

# Blue Plus HSA with Mayo Clinic Bronze \$4,500 Plan 616



## Mayo Clinic network

### Benefit highlights for small businesses

January 1, 2016 – December 31, 2016

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.  Embedded: The plan begins paying benefits that require cost sharing for the first family member who meets the per-person deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.	\$4,500 per person \$9,000 family	\$10,000 per person \$20,000 family
<b>Your coinsurance</b> The percent you pay after your deductible is met.	30%	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.	\$6,550 per person \$13,100 family	\$30,000 per person \$60,000 family
<b>Visits to:</b> <ul style="list-style-type: none"> <li>health care provider's office</li> <li>specialist</li> <li>retail health clinic</li> <li>urgent care</li> <li>e-visits</li> </ul>	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
<b>Other professional services in the office</b> <ul style="list-style-type: none"> <li>lab and diagnostic imaging/X-ray services</li> </ul>	30% after deductible	50% after deductible
<b>Prescription drugs</b> GenRx with open formulary	30% after deductible	50% after deductible
<b>Preventive care</b> (including vision exam)	0% (no deductible)	50% after deductible
<b>Preventive drugs</b> 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
<b>Well child care</b> (ages 0 to 6, including vision exam)	0% (no deductible)	0% (no deductible)
<b>Prenatal care</b>	0% (no deductible)	0% (no deductible)
<b>Maternity</b> (labor, delivery and post-delivery care)	30% after deductible	50% after deductible
<b>Emergency care</b> <ul style="list-style-type: none"> <li>physician</li> <li>facility</li> </ul>	30% after deductible 30% after deductible	30% after deductible 30% after deductible
<b>Ambulance</b>	30% after deductible	30% after deductible
<b>Ambulatory surgical center</b>	30% after deductible	50% after deductible
<b>Hospital</b> (outpatient) <ul style="list-style-type: none"> <li>physician</li> <li>facility</li> <li>lab and diagnostic imaging/X-ray services</li> </ul>	30% after deductible 30% after deductible 30% after deductible	50% after deductible 50% after deductible 50% after deductible
<b>Hospital visit</b> (inpatient) <ul style="list-style-type: none"> <li>physician</li> <li>facility</li> </ul>	30% after deductible 30% after deductible	50% after deductible 50% after deductible
<b>Chiropractic, physical, occupational and speech therapy</b>	30% after deductible	50% after deductible
<b>Eyewear for members under age 19</b> <ul style="list-style-type: none"> <li>lenses and one pair of standard collection frames or contact lenses</li> </ul>	30% 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](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 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.

Mayo Clinic is an independent, nonprofit healthcare provider.

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

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](http://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.

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