Northfield School District #659
$1,500 Deductible HRA
January 01, 2016

	In network* MN network — Aware National network — BlueCard PPO	Out of network**
Calendar-year deductible The deductibles for all networks cross apply. Deductible carryover applies.	Medical $1,500 single $3,000 family	Medical $1,500 single $3,000 family
Coinsurance	Deductible then 100% coins.	Deductible then 80% coins.
Calendar-year out-of-pocket maximum The out-of-pocket maximums for all networks cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical $1,500 single $3,000 family Prescription: $750 per person; $1000 per family	Medical $3,500 single $6,000 family Prescription: $750 per person; $1000 per family
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care		
• well-child care to age 6	100%	100%
• prenatal care	100%	100%
• preventive medical evaluations age 6 and older	100%	100%
• cancer screening	100%	100%
• preventive hearing and vision exams	100%	100%
• immunizations and vaccinations	100%	100%
Physician services		
• in-hospital medical visits	Deductible then 100% coins.	Deductible then 80% coins.
• surgery and anesthesia	Deductible then 100% coins.	Deductible then 80% coins.
• professional lab services	Deductible then 100% coins.	Deductible then 80% coins.
• office visits due to illness or injury	Deductible then 100% coins.	Deductible then 80% coins.
• urgent care (clinic-based)	Deductible then 100% coins.	Deductible then 80% coins.
• retail health clinic	100%	100%
• professional diagnostic imaging	Deductible then 100% coins.	Deductible then 80% coins.
• allergy injections and serum	Deductible then 100% coins.	Deductible then 80% coins.
Other professional services		
• chiropractic manipulation	Deductible then 100% coins.	Deductible then 80% coins.
• chiropractic therapy	Deductible then 100% coins.	Deductible then 80% coins.
• home health care	Deductible then 100% coins.	Deductible then 80% coins.
• physical therapy, occupational therapy, speech therapy	Deductible then 100% coins.	Deductible then 80% coins.
Inpatient hospital services	Deductible then 100% coins.	Deductible then 80% coins.
Outpatient hospital services		
• facility diagnostic imaging	Deductible then 100% coins.	Deductible then 80% coins.
• facility lab services	Deductible then 100% coins.	Deductible then 80% coins.
• chemotherapy and radiation therapy	Deductible then 100% coins.	Deductible then 80% coins.
• physical, occupational and speech therapy	Deductible then 100% coins.	Deductible then 80% coins.
• scheduled outpatient surgery	Deductible then 100% coins.	Deductible then 80% coins.
• urgent care (hospital-based)	Deductible then 100% coins.	Deductible then 100% coins.
Emergency care		
• emergency room	Deductible then 100% coins.	
• physician charges	Deductible then 100% coins.	
• ambulance (medically necessary transport to the nearest facility equipped to treat condition)	Deductible then 100% coins.	
Medical supplies	Deductible then 100% coins.	Deductible then 80% coins.

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Behavioral health (mental health and chemical dependency care)		
• inpatient care	Deductible then 100% coins.	Deductible then 80% coins.
• outpatient care	Deductible then 100% coins.	Deductible then 80% coins.
• professional care	Deductible then 100% coins.	Deductible then 80% coins.
Prescription Drugs • **retail** (31-day limit) **FlexRx preferred drug list**		
• closed plan design		
• preferred generic	$20 copay	$20 copay or 40% whichever is greater
• preferred brand	$20 copay	$20 copay or 40% whichever is greater
• non-preferred	No Coverage	No Coverage
• **90dayRx – Mail order pharmacy** (90-day limit) FlexRx preferred drug list		
• closed plan design		
• preferred generic	$40 copay	No coverage
• preferred brand	$40 copay	No coverage
• non-preferred	No Coverage	No coverage
• **90dayRx – Retail pharmacy** (90-day limit) FlexRx preferred drug list		
• closed plan design		
• preferred generic	$40 copay	No coverage
• preferred brand	$40 copay	No coverage
• non-preferred	No Coverage	No coverage
	90dayRx applies to participating and/or mail service pharmacy. Identified specialty drugs purchased through a specialty pharmacy network supplier are eligible for coverage (no coverage for specialty drugs purchased through a nonparticipating specialty pharmacy supplier). The patient will pay the difference if a brand-name drug is selected when a generic drug is available. The drug list uses a step therapy program. Visit the prescription drugs section of **www.bluecrossmn.com** for more details.	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **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 (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.)

This is only a summary. Read your Certificate of Coverage for more information about what is and isn't covered. Services that aren't covered include those that are cosmetic, investigative, not medically necessary or covered by workers' compensation or non-fault insurance.