# Classic Blue

An overview of benefits and services provided by this plan.

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CB Proposal
RW13

## This benefit plan covers these services and more.

### Who is eligible for benefits?

If you have family coverage, benefits are available for you, your spouse and eligible children. If you have single plus dependent coverage, you and your eligible children are covered. Eligible children include:

- Children under age 26. Coverage will be continued until the end of the month in which the child becomes age 26.
- Children placed with you or your covered spouse for adoption, or children which you or your covered spouse have legal guardianship or are court ordered to provide health benefits.
- Grandchildren of yours or your covered spouse if:
  - The parent of the grandchild is unmarried.
  - The parent of the grandchild is a covered eligible dependent.
  - The parent and grandchild are primarily dependent on you or your covered spouse for their support.
- Children incapable of self-support because of mental retardation or a physical handicap that began before they reached 26 years of age and who are primarily dependent on you or your covered spouse.

### Outpatient prescription drug benefits.

Benefits are available nationwide at any pharmacy participating in the preferred pharmacy network. To locate a participating pharmacy, call the special toll-free number listed on the back of your ID card. When you use this national network, your claims are filed for you.

Prescription drugs are categorized as formulary, nonformulary, nonpayable or restricted-use drugs. A restricted-use drug may have a dispensing limit and/or require prior approval.

When a generic drug is available but not accepted, the member is responsible for the difference between the cost of the generic and brand name drug. Prescriptions filled at a nonparticipating pharmacy must be paid in full and a paper claim submitted. All costs above the allowance are the member's responsibility.

### Preventive screening services.

Well child care for members to the member's 6th birthday according to guidelines supported by the Health Resources and Services Administration.

Preventive screening services for members age 6 and older according to A or B Recommendations of the U.S. Preventive Services Task Force and issued by the Health Resources and Services Administration, including:

- Routine physical examination
- Routine diagnostic screenings
- Mammography screening (for members age 35 and older)
- Cervical cancer screening
- Colorectal cancer screening (for members age 50 through 75)
  - Fecal occult blood testing and
  - Colonoscopy or
  - Sigmoidoscopy
- Certain nutritional counseling
- Tobacco cessation services

Benefits other than those recommended by the U. S. Preventive Services Task Force will be subject to cost sharing amounts. Refer to the benefit plan for further details.

A health care provider will counsel members as to how often preventive services are needed based on the age, gender and medical status of the member.

*This benefit grid presents a brief overview of covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written benefit plan governs the benefits available.*

| Description of Benefits | Copayment | Benefit Amount with a participating BCBSND provider | | Special Conditions |
|---|---|---|---|---|
| | | Amounts are a % of the allowed charge after the deductible is met. | | |
| | Amount you pay per visit | Before out-of-pocket maximum is met | After out-of-pocket maximum is met | |
| **Inpatient Hospital Services** | | 90% | 100% | Preauthorization may be required. |
| **Outpatient Hospital Services** | | 90% | 100% | |
| Physical Therapy | $20 | 80% | 100% | Benefits are based on the medical guidelines established by Blue Cross Blue Shield of North Dakota. Deductible does not apply. |
| Occupational & Speech Therapy | $20 | 80% | 100% | Benefits are available for 90 consecutive calendar days per condition beginning on the date of the 1st therapy treatment for the condition. Additional benefits may be allowed after the 90 days when medically appropriate and necessary. Deductible does not apply. |
| **Professional Health Care Provider Services** | | | | |
| Inpatient, Outpatient & Surgical Services | | 90% | 100% | |
| **Wellness Services** | | | | |
| Immunizations | | 100% | 100% | Deductible does not apply. |
| Well Child Care *(to member's 6th birthday)* | | 100% | 100% | Deductible does not apply. |
| Preventive Screening Services *(members 6 and older)* | | 100% | 100% | Benefits other than those recommended by the U.S. Preventive Services Task Force and issued by the Health Resources and Services Administration will be subject to cost sharing amounts. The number of visits for these services may vary by age group. Refer to the benefit plan for details. Deductible does not apply. |
| Colonoscopy or Sigmoidoscopy | | 100% | 100% | |
| Mammography, Pap Smear & Fecal Occult Blood Testing | | 100% | 100% | Deductible does not apply. |
| Tobacco Cessation Services | | 100% | 100% | Prescription and payable over-the-counter tobacco cessation medications or drugs must be obtained with a prescription order. Deductible does not apply. |
| Related Office Visit | | 100% | 100% | Deductible does not apply. |
| **Contraceptive Services** | | 100% | 100% | Prescription contraceptives obtainable with a prescription order are paid under the Outpatient Prescription Medications or Drugs benefit below. Deductible does not apply. |
| Related Office Visit | | 100% | 100% | Deductible does not apply. |
| **Home & Office Visits** | $25 | 90% | 100% | Deductible does not apply. |
| **Diagnostic Services** | | | | |
| Lab, X-ray, MRI | | 90% | 100% | |
| Allergy Testing | | 80% | 100% | |
| **Radiation Therapy, Chemotherapy & Dialysis** | | 90% | 100% | |
| **Maternity Services** | | 90% | 100% | Deductible does not apply for pre and postnatal care. |
| Inpatient, Outpatient, Pre & Postnatal Care | | | | |
| **Psychiatric & Substance Abuse Services** | | 100% / 90% | 100% | Preauthorization may be required. Refer to the benefit plan for details. |
| Inpatient, Partial Hospitalization, Intensive Outpatient Program, Residential Treatment & Outpatient Services | | | | |
| **Emergency Services** | | 90% | 100% | Preauthorization is not required. |
| Professional Health Care Provider Visit | $25 | 90% | 100% | Deductible does not apply to the office or emergency room visit. |
| Emergency Room Charge | $75 | 90% | 100% | Deductible does not apply. |
| **Ambulance Services** | | 80% | 100% | |
| **Skilled Nursing Facility Services** | | 80% | 100% | Preauthorization is required. |
| **Home Health Care Services** | | 80% | 100% | Preauthorization is required. |
| **Hospice Services** | | 80% | 100% | Preauthorization is required. |
| **Chiropractic Services** | | | | |
| Home & Office Visits | $25 | 90% | 100% | Deductible does not apply. |
| Therapy & Manipulations | $20 | 80% | 100% | Deductible does not apply. |
| Diagnostic Services | | 90% | 100% | |
| **Medical Supplies & Equipment** | | 80% | 100% | |

| Description of Benefits | Copayment | Benefit Amount | | Special Conditions |
|---|---|---|---|---|
| | | Before prescription drug coinsurance maximum is met | After prescription drug coinsurance maximum is met | Benefits are subject to the Outpatient Prescription Drug Coinsurance Maximum Amount. |
| **Outpatient Prescription Medications or Drugs** | | | | Formulary contraceptive drugs obtainable with a prescription order are paid at 100% of allowed charge. Copayment and deductible amounts do not apply. |
| Formulary | $15 | 80% | 100% | One copayment amount per prescription order or refill for a 1–34 day supply. Two copayment amounts per prescription order or refill for a 35–100 day supply. Two copayment amounts per prescription order or refill for a 2–month or 3–month supply of nonformulary oral contraceptives. Deductible does not apply. |
| Nonformulary | $15 | 50% sanction | 50% sanction | |

## Cost Sharing Amounts

| | 100 | 250 | 500 | 1000 | 1500 | 2000 | 3000 | 5000 |
|---|---|---|---|---|---|---|---|---|
| **Single Coverage** Or an individual family member | | | | | | | | |
| Deductible amount | $100 | $250 | $500 | $1,000 | $1,500 | $2,000 | $3,000 | $5,000 |
| Coinsurance maximum | $1,000 | $1,000 | $1,500 | $1,500 | $2,000 | $2,000 | $2,000 | $2,000 |
| Out-of-pocket maximum | $1,100 | $1,250 | $2,000 | $2,500 | $3,500 | $4,000 | $5,000 | $7,000 |
| **Single Plus Dependent Coverage** Individual plus eligible children | | | | | | | | |
| Deductible amount | $150 | $375 | $750 | $1,500 | $2,250 | $3,000 | $4,500 | $7,500 |
| Coinsurance maximum | $1,500 | $1,500 | $2,250 | $2,250 | $3,000 | $3,000 | $3,000 | $3,000 |
| Out-of-pocket maximum | $1,650 | $1,875 | $3,000 | $3,750 | $5,250 | $6,000 | $7,500 | $10,500 |
| **Family Coverage** | | | | | | | | |
| Deductible amount | $200 | $500 | $1,000 | $2,000 | $3,000 | $4,000 | $6,000 | $10,000 |
| Coinsurance maximum | $2,000 | $2,000 | $3,000 | $3,000 | $4,000 | $4,000 | $4,000 | $4,000 |
| Out-of-pocket maximum | $2,200 | $2,500 | $4,000 | $5,000 | $7,000 | $8,000 | $10,000 | $14,000 |

This chart reflects the cost sharing amounts for each benefit period. Outpatient prescription drug cost sharing amounts do not apply to the out-of-pocket maximum.

**Outpatient Prescription Drug Coinsurance Maximum Amount** $1,000 per member per benefit period

When the prescription drug coinsurance maximum amount has been met, copayment amounts will continue to apply, and formulary drugs will be covered at 100% of the allowed charge for the remainder of the benefit period. Copayment amounts and the nonformulary sanction do not apply to this coinsurance maximum.

**Employer contribution.**

To qualify for a group health plan, the employer must contribute a minimum of 50% toward the single premium payment.

**Waiting period for pre-existing conditions.**

This plan applies a waiting period of 365 days to services, supplies or charges for the care or treatment a member receives for a pre-existing condition. A pre-existing condition is a condition, disease, illness or injury for which the member received medical advice or treatment within the 6-month period immediately preceding the individual member's enrollment date under the benefit plan. Members under age 19 will not be subject to a waiting period.

**Qualifying previous coverage.**

Days of continuous coverage under qualifying previous coverage will apply toward the waiting period if continuous to a date within 63 days prior to the individual member's enrollment date under the benefit plan.

**Late enrollees.**

If an eligible employee or eligible dependent does not apply when first eligible, they may apply as late enrollees during the annual enrollment period. A waiting period for late enrollees will apply. See the benefit plan for special enrollment provisions.

**Call toll-free 1-800-342-4718**
**Fargo area call 277-2227**
**www.BCBSND.com**

For premium rates and further details of the coverage, including definitions; exclusions; criteria for medically appropriate and necessary care; credentialing process; confidentiality policy; description of experimental drugs, medical devices or treatments; grievance and appeals process; provider listings; drugs eligible for coverage; reductions or limitations; and the terms under which this benefit plan may be continued, see your Account Executive or write to Blue Cross Blue Shield of North Dakota.