

**Comparison of Plan Benefits
For
Hennepin County Medical Center Resident Physicians Group**

Effective July 1, 2009

AWARE Gold Plan

Comprehensive Major Medical

Service	BlueCross Participating Providers	Nonparticipating providers	Licensed health care professional
Provider Networks To find participating providers: 1. Go to the Provider Finder at www.bluecrossmn.com 2. Call the BlueCross Customer Service Specialists at 651-662-5001 or 1-800-531-6676.	When services are provided by a participating provider, the provider will file claims directly to BCBSM on your behalf and has agreed to the allowed amount payment as payment in full, less your deductible or copay.	You still receive benefits when you use an out of network provider, however you may be responsible for filing your own claims and payment to the provider. Any difference between the billed charge and the allowed amount allowance is your responsibility.	When services are provided by a participating provider, the provider will file claims directly to BCBSM on your behalf and has agreed to the allowed amount payment as payment in full, less your deductible or copay. You still receive benefits when you use an out of network provider, however you may be responsible for filing your own claims and payment to the provider. Any difference between the billed charge and the allowed amount allowance is your responsibility.
Eligible Dependents	Spouse and unmarried dependent children to age 19, students to age 25.		Spouse and unmarried dependent children to age 19, students to age 25.
Individual Lifetime Maximum	\$5,000,000 per person		\$5,000,000 per person
Deductible	<u>Hospital Only</u> \$200 Individual \$600 Family	<u>Physician</u> <u>Hospital</u> \$200 Individual \$200 Individual \$600 Family \$600 Family	\$400 Individual \$1,200 Family
Coinsurance (Amount you pay after your deductible is satisfied)	20% of eligible medical charges for in hospital medical stays	20% of eligible charges after the deductible.	20% of eligible charges
Annual Out of Pocket Maximum (Includes the deductible, office call copays and coinsurance -- Does not include prescription copays, non-covered charges or amounts over the allowed amount.)	\$2,500 per person per calendar year. Combined for both networks	\$2,500 per person per calendar year. Combined for both networks Allowed amount limitations apply.	\$2,000 Individual \$4,000 Family Allowed amount limitations apply when nonparticipating providers are used.

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Physician Office Visits for illness or injuries (office visits, lab, x-ray and in office surgery)	\$25.00 copay per visit; 100% thereafter.	After the deductible, 80% coverage of the first \$3,000; 100% coverage thereafter. Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.
Routine/Preventive Care (routine physical, routine eye exams, lab, x-rays, immunizations, vaccinations, cancer screening tests) Prenatal care, well-child care	No copay, 100% coverage. No copay, 100% coverage.	After the deductible, 80% coverage of the first \$3,000; 100% coverage thereafter. Allowed amount limitations apply.	No deductible, 100% coverage up to a maximum of \$500.00 per person per calendar year. No coverage thereafter. No deductible, 100% coverage. Allowed amount limitations apply when nonparticipating providers are used.
Physician services for surgery, anesthesia, obstetrics and in-hospital medical visits	100% coverage	After the deductible, 80% coverage of the first \$3,000; 100% coverage thereafter. Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.
Inpatient Hospital Services (room and board, lab tests, x-rays, medication and medical supplies)	After the deductible, 80% coverage of the first \$2,000; 100% thereafter.	After the deductible, 80% coverage of the first \$2,000; 100% thereafter. Allowed amount limitations apply. <i>Preadmission Notification Required or you may be responsible for an additional portion of the bill.</i>	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used. <i>Preadmission Notification Required at nonparticipating providers or you may be responsible for an additional portion of the bill.</i>
Outpatient Hospital Services (Lab tests, x-rays, kidney dialysis, radiation or chemotherapy, physical therapy, surgery)	100% coverage	100% coverage Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.
Ambulance (transport to the nearest qualified facility to treat the condition)	80% coverage	80% coverage Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.
Home Health Care <i>Coverage provided up to a maximum benefit of \$25,000 per calendar year.</i>	100% coverage	100% coverage Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.

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Durable Medical Equipment/ Medical Supplies (casts, splints, wheelchair, hearing aid coverage for 18 or younger due to congenital malformation of the ears not correctable by other covered procedures and limited to 1 per ear every three years.)	80% coverage	80% coverage	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.
Emergency Room Services	\$75 copay; 100% coverage thereafter.	\$75 copay per visit; 100% coverage thereafter. Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.
Chiropractic Care and Physical Therapy <i>When a nonparticipating provider is used, coverage is provided up to a maximum benefit of \$500 per calendar year.</i>	\$25.00 copay per visit; 100% coverage thereafter.	After the deductible, 80% coverage of the first \$3,000; 100% coverage thereafter. Allowed amount limitations apply.	After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.

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<p>Prescription Drugs You pay your copay at time of purchase. Copay applies to:</p> <ul style="list-style-type: none"> • 31 day supply • insulin and diabetic supplies 	<p>\$15.00 copayment for formulary generic drugs \$30.00 copayment for formulary brand name drugs \$45.00 copayment for nonformulary drugs</p> <p>90-day RX program available through mail order and select retail pharmacies. Copays for a 90 day supply are: \$30.00 copayment for formulary generic drugs \$60.00 copayment for formulary brand name drugs \$90.00 copayment for nonformulary drugs</p> <p><i>If you elect a brand name drug when there is a generic equivalent available, you will pay the copay plus the difference in cost between the generic and brand name.</i></p> <p>Out of pocket maximum is \$500.00 per person</p>	<p>\$15.00 copayment for formulary generic drugs \$30.00 copayment for formulary brand name drugs \$45.00 copayment for nonformulary drugs</p> <p>90-day RX program available through mail order or select retail pharmacies. Copays for a 90 day supply are: \$30.00 copayment for formulary generic drugs \$60.00 copayment for formulary brand name drugs \$90.00 copayment for nonformulary drugs</p> <p><i>If you elect a brand name drug when there is a generic equivalent available, you will pay the copay plus the difference in cost between the generic and brand name.</i></p> <p>Out of pocket maximum is \$750.00 per person, \$1,000 per family</p>	<p>\$15.00 copayment for formulary generic drugs \$30.00 copayment for formulary brand name drugs \$45.00 copayment for nonformulary drugs</p> <p>90-day RX program available through mail order or select retail pharmacies. Copays for a 90 day supply are: \$30.00 copayment for formulary generic drugs \$60.00 copayment for formulary brand name drugs \$90.00 copayment for nonformulary drugs</p> <p><i>If you elect a brand name drug when there is a generic equivalent available, you will pay the copay plus the difference in cost between the generic and brand name.</i></p> <p>Out of pocket maximum is \$750.00 per person, \$1,000 per family</p>
<p>Inpatient Mental Health and Chemical Dependency Care</p>	<p>After the deductible, 80% coverage of the first \$2,000; 100% thereafter.</p>	<p>After the deductible, 80% coverage of the first \$2,000; 100% thereafter. Allowed amount limitations apply. <i>Preadmission Notification Required or you may be responsible for an additional portion of the bill.</i></p>	<p><i>After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter.</i> Allowed amount limitations apply when nonparticipating providers are used. <i>Preadmission Notification Required at nonparticipating providers or you may be responsible for an additional portion of the bill</i></p>
<p>Outpatient Mental Health Care</p>	<p>\$25.00 copay per visit; 100% coverage thereafter</p>	<p>After the deductible, 80% coverage of the first \$3,000; 100% coverage thereafter. Allowed amount limitations apply.</p>	<p>After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.</p>
<p>Outpatient Chemical Dependency Care</p>	<p>\$25.00 copay per visit, 100% coverage thereafter.</p>	<p>After the deductible, 80% coverage of the first \$3,000; 100% coverage thereafter. Allowed amount limitations apply.</p>	<p>After the deductible, 80% coverage up to the out of pocket maximum; 100% coverage thereafter. Allowed amount limitations apply when nonparticipating providers are used.</p>

Preadmission Information

To obtain preadmission notification for inpatient admissions or home health care, call 1-800-382-2000, extension 5270. If you do not obtain preadmission notification for an inpatient admission any benefits related to the services provided would be subject to an additional copayment.

Questions?

For questions or concerns with your benefits or a claim, please contact the Blue Cross Blue Shield of Minnesota (BCBSM) Customer Service Specialists at:

651-662-5001

Or

1-800-531-6676

Prescription Drug/ Network Information

Your prescription drug coverage is through Prime Therapeutics, Inc. and their National network. To locate participating pharmacies call Toll free 1-800-509-0545.

Health care information is available online, anytime... Our online service center is designed to give you around-the-clock access to claims, online customer service, information about member health programs and more. Everything you need is just a click away:

- **Keep track of your claims**
- **Find the care that's right for you**
- **Find out about your health plan**
- **Use the Wellness Center**

Go to www.bluecrossmn.com/servicecenter to register!

This summary is intended as a guide to the coverage provided, for a complete description of the benefits, please refer to your Certificate of Coverage. In the case of a discrepancy, the Certificate of Coverage will prevail.

Contributions – Resident	CMM	Aware Gold
Single	\$34.20	\$96.90
Family	\$393.58	\$575.14