

## 2012 Summary of Plan Benefits Comparison For Concordia College

Service	Lower Deductible	Higher Deductible
<b>Eligible Dependents</b>	Spouse and dependent children to age 26.	Spouse and dependent children to age 26.
<b>Individual Lifetime Maximum</b>	Unlimited	Unlimited
<b>Deductible</b>	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 Family
<b>Medical Out of Pocket Maximum</b> (Includes the medical deductible and coinsurance – (Does not include copays, medical or prescription and any ineligible charges or charges over the allowed amount).	\$3,000 Individual \$6,000 Family	\$3,500 Individual \$7,000 Family
<b>Routine/Preventive Care</b> Routine Physicals, age 6 and older, office visits, lab, x-rays, immunizations, routine vision or hearing exam)  Well Baby Care up to age 6, Prenatal Care	100%  100%	100%  100%
<b>Physician services</b> Office Visits due to Illness and Injury, and Cancer Screening.  All other services in the office	100% after a \$30 copay.  100%	100% after a \$35 copay.  100%
<b>Urgent Care Facility</b>	100% after a \$30 copay.	100% after a \$35 copay.
<b>Inpatient Hospital</b> (room and board, lab tests, x-rays, medication and medical supplies)  <b>Inpatient Hospital Physician</b>	After the deductible, 80% coverage to the out of pocket maximum; then 100% **\$250 Penalty if not pre-authorized.  100%	After the deductible, 75% coverage to the out of pocket maximum; then 100% **\$250 Penalty if not pre-authorized.  100%
<b>Outpatient Hospital Facility</b> (Lab tests, x-rays, surgery, kidney dialysis, radiation or chemotherapy, physical therapy, surgery)  <b>Outpatient Hospital Physician</b>	After the deductible, 80% coverage to the out of pocket maximum; then 100%  100%	After the deductible, 75% coverage to the out of pocket maximum; then 100%  100%
<b>Emergency Room Services</b> Emergency Room  Physician Services	100% after a \$100 copay. Copay will be waived if admitted within 24 hours.  100%	100% after a \$100 copay. Copay will be waived if admitted within 24 hours.  100%
<b>Chiropractic Care</b>	100% after a \$30 copay.	100% after a \$35 copay.
<b>Home Health Care</b>	100% coverage.	100% coverage.

<b>Service</b>	<b>\$500 CMM Plan Benefit</b>	<b>\$1,000 CMM Plan Benefit</b>
<b>Prescription Drugs</b> Retail <ul style="list-style-type: none"> <li>31-day supply</li> <li>a 3-cycle supply of oral contraceptives</li> </ul> Mail Order – 90 Day Supply	\$8 generic, \$30 Formulary Brand, \$50 Non-Formulary Brand.  \$16 generic, \$60 Formulary Brand, \$100 Non-Formulary Brand.	\$10 generic, \$40 Formulary Brand, \$60 Non-Formulary Brand.  \$20 generic, \$80 Formulary Brand, \$120 Non-Formulary Brand.
<b>Mental Health &amp; Chemical Dependency Care</b> Inpatient Care  Outpatient Facility Care	After the deductible, 80% coverage to the out of pocket maximum; then 100%  100%	After the deductible, 75% coverage to the out of pocket maximum; then 100%  100%
<b>Mental Health and Chemical Dependency</b> Outpatient Professional Care	100% after a \$30 copay.	100% after a \$35 copay.
<b>PT/OT/ST</b> Inpatient & Outpatient Hospital & Physician Services  Professional Care at a Clinic	After the deductible, 80% coverage to the out of pocket maximum; then 100%.  100% after a \$30 copay.	After the deductible, 75% coverage to the out of pocket maximum; then 100%.  100% after a \$35 copay.
<b>Ambulance</b> Transportation to the nearest qualified facility to treat the condition.	100%	100%
<b>Medical Supplies</b> (Wheelchairs, splints, casts, etc.)	100%	100%

### 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:

**651-662-5004**  
or  
**1-866-870-0348**

### Prescription Drug/ Network Information

Your prescription drug coverage is through Prime Therapeutics, Inc. and their Select Net Network. To locate participating pharmacies call toll free 1-800-509-0545.

Please note you still have coverage when using a Non-participating providers, except you will be responsible for any charges that exceed the usual and customary amount/allowed

**This summary is intended as a guide to the coverage provided, for a complete description of the benefits, please refer to your Summary Plan Description. If there is a discrepancy between this Summary and the Summary Plan Description the Summary Plan Description is correct.**