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

West Central Ed District

$500 Deductible with $25 copay

Effective Date: 10/1/2016

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

	IN - NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Calendar Year Deductible	$500 Single $1,000 Family	
Calendar Year Out-of-Pocket Maximum The in and out-of-network maximums accumulate separately. Non-covered charges and charges in excess of our allowed amount do not apply to the out-of-pocket maximum.	Medical $1,800 Single $5,000 Family Prescription $750 Single $1,500 Family	Medical $2,700 per person
Coinsurance	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
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 60% coinsurance.
Physician Services		
• In-Hospital Medical Visits • Surgery and Anesthesia • Inpatient Lab and X-rays, etc.	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Office Visits due to Illness or Injury • Urgent Care (Clinic Based)	100% after $25 copay.	Deductible then 60% coinsurance.
• Retail Health Clinic	100%, no copay	Deductible then 60% coinsurance.
• Outpatient Lab and X-ray	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Allergy Injections and Serum	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
Other Professional Services		
• Chiropractic Care	100% after $25 copay for office visits. All other services subject to deductible then 80% coinsurance.	Deductible then 60% with extended network providers. No coverage with nonparticipating providers.
• Home Health Care	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Physical Therapy, Occupational Therapy, Speech Therapy	100% after $25 copay for office visits. All other services subject to deductible then 80% coinsurance.	Deductible then 60% coinsurance.

	IN - NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Inpatient Hospital Services 365 days of medically necessary care in an average semi-private room.	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
Outpatient Hospital Services		
• Diagnostic Tests • Pre-Admission Tests and Exams • Lab and X-Ray	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Chemotherapy and Radiation Therapy • Physical, Occupational and Speech Therapy • Kidney Dialysis • Scheduled Outpatient Surgery • Non-emergency ï Illness Related visits	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Urgent Care (Hospital based)	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
Emergency Care		
• Emergency Room	100% after $100 copay.	
• Physician Services	Deductible then 80% coinsurance.	Deductible then 80% coinsurance.
Ambulance *Medically necessary transport to nearest facility*	80%	
Medical Supplies	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
Behavioral Health Care (Mental Health and Chemical Dependency Care)		
• Inpatient Care	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Outpatient Care	Deductible then 80% coinsurance.	Deductible then 60% coinsurance.
• Professional Care	100% after $25 copay for office visits. All other services subject to deductible then 80% coinsurance.	Deductible then 60% coinsurance.
Prescription Drugs		
Retail ï 31 day limit GEN RX	$9 Preferred Generic $40 Preferred Brand $90 Non-preferred Patient will pay difference if brand name is selected when a generic is available. Specialty Drugs: 20% coinsurance to a maximum of $200.	
90dayRx ï 90 day limit *(PrimeMail and Participating Retail Pharmacies)*	$18 Preferred Generic $80 Preferred Brand $180 Non-preferred Patient will pay difference if brand name is selected when a generic is available.	

**This is only an outline of plan benefits. The contract and certificate include complete details of what is and isnôt 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 workersôcompensation 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.