

# BlueAccess<sup>SM</sup> HSA Silver \$4,600 Plan 642



## Aware<sup>®</sup> network

Benefit summary for small businesses | January 1, 2024 – December 31, 2024

Key benefits	In network	Out of network
<b>Your deductible</b> 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.  Non-embedded: The family pays all cost from providers up to the family deductible amount before the plan begins to pay. The single deductible applies to single coverage only.	\$4,600 single \$9,200 family	\$10,000 single \$20,000 family
<b>Your coinsurance</b> The percent you pay after your deductible is met.	0%	50%
<b>Your out-of-pocket maximum</b> 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.  Non-embedded: The family pays all applicable cost sharing up to the family out-of-pocket maximum. The single out-of-pocket maximum applies to single coverage only.	\$4,600 single \$9,200 family	\$30,000 single \$60,000 family
<b>Preventive care</b> (including vision screening) <b>Well baby care</b> (ages 0 to 6, including vision screening) <b>Prenatal care</b>	0% (no deductible) 0% (no deductible) 0% (no deductible)	50% after deductible 0% (no deductible) 0% (no deductible)
<b>Visits to:</b> <ul style="list-style-type: none"> <li>health care provider's office</li> <li>mental health or substance abuse provider's office</li> <li>specialist</li> <li>retail health clinic</li> <li>urgent care</li> <li>e-visits</li> </ul>	0% after deductible 0% after deductible 0% after deductible 0% after deductible 0% after deductible 0% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
<b>Other professional services in the office</b> <ul style="list-style-type: none"> <li>lab, pathology, advanced and standard imaging</li> </ul>	0% after deductible	50% after deductible
<b>Prescription drugs</b> 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: 0% after deductible Tier 3: 0% after deductible Tier 4: 0% after deductible Tier 5: 0% after deductible	No coverage
<b>Maternity</b> (labor, delivery and post-delivery care)	0% after deductible	50% after deductible
<b>Emergency care</b> <ul style="list-style-type: none"> <li>physician</li> <li>facility</li> </ul>		0% after deductible 0% after deductible
<b>Ambulance</b>		0% after deductible
<b>Outpatient facility services</b> <ul style="list-style-type: none"> <li>physician</li> <li>facility</li> <li>lab, pathology, advanced and standard imaging</li> </ul>	0% after deductible 0% after deductible 0% after deductible	50% after deductible 50% after deductible 50% after deductible
<b>Inpatient facility services</b> (including mental health and substance abuse) <ul style="list-style-type: none"> <li>physician</li> <li>facility</li> </ul>	0% after deductible 0% after deductible	50% after deductible 50% after deductible
<b>Skilled Nursing facility services</b> 120 days per period of confinement	0% after deductible	50% after deductible
<b>Chiropractic, physical, occupational and speech therapy</b> (habilitative and rehabilitative)	0% after deductible	50% after deductible
<b>Hospice and Home Infusion Therapy</b>	0% after deductible	No coverage
<b>Home Health Care</b> 120 visits per calendar year	0% after deductible	No coverage

Key benefits	In network	Out of network
<b>Durable Medical Equipment</b>	0% after deductible	50% after deductible
<b>Eyewear for members age 18 and younger</b> • lenses and one pair of standard collection frames or contact lenses	0% 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 [bluecrossmn.com](http://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

If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the DIFFERENCE between what Blue Cross 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 Cross 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 [bluecrossmn.com](http://bluecrossmn.com).

For a list of drugs on your specified Preferred drug list, visit [bluecrossmn.com/smallgroupshadruglist2024](http://bluecrossmn.com/smallgroupshadruglist2024) 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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