



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

	In Network	Out of Network
Deductible	\$600 Single \$1,200 Family- Embedded Fourth Quarter carryover	
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.	<u>Medical and Prescription</u> \$2,100 Single \$4,200 Family	
Coinsurance	70%	60%
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		
<ul style="list-style-type: none"> Well Child Care through age 5 Prenatal Care 	100%	100%
<ul style="list-style-type: none"> Routine Physicals ages 6 and older Office Visits Cancer Screening Routine Hearing and Vision Exams Immunizations and Vaccinations 	100%	Deductible then 60% coinsurance
Physician Services		
<ul style="list-style-type: none"> In-Hospital Medical Visits Surgery and Anesthesia Inpatient Lab and X-rays, etc. 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Office Visits due to Illness or Injury Urgent Care (Clinic Based) 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Outpatient Lab and X-ray Allergy Injections and Serum 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
Other Professional Services		
<ul style="list-style-type: none"> Chiropractic Care 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Home Health Care 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Physical Therapy, Occupational Therapy, Speech Therapy 	Deductible then 70% coinsurance	Deductible then 60% coinsurance

	In Network	Out of Network
Inpatient Hospital Services 365 days of medically necessary care in an average semi-private room.	Deductible then 70% coinsurance	Deductible then 60% coinsurance
Outpatient Hospital Services		
<ul style="list-style-type: none"> Diagnostic Tests Pre-Admission Tests and Exams Lab and X-Ray 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Chemotherapy and Radiation Therapy Physical, Occupational and Speech Therapy Kidney Dialysis Scheduled Outpatient Surgery Non-emergency – Illness Related visits 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Urgent Care (Hospital based) 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
Emergency Care		
<ul style="list-style-type: none"> Emergency Room 	Deductible then 70% coinsurance	
<ul style="list-style-type: none"> Physician Services 	Deductible then 70% coinsurance	
Ambulance <i>Medically necessary transport to nearest facility</i>	Deductible then 70% coinsurance	
Medical Supplies	Deductible then 70% coinsurance	Deductible then 60% coinsurance
Behavioral Health Care (Mental Health and Chemical Dependency Care)		
<ul style="list-style-type: none"> Inpatient Care 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Outpatient Care 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
<ul style="list-style-type: none"> Professional Care 	Deductible then 70% coinsurance	Deductible then 60% coinsurance
Prescription Drugs		
Retail – 31 day limit	Deductible then 70% coinsurance	
Flex RX Formulary	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 <i>(PrimeMail and Participating Retail Pharmacies)</i>	Deductible then 70% 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