



Effective Date: 2016

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

	In Network Providers	Out-of-Network Providers
<b>Deductible</b>	\$5,000 Single <b>No fourth quarter carryover, Embedded</b>	\$10,000 Family
<b>Out-of-Pocket Maximum –</b>  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.	<u>Medical and Prescription</u> \$5,000 Single \$10,000 Family	<u>Medical and Prescription</u> \$5,500 Single \$11,000 Family
<b>Coinsurance</b>	100%	80%
<b>Benefit Payment Levels</b>	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.
<b>Lifetime Maximum per Person</b>	Unlimited	
<b>Dependent Child Age Limit</b>	To age 26, through the calendar month of the birthday.	

**COVERED CHARGES**

<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>Well Child Care through age 5</li> <li>Prenatal Care</li> </ul>	100%	100%
<ul style="list-style-type: none"> <li>Routine Physicals ages 6 and older</li> <li>Office Visits</li> <li>Cancer Screening</li> <li>Routine Hearing and Vision Exams</li> <li>Immunizations and Vaccinations</li> </ul>	100%	Deductible then 80% coinsurance.
<b>Physician Services</b>		
<ul style="list-style-type: none"> <li>In-Hospital Medical Visits</li> <li>Surgery and Anesthesia</li> <li>Inpatient Lab and X-rays, etc.</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Office Visits due to Illness or Injury</li> <li>Urgent Care (Clinic Based)</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Outpatient Lab and X-ray</li> <li>Allergy Injections and Serum</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<b>Other Professional Services</b>		
<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	Deductible then 100% coinsurance	Deductible then 80% coinsurance
<ul style="list-style-type: none"> <li>Home Health Care</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Physical Therapy, Occupational Therapy, Speech Therapy</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.

	In Network Providers	Out-of-Network
<b>Inpatient Hospital Services</b> 365 days of medically necessary care in an average semi-private room.	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<b>Outpatient Hospital Services</b>		
<ul style="list-style-type: none"> <li>Diagnostic Tests</li> <li>Pre-Admission Tests and Exams</li> <li>Lab and X-Ray</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Chemotherapy and Radiation Therapy</li> <li>Physical, Occupational and Speech Therapy</li> <li>Kidney Dialysis</li> <li>Scheduled Outpatient Surgery</li> <li>Non-emergency – Illness Related visits</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Urgent Care (Hospital based)</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<b>Emergency Care</b>		
<ul style="list-style-type: none"> <li>Emergency Room</li> </ul>	Deductible then 100% coinsurance.	
<ul style="list-style-type: none"> <li>Physician Services</li> </ul>	Deductible then 100% coinsurance.	Deductible then 100% coinsurance.
Ambulance <i>Medically necessary transport to nearest facility</i>	Deductible then 100% coinsurance.	
Medical Supplies	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<b>Behavioral Health Care (Mental Health and Chemical Dependency Care)</b>		
<ul style="list-style-type: none"> <li>Inpatient Care</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Outpatient Care</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<ul style="list-style-type: none"> <li>Professional Care</li> </ul>	Deductible then 100% coinsurance.	Deductible then 80% coinsurance.
<b>Prescription Drugs</b>		
Retail – 31 day limit GenRX Formulary	Deductible then 100% coinsurance.  No coverage for prescriptions not on our Preferred list. If generic is available and name brand is selected patient pays the difference.	
90dayRx – 90 day limit <i>(PrimeMail and Participating Retail Pharmacies)</i>	Deductible then 100% coinsurance.  No coverage for prescriptions not on our Preferred list. If generic is available and name brand is selected patient pays the difference.	

The deductible and/or out-of-pocket maximum levels may need to be increased annually as FEDERAL INTERNAL REVENUE SERVICE requirements on Health Savings Account are updated.

\*\*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.

850 calendar year / 855 plan year