

BlueCross BlueShield of TN - PPO Plan (Network P)

Effective Date - January 1, 2010

| 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 | \$90 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 \$750 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 to 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
- wellness or other preventive services at age 6 or over, unless as listed in a well-care 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.

\$5/\$30/\$45 Prescription Drug Plan
\$10/\$60/\$90 Specialty Drug Plan

| | |
|--------------------------------|--|
| Generic Drugs | \$ 5 Copay per prescription, up to 30 day supply |
| Preferred Brand Name Drugs | \$30 Copay per prescription, up to 30 day supply |
| Non-preferred Brand Name Drugs | \$45 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 \$5

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 \$30

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 \$45

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 1-888-239-0725 (phone) 1-866-387-1003 (fax) | Caremark Specialty Pharmacy Services 1-866-295-2779 (phone) 1-866-295-2778 (fax) | CuraScript Pharmacy/ Priority Healthcare 1-888-773-7376 (phone) 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 | \$75.00 |
| Employee + One | \$140.00 |
| Employee + Family | \$159.00 |

Insurance Incentives for 2010

- Proof of employee annual physical in 2009 = a \$50.00 monthly / \$600 annual health insurance deduction credit.
- Signing a Waiver that the employee is tobacco free for 30 consecutive days as of 12:00 December 31,2009 = \$50.00 monthly / \$600 annual health insurance deduction credit. Tobacco free discount incentives for those who sign Waivers in 2010. Please see Fredia Black for more information.

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 your physician what is right for you.

You and each eligible dependent age 6 and older may receive preventive health services, not to exceed \$750, 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
- Pneumococcal 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).

BlueCross BlueShield of TN - HSA Plan (Network P)

Effective Date - January 1, 2010

| Benefit Highlights | In-Network Benefits | Out-of-Network Benefits |
|---|----------------------------|--------------------------------|
| Annual Deductible | | |
| Individual | \$2,000 | \$4,000 |
| Family | \$4,000 | \$8,000 |
| If more than one person is covered under the group health plan, the full family deductible must be satisfied before benefits will be paid for the employee or any covered family members. | | |
| Annual Out-of-Pocket Maximum | | |
| Individual | \$2,000 | \$6,000 |
| Family | \$4,000 | \$12,000 |
| Dependent Age Limit | To age 24 | |
| Lifetime Maximum | \$5,000,000 | |
| Preexisting Conditions Waiting Period | 12 months | |
| Office Visits | | |
| Office Visits | 100% After Deductible | 80% After Deductible |
| Routine Diagnostic Lab, X-ray & Injections | 100% After Deductible | 80% After Deductible |
| Advanced Radiological Imaging | 100% After Deductible | 80% After Deductible |
| Preventive Health Care Services | | |
| Well Child Care (to age 6) | 100% After \$20 Copay | 80% After Deductible |
| Annual Well Women Exam | 100% After \$20 Copay | 80% After Deductible |
| Annual Mammography Screening | 100% | 80% After Deductible |
| Prostate Cancer Screening | 100% | 80% After Deductible |
| Immunizations | 100% | 80% After Deductible |
| Well Care Rider Services (ages 6 and up) - See Well Care Rider for more information | 100% After \$20 Copay | 80% After Deductible |
| Services Received at a Facility (includes professional and facility charges) | | |
| Inpatient Services | 100% After Deductible | 80% After Deductible |
| Outpatient Services | 100% After Deductible | 80% After Deductible |
| Routine Diagnostic Services - Outpatient | 100% After Deductible | 80% After Deductible |
| Advanced Radiological Services - Outpatient | 100% After Deductible | 80% After Deductible |
| Other Outpatient Services | 100% After Deductible | 80% After Deductible |
| Emergency Care Services | 100% After Deductible | 80% After Deductible |
| Medical Equipment | | |
| Durable Medical Equipment - \$2,500 annual limit | 100% After Deductible | 80% After Deductible |
| Prosthetics - \$20,000 annual limit | 100% After Deductible | 80% After Deductible |
| Orthotic Appliances | 100% After Deductible | 80% After Deductible |

| | | |
|--|-----------------------|-----------------------|
| Behavioral Health | | |
| Inpatient: Unlimited days per calendar year | 100% After Deductible | 80% After Deductible |
| Outpatient: Unlimited days per calendar year | 100% After Deductible | 80% After Deductible |
| Therapeutic Services | | |
| Therapy (limited to 20-36 visits per year per therapy type) | 100% After Deductible | 80% After Deductible |
| Skilled Nursing Facility & Rehabilitation Facility Services | | |
| Limited to 60 days combined | 100% After Deductible | 80% After Deductible |
| Home Health Services | | |
| Limited to 60 visits per year | 100% After Deductible | 80% After Deductible |
| Hospice Services | 100% After Deductible | 80% After Deductible |
| Ambulance Services | 100% After Deductible | 100% After Deductible |
| Pharmacy - Prescription Drugs | 100% After Deductible | 80% After Deductible |

High Deductible Health Plans Prescription Drug Coverage with the Preventive Drug List

Benefits are available for prescription drugs when filled by a BlueCross BlueShield of Tennessee participating pharmacy, subject to you deductible and coinsurance.

In-network Pharmacy

Benefits are subject to your In-network and coinsurance

Out-of-Network Pharmacy

Benefits are subject to your out-of-network deductible and coinsurance

When you get your prescription filled, you are only responsible for paying your deductible and coinsurance. Once your deductible is met, you only need to pay the applicable coinsurance at point of sale. The pharmacy will electronically file your claim with BlueCross BlueShield of Tennessee. For the best benefits, get your prescription filled at a participating pharmacy.

Benefits are available for brand name drugs and generic drugs. Generic drugs offer the best value. A generic drug is a safe and effective alternative to a name brand drug. When your doctor writes your prescription, ask about using a generic drug.

Limitations - These limitations apply to each prescription order.

Benefits will be provided for

- up to a 100-calendar-day supply of prescription drugs obtained at retail pharmacies or
- up to a 102-calendar-day supply of prescription drug obtained through home delivery.

Some drugs require prior authorizations, step therapy or have quantity limitations. Please refer to the special drugs list on the pharmacy page on www.bcbst.com for more details.

Step Therapy

Step Therapy is a form of Prior Authorization. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug.

However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor contact the Plan to request an exception. If the request is approved, the Plan will cover the requested drug.

Preventive Drug List - \$5/\$25/\$50 Copayment

For prescription drugs on the Preventive Drug List you pay copayment amounts instead of hte deductible and coinsurance. This allows you to obtain your medication for preventive indications without first meeting the deductible. Copayment amounts do apply to your annual out-of-pocket maximum.

| | |
|--------------------------------|---|
| Generic Drugs | \$5 Copay per prescription, each 34 day supply |
| Preferred Brand Name Drugs | \$25 Copay per prescription, each 34 day supply |
| Non-preferred Brand Name Drugs | \$50 Copay per prescription, each 34 day supply |

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

Generic Drugs - your copay is \$5

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 \$25

The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs with a therapeutic class. When your doctor prescribes a preferred brand drug on the preventive drug list, your copay is \$25. But if you receive 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.

Non-Preferred Brand Drugs - your copay is \$50

When your doctor prescribes a brand drug on the preventive drug list that is not a Preferred Drug you pay the highest copay of \$50. But if you receive a brand name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand name and generic drug.

Some drugs require prior authorization or have quantity limitations. Please refer to the special drug lists on the pharmacy page on www.bcbsnc.com for more information.

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. Simply mail a completed form along with the written prescription and payment in one of the envelopes provided or visit the pharmacy section at www.bcbst.com for other helpful ways to have your prescriptions delivered to your home or another preferred address.

Out-of-Network Pharmacies

If a prescription is filled at an out-of-network pharmacy, you must pay all cost. 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. Your pharmacy network provides tremendous accessibility in Tennessee as well nationally. A directory of participating pharmacies is available online at www.bcbst.com. Click on Find a Pharmacy, and enter the pharmacy network code that appears in the bottom center of your BlueCross BlueShield of Tennessee ID card. This code will start with RX (RX03, for example).

Self-Administered Specialty Pharmacy Network and Coverage

You have a separate network for Specialty Drugs: the Specialty Pharmacy Network. You receive the highest level of benefits when you use a Specialty Pharmacy Provider for your self-administered Specialty Drugs. Accredo Health Group, Caremark Specialty Pharmacy Services, and CuraScript Pharmacy 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 |
|-----------------------------|---|----------------------------|
| 1-888-239-0725 | 1-800-237-2767 | 1-888-773-7376 |
| 1-888-387-1004 (fax) | 1-800-323-2445 (fax) | 1-888-773-7386 (fax) |

You may purchase self-administered Specialty Drugs from a retail pharmacy, but your cost may be higher. When purchasing self-administered Specialty Drugs 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 Deductible and Coinsurance amount.

Please refer to the Specialty Drug list to see which drugs are covered as self-administered

Specialty Drugs. Go to www.bcbst.com/pharmacy.
 Specialty Drugs are limited to a 30-day supply per Prescription.

| | Specialty Pharmacy Network | Other Network Pharmacies | Out-of-Network Pharmacies |
|---|--|--|--|
| A Self-Administered Specialty Drug, as indicated on Our Specialty Drug List | Benefits are subject to your in-network deductible and coinsurance | Benefits are subject to your in-network deductible and coinsurance | Benefits are subject to your out-of-network deductible and coinsurance |

(Please refer to Your EOC for information on benefits for provider-administered Specialty Drugs, 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.

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

| | |
|-------------------|----------|
| Employee | \$65.00 |
| Employee + One | \$120.00 |
| Employee + Family | \$127.50 |

Insurance Incentives for 2010

- Proof of employee annual physical in 2009 = a \$50.00 monthly / \$600 annual health insurance deduction credit.
- Signing a Waiver that the employee is tobacco free for 30 consecutive days as of 12:00 December 31,2009 = \$50.00 monthly / \$600 annual health insurance deduction credit. Tobacco free discount incentives for those who sign Waivers in 2010. Please see Fredia Black for more information.

Customer Service
1-800-451-9097