BlueCross BlueShield of TN - PPO Plan #1

Effective Date - January 1, 2009

Benefit Features	Network Providers	Out-of-Network Providers[2]
Annual Deductible		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Annual Out-of-Pocket Maximum Amount		
Individual	$1,500	$4,500
Family	$3,000	$9,000
Dependent Age Limit	To age 24	To age 24
Lifetime Maximum Benefit	$5,000,000	
Pre-Existing Waiting Period [1]	12 months	12 months
Benefits for Covered Services	**Network Benefits**	**Out-of-Network Benefits [2]**
Practitioner Office Services		
Office Visits	90% after Deductible	70% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	90% after Deductible	70% after Deductible
Non-routine Diagnostic Services [5]	90% after Deductible	70% after Deductible
Provider Admin Specialty Pharmacy Products	$35 Copay	70% after Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	$10 Copay	70% after Deductible
Annual Well Woman Exam	$10 Copay	70% after Deductible
Annual Mammography Screening	No Additional Copay	70% after Deductible
Annual Cervical Cancer Screening	No Additional Copay	70% after Deductible
Prostate Cancer Screening	No Additional Copay	70% after Deductible
Immunizations (to age 6)	No Additional Copay	70% after Deductible
Well Care Rider Services (ages 6 and up) (Exams, Screenings & Immunizations) [10]	$10 Copay	70% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3]	90% after Deductible	70% after Deductible
Outpatient Surgery [4]	90% after Deductible	70% after Deductible
Routine Diagnostic Services-Outpatient	90% after Deductible	70% after Deductible
Non-routine Diagnostic Services-Outpatient [5]	90% after Deductible	70% after Deductible
Other Outpatient Services [6]	90% after Deductible	70% after Deductible
Emergency Care Services [7]	90% after Deductible	90% after Deductible
Emergency Care Non-Routine Diagnostics [5]	90% after Deductible	90% after Deductible
Medical Equipment		
Durable Medical Equipment, Prosthetic & Orthotic Appliances	90% after Deductible	70% after Deductible
Therapeutic Services [8]		
Therapy (Limited to 30-36 visits per year per therapy type)	90% after Deductible	70% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3]		
Limited to 60 days combined	90% after Deductible	70% after Deductible
Home Health Services [9]		
Limited to 60 visits per year	90% after Deductible	70% after Deductible
Hospice Services [9]	100%	70% after Deductible
Ambulance Service	90% after Deductible	90% after Deductible

Notes (see benefit summary on prior page):

1. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.

2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.

3. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.

4. Certain surgical procedures require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.

Call Customer Service to determine which procedures require prior approval.

5. CAT scans, MRIs, nuclear medicine and other similar technologies.

6. Includes services such as chemotherapy, radiation therapy, infusions, and renal dialysis.

7. ER services include all services in conjunction with ER visit except non-routine diagnostic services.

8. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.

9. Requires prior approval.

10. Well Care Rider services are limited to $300 per year.

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PPO Benefit Exclusions:

- routine transportation, supportive environmental equipment, maintenance or custodial care, social casework, or meal delivery
- homemaker or housekeeping services, meals, funeral or financial counseling
- office visits and physical exams for school, camp, employment, travel insurance, marriage or legal proceedings and related immunizations and tests
- second surgical opinions given by a practitioner in the same medical group as the practitioner who initially recommended the surgery
- routine foot care for the treatment of flat feet, corns, bunion, calluses, toenails, fallen arches, weak feet or chronic foot strain
- foot orthotics, shoe inserts and custom made shoes except for diabetic patients or as part of a leg brace
- custodial, domiciliary or private duty nursing services
- inpatient hospital stays primarily for therapy
- private duty nursing
- service which could be provided in a less intensive setting
- transportation for the sole convenience of the member
- transportation that is not essential to reduce the probability of harm to the patient
- ambulance services when the member is not transported to a facility
- services or supplies that are designed to medically enhance a member's level of fertility in the absence of a disease
- assisted reproductive technology (ART), such as *GIFT,ZIFT*, invitro-fertilization and fertility drugs
- services or supplies for the reversals of sterilizations
- elective abortions
- services, supplies or prosthetics primarily to improve appearance, including wigs or other hair prostheses or transplants
- surgeries in order to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance
- surgeries and related services to change gender
- treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care and duplicative therapies
- enhancement therapy which is designed to improve the member's physical status beyond their pre-injury or pre-illness state
- modalities that do not require the attendance or supervision of a licensed therapist, including activities which are primarily social or recreational in nature, simple exercise programs, hot and cold packs applied in the absence of associated therapy modalities, repetitive exercises or tasks which can be performed by the member without a therapist, in a home setting, routine dressing changes.
- behavioral therapy, play therapy, communication therapy and therapy for self-correcting language dysfunctions
- complementary and alternative therapeutic services whose value has not yet been determined to be medically necessary,including massage therapy, acupuncture, aquatic therapy, craniosacral therapy, neuromuscular reeducation, vision exercise therapy, and cognitive therapy
- charges exceeding the maximum allowable charge for the total cost of purchase of durable medical equipment
- unnecessary repair, adjustment or replacement or duplicates of any durable medical equipment
- supplies and accessories that are not necessary for the effective functioning of the covered medical equipment
- items to replace those which were lost, damaged, stolen or prescribed as a result of new technology
- motorized scooters, "deluxe" or "enhanced" equipment
- contacts after the initial pair following cataract surgery
- hearing aids
- surgery or services as a result of an injury to the jaw, natural teeth, mouth, or face not completed within 12 months of the date of the accident
- treatment for routine dental care and related services including but not limited to replacement of teeth, bone grafts, treatment of teeth roots, treatment of injuries due to biting and chewing, crowns, plates, x-rays, fillings, removal of non-impacted teeth
- treatment for correction of underbite, overbite, and misalignment of the teeth, including orthognathic surgery and braces for dental indications
- behavioral health services except as listed in a separate rider
- services and supplies to detect or correct refractive errors of the eyes, except as listed in a separate rider
- eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses, except as listed in a separate rider
- eye exercises and/or therapy
- visual training
- pharmaceuticals which may be purchased without a prescription
- pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider
- services or supplies not listed as a covered service in the Evidence of Coverage
- services or supplies that are determined to be not medically necessary or determined to be experimental or investigational in nature
- illness or injury resulting from war and covered by veteran's benefit or other coverage for which the member is legally entitled and which occurred before the member's coverage began under this contract.
- self treatment or training
- staff consultations required by hospital or other facility rules
- services which are free
- services or supplies related to any treatment or services resulting from the member's participation in a felony, riot, or insurrection
- treatment of work related illness or injury, regardless of the presence or absence of worker's compensation coverage, unless resulting from self-employment by a sole proprietor or partner of the insured group who had elected not be covered by the worker's compensation law
- personal and convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds and other recreational equipment, weight loss programs, physical fitness programs or self-help devices which are not primarily medical in nature, even if ordered by a practitioner
- wellcare or other preventive services at age 6 or over, unless as listed in a wellcare rider, including but not limited to well-child care, periodic health assessments, immunizations, eye and ear examinations to determine the need for vision and hearing correction
- telephone or e-mail consultations, or charges for failure to keep a scheduled appointment, or handling fees
- services for providing requested medical information or completing forms
- court-ordered examinations and treatment
- room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day
- any service stated in the Evidence of Coverage as a Non-Covered Service or Limitation
- charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum or any other limitations listed under the Evidence of Coverage or its attachments
- 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
- benefits for Pre-existing Conditions (until any pre-existing waiting periods have been met)
- organ transplants when prior approval through transplant case management is not obtained
- transplant related charges above the Transplant Maximum Allowable Charge
- removal of an organ from a member for purposes of transplantation into another person, except as covered by the donor organ procurement provision
- services performed by a family member
- nicotine replacement therapy and aids to smoking cessation including patches
- human growth hormones except for specific conditions shown in Evidence of Coverage
- safety items or items to affect performance primarily in sports related activities
- services and supplies related to obesity, including surgical or other treatment of morbid obesity
- cosmetic services including surgical or other services, drugs, or devices, including removal of tattoos, removal of moles, facelifts, blepharoplasty, keloid removal, dermabrasion, chemical peels, rhinoplasty, breast augmentation and breast reduction
- services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a member, surrogate parenting, sperm preservation
- treatment of sexual dysfunction, including erectile dysfunction (e.g.Viagra), delayed ejaculation, anorgasmia and decreased libido

Please Note: This benefit summary is only a brief description of PPO benefits. All benefit determinations are governed by the Master Contract on file with the employer.

$10/$20/$35 Prescription Drug Plan

Generic Drugs $10 Copay per prescription, up to 30 day supply
Preferred Brand Name Drugs $20 Copay per prescription, up to 30 day supply
Non-preferred Brand Name Drugs $35 Copay per prescription, up to 30 day supply

The copayment is the amount you pay to a network pharmacy for each prescription you have filled. Your copayment is dependent upon which brand level of drug you choose.

Generic Drugs- your copay is $10
Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

Preferred Brand Drugs- your copay is $20
The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your copay is $20.

Non-Preferred Brand Drugs- your copay is $35
When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of $35.

Pricing at Participating Pharmacies
When a member receives a prescription at a pharmacy, he or she typically pays the appropriate copayment (either generic or brand under a two-tier plan; or generic, preferred brand or non-preferred brand under a three-tier plan). Members pay less than the copayment if the pharmacy's usual price for the drug is less than the copayment.

Choosing a Brand when a Generic Equivalent is Available
You'll always save money when using generics. In fact, all you pay is the generic copay. But if you or your physician request a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

Limitations
These limitations apply to each prescription order.

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs, and/or
- up to a 90-calendar-day supply of prescription drugs obtained through Prescription Home Delivery or the Home Delivery Retail Network.

Refills

Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original prescription.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

Prescription Home Delivery

Enjoy the convenience of prescription home delivery by calling 1-877-683-6837, or completing a Caremark.com mail order form. Simply mail the completed form along with the written prescription and payment in the Caremark.com envelope. For more information, visit the pharmacy section at www.bcbst.com.

Home Delivery Retail Network

Another convenient way to obtain up to a 90-calendar-day supply of drugs is through the Home Delivery Retail network. The Home Delivery Retail Network is a network of retail pharmacies that are permitted to dispense prescription drugs to BlueCross BlueShield of Tennessee members on the same terms as pharmacies in the Home Delivery Network. A directory of the participating Home Delivery Retail Network is available online at www.bcbst.com.

Out-of-Network Pharmacies

If a prescription is filled at an out-of-network pharmacy, you must pay all costs. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

A Broad Network of Retail Pharmacies

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. The RX04 pharmacy network provides tremendous accessibility with over 60,000 pharmacies nationally and over 1,500 in Tennessee, including every national chain and many independent pharmacies. A directory of participating pharmacies is available online at www.bcbst.com.

Self-Administered Specialty Pharmacy Network and Coverage

You have a separate network for Specialty Pharmacy Products: the specialty pharmacy network. You receive the highest level of benefits when you use a specialty pharmacy network provider for your self-administered Specialty Pharmacy Products. Accredo Health Group, Caremark Specialty Pharmacy Services, and CuraScript Pharmacy/Priority Healthcare are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

Accredo Health Group	Caremark Specialty Pharmacy Services	CuraScript Pharmacy/ Priority Healthcare
1-888-239-0725 (phone)	1-866-295-2779 (phone)	1-888-773-7376 (phone)
1-866-387-1003 (fax)	1-866-295-2778 (fax)	1-888-773-7386 (fax)

You may purchase self-administered specialty pharmacy products from a retail pharmacy, but your copay will be higher. When purchasing self-administered Specialty Pharmacy Products from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

Please refer to the Specialty Pharmacy Products List to see which drugs are covered as self-administered specialty pharmacy products. Go to www.bcbst.com/Pharmacy.

Specialty Pharmacy Products are limited to a **30-day supply** per Prescription.

	Specialty Pharmacy Network	Other Network Pharmacies	Out-of-Network Pharmacies
A Self-Administered Specialty Pharmacy Product, as indicated on Our Specialty Pharmacy Products list.	$35 Drug Copayment per Prescription	$70 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
If a drug that is on Our Specialty Pharmacy Products list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be:			
If a drug that is on Our Specialty Pharmacy Products list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be: A Generic Drug that is also a Self-Administered Specialty Pharmacy Product, as indicated on Our Specialty Pharmacy Products list.	$10 Drug Copayment per Prescription	$20 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
A Preferred Brand Drug that is also a Self-Administered Specialty Pharmacy Product, as indicated on Our Specialty Pharmacy Products list.	$20 Drug Copayment per Prescription	$40 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
(Please refer to Your EOC for information on benefits for provider-administered Specialty Pharmacy Products, which are covered as a Medical benefit.) Need More Information? For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at www.bcbst.com. *RX04-MACA 10-20-35* *Updated 10/17/06*			

Benefits will not be provided for:

- drugs for the treatment of onychomycosis (e.g., nail fungus), except for: 1) diabetics; or 2) immuno-compromised patients.
- growth hormones, except for: 1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with "Turner'' syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan.
- drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceeds that specified by the Plan's P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail internet Pharmacy;
- contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- medications intended to terminate a pregnancy (e.g., RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- all newly FDA approved drugs prior to review by the Plan's P & T Committee;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;

- Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs; and
- Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list.
- Prescription Drugs or refills dispensed:
- in quantities in excess of amounts specified in the BENEFIT PAYMENT section;
- without Our Prior Authorization when required; or
- which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC

RX04-MACA 10-20-35

Updated 10/17/06

These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully

Employee Premium Semi-Monthly Rates
(24 payroll deductions per year)

Employee	$15.00
Employee + One	$77.50
Employee + Family	$77.50

Customer Service
1-800-451-9097

Extended Well Care

To maintain your health throughout your life, you should receive the proper tests and immunizations at the appropriate time and frequency. Many factors, including your age, gender, family history, and other special needs, determine when particular services are beneficial. Therefore, you should discuss with you physician what is right for you.

You and each eligible dependent age 6 and older may receive preventive health services, not to exceed $300, per calendar year*. All services must be medically necessary and appropriate and recommended by the U.S. Preventive Health Task Force, or in conjunction with the plan's preventive health care guidelines.

All well care benefits listed are subject to the terms, conditions, limitations, and exclusions contained in the Group Master Contract and the Evidence of Coverage. All services covered by the Wellcare Rider are subject to normal contract benefits, which are determined by type of service and place of service. *

The following is a list of items that are covered as a part of the annual preventive health exam for persons age 6 and older:

•Annual Health Assessment
•Childhood immunizations
•Blood pressure screening
•Periodic cholesterol screening
•Periodic colorectal cancer screening, not subject to the $300 calendar year limit*
•Flu shot
•Tetanus-diphtheria (Td) booster
•Pneumoccocal immunization
•Other recommended adult immunizations and immunizations not completed in childhood
•Immunizations for travel to foreign countries
•Other prescribed x-ray and lab screenings associated with preventive care
•Vision and hearing screenings performed by the physician during the preventive health exam

Most of these services are not needed every year, or may be appropriate only for people of particular age groups, genders, or those who meet other specific health criteria.

*Important Note Regarding Colonoscopy and Sigmoidoscopy Benefits:
All services covered by the Wellcare Rider are subject to normal contract benefits, which are determined by type of service and place of service. When Wellcare Rider services are provided in a physician's office, as the majority are, the office visit benefit applies. However, colonoscopy and sigmoidoscopy are invasive diagnostic surgical procedures, so surgery benefits apply to these services. Sigmoidoscopies and colonoscopies performed in the physician's office are subject to the office surgery benefit (copay or deductible/coinsurance, depending on the benefit plan). Sigmoidoscopies and colonoscopies performed in an outpatient facility are subject to the outpatient surgery benefit (usually deductible/coinsurance).