

**2007 Summary of Benefits - Medical Plan 1**  
**BlueCross BlueShield of Tennessee**

**Erlanger Health System**

	<b>Erlanger Hospitals</b>	<b>BCBS Network Providers</b>	<b>Non BCBS Network Providers[2]</b>
<b>Annual Deductible</b>			
Individual	\$1,000	\$1,000	\$2,000
Family	\$2,000	\$2,000	\$4,000
<b>Annual Out-of-Pocket Maximum Amount (includes the ded)</b>			
Individual	\$4,000	\$4,000	\$12,000
Family	\$8,000	\$8,000	\$24,000
<b>Lifetime Maximum Benefit</b>	Unlimited		\$2,000,000
<b>Pre-Existing Waiting Period [1]</b>	12 months		
<b>Services Received at a Facility (includes facility charges only)</b>	<b>Erlanger Hospitals</b>	<b>BCBS Providers</b>	<b>Non BCBS Providers</b>
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]	80% after deductible	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	\$150	\$150
Emergency Room Non-Routine Diagnostics [5]	80% after deductible	70% after deductible	60% after deductible
<b>Physician Services</b>		<b>BCBS Providers</b>	<b>Non BCBS Providers</b>
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
<b>Preventive Health Care Services</b>			
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
<b>Medical Equipment</b>			
Durable Medical Equipment, Prosthetic & Orthotic Appliances		80% after deductible	60% after deductible
<b>Therapeutic Services [8]</b>			
Therapy (Limited to 30-36 visits per year per therapy type)		\$35 Copay	60% after deductible
<b>Skilled Nursing Facility &amp; Rehabilitation Facility Services [3]</b>			
Limited to 60 days combined		80% after deductible	60% after deductible
<b>Home Health Services [9]</b>			
Limited to 60 visits per year		80% after deductible	60% after deductible
<b>Hospice Services [9]</b>		100%	60% after deductible
<b>Ambulance Service</b>		\$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](http://www.bcbst.com) for Specialty Pharmacy Drug List