BlueAccess HSA Silver $3,200 Plan 642

Aware® Network

Benefit highlights for small businesses

January 1, 2016 – December 31, 2016

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. Non-embedded: The plan begins paying benefits that require cost sharing when the entire family deductible is met. The deductible can be met by one or a combination of several family members. The single deductible applies to single coverage only.	$3,200 single $6,400 family	$10,000 single $20,000 family
Your coinsurance The percent you pay after your deductible is met.	0%	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.	$3,200 single $6,400 family	$30,000 single $60,000 family
Visits to: • health care provider's office • specialist • retail health clinic • urgent care • e-visits	 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
Other professional services in the office • lab and diagnostic imaging/X-ray services	0% after deductible	50% after deductible
Prescription drugs GenRx with open formulary	0% after deductible	50% after deductible
Preventive care (including vision exam)	0% (no deductible)	50% after deductible
Preventive drugs Preferred drugs on the GenRx preventive drug list for the following selected categories: diabetes medication, diabetic supplies, high blood pressure and high cholesterol	0% (no deductible)	50% after deductible
Well child care (ages 0 to 6, including vision exam)	0% (no deductible)	0% (no deductible)
Prenatal care	0% (no deductible)	0% (no deductible)
Maternity (labor, delivery and post-delivery care)	0% after deductible	50% after deductible
Emergency care • physician • facility	 0% after deductible 0% after deductible	 0% after deductible 0% after deductible
Ambulance	0% after deductible	0% after deductible
Ambulatory surgical center	0% after deductible	50% after deductible
Hospital (outpatient) • physician • facility • lab and diagnostic imaging/X-ray services	 0% after deductible 0% after deductible 0% after deductible	 50% after deductible 50% after deductible 50% after deductible
Hospital visit (inpatient) • physician • facility	 0% after deductible 0% after deductible	 50% after deductible 50% after deductible
Chiropractic, physical, occupational and speech therapy	0% after deductible	50% after deductible
Eyewear for members under age 19 • 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. To check status, use the “Find a doctor” web tool on **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 contract 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 in the network is an independent contractor and is not our agent.

This information is available in other ways for people with disabilities or who need it translated into another language by calling **1-800-382-2000** (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**.

Blue Cross may change premium rates: on an annual renewal date, when you add or delete a dependent, or if you move to a different Blue Cross plan. Factors that may affect changes in premium rates include the age of covered members, where you reside and whether a member uses tobacco.

ABJ3

CM7415R01 (10/15)