BlueValue HSA Bronze $5,500 Plan 654

Group Value Network

Benefit highlights for small businesses

January 1, 2019 – December 31, 2019

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: 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	$5,500 per person $11,000 family	$10,000 per person $20,000 family
Your coinsurance The percent you pay after your deductible is met.	25%	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	$6,750 per person $13,500 family	$30,000 per person $60,000 family
Visits to: • health care provider's office • mental health or substance abuse provider's office • specialist • retail health clinic • urgent care • e-visits	 25% after deductible 25% after deductible 25% after deductible 25% after deductible 25% after deductible 25% 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 • lab, pathology, advanced and standard imaging	 25% 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 and high cholesterol	Tier 1: 0% (no deductible) Tier 2: 25% after deductible Tier 3: 25% after deductible Tier 4: 25% after deductible Tier 5: 25% 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)	25% after deductible	50% after deductible
Emergency care • physician • facility	 25% after deductible 25% after deductible	
Ambulance	25% after deductible	
Ambulatory surgical center	5% after deductible	50% after deductible
Outpatient facility services • physician • facility • lab, pathology, advanced and standard imaging	 25% after deductible 25% after deductible 25% after deductible	 50% after deductible 50% after deductible 50% after deductible
Inpatient facility services (including mental health and substance abuse) • physician • facility	 25% after deductible 25% after deductible	 50% after deductible 50% after deductible
Skilled Nursing facility services 120 days per period of confinement	25% after deductible	50% after deductible
Chiropractic, physical, occupational and speech therapy (habilitative and rehabilitative)	25% after deductible	50% after deductible
Hospice and Home Infusion Therapy	25% after deductible	No coverage

Key benefits	In network	Out of network
Home Health Care 120 visits per calendar year	25% after deductible	No coverage
Durable Medical Equipment	25% after deductible	50% after deductible
Eyewear for members age 18 and younger • lenses and one pair of standard collection frames or contact lenses	25% 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 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.

Doctor On Demand is an independent company providing telehealth services.

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/basicrxsmallgrouphsa2019** 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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BlueCross BlueShield Minnesota

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.