

2008 Summary of Benefits - Medical Plan 2

Erlanger Health System

BlueCross BlueShield of Tennessee

	Erlanger Hospitals	BCBS Providers	Non BCBS Providers[2]
Annual Deductible			
Individual	\$750	\$750	\$2,000
Family	\$1,500	\$1,500	\$4,000
Annual Out-of-Pocket Maximum Amount (includes the ded)			
Individual	\$3,000	\$3,000	\$12,000
Family	\$6,000	\$6,000	\$24,000
Lifetime Maximum Benefit	Unlimited		\$2,000,000
Pre-Existing Waiting Period [1]	12 months		
Services Received at a Facility (includes facility charges only)	Erlanger Hospitals	BCBS Providers	Non BCBS Providers
Inpatient Services [3]	80% after deductible	70% after deductible	60% after deductible
Outpatient Surgery [4]	80% after deductible	70% after deductible	60% after deductible
Routine Diagnostic Services-Outpatient	100%	100%	60% after deductible
Non-routine Diagnostic Services-Outpatient [5]	\$100 copay	70% after deductible	60% after deductible
Other Outpatient Services [6]	80% after deductible	70% after deductible	60% after deductible
Provider-Administered Specialty Pharmacy Products [10]	\$50 copay	\$50 copay	60% after deductible
Emergency Room Services [7]	\$150 copay	\$150 copay	\$150 copay
Emergency Room Non-Routine Diagnostics [5]	\$100 copay	70% after deductible	70% after deductible
Physician Services		BCBS Providers	Non BCBS Providers
Office Visits		\$35 PCP, \$50 spec.	60% after deductible
Routine Diagnostic Lab, X-Ray, & Injections		100%	60% after deductible
Non-routine Diagnostic Services [5]		80% after deductible	60% after deductible
Provider-Administered Specialty Pharmacy Products [10]		\$50 copay	60% after deductible
Services Received at a Facility (includes professional charges only)		80% after deductible	60% after deductible
Preventive Health Care Services			
Well Child Care (to age 6)		100%	60% after deductible
Annual Well Woman Exam		100%	60% after deductible
Annual Mammography Screening		100%	60% after deductible
Annual Cervical Cancer Screening		100%	60% after deductible
Prostate Cancer Screening		100%	60% after deductible
Immunizations (to age 6)		100%	60% after deductible
Medical Equipment			
Durable Medical Equipment,		80% after deductible	60% after deductible
Prosthetic & Orthotic Appliances		80% after deductible	60% after deductible
Therapeutic Services [8]			
Therapy (Limited to 30-36 visits per year per therapy type)		80% after deductible	60% after deductible
Chiropractic (Limited to \$750 including acupuncture)		\$35 copay	60% after deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3]			
Limited to 60 days combined		80% after deductible	60% after deductible
Home Health Services [9]			
Limited to 60 visits per year		80% after deductible	60% after deductible
Hospice Services [9]		100%	60% after deductible
Ambulance Service		\$50 copay	\$50 copay

Notes:

- HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.
- 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.
- 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.
- Surgeries include invasive diagnostic procedures such as colonoscopy and sigmoidoscopy.
- CAT scans, MRIs, nuclear medicine and other similar technologies.
- Includes services such as chemotherapy, radiation therapy, and renal dialysis.
- Copayments are waived if patient is admitted to the hospital
- 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.
- Requires prior approval.
- Refer to www.bcbst.com for Specialty Pharmacy Drug List