Simply Blue℠ with Blue Performance℠ (Enhanced or Regional) network

Coverage effective date from 7-1-12 to 12-31-13

Plan highlights apply to plans with the following group numbers:

Drug option 1: YB749,YB750, YB751,YB752,YB753,YB754

Drug option 2: YB758,YB759,YB760, YB761,YB762,YB763

	In network Tier 1	In network Tier 2	Out of network
Calendar-year deductible options Amount you pay toward health care before your plan starts to pay. No member can contribute more than the "per person" amount toward a family deductible. Amounts paid toward the Tier 2 and out-of-network deductible apply to the Tier 1 deductible.	(a) $3,000/person -$6,000/family (b) $6,000/person -$12,000/family (c) $9,000/person -$18,000/family	(a) $4,500/person -$9,000/family (b) $9,000/person -$18,000/family (c) $13,500/person - $27,000/family	(a) $6,000/person -$12,000/family (b) $12,000/person -$24,000/family (c) $18,000/person - $36,000/family
Out-of-pocket maximum After this amount is reached, your plan pays 100% of covered services. Copays and prescription drug coinsurance amounts do not apply to the out-of-pocket maximum. Amounts paid toward the Tier 2 and out-of-network out-of-pocket maximum apply to the Tier 1 out-of-pocket maximum.	(a) $3,000/person -$6,000/family (b) $6,000/person -$12,000/family (c) $9,000/person -$18,000/family	(a) $6,000/person -$12,000/family (b) $12,000/person -$24,000/family (c) $18,000/person - $36,000/family	(a) $9,000/person (b) $18,000/person (c) $27,000/person
Coinsurance Percentage you pay after deductible	You pay 0% after deductible	You pay 20% after deductible	You pay 40% after deductible
Lifetime maximum	Unlimited		
Prescription drugs (GenRx drug list) Pharmacy – RxNetwork A 31-day supply. 90-day supply available through 90dayRx program at participating retail pharmacies or by PrimeMail[1]	**Option 1:** Preferred generic drugs: $10 copay Preferred brand drugs: $50 copay Non-preferred generic and brand drugs: $90 copay **Option 2:** Preferred generic drugs: $10 copay Preferred brand drugs: You pay 100% at Blue Cross discounted rate (deductible does not apply) Non-preferred generic and brand drugs: Not covered		
Physician services • Office visits or retail health clinic visits for illness or injury	You pay (a) $30, (b) $40, or (c) $50 (depending on deductible) copay for first three visits; subsequent visits you pay 0% after deductible	You pay (a) $30, (b) $40, or (c) $50 (depending on deductible) copay for first three visits; subsequent visits you pay 20% after deductible	You pay 40% after deductible
• Urgent care visits	You pay $100 copay first visit; subsequent visits you pay 0% after deductible	You pay $100 copay first visit; subsequent visits you pay 20% after deductible	You pay 40% after deductible
All other professional services in the office	You pay 0% after deductible	You pay 20% after deductible	You pay 40% after deductible
Preventive care	You pay 0% (no deductible)	You pay 20% (no deductible)	Not covered
Prenatal care, well child, immunizations to age 18	You pay 0% (no deductible)		
Emergency care • Outpatient facility services	You pay $250 copay for the first visit; subsequent visits you pay 0% after deductible		
• Outpatient professional services	You pay 0% (no deductible) for the first visit; subsequent visits you pay 0% after deductible		
Inpatient hospital services; inpatient professional; lab and diagnostic imaging/X-ray services	You pay 0% after deductible	You pay 20% after deductible	You pay 40% after deductible (maximum of 45 days per person per calendar year)
Outpatient hospital services; outpatient lab and diagnostic imaging/X-ray services	You pay 0% after deductible	You pay 20% after deductible	You pay 40% after deductible
Ambulance	You pay 0% (no deductible)		
Chiropractic care	You pay 0% after deductible	You pay 20% after deductible	You pay 40% after deductible (maximum of 15 services per person per calendar year)
Physical, occupational, speech therapy	You pay 0% after deductible	You pay 20% after deductible	You pay 40% after deductible (combined maximum of 15 services per person per calendar year)
Home health care (maximum of 180 visits per person per calendar year)	You pay 0% after deductible	You pay 20% after deductible	Not covered
Mental health/substance abuse	Option 1: You pay 0% after deductible Option 2: Not covered	Option 1: You pay 20% after deductible Option 2: Not covered	Option 1: You pay 40% after deductible Option 2: Not covered
Maternity labor, delivery, post-delivery care and maternity complications	Not covered		

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Your out-of-pocket costs depend on the network status of your provider. To check provider status, call Blue Cross and Blue Shield of Minnesota customer service or visit **bluecrossmn.com**.

Lowest out-of-pocket costs: in-network Tier 1 providers
Higher out-of-pocket costs: in-network Tier 2 and out-of-network participating providers
Highest out-of-pocket costs: out-of-network **nonparticipating** providers (You are responsible for the difference between Blue Cross' allowed amount and the amount billed by nonparticipating providers. 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.)

When you choose a network provider you will receive the highest benefit levels and the lowest out-of-pocket costs. 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, intensive behavioral therapy programs for treatment of autism spectrum disorders, eyewear, dental services, services that are experimental, not medically necessary or received while on military duty. Preexisting conditions you had during the six months before your enrollment date are not covered except for individuals under age 19. This limit applies for 12 months. Prior continuous coverage without a gap in coverage greater than 63 days counts toward reducing the 12-month period.

Deductible, copays and out-of-pocket maximums are subject to adjustments at our annual renewal based on Consumer Price Index.

[1]PrimeMail is a mail-service pharmacy owned and operated by Prime Therapeutics LLC, an independent company providing pharmacy benefit management services.

X18649R02 (05/12)