BlueCross BlueShield of Minnesota
An independent licensee of the Blue Cross and Blue Shield Association

$1,200 CDHP 2016

The Minnesota Service Cooperatives

THIS IS ONLY A SUMMARY AND IS SUBJECT TO THE TERMS OF THE CONTRACT**

	In Network	Out of Network
Year Deductible	$1,200 Single $2,400 Family- Embedded Fourth Quarter carryover	
Year Out-of-Pocket Maximum The in and out-of-network maximums Cross apply Non-covered charges and charges in excess of our allowed amount do not apply to the out-of-pocket maximum.	Medical and Prescription $1,200 Single $2,400 Family	Medical and Prescription $3,500 Single $6,500 Family
Coinsurance	100%	80%
Benefit Payment Levels	Payment for Participating Network Providers as described. Most payments are based on allowed amount.	If non-participating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Lifetime Maximum per Person	Unlimited.	
Dependent Child Age Limit	To age 26, through the calendar month of the birthday.	

COVERED CHARGES

Preventive Care		
• Well Child Care through age 5 • Prenatal Care	100%	100%
• Routine Physicals ages 6 and older • Office Visits • Cancer Screening • Routine Hearing and Vision Exams • Immunizations and Vaccinations	100%	Deductible then 80% coinsurance.
Physician Services		
• In-Hospital Medical Visits • Surgery and Anesthesia • Inpatient Lab and X-rays, etc.	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Office Visits due to Illness or Injury • Urgent Care (Clinic Based)	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Outpatient Lab and X-ray	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Allergy Injections and Serum	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
Other Professional Services		
• Chiropractic Care	Deductible then 100% coinsurance.	Deductible then 80% coinsurance
• Home Health Care	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Physical Therapy, Occupational Therapy, Speech Therapy	Deductible then 100% coinsurance.	Deductible then 80% coinsurance

	In Network	Out of Network
Inpatient Hospital Services 365 days of medically necessary care in an average semi-private room.	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
Outpatient Hospital Services		
• Diagnostic Tests • Pre-Admission Tests and Exams • Lab and X-Ray	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Chemotherapy and Radiation Therapy • Physical, Occupational and Speech Therapy • Kidney Dialysis • Scheduled Outpatient Surgery • Non-emergency – Illness Related visits	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Urgent Care (Hospital based)	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
Emergency Care		
• Emergency Room	Deductible then 100% coinsurance.	
• Physician Services	Deductible then 100% coinsurance.	
Ambulance *Medically necessary transport to nearest facility*	Deductible then 100% coinsurance.	
Medical Supplies	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
Behavioral Health Care (Mental Health and Chemical Dependency Care)		
• Inpatient Care	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Outpatient Care	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
• Professional Care	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
Prescription Drugs		
Retail – 31 day limit Flex RX Formulary	Deductible then 100% coinsurance No coverage for prescriptions not on our Preferred list. If generic is available and name brand selected patient pays the difference.	
90dayRx – 90 day limit *(PrimeMail and Participating Retail Pharmacies)*	Deductible then 100% coinsurance No coverage for prescriptions not on our Preferred list. If generic is available and name brand selected patient pays the difference.	

Deductible amounts and out-of-pocket maximums may increase annually to keep pace with inflation.

******This is only an outline of plan benefits. The contract and certificate include complete details of what is and isn't covered. Services not covered include items primarily used for non-medical purposes, over-the-counter drugs/nutritional supplements, services that are complementary, experimental, not medically necessary, or covered by workers' compensation or no-fault auto insurance. We feature a large network of health care providers. Each provider is an independent contractor and is not our agent. Nonparticipating providers do not have contracts with Blue Cross and Blue Shield of Minnesota. Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association.

Administered by Blue Cross and Blue Shield of Minnesota, a nonprofit independent licensee of the Blue Cross and Blue Shield Association