Plan Highlights

BlueCross BlueShield Minnesota

BLUEBASIC $2,200/$4,400 deductible and 20% coinsurance

For individuals and families

Consumer Value® network

Your costs	In Consumer Value network	Out of network
Your deductible What you pay for covered health care services each calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply to the in-network deductible.	$2,200 per person $4,400 per family	$10,000 per person $20,000 per family
Your coinsurance The percent you pay for your covered health care services after you meet your deductible.	20%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply to the in-network out-of-pocket maximum.	$5,650 per person $11,300 per family	unlimited
Key benefits Includes care for mental health and substance abuse	**You pay**	
	In Consumer Value network	Out of network
Preventive care/tests	0% (no deductible)	50% after deductible is met
Prenatal and well-child care	0% (no deductible)	0% (no deductible)
Prescription drugs GenRx with open formulary	• Preferred generic: $10 copay • Preferred brand: $50 copay • Non-preferred: $90 copay • Specialty drugs: 20% to a maximum of $200 per prescription	• Preferred generic: $10 copay • Preferred brand: $50 copay • Non-preferred: $90 copay • Specialty drugs: No coverage
Visits to • Health care provider's office, retail health clinic or urgent care clinic • Specialist	• $45 copay • $65 copay	50% after deductible is met
Chiropractic, physical, occupational and speech therapy	20% after deductible is met	50% after deductible is met
Online Care Anywhere® e-visit	Two free visits, then $45 copay	50% after deductible is met
Emergency care	20% after deductible is met	20% after deductible is met

Key benefits Includes care for mental health and substance abuse	You pay	
	In Consumer Value network	Out of network
Maternity	20% after deductible is met	50% after deductible is met
Hospital visit (outpatient) • Facility • Physician	20% after deductible is met	50% after deductible is met
Hospital stay (inpatient) • Facility • Physician	20% after deductible is met	50% after deductible is met
Diagnostic tests (X-rays, blood work)	20% after deductible is met	50% after deductible is met
Imaging tests (for example, MRIs, CT or CAT scans, PET scans)	20% after deductible is met	50% after deductible is met
Eyewear for children for one pair of lenses and one pair of frames for members age 18 and under	20% after deductible is met	50% after deductible is met
Dental for children For members age 18 and under as required by health care reform.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.

For January 1, 2014, to December 31, 2014. **(AAE9)**

Your out-of-pocket costs for most services depend on the network status of your health care provider. To check provider status, use the "Find a doctor" web tool on **bluecrossmn.com**.
Lowest out-of-pocket costs: in-network providers
Higher out-of-pocket costs: out-of-network participating providers
Highest out-of-pocket costs: out-of-network **nonparticipating** providers

If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the DIFFERENCE between what Blue Cross would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket maximum. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on Blue Cross' allowed amount, which is typically lower than the amount billed by the provider.

This is only a summary. Your contract will provide a detailed description of what is and is not covered. Services not covered include custodial care or rest cures, bariatric surgery, infertility, adult eyewear, adult dental services, services that are experimental, not medically necessary or received while on military duty and certain services for the treatment of autism.

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-5040** (voice), or **1-800-711-9875** (toll free).

For (TTY) call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

Hours: 8 a.m. to 5 p.m., Central Time, Monday through Thursday; 9 a.m. to 5 p.m. Central Time, Friday.

Attention. If you want free help translating this information, call the above number.
Atencion. Si desea recibir asistencia gratuita para traduca esta informacion, llame al numero que aparece mas arriba.

Blue Cross may change premium rates: on an annual renewal date, when you add or delete a dependent, or if you move to a different Blue Cross plan. Factors that may affect changes in premium rates include the age of covered members, where you reside, and whether a member uses tobacco.

To see benefit and premium information about all Blue Cross actively marketed individual health plans available to you, please go to **healthcare.gov**.

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