intended to restore or improve bodily function lost as the result of illness,

injury, autism in children under age 12, or cleft palate.

Covered Services

Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner.

Therapeutic/rehabilitative services include: (1) physical therapy; (2) speech therapy; (3) occupational therapy; (4) chiropractic therapy; and (5) cardiac and pulmonary rehabilitative services, (6) vision therapy; (7) aquatic therapy; and (8) behavioral therapy for Autism Spectrum Disorders only.

Speech therapy is Covered for disorders of articulation and swallowing, resulting from Acute illness or injury or cleft palate. Speech therapy is also covered for treatment of Autism Spectrum Disorders, Attention Deficit Disorders, Attention Hyperactivity Disorders, Alzheimer's Disease, Dementia, Mental Retardation, and Stuttering/Stammering. Speech therapy is not covered for other conditions not specifically listed in this section.

Coverage is limited as indicated in Attachment C: Schedule of Benefits.

The limit on the number of visits for therapy applies to all visits for that

therapy, whether received in a Practitioner's office, outpatient facility or home health setting.

Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing or rehabilitative facility section, and are not subject to the therapy visit limits.

Exclusions

Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.

Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.

Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) cognitive rehabilitation; (5) vision exercise therapy; and (6) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes performed as part of a physical therapy visit.

Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2)

simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver.

Behavioral therapy except as otherwise specified, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health section (if applicable to Your Group Coverage).

Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

Autism Spectrum Disorders Coverage

The following therapy services are covered for the treatment of Autism Spectrum Disorders: intensive speech therapy, physical therapy, occupational therapy, and behavioral therapy that help to improve communication skills and functioning of everyday life activities. Coverage for therapy services associated with Autism Spectrum Disorders is limited to dependents 12 years of age or younger. Coverage is also limited to a total of 60 treatment visits per therapy per calendar year.

Chiropractic Services

Benefits are available up to \$1,000 per Member per Calendar Year for services and supplies furnished or provided by a licensed Chiropractor only in connection with massage or spinal manipulation for dislocation, subluxation or misplacement of vertebrae, or strains and sprains of soft tissue related to the spine.

Organ Transplants

As soon as Your Provider tells You that You might need a transplant, You or Your Provider must contact the administrator's Transplant Case Management department.

Medically Necessary and Appropriate services and supplies provided to You, when You are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in Our sole discretion, are not experimental or Investigational and that are Medically Necessary and Medically Appropriate.

You have access to three levels of benefits: In-Transplant Network, In-Network, and Out-of-Network. If You go to an In-Transplant Network Provider, You will have the highest level of benefits. (See section 3.f. for kidney transplant benefit information.)

Transplant Services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment Authorization that must be obtained from Us before any pre-transplant evaluation or any Covered Procedure is performed. (See Prior Authorization Procedures below.)

1. Prior Authorization Procedures

To obtain Prior Authorization, You or Your Practitioner must contact the administrator's Transplant Case

Management department before pre-transplant evaluation or Transplant Services are received. Authorization should be obtained as soon as possible after You have been identified as a possible candidate for Transplant Services.

Transplant Case Management is a mandatory program for those Members seeking Transplant Services. Call the 800 number on Your membership ID card for customer service, and ask to be transferred to Transplant Case Management. We must be notified of the need for a transplant in order for the pre-transplant evaluation and the transplant to be Covered Services.

Covered Services

The following Medically Necessary and Appropriate Transplant Services and supplies that have received Prior Authorization and are provided in connection with a Covered Procedure:

Medically Necessary and Appropriate services and supplies, otherwise Covered under this EOC.

Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. **Not all In-Network Providers are in Our Transplant Network. Please check with a Transplant case manager to see which hospitals are in Our Transplant network.**

Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for You and a companion. The companion must be Your spouse,

family member, Your guardian or other person approved by Transplant Case Management. In order to be reimbursed, travel must be approved by Transplant Case Management. In many cases, travel will not be approved for kidney transplants.

Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the Transplant Network.

Meals and lodging expenses, limited to \$150 daily.

The aggregate limit for travel expenses is \$25,000 per Covered Procedure if the member uses an in-transplant network facility and \$10,000 per Covered Procedure if another facility is used.

Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; and (5) donor follow-up care. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

If only the donor is a Member, then only the donor (if living) receives benefits. No benefits will be paid to the transplant recipient. Benefits are limited to those not available from any other source, including other insurance programs, other contractor coverage or any government program.

If both donor and recipients are Covered by a TVA Plan, all expenses will be applied to the recipients lifetime transplant maximum.

Conditions/Limitations

The following limitations and/or conditions apply to services, supplies or Charges:

You or Your physician must notify Transplant Case Management prior to Your receiving any Transplant Service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;

Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with Us in coordination of these services;

Failure to notify Us of proposed Transplant Services, or to coordinate all transplant related services with Us, will result in the reduction or exclusion of payment for those services;

You must go through Transplant Case Management and receive Prior

Authorization for Your transplant to be Covered;

Once You have notified Transplant Case Management and received Prior Authorization, You may decide to have the transplant performed outside the Transplant Network. **However, Your benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the service provided will be Covered.**

- i. In-Transplant Network transplants. You have the transplant performed at an In-Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in Attachment C: Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider cannot bill You for any amount over the Transplant Maximum Allowable Charge for the transplant, which limits Your liability;
- ii. In-Network transplants. You have the transplant performed outside the Transplant Network, but still at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider. The Plan will reimburse the In-Network or BlueCard PPO Participating Provider at the benefit levels listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. The Provider also has the right to bill You for any amount not Covered by the Plan – this amount may be substantial;
- iii. Out-of-Network transplants. You have the transplant performed by an Out-of-Network Provider (i.e., outside the Transplant Network, and not at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse

the Out-of-Network Provider only at the benefit level listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan - this amount may be substantial;**

You can find out what the Transplant Maximum Allowable Charge is for Your transplant by contacting Transplant Case Management. Remember, the Transplant Maximum Allowable Charge can and does change from time to time.

Kidney transplants. There are two levels of benefits for kidney transplants: In-Network and Out-of-Network:

- i. In-Network kidney transplants. You have a kidney transplant performed at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider. You receive the highest level of reimbursement for Covered Services. The In-Network or BlueCard PPO Participating Provider cannot bill You for any amount over the Maximum Allowable Charge for the transplant, which limits Your liability;
- ii. Out-of-Network kidney transplants. You have a kidney transplant performed by an Out-of-Network Provider (i.e., not at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse the Out-of-Network Provider only at the benefit level listed in Attachment C: Schedule of Benefits, at the Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan - this amount may be substantial;**

If You go through Transplant Case Management for Your transplant, follow its procedures, cooperate fully with them, and have Your transplant performed at an In-Transplant Network Institution, the transplant expenses specified in Attachment C: Schedule of Benefits are Covered/

Exclusions

The following services, supplies and charges are not Covered under this section:

Transplants and related services that did not receive Prior Authorization;

Any service specifically excluded under Attachment B: Other Exclusions, except as otherwise provided in this section;

Services or supplies not specified as Covered Services under this section;

Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;

Non-Covered Services;

Services that are covered under any private or public research fund, regardless of whether You applied for or received amounts from such fund;

Any non-human, artificial or mechanical organ;

Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;

Donor services including screening and assessment procedures that

have not received Prior Authorization from Us;

Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;

Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within 3 months of harvest;

Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an inpatient Hospital Service or outpatient facility service, if Medically Necessary.

Note: If You receive Prior Authorization through Transplant Case Management, but do not obtain services through the Transplant Network, You will have to pay the Provider any additional charges not Covered by the Plan.

Dental Services

Medically Necessary and Appropriate services performed by a doctor of dental Surgery (DDS), a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental related oral Surgery except as indicated below.

Covered Services

Dental services and oral surgical care resulting from an injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services must be received within 36 months of the accident.

For dental services not listed in subsection a. above, general anesthesia, nursing and related hospital expenses in connection

with an inpatient or outpatient dental procedure are Covered, only when one of the conditions listed below is met.

Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;

Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;

Mental illness or behavioral condition that precludes dental Surgery in the office;

Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a hospital; or

Dental treatment or Surgery performed on a Member 8 years of age or younger, where such procedure cannot be provided safely in a dental office setting.

Prior Authorization for inpatient services is required.

Oral Appliances to treat obstructive sleep apnea, if Medically Necessary.

Tooth extraction needed due to accidental injury of teeth caused by external trauma.

Orthognathic surgery.

Exclusions

Routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) tooth extraction, except as listed above; (8) periodontal Surgery; (9)

prophylactic removal of teeth; (10) root canals (11) preventive care (cleanings, x-rays); (12) replacement of teeth (including implants, false teeth, bridges); (13) bone grafts (alveolar Surgery); (14) treatment of injuries caused by biting and chewing; (15) treatment of teeth roots; and (16) treatment of gums surrounding the teeth.

Treatment for correction of underbite, overbite, and misalignment of the teeth, including, but not limited to, braces for dental indications, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth.

Temporomandibular Joint Dysfunction (TMJ)

Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

Covered Services

Diagnosis and treatment of TMJ or TMD.

Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.

Non-surgical TMJ includes: (1) history exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; and (5) appliances to stabilize jaw joint.

Exclusions

Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care

(cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.

Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

Covered Services

Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear cardiac imaging.

Diagnostic laboratory services ordered by a Practitioner.

Exclusions

Diagnostic services that are not Medically Necessary and Appropriate.

Diagnostic services not ordered by a Practitioner.

Durable Medical Equipment

Medically Necessary and Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA

for the illness or injury for which it is prescribed; and (5) are not solely for Your convenience.

Covered Services

Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.

The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered Durable Medical Equipment.

Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.

The replacement of items needed as the result of normal wear and tear, defects, obsolescence or aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.

Exclusions

Charges exceeding the total cost of the Maximum Allowable Charge to purchase the Durable Medical Equipment.

Unnecessary repair, adjustment or replacement or duplicates of any such Durable Medical Equipment.

Supplies and accessories that are not necessary for the effective functioning of the Covered equipment.

Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.

Items that require or are dependent on alteration of home, workplace or transportation vehicle.

Motorized scooters, exercise equipment, hot tubs, pools, saunas.

“Deluxe” or “enhanced” equipment. The most basic equipment that will provide the needed medical care will determine the benefit.

Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind,

Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management.

Prosthetics/Orthotics

Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) Surgery.

1. Covered Services

The initial purchase of surgically implanted prosthetic or orthotic devices.

The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.

Splints and braces that are custom made or molded, and are incident to a Practitioner's services or on a Practitioner's order.

The replacement of Covered items required as a result of growth, normal wear and tear, defects or aging.

The initial purchase of artificial limbs or eyes.

The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the Surgery. Benefits for eyeglasses or contact lens are limited as indicated in Attachment C: Schedule of Benefits.

Hearing aids, limited as indicated in Attachment C: Schedule of Benefits.

Wigs for hair loss resulting from injury, chemotherapy or radiation therapy.

Exclusions

Prosthetics primarily for cosmetic purposes, including but not limited to wigs (except as specified above), or other hair prosthesis or transplants.

Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.

The replacement of contacts after the initial pair has been provided following cataract Surgery.

Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace.

Diabetes Treatment

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling.

Covered Services

Blood glucose monitors, including monitors designed for the legally blind.

Diabetic test strips.

Injection aids.

Syringes.

Lancets.

Glucagon emergency kits.

Insulin pumps, infusion devices, and appurtenances, not subject to the benefit limit for Durable Medical Equipment indicated in Attachment C: Schedule of Benefits. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired.

Podiatric appliances for prevention of complications associated with diabetes.

Initial diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined by administrator to be Medically Necessary with a diagnosis of diabetes, limited to \$500 per person per program. Coverage for additional training and education may be available up

to \$500 per person per program when a significant change occurs in the patient's symptoms or condition that necessitates a change in the patient's self-management or when a physician determines that re-education or refresher training is needed and determined by administrator to be Medically Necessary.

Exclusions

Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

Supplies not required by state statute.

Supplies

Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury.

Covered Services

Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility, or inpatient facility.

Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's prescription.

Exclusions

Supplies that can be obtained without a prescription, except for diabetic supplies. Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.

Home Health Care Services

Medically Necessary and Appropriate services and supplies authorized by the Plan and provided in Your home by a Practitioner who is primarily engaged in providing home health care services. Home visits by a skilled nurse require Prior Authorization. Physical, speech or occupational therapy provided in the home does not require Prior Authorization, but does apply to the Therapy Services visit limits shown in Attachment C: Schedule of Benefits.

Covered Services

Part-time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse.

Home infusion therapy.

Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit).

Medical social services.

Dietary guidance.

Coverage is limited as indicated in Attachment C: Schedule of Benefits.

Exclusions

Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (9) convenience items.

Services that were not Authorized by the Plan.

Hospice

Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less.

Covered Services

Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

This Plan provides benefits for specific services in a hospice facility. These services are the same as those listed above and are only paid to the extent that benefits do not exceed those that would be received in an home setting.

Exclusions

Inpatient hospice services except as listed above or as otherwise approved by Case Management.

Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; (7) funeral or financial counseling.

Behavioral Health Services

Prior Authorization Requirements

Prior Authorization is required for:

All inpatient levels of care. Inpatient levels of care include Acute care, residential care, partial hospital

care, and intensive outpatient programs.

Electro-convulsive therapy (ECT) provided on an inpatient or outpatient basis.

Call the toll-free number indicated on Your membership ID card if You have questions about Prior Authorization requirements for Behavioral Health Services.

Covered Services

Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features.

Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders.

Exclusions

Pastoral counseling.

Marriage and family counseling without a behavioral health diagnosis.

Vocational and educational training and/or services.

Custodial or domiciliary care.

Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.

Sleep disorders.

Services related to mental retardation.

Habilitative as opposed to rehabilitative services, i.e.,

services to achieve a level of functioning the individual has never attained.

Court ordered examinations and treatment, unless Medically Necessary.

Pain management.

Hypnosis or regressive hypnotic techniques.

Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.

IMPORTANT NOTE: All inpatient treatment (including acute, residential, partial hospitalization and intensive outpatient treatment) requires Prior Authorization. If You receive inpatient treatment, including treatment for substance abuse, that did not receive Prior Authorization, and You sign a Provider's waiver stating that You will be responsible for the cost of the treatment, You will not receive Plan benefits for the treatment. You will be financially responsible, according to the terms of the waiver.

Vision

Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries that impair vision.

Covered Services

Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.

First set of eyeglasses or contact lens required to adjust for vision changes due to cataract surgery.

Vision therapy.

Exclusions

Benefits will not be provided for the following services, supplies or charges:

Services, surgeries and supplies to detect or correct refractive errors of the eyes.

Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.

Eye exercises.

Visual training.

Prescription Drugs

Medically Necessary and Appropriate pharmaceuticals for the treatment of disease or injury.

Covered Services

Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.

Pharmaceuticals that are dispensed or intended for use while You are confined in a hospital, skilled nursing facility or other similar facility.

Exclusions

This Plan does not provide coverage for prescription drugs except as indicated above.

Those pharmaceuticals that may be purchased without a prescription.

Provider-administered Specialty Drugs

Medically Necessary and Appropriate specialty pharmaceuticals for the treatment of disease, administered by a Practitioner or home health care agency. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced or denied. Call customer service at the number listed on Your membership ID card or check Our web site (www.bcbst.com) to find out which Specialty Drugs require Prior Authorization.

1. Covered Services

- a. Provider administered Specialty Drugs as identified on the administrator's Specialty Drugs list (includes administration by a qualified provider).
2. Exclusions
 - a. Self-administered Specialty Drugs as identified on the Plan's specialty drug list, except as may be Covered in the Prescription Drugs section.

Bariatric Surgery

1. Covered Services

Gastric bypass surgery.

Lap band surgery.

All other variations of bariatric surgery will be based on the Plan Administrator's medical policies in effect at the time of the procedure and the Plan Administrator's determination of Medical Necessity.

Exclusions

Services or supplies for treatment of obesity and/or for inpatient treatment of bulimia, anorexia, or other eating disorders which consist primarily of behavioral modification, diet and weight monitoring, unless Medically Necessary or Appropriate for surgical intervention procedure (and surgically related services) due to life threatening conditions/complications related to the morbid obesity.

EVIDENCE OF COVERAGE

ATTACHMENT B: OTHER EXCLUSIONS

This EOC does not provide benefits for the following services, supplies or charges:

1. Services or supplies not listed as Covered Services under Attachment A: Covered Services.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate.
3. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. Illness or injury resulting from war that occurred before Your Coverage began under this EOC and that is covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
5. Self-treatment or training.
6. Staff consultations required by hospital or other facility rules.
7. Services that are free.
8. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an Employee who is (1) a sole-proprietor of the Employer; (2) a partner of the Employer; or (3) a corporate officer of the Employer, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
9. Personal, physical fitness, recreational and convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters, (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) devices and computers to assist in communication or speech; or (16) self-help devices that are not primarily medical in nature, even if ordered by a Practitioner.
10. Services or supplies received before Your effective date for Coverage with this Plan.
11. Services or supplies related to a Hospital Confinement received before Your effective date for Coverage with this Plan.
12. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered. The only exception to this is described under the Extended Benefits section.
13. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
14. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges;
15. Charges for failure to keep a scheduled appointment;
16. Charges for telephone consultations, e-mail or web based consultations, or telemedicine services, except as may be provided for by specially arranged Care Management programs or emerging health care programs as described in the Prior Authorization, Care Management, Medical Policy and Patient Safety section of this EOC;
17. Court ordered examinations and treatment, unless Medically Necessary.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
19. Benefits for Pre-existing Conditions until any Pre-existing Condition Waiting Periods have been met. Refer to Pre-existing Condition Waiting Period in Attachment C: Schedule of Benefits.
20. Charges in excess of the Maximum Allowable Charge for Covered Services.
21. Any service stated in Attachment A as a non-Covered Service or limitation.
22. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
23. Any charges for handling fees.

24. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.

metabolized by an individual, given that individual's genetic makeup.
25. Human growth hormones.
26. Safety items, or items to affect performance primarily in sports-related activities.
27. Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
28. Cosmetic services. This exclusion also applies to surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins and varicose veins, except as appropriate per medical policy; (12) piercing ears or other body parts; (13) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (14) rhinoplasty, except as appropriate per medical policy; (15) panniculectomy; (16) abdominoplasty; (17) thighplasty; and (18) brachioplasty;
29. Blepharoplasty and browplasty, except for: (1) correction of injury to the orbital area resulting from physical trauma or non-cosmetic Surgical Procedures (e.g., removal of malignancies); (2) treatment of edema and irritation resulting from Graves' disease; or (3) correction of trichiasis, ectropion, or entropion of the eyelids;
30. Services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a Member. Services and charges relating to surrogate parenting.
31. Sperm preservation.
32. Services or supplies for Maintenance Care.
33. Private duty nursing.
34. Pharmacogenetic testing or pharmacogenomics (a procedure or test to determine how a drug will be

metabolized by an individual, given that individual's genetic makeup.
35. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido.
36. Services or supplies related to complications of cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss.
37. Services or supplies for methadone, methadone maintenance therapy, buprenorphine and buprenorphine maintenance therapy.
38. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.
39. Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) Emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning;
40. Vagus nerve stimulation for the treatment of depression;
41. Artificial intervertebral disc;
42. Balloon sinuplasty for treatment of chronic sinusitis;
43. Treatment for benign gynecomastia;
44. Treatment for hyperhidrosis;
45. Percutaneous intradiscal eletrothermal annuloplasty and percutaneous intradiscal radiofrequency thermocoagulation to treat chronic discogenic back pain. These procedures allow controlled delivery of heat to the intervertebral disc through an electrode or coil.

EVIDENCE OF COVERAGE

ATTACHMENT C: PPO SCHEDULE OF BENEFITS-COPAY PLAN

Group Name: THE TENNESSEE VALLEY AUTHORITY

COPAY PLAN

Group Number: 82333

Effective Date: January 1, 2012

Network: P

PLEASE READ THIS IMPORTANT STATEMENT: In-Network benefits apply to services received from Network Providers.

Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge, not to the Provider's billed charge (unless otherwise specified). When using Out-of-Network Providers, You must pay the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial. **For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the Definitions section of this EOC.**

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care (to age 6) Birth to Age 1 - 5 exams (including routine immunizations), in addition to the initial physician exam in the hospital Age 1 up to age 2, 3 exams (including routine immunizations), per 12 month period Age 2 up to age 3, 2 exams (including routine immunizations), per 12 month period Age 3 up to age 6, 1 exam (including routine immunizations) per 12 month period	100%	100% of Billed Charges
Well Care - Age 6 and up Includes annual health assessment and covered screenings	100%	100% of Billed Charges
Well Woman Exam	100%	100% of Billed Charges
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	100% of Billed Charges
Covered Immunizations	100%	100% of Billed Charges
Other Covered Well Care Screenings, age 6 and above	100%	100% of Billed Charges
Services Received at the Practitioner's office		

Office Exams and Consultations		
Diagnosis and treatment of illness or injury	100% after \$25 Copayment	70% of the Maximum Allowable Charge

<p>Maternity care</p> <p>The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see Inpatient Hospital Stays, including maternity stays in the section Services Received at a Facility. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply.</p>	100% after \$25 Copayment	70% of the Maximum Allowable Charge
Injections and Immunizations		
Allergy injections and allergy extract	No Additional Copayment	70% of the Maximum Allowable Charge
Provider-administered Specialty Drugs	100% after \$25 Copayment	70% of the Maximum Allowable Charge
<p>All other medicine injections, excluding Specialty Drugs</p> <p>For surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.</p>	100%	70% of the Maximum Allowable Charge
Diagnostic Services		
Allergy Testing	<p>If billed with an office visit –100% after \$25 Copayment</p> <p>If no office visit – 100%</p>	70% of the Maximum Allowable Charge
<p>Advanced Radiological Imaging</p> <p>Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.</p>	100% after \$50 Copayment per procedure	70% of the Maximum Allowable Charge
Other covered diagnostic services for illness or injury	100% after \$25 Copayment	70% of the Maximum Allowable Charge
Maternity care diagnostic services	No Additional Copayment	70% of the Maximum Allowable Charge
Diagnostic flexible sigmoidoscopy and diagnostic colonoscopy	100% after \$200 Copayment per procedure	70% of the Maximum Allowable Charge

Other office procedures, services or supplies		
<p>Office Surgery, including anesthesia, performed in and billed by the Practitioner's office</p> <p>Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p> <p>Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., endoscopy).</p>	100% after \$25 Copayment	70% of the Maximum Allowable Charge
<p>Therapy Services: Speech and occupational therapy limited to 60 visits per therapy type per Calendar Year; Chiropractic therapy limited to \$1,000 per Calendar Year; Cardiac and pulmonary rehab therapy limited to 36 visits per Calendar Year</p>	100% after \$25 Copayment per visit	70% of the Maximum Allowable Charge
<p>Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider-Administered Specialty Drugs section for applicable benefit.</p>	100% after \$25 Copayment	70% of the Maximum Allowable Charge
DME, Orthotics and Prosthetics	100% after \$200 annual Copayment	70% of the Maximum Allowable Charge after \$200 annual Copayment
Supplies	100%	70% of the Maximum Allowable Charge
Other covered office services	100% after \$25 Copayment	70% of the Maximum Allowable Charge
Services Received at a Facility		

Inpatient Hospital Stays, including maternity stays:		
Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	100% after \$500 Copayment per admission	70% of the Maximum Allowable Charge
Practitioner charges (including global maternity delivery charges billed as inpatient service)	100%	70% of the Maximum Allowable Charge
Skilled Nursing or Rehab Facility stays		
(Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	100%	70% of the Maximum Allowable Charge
Practitioner charges	100%	70% of the Maximum Allowable Charge
Hospital Emergency Care Services		
Emergency Room charges	100% after \$100 Copayment per visit (Copayment waived if admitted)	Treatment of an Emergency: 100% after \$100 Copayment per visit (Copayment waived if admitted) Non-Emergency Treatment: 70% of the Maximum Allowable Charge
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	100% after \$50 Copayment per procedure	Treatment of an Emergency: 100% after \$50 Copayment per procedure Non-Emergency Treatment: 70% of the Maximum Allowable Charge
All Other Hospital Charges	100%	Treatment of an Emergency: 100% Non-Emergency Treatment: 70% of the Maximum Allowable Charge
Practitioner Charges	100%	Treatment of an Emergency: 100% Non-Emergency Treatment: 70% of the Maximum Allowable Charge

Outpatient Facility Services
Outpatient Surgery

Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.

Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).

Facility charges	100% after \$200 Copayment per procedure	70% of the Maximum Allowable Charge
Practitioner charges	100%	70% of the Maximum Allowable Charge
Outpatient Diagnostic Services		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	100% after \$50 Copayment per procedure	70% of the Maximum Allowable Charge
All other Diagnostic Services for illness or injury	100%	70% of the Maximum Allowable Charge
Maternity care diagnostic services	100%	70% of the Maximum Allowable Charge
Diagnostic flexible sigmoidoscopy and diagnostic colonoscopy	100% after \$200 Copayment per procedure	70% of the Maximum Allowable Charge

Other Outpatient procedures services, or supplies		
<p>Non-routine injections, immunizations and treatments:</p> <p>Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider Administered Specialty Drugs section for applicable benefit.</p>	100%	70% of the Maximum Allowable Charge
<p>Therapy Services:</p> <p>Speech and occupational therapy limited to 60 visits per therapy type per Calendar Year;</p> <p>Chiropractic therapy limited to \$1,000 per Calendar Year;</p> <p>Cardiac and pulmonary rehab therapy limited to 36 visits per Calendar Year</p>	100% after \$25 Copayment per visit	70% of the Maximum Allowable Charge
DME, Orthotics and Prosthetics	100% after \$200 annual Copayment	70% of the Maximum Allowable Charge after \$200 annual Copayment
Supplies	100%	70% of the Maximum Allowable Charge
Provider Administered Specialty Drugs	100%	70% of the Maximum Allowable Charge
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis	100% after \$25 Copayment	70% of the Maximum Allowable Charge
Other Services		
Ambulance	<p>Independent air and ground ambulance service - 100%</p> <p>Facility ground ambulance service - 100% of the Maximum Allowable Charge</p> <p>Facility air ambulance service - 100%</p>	100%
<p>Home Health Care Services, including home infusion therapy</p> <p>Prior Authorization is required for skilled nurse visits in the home.</p> <p>Physical, speech or occupational</p>	100%	70% of the Maximum Allowable Charge

therapy provided in the home do not require Prior Authorization.		
Hospice Care	100%	100% of the Maximum Allowable Charge
DME, Orthotics and Prosthetics	100% after \$200 annual Copayment	70% of the Maximum Allowable Charge after \$200 annual Copayment
Supplies	100%	70% of the Maximum Allowable Charge

Organ Transplant Services		
<p>Organ Transplant Services, all transplants except kidney</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.</p>	<p>In-Transplant Network benefits: \$500 Copayment per global period, Network Out-of-Pocket Maximum applies.</p>	<p>Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee): \$500 Copayment per global period Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.</p>
<p>Organ Transplant Services, kidney transplants</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization.</p>	<p>Network Providers: \$500 Copayment; Network Out-of-Pocket Maximum applies.</p>	<p>Out-of-Network Providers: 70% of Maximum Allowable Charge (MAC), Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not Covered.</p>

Schedule of Behavioral Health Services/Inpatient-Only Utilization Review

<p>Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from</p>	<p align="center">In-Network Benefits for Covered Services received from Network Providers</p>	<p align="center">Out-of-Network Benefits for Covered Services received from Out-of-Network Providers</p>
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Out-of-Network Providers and Non-Contracted Providers.		
Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment) and treatment in halfway houses or group homes Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility Charges	100% after \$500 Copayment per admission	70% of the Maximum Allowable Charge
Practitioner charges	100%	70% of the Maximum Allowable Charge
Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner’s office or community mental health center).	100% after \$25 Copayment per visit	70% of the Maximum Allowable Charge
Miscellaneous Limits:	In-Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Lifetime Maximum	Unlimited	
Deductible		
Individual	None	
Family	None	
Out-of-Pocket Maximum		
Individual	\$1,500	\$3,000
Family Note: Family Out-of-Pocket Maximum applies to Individual-plus-Child(ren) and Individual-plus-Spouse tiers if available to employee	\$1,500 per Member, not to exceed \$3,000 for all Covered Family Members.	\$3,000 per Member, not to exceed \$6,000 for all Covered Family Members
Pre-existing Condition Waiting Period	6 Months ¹	
Hearing Aids (In-Network and Out-of-Network Combined)	\$1,500 every three years	
Wigs (In-Network and Out-of-Network Combined)	\$200 per occurrence	

1. HIPAA regulations apply. A Member’s Pre-existing Condition Waiting Period can be reduced by the Member’s applicable “Creditable Coverage”.

When services that require Prior Authorization are received from Out-of-Network Providers, and Network Providers outside Tennessee, You are responsible for obtaining Prior Authorization. Benefits may be reduced to 50% for Out-of-Network Providers and Network Providers outside Tennessee when Prior Authorization is not obtained

EVIDENCE OF COVERAGE

ATTACHMENT C: PPO SCHEDULE OF BENEFITS-80% COINSURANCE PLAN

Group Name: THE TENNESSEE VALLEY AUTHORITY

80% COINSURANCE PLAN

Group Number: 82333

Effective Date: January 1, 2012

Network: P

PLEASE READ THIS IMPORTANT STATEMENT: In-Network benefits apply to services received from Network Providers.

Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge, not to the Provider's billed charge (unless otherwise specified). When using Out-of-Network Providers, You must pay the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial. For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the Definitions section of this EOC.

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care (to age 6) Birth to Age 1 - 5 exams (including routine immunizations), in addition to the initial physician exam in the hospital Age 1 up to age 2, 3 exams (including routine immunizations), per 12 month period Age 2 up to age 3, 2 exams (including routine immunizations), per 12 month period Age 3 up to age 6, 1 exam (including routine immunizations) per 12 month period	100%	100% of Billed Charges
Well Care - Age 6 and up Includes annual health assessment and covered screenings	100%	100% of Billed Charges
Well Woman Exam	100%	100% of Billed Charges
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	100% of Billed Charges
Covered Immunizations	100%	100% of Billed Charges
Other Well Care Screenings, age 6 and above	100%	100% of Billed Charges
Services Received at the Practitioner's office		

Office Exams and Consultations		
Diagnosis and treatment of illness or injury	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Maternity care	80% after Deductible	70% of the Maximum Allowable Charge after Deductible

Injections and Immunizations		
Allergy injections and allergy extract	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs For surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Diagnostic Services		
Allergy Testing	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other covered diagnostic services for illness or injury	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Diagnostic flexible sigmoidoscopy and diagnostic colonoscopy	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other office procedures, services or supplies		
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include incisions,	80% after Deductible	70% of the Maximum Allowable Charge after Deductible

excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., endoscopy).		
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<p>Therapy Services:</p> <p>Speech and occupational therapy limited to 60 visits per therapy type per Calendar Year;</p> <p>Chiropractic therapy limited to \$1,000 per Calendar Year;</p> <p>Cardiac and pulmonary rehab therapy limited to 36 visits per Calendar Year.</p>	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
<p>Non-routine treatments:</p> <p>Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider-Administered Specialty Drugs section for applicable benefit.</p>	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other covered office services	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
<p>Inpatient Hospital Stays, including maternity stays:</p> <p>Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
Facility charges	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
<p>Skilled Nursing or Rehab Facility stays</p> <p>Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		

Facility charges	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 70% of the Maximum Allowable Charge after Deductible

Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 70% of the Maximum Allowable Charge after Deductible
All Other Hospital charges	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 70% of the Maximum Allowable Charge after Deductible
Practitioner Charges	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 70% of the Maximum Allowable Charge after Deductible
Outpatient Facility Services		
Outpatient Surgery		
Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).		
Facility charges	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Outpatient Diagnostic Services		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Diagnostic flexible sigmoidoscopy and diagnostic colonoscopy	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures services, or supplies		
Non-routine injections, immunizations and treatments:	80% after Deductible	70% of the Maximum Allowable Charge after Deductible

Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider Administered Specialty Drugs section for applicable benefit.		
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<p>Therapy Services: Speech and occupational therapy limited to 60 visits per therapy type per Calendar Year;</p> <p>Chiropractic therapy limited to \$1,000 per Calendar Year;</p> <p>Cardiac and pulmonary rehab therapy limited to 36 visits per Calendar Year</p>	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Provider Administered Specialty Drugs	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
All other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other Services		
Ambulance	<p>Independent air and ground ambulance service – 80% after Deductible</p> <p>Facility ground ambulance service – 80% of the Maximum allowable Charge after Deductible</p> <p>Facility air ambulance service – 80% after Deductible</p>	Facility ground and air ambulance service – 80% of billed charges after Deductible
<p>Home Health Care Services, including home infusion therapy</p> <p>Prior Authorization is required for skilled nurse visits in the home.</p> <p>Physical, speech or occupational therapy provided in the home do not require</p>	80% after Deductible	70% of the Maximum Allowable Charge after Deductible

Prior Authorization		
Hospice Care	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	70% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	70% of the Maximum Allowable Charge after Deductible

Organ Transplant Services

<p>Organ Transplant Services, all transplants except kidney</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.</p>	<p>In-Transplant Network benefits:</p> <p>80% after Network Deductible, Network Out-of-Pocket Maximum applies.</p>	<p>Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee):</p> <p>80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.</p>	<p>Out-of-Network Providers:</p> <p>70% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.</p>
<p>Organ Transplant Services, kidney transplants</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other transplant service is performed to request</p>	<p>Network Providers:</p> <p>80 % after Network Deductible; Network Out-of-Pocket Maximum applies.</p>	<p>Out-of-Network Providers:</p> <p>70% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.</p>	

Authorization.		
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**Schedule of Behavioral Health Services
Inpatient-Only Utilization Review**

<p>Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.</p>	<p align="center">In-Network Benefits for Covered Services received from Network Providers</p>	<p align="center">Out-of-Network Benefits for Covered Services received from Out-of-Network Providers</p>
<p>Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment) and treatment in halfway houses or group homes. Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
<p>Facility Charges</p>	<p align="center">80% after Deductible</p>	<p align="center">70% of the Maximum Allowable Charge after Deductible</p>
<p>Practitioner charges</p>	<p align="center">80% after Deductible</p>	<p align="center">70% of the Maximum Allowable Charge after Deductible</p>
<p>Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner’s office or community mental health center).</p>	<p align="center">80% after Deductible</p>	<p align="center">70% of the Maximum Allowable Charge after Deductible</p>

Miscellaneous Limits:	In-Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Lifetime Maximum	Unlimited	
Deductible		
Individual	\$300	
Family Note: Family Deductible applies to Individual-plus-Child(ren) and Individual-plus-Spouse tiers if available to employee	\$600	
Out-of-Pocket Maximum		
Individual	\$2,500	\$5,000
Family Note: Family Out-of-Pocket Maximum applies to Individual-plus-Child(ren) and Individual-plus-Spouse tiers if available to employee	\$2,500 per Member, not to exceed \$5,000 for all Covered Family Members.	\$5,000 per Member, not to exceed \$10,000 for all Covered Family Members
Pre-existing Condition Waiting Period	6 Months ¹	
Hearing Aids (In-Network and Out-of-Network Combined)	\$1,500 every three years	
Wigs (In-Network and out-of-Network Combined)	\$200 per occurrence	

1. HIPAA regulations apply. A Member's Pre-existing Condition Waiting Period can be reduced by the Member's applicable Creditable Coverage.

When services that require Prior Authorization are received from Out-of-Network Providers, and Network Providers outside Tennessee, You are responsible for obtaining Prior Authorization. Benefits may be reduced to 50% for Out-of-Network Providers and Network Providers outside Tennessee when Prior Authorization is not obtained.

EVIDENCE OF COVERAGE

ATTACHMENT C: PPO SCHEDULE OF BENEFITS-(CDHP)

**Group Name: THE TENNESSEE VALLEY AUTHORITY
Consumer-Directed Health Plan (CDHP)**

Group Number: 82333

Effective Date: January 1, 2012

Network: P

The CDHP is a high-deductible health plan and has a higher Calendar Year deductible than a typical health plan. Most services are Covered only after You meet Your Deductible. Some preventive care benefits may be paid before the Deductible is satisfied.

When You are Covered under the CDHP, You may qualify for tax savings by contributing to a Health Savings Account (HSA). An HSA is a personal tax-exempt account used to pay for qualified medical expenses. HSAs are regulated by the Internal Revenue Service (IRS). If you qualify for an HSA and open the account as instructed by TVA, TVA will make an annual contribution as agreed to in collective bargaining. For 2012, the TVA annual contribution equates to one-half of the annual deductible amount. You may make additional tax-free contributions to the HSA up to the IRS limits.

If You are Covered under the CDHP, your prescription-drug expenses are credited toward the Deductible.

The Deductible in the CDHP applies on a contract basis.

- If you are covered in an individual plan, you must meet the individual Deductible before benefits will be paid under the Plan.
- If you are covered under a family plan, the family Deductible must be met before benefits will be paid under the Plan.

Note: The Family Deductible applies to Individual-plus-Child(ren)e and Individual-plus-Spouse tiers if available to employee

PLEASE READ THIS IMPORTANT STATEMENT: Network level benefits apply to services received from Network Providers.

Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge, not to the Provider's billed charge (unless otherwise specified). When using Out-of-Network Providers, the Member must pay the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial. For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the Definitions section of this EOC.

Covered Services	Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care - Children (to age 6) Includes: Birth to Age 1 - 5 exams (including routine immunizations), in addition to the initial physician exam in the hospital Age 1 up to age 2, 3 exams (including routine immunizations), per 12 month period Age 2 up to age 3, 2 exams (including routine immunizations), per 12 month period Age 3 up to age 6, 1 exam (including routine immunizations) per 12 month period	100%	100% of Billed Charges
Well Care – Age 6 and up Includes annual health assessment and covered screenings:	100%	100% of Billed Charges
Well Woman Exam	100%	100% of Billed Charges
Mammogram, Cervical Cancer Screening, and Prostate Cancer Screening	100%	100% of Billed Charges
Covered Immunizations	100%	100% of Billed Charges
Other Covered Well Care Screenings, age 6 and above	100%	100% of Billed Charges
Services Received at the Practitioner’s Office		
Office Exams and Consultations		
Diagnosis and treatment of illness or injury	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Maternity care	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

For surgery injections, please see Office Surgery under the Other Office Procedures, Services or Supplies section		
Diagnostic Services		
Allergy testing	80% after Deductible	80% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other covered diagnostic services for illness or injury	80% after Deductible	60% of the Maximum Allowable charge after Deductible
Maternity care diagnostic services	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Diagnostic flexible sigmoidoscopy and diagnostic colonoscopy	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other office procedures, services, or supplies		
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., endoscopy).	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

<p>Therapy Services:</p> <p>Speech and occupational therapy limited to 60 visits per therapy type per Calendar Year; Chiropractic therapy limited to \$1,000 per Calendar Year; Cardiac and pulmonary rehab therapy limited to 36 visits per Calendar Year</p>	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
<p>Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider-Administered Specialty Drugs section for applicable benefit</p>	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	60% of the Maximum Allowable charge after Deductible
Other covered office services	80% after Deductible	60% of the Maximum Allowable charge after Deductible

Services Received at a Facility		
Inpatient Hospital Stays, including Behavioral Health Services and maternity stays:		
Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays		
Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 60% of of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 60% of Maximum Allowable Charge after Deductible
All Other Hospital Charges	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 60% of Maximum Allowable Charge after Deductible
Practitioner Charges	80% after Deductible	Treatment of an Emergency: 80% after Deductible Non-Emergency Treatment: 60% of the Maximum Allowable Charge after Deductible

Outpatient Facility Services
Outpatient Surgery

Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.

Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).

Facility charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

Outpatient Diagnostic Services		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
All other diagnostic services for illness or injury	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Diagnostic flexible sigmoidoscopy and diagnostic colonoscopy	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures services, or supplies		
Non-routine injections, immunizations and treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider Administered Specialty Drugs section for applicable benefit	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Therapy Services: Speech and occupational therapy limited to 60 visits per therapy type per Calendar Year; Chiropractic therapy limited to \$1,000 per Calendar Year; Cardiac and pulmonary rehab therapy limited to 36 visits per Calendar Year	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Provider Administered Specialty Drugs	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, renal dialysis, and sleep studies	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other Services		
Ambulance	Independent air and ground ambulance service – 80% Of billed charges after Deductible Facility ground ambulance service -	Facility ground and air ambulance service - 80% of billed charges after Deductible

	<p>80% of the Maximum Allowable Charge after Deductible</p> <p>Facility air ambulance service - 80% of billed charges after Deductible</p>	
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Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Physical, speech or occupational therapy provided in the home does not require Prior Authorization.	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Hospice Care	80% after Deductible	80% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Organ Transplant Services		
Organ Transplant Services, all transplants except kidney All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	In-Transplant Network benefits: 80% after Network Deductible, Network Out-of-Pocket Maximum applies.	Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee): 80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.
Organ Transplant Services, kidney transplants All Organ Transplants require Prior Authorization. Benefits will be	Network Providers: 80% after Network Deductible; Network Out-of-Pocket Maximum applies.	Out-of-Network Providers: 60% of Maximum Allowable Charge (MAC),

<p>denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization.</p>		<p>after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not Covered.</p>
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**Schedule of Behavioral Health Services
Inpatient-Only Utilization Review**

Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers.	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
<p>Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment)</p> <p>Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization. Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
Facility Charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
<p>Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner’s office or community mental health center).</p>	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Miscellaneous Limits:	Network Providers	Out-of-Network Providers
Lifetime Maximum	Unlimited	Unlimited
Deductible²		
Individual	\$1,200	\$2,000
Family ³	\$2,400	\$4,000
Note: Family Deductible applies to Individual-plus-Child(ren) and Individual-plus-Spouse tiers if available to employee		
Out-of-Pocket Maximum		
Individual	\$4,500	\$9,000

Family Note: Family Out-of-Pocket Maximum applies to Individual-plus-Child(ren) and Individual-plus-Spouse tiers if available to employee	\$9,000	\$18,000
Pre-existing Condition Waiting Period	6 Months ¹	
Hearing Aids (In-Network and Out-of-Network Combined)	\$1,500 every three years	
Wigs (In-Network and Out-of-Network Combined)	\$200 per occurrence	

1. HIPAA regulations apply. A Member's Pre-existing Condition Waiting Period can be reduced by the Member's applicable Creditable Coverage.
2. Benefits will not be provided for any Covered Family Member until the entire Family Deductible amount is met.
3. If Your HDHP is in conjunction with an HSA, and You change from Family to Self-only Coverage during an Annual Benefit Period, only expenses incurred by You while under Family Coverage will be allocated to the Self-only Deductible.

When services that require Prior Authorization are received from Out-of-Network Providers, and Network Providers outside Tennessee, You are responsible for obtaining Prior Authorization. Benefits may be reduced to 50% for Out-of-Network Providers and Network Providers outside Tennessee when Prior Authorization is not obtained.

GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BCBST is an independent corporation operating under a license from the BlueCross BlueShield Association (the “Association.”) That license permits BCBST to use the Association’s service marks within its assigned geographical location. BCBST is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

RELATIONSHIP WITH NETWORK PROVIDERS

Independent Contractors

Network Providers are not employees, agents or representatives of the administrator. Such Providers contract with the administrator, which has agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Employer and the administrator do not make medical treatment decisions under any circumstances.

While the administrator has the authority to make benefit and eligibility determinations and interpret the terms of Your Coverage, the Employer, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage (“Coverage Decisions.”) Both the administrator and the Employer make Coverage Decisions based on the terms of this EOC, the ASA, the administrator’s participation agreements with Network Providers, the administrator’s internal guidelines, policies, procedures, and applicable State or Federal laws.

The administrator’s participation agreements permit Network Providers to dispute the administrator’s Coverage decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the Grievance Procedure section of this EOC. The participation agreement requires Network Providers to fully and fairly explain the administrator’s Coverage decisions to You, upon request, if You decide to request that the administrator reconsider a Coverage decision.

The administrator has established various incentive arrangements to encourage Network Providers to provide Covered Services to You in an appropriate and cost effective manner. You may request information about Your Provider’s payment arrangement by contacting the administrator’s customer service department.

Termination of Providers’ Participation

The administrator or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Agreement. The administrator does not promise that any specific Network Provider will be available to render services while You are Covered.

Provider Directory

You may check to see if a Provider is in Your Plan’s Network by going online to www.bcbst.com.

STATEMENT OF RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with

childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Patients who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy are entitled to coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. Please refer to the Covered Services section of this EOC for details.

NOTICE REGARDING CERTIFICATES OF CREDITABLE COVERAGE

This Plan contains a Pre-Existing Condition Exclusion, which may limit Your Coverage. The Pre-Existing Condition Waiting Period for any Pre-Existing Condition will be reduced by the total amount of time You were covered by similar creditable health coverage, unless Your coverage was interrupted for more than 63 days. Periods of similar creditable health coverage prior to a break in coverage of 63 days or more shall not be deducted from the Pre-Existing Condition Waiting Period. Any period of time You had to wait to be eligible under an employer's plan is not considered an interruption of coverage.

You have the right to demonstrate the amount of Creditable Coverage You have, including any waiting periods that were applied before You became eligible for Coverage. For any period after July 1, 1996, You can ask a plan sponsor, health insurer or HMO to provide You with a "certification form" documenting the periods during which You had health benefit coverage. If You are having trouble obtaining documentation of Your prior Creditable Coverage, You may contact the Plan for assistance in obtaining documentation of prior Creditable Coverage from any prior plan or issuer.

If You lose eligibility for Coverage under this Plan, We will send You a Certificate of Creditable Coverage, at Your last address, on file with Us. We will issue the Certificate of Creditable Coverage automatically when We receive notice that You are no longer eligible for Coverage under this Plan. You may request additional copies of the Certificate of Creditable Coverage at any time up to 24 months following the date Your Coverage ended under this Plan. To request copies, please write or call us at:

CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402
(800) 245-7942

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave. Check with the Employer to see if this provision applies.

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (HEALTH CARE REFORM)

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of annual or lifetime limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number on Your membership ID card. You may also reference the website of the Employee Benefits Security Administration, U.S. Department of Labor at www.dol.gov/ebsa/healthreform, which has a table summarizing which protections do and do not apply to grandfathered health plans.

RIGHT OF REIMBURSEMENT

A. Reimbursement Rights

In the event the Plan makes any payments for Covered Services on a Member's behalf, and then the Member is later compensated by a third party for illnesses or injuries related to those Covered Services, the Plan has a right to reimbursement of any and all payments made by the Plan for those Covered Services.

Specifically, the Plan has the right to be reimbursed by such Member for any and all amounts equal to the Plan's payments from:

- the insurance of the injured party;
- the person, company (or combination thereof) that caused the illness or injury, or their insurance company; or
- any other source, including medical payment coverage or similar medical reimbursement policies.

In addition, the Plan's rights include the right to reimbursement for the reasonable value of any prepaid services rendered by Network Providers pursuant to Covered Services on the Member's behalf.

This right of reimbursement under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise, and the Plan's reimbursement will not be reduced by the Member's negligence, nor by attorney fees and costs the Member incurs.

B. Debt Owed to Federal Government/Priority Right of Reimbursement

The Tennessee Valley Authority ("TVA") is a Federal corporate agency and the Plan sponsor. Any and all payments to which the Plan is entitled pursuant to its right of reimbursement under this provision constitute debts owed to TVA, TVA has an absolute right to recover the entire amount of any debts owed to the agency.

In addition to the above, the Plan shall have first lien and right to reimbursement. The Plan's first lien supercedes any right the Member may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery the Member might procure regardless of whether the Member received compensation for any damages or expenses, including attorneys' fees or costs. This priority right of reimbursement supersedes the Member's right to be made whole from any recovery, whether full or partial. In addition, the Member agrees to do nothing to prejudice or oppose the Plan's right to reimbursement and the Member acknowledges that the Plan precludes operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. Members agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

- Any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from Your own insurance and/or from the third party (or their insurance);
- Any auto or recreational vehicle insurance coverage or benefits; or
- Business and homeowner medical liability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from those parties.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the Member is a minor.

This priority right of reimbursement will not be reduced by attorney fees and costs the Member incurs.

The Plan may enforce its right of reimbursement against, without limitation, any tortfeasors, other responsible third parties or against available insurance coverages, including underinsured motorist coverage. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

Members are required to notify the administrator promptly if they are involved in an incident that gives rise to such priority right of reimbursement, to enable the administrator to protect the Plan's rights under this section. Members are also required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of TVA the Plan sponsor, deems necessary to protect the Plan's rights under this section and under Federal law with respect to debts owed to a Federal agency.

The Member shall not do anything to hinder, delay, impede or jeopardize the Plan's priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the Plan to withhold any and all benefits due the Member under the Plan or entitle TVA to take any other actions necessary and permitted to collect a debt owed to a Federal agency. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan's priority right of reimbursement.

If the Plan has to file suit, or otherwise litigate to enforce its priority right of reimbursement, the Member is responsible for paying any and all costs, including attorneys' fees, the Plan incurs in addition to the amounts recovered through the priority right of reimbursement.

Legal Action and Costs

If a Member settles any claim or action against any third party, the Member shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The Member shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Member in such circumstances.

Additionally, the Plan has the right to sue on the Member's behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan.

Settlement or Other Compromise

Members must notify the administrator prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan's rights so that the Plan may be present and protect its priority right of reimbursement.

The right of reimbursement is based on (i) the Plan language in effect at the time of judgment, payment or settlement, and (ii) that the payments subject to the Plan's right of reimbursement constitute debts to TVA, a Federal corporate agency, and under Federal law, TVA has a right to recover any debts owed to it by an individual.

The Plan, or its representative, may enforce the priority right of reimbursement set forth under this provision.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

LEGAL OBLIGATIONS

The group health plan (the Plan) sponsored by the Tennessee Valley Authority (TVA) is required by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, to maintain the privacy of all protected health information (PHI) in accordance with HIPAA; provide this notice of privacy practices to all enrollees; inform enrollees of our legal obligations with respect to their PHI; and advise enrollees of additional rights concerning their PHI. The Plan must follow the privacy practices contained in this notice from its effective date of April 14, 2003, and continue to do so until this notice is changed or replaced. As used in this notice, the Plan means the self-insured health plans sponsored by TVA for the payment of medical, dental, or prescription drug and vision claims. The Plan also includes the self-referral Employee Assistance Program to the extent you request medical services under it, the health care flexible spending account to the extent that you maintain one to help reimburse medical expenses, the Live Well and Health Check Programs, and the TVA-sponsored Disease Management Program.

Since 1974, TVA has maintained its records under the Federal Privacy Act, which requires TVA to protect employees' personal information. The requirements under HIPAA reinforce TVA's current practices relating to the protection of employees' personal information.

HIPAA privacy requirements are related to PHI. PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form (oral, written, or electronic). PHI also includes genetic information as defined in Title I of the Genetic Information Nondiscrimination Act (GINA), which includes information about an individual's genetic tests, genetic tests of the individual's family members, or the "manifestation of a disease or disorder" in these family members (i.e., family medical history).

The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all PHI that is maintained, including information created or received before the changes were made. All present enrollees of the Plan and all past enrollees for whom the Plan still maintains PHI will be notified of any material changes by receiving a new Notice of Privacy Practices.

You may request a copy of this Notice of Privacy Practices at any time by contacting the Tennessee Valley Authority group health plan at 400 W. Summit Hill Drive, WT 8D-K, Knoxville, Tennessee 37902.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment, Payment and Health Care Operations

Your PHI may be used and disclosed by the Plan or its business associates for treatment, payment, and health care operations without your authorization.

Treatment: Treatment generally means the provision, coordination or management of health care. For example, the Plan may disclose information to a doctor or hospital that asks for it for purposes of your medical treatment.

Payment: Payment generally encompasses the activities of the Plan to fulfill its coverage responsibilities and to provide benefits on your behalf. For example, information on Plan coverage and benefits may be used or disclosed to pay claims for services provided to you by doctors or hospitals which are covered under your health insurance policy.

Health Care Operations: Health Care Operations generally means the activities which the Plan must undertake to operate the Plan and to support your treatment and the payment of your claims. For example, PHI may be used and disclosed to conduct quality assessment and improvement activities, to engage in care coordination, to provide disease management or case management, and to pursue rights of recovery and subrogation.

Other Uses and Disclosures for Which Authorization Is Not Required

Your PHI may also be used or disclosed by the Plan without your authorization under the following circumstances:

Disclosures to Family and Friends: Your PHI may be disclosed under certain circumstances to family members, other relatives and your close personal friends who can reasonably demonstrate that they are involved with your care or payment for that care if the information is directly relevant to such involvement or payment. If you do not wish any particular family member, relative or friend to receive any of your information, you may send a letter to us, at the address listed at the end of this notice, making this request.

Plan Sponsors: Your PHI and that of others enrolled in the Plan may be disclosed to the Plan's sponsor, TVA, so that it can assist in the administration of the Plan.

Research: Your PHI may be used or disclosed for research purposes in limited circumstances.

As Required by Law: Your PHI may be used or disclosed as required by law. For example, PHI must be disclosed to the U.S. Department of Health and Human Services upon request for purposes of determining the Plan's compliance with Federal privacy laws.

Court or Administrative Order: PHI may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

Health or Safety: PHI may be released to the extent necessary to avert a serious and imminent threat to your health or safety or to the health or safety of others under certain circumstances.

Health Oversight and Law Enforcement Activities: PHI may be disclosed to Health Oversight agencies for oversight activities, including TVA's Office of Inspector General, and Law Enforcement agencies for law enforcement purposes, under certain circumstances.

Public Health Activities: PHI may be disclosed to public health authorities for purposes of certain public health activities. PHI may also be used or disclosed under certain circumstances if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Abuse or Neglect: Your PHI may be disclosed when authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence.

Coroners and Funeral Directors: PHI may be disclosed to a coroner or medical examiner under certain circumstances. PHI may also be disclosed to a funeral director as necessary to carry out their duties with respect to the decedent.

Specialized Government Functions: PHI of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. PHI may be disclosed under certain circumstances to authorized Federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities and for the provision of protective services to the President and other authorized officials.

Workers' Compensation: PHI may be disclosed as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Uses and Disclosures Pursuant to Authorization

Written Authorizations: You may provide written authorization to use your PHI or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time, but this revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

Psychotherapy Notes: Except under certain circumstances, your written authorization must be obtained before the Plan will use or disclose psychotherapy notes about you from your therapist. The Plan may use and disclose such notes when needed by the Plan to defend against you in litigation filed by you.

Marketing: The Plan cannot use your PHI for marketing purposes without your authorization, unless the activity relates to certain specific exceptions as permitted by HIPAA.

Genetic Nondiscrimination

The Plan will use genetic information only as permitted by GINA. As required by GINA, the Plan will not (i) adjust premiums based on genetic information; (ii) request or require that an individual or family member undergo a genetic test; (iii) request, require or purchase genetic information for underwriting or before enrollment in the Plan; or (iv) use or disclose genetic information for underwriting purposes (even with an authorization).

INDIVIDUAL RIGHTS

Breach Notification

The Plan will notify individuals if a breach of their unsecured PHI occurs in accordance with and as required by HIPAA as amended by the American Recovery and Reinvestment Act of 2009 (P.L. 111-5, "ARRA") and ARRA's Health Information Technology for Economic and Clinical Health (HITECH) Act. In the event the Plan determines that the breach could result in a significant risk of financial, reputational or other harm to the individuals, such notification will occur within 60 days after the Plan discovers the breach. Unsecured PHI is PHI that is not secured using a technology or methodology specified by the U.S. Department of Health and Human Services (i.e., encryption or destruction).

Other Rights

You have the right to look at or get copies of your PHI, with limited exceptions. **You must make the request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information at the end of this notice, or you may send a letter to us, at the address listed at the end of this notice, requesting access to your PHI. If you request copies of your PHI, you will be charged a reasonable fee for the copies and postage if you want the copies mailed to you.** You may also request information from our plan administrators (e.g., BlueCross BlueShield of Tennessee, Medco Health, SHPS, etc.), who maintain information regarding claims, diagnoses, and treatment in order to pay your claims. In the event the Plan maintains electronic health records ("EHRs"), you have the right to request an electronic copy of your EHR.

You have the right to receive an accounting of the disclosures of your PHI by the Plan or by a business associate of the Plan. This accounting will list each disclosure that was made of your PHI to anyone other than you or someone authorized by you for any reason, other than treatment, payment, healthcare operations and certain other activities not subject to an accounting as set forth in HIPAA, since six (6) years prior to the date of the request. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the PHI disclosed, the reason for the disclosure, and certain other information. You may also request an accounting of disclosures from our plan administrators. In the event the Plan maintains EHRs, you have the right to receive an accounting of the disclosure of your EHR by the Plan, which will list each disclosure that was made of your EHR to anyone other than you or someone authorized by your for any reason, including for purposes of treatment, payment, and healthcare operations.

You have the right to request restrictions on the Plan's use or disclosure of your PHI. While we will consider all requests for restrictions carefully, we are not required to agree to all requests, unless the request is to restrict the

disclosure of PHI for purposes of plan payment or healthcare operations where you have already paid the provider in full out-of-pocket for the services related to that PHI. You may also request this of our plan administrators.

You have the right to request confidential communications about your PHI by alternative means or alternative locations. While we will consider reasonable requests carefully, we are not required to agree to all requests. You may also request this of our plan administrators.

You have the right to request that the Plan amend your PHI. **Your request must be in writing, and it must explain why the information should be amended.** The Plan may deny your request if the PHI you seek to amend was not created by the Plan, if the PHI is accurate and complete, or for certain other reasons. You may also request this of our plan administrators.

Your rights may be exercised through a personal representative. Your personal representative will be required to provide evidence of authority to act on your behalf. Once this has been determined, except under certain limited circumstances, the personal representative will have all the rights you have as listed above.

QUESTIONS AND COMPLAINTS

If you want more information concerning the Plan's privacy practices or have questions or concerns, please contact the Complaint Official listed below.

If you are concerned that the Plan has violated your privacy rights, or you disagree with a decision made about access to your PHI, or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may file a complaint with us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

The Plan supports your right to protect the privacy of your PHI. There will be no retaliation in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official: Manager, Employee Benefits
400 W. Summit Hill Drive, WT 8D
Knoxville, Tennessee 37902

Complaint Official: Senior Analyst, Employee Benefits - Benefit Plans
400 W. Summit Hill Drive , WT 8D
Knoxville, Tennessee 37902

Or call the TVA Employee Service Center at 1-888-275-8094.



**BlueCross BlueShield
of Tennessee***

1 Cameron Hill Circle

Chattanooga, Tennessee

37402

www.bcbst.com

BENEFIT QUESTIONS?
Call the Customer Service
Number on the membership I.D. Card

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