

High Value HSA Silver \$3,250 Plan 553



High Value Network

Benefit highlights for small businesses

January 1, 2023 – December 31, 2023

Key benefits	In network	Out of network
Your deductible The amount you pay per calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply to the in-network deductible. Embedded: Each individual in the family pays all costs from providers up to the individual deductible amount before the plan begins to pay, with a maximum combined deductible for the family at the family deductible amount.	\$3,250 per person \$6,500 family	\$10,000 per person \$20,000 family
Your coinsurance The percent you pay after your deductible is met.	30%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in medical and prescription drug deductibles and coinsurance. Amounts paid out of network DO NOT apply to the in-network out-of-pocket maximum. Embedded: Each individual in the family only pays any applicable cost sharing up to the individual out-of-pocket maximum, and the entire family only pays any applicable cost sharing up to the family out-of-pocket maximum.	\$5,500 per person \$11,000 family	\$30,000 per person \$60,000 family
Visits to: <ul style="list-style-type: none"> health care provider's office mental health or substance abuse provider's office specialist retail health clinic urgent care e-visits 	30% after deductible 30% after deductible 30% after deductible 30% after deductible 30% after deductible 30% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
Other professional services in the office <ul style="list-style-type: none"> lab, pathology, advanced and standard imaging 	30% after deductible	50% after deductible
Prescription drugs Classic pharmacy network with BasicRx Tier 1 = drugs on the BasicRx preventive drug list for the following selected categories: diabetes medication, diabetic supplies, high blood pressure, high cholesterol, and antidepressants	Tier 1: 0% (no deductible) Tier 2: 30% after deductible Tier 3: 30% after deductible Tier 4: 30% after deductible Tier 5: 30% after deductible	No coverage
Preventive care (including vision screening)	0% (no deductible)	50% after deductible
Well baby care (ages 0 to 6, including vision screening)	0% (no deductible)	0% (no deductible)
Prenatal care	0% (no deductible)	0% (no deductible)
Maternity (labor, delivery and post-delivery care)	30% after deductible	50% after deductible
Emergency care <ul style="list-style-type: none"> physician facility 		30% after deductible 30% after deductible
Ambulance		30% after deductible
Ambulatory surgical center	10% after deductible	50% after deductible
Outpatient facility services <ul style="list-style-type: none"> physician facility lab, pathology, advanced and standard imaging 	30% after deductible 30% after deductible 30% after deductible	50% after deductible 50% after deductible 50% after deductible
Inpatient facility services (including mental health and substance abuse) <ul style="list-style-type: none"> physician facility 	30% after deductible 30% after deductible	50% after deductible 50% after deductible
Skilled Nursing facility services 120 days per period of confinement	30% after deductible	50% after deductible

Key benefits	In network	Out of network
Chiropractic, physical, occupational and speech therapy (habilitative and rehabilitative)	30% after deductible	50% after deductible
Hospice and Home Infusion Therapy	30% after deductible	No coverage
Home Health Care 120 visits per calendar year	30% after deductible	No coverage
Durable Medical Equipment	30% after deductible	50% after deductible
Eyewear for members age 18 and younger • lenses and one pair of standard collection frames or contact lenses	30% after deductible	No coverage

Your out-of-pocket costs depend on the network status of your provider. This plan's network has a limited number of in-network providers. If you visit a provider or a location that's not in this plan's network, you will pay more for your care, and the costs associated with your care will not count towards your in-network cost sharing (for example, the in-network deductible and out-of-pocket maximum). Be sure to find out if your doctor is in this plan's network (note the network's name at the top of this document). To check status, use the "Find a doctor" web tool on bluecrossmnonline.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

If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the DIFFERENCE between what Blue Plus 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 Plus' allowed amount, which is typically lower than the amount billed by the provider.

This is only a summary. Your benefit book will provide a detailed description of what is and is not covered. Services not covered include custodial care or rest cures, bariatric surgery, infertility, adult eyewear, adult dental services, services that are experimental, not medically necessary or received while on military duty and certain services for the treatment of autism.

Each health care provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services. Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

HMO Minnesota, dba Blue Plus, is an affiliate of Blue Cross and Blue Shield of Minnesota

This information is also available in other ways to people with disabilities. To reach customer service, call **1-888-279-4210** (toll-free).

For TTY call 711

Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

Attention. If you want free help translating this information, call the above number.

Atencion. Si desea recibir asistencia gratuita para traduca esta informacion, llame al numero que aparece mas arriba.

For more information, visit bluecrossmnonline.com.

For a list of drugs on your specified Preferred drug list, visit bluecrossmn.com/basicrxsmallgroupshsa2023 or contact Customer Service.

Rates are changed on an annual basis. Rates may also change during the year if the number of dependents covered under your contract changes, or if you move to a different premium rating area or change plans.

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