Plan Highlights

BlueCross BlueShield Minnesota

BLUEBASIC $2,000/$4,000 deductible and 20% coinsurance — Plan 619

For small businesses with one to 50 employees — Consumer Value® network

Your costs	In Consumer Value network	Out of network
Your deductible What you pay for covered health care services each calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply in network.	$2,000 per person $4,000 per family	$10,000 per person $20,000 per family
Your coinsurance The percent you pay for your covered health care services after you meet your deductible.	20%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply in network.	$5,350 per person $10,700 per family	unlimited
Key benefits Includes care for mental health and substance abuse	**You pay**	
	In Consumer Value network	Out of network
Preventive care/tests	$0 (no deductible)	50% after deductible is met
Prenatal and well-child care	$0 (no deductible)	$0 (no deductible)
Prescription drugs GenRx with open formulary	• Preferred generic: $15 copay • Preferred brand: $60 copay • Non-preferred: $90 copay • Specialty drugs: 20% to a maximum of $200 per prescription	• Preferred generic: $15 copay • Preferred brand: $60 copay • Non-preferred: $90 copay • Specialty drugs: No coverage
Visits to • Health care provider's office, retail health clinic or urgent care clinic • Specialist	• $45 copay • $65 copay	50% after deductible is met
Chiropractic, physical, occupational and speech therapies	20% after deductible is met	50% after deductible is met
Online Care Anywhere® e-visit	Two free visits, then $45 copay	50% after deductible is met
Emergency care	$250 copay	$250 copay

Key benefits Includes care for mental health and substance abuse	You pay	
	In Consumer Value network	Out of network
Hospital visit (outpatient) • Facility • Physician	20% after deductible is met	50% after deductible is met
Hospital stay (inpatient) • Facility • Physician	20% after deductible is met	50% after deductible is met
Diagnostic tests (X-rays, blood work)	20% after deductible is met	50% after deductible is met
Imaging tests (for example, MRIs, CT or CAT scans, PET scans)	20% after deductible is met	50% after deductible is met
Eyewear for children For one pair of lenses and one pair of frames for members age 18 and under	20% after deductible is met	50% after deductible is met
Dental for children For members age 18 and under as required by health care reform.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.

For January 1, 2014, to December 31, 2014. **(AABU)**

Your out-of-pocket costs depend on the network status of your health care provider. To check provider 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.

This information is also available in other ways to people with disabilities by calling customer service at **(651) 662-5563** (voice), or **1-800-262-0828** (toll free).

For (TTY) call **(651) 662-8700**, or **1-888-878-0137** (TTY), or 711, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877-627-3848** (Speech-to-Speech).

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

Plan Highlights

BlueCross BlueShield Minnesota

BLUEBASIC $2,000/$4,000 deductible and 30% coinsurance — Plan 621

For small businesses with one to 50 employees — Consumer Value® network

Your costs	In Consumer Value network	Out of network
Your deductible What you pay for covered health care services each calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply in network.	$2,000 per person $4,000 per family	$10,000 per person $20,000 per family
Your coinsurance The percent you pay for your covered health care services after you meet your deductible.	30%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply in network.	$5,350 per person $10,700 per family	unlimited
Key benefits Includes care for mental health and substance abuse	**You pay**	
	In Consumer Value network	Out of network
Preventive care/tests	$0 (no deductible)	50% after deductible is met
Prenatal and well-child care	$0 (no deductible)	$0 (no deductible)
Prescription drugs GenRx with open formulary	• Preferred generic: $10 copay • Preferred brand: $50 copay • Non-preferred: $90 copay • Specialty drugs: 20% to a maximum of $200 per prescription	• Preferred generic: $10 copay • Preferred brand: $50 copay • Non-preferred: $90 copay • Specialty drugs: No coverage
Visits to • Health care provider's office, retail health clinic or urgent care clinic • Specialist	30% after deductible is met	50% after deductible is met
Chiropractic, physical, occupational and speech therapies	30% after deductible is met	50% after deductible is met
Online Care Anywhere® e-visit	Two free visits, then 30% after deductible is met	50% after deductible is met
Emergency care	30% after deductible is met	30% after deductible is met

Key benefits Includes care for mental health and substance abuse	You pay	
	In Consumer Value network	Out of network
Hospital visit (outpatient) • Facility • Physician	30% after deductible is met	50% after deductible is met
Hospital stay (inpatient) • Facility • Physician	30% after deductible is met	50% after deductible is met
Diagnostic tests (X-rays, blood work)	30% after deductible is met	50% after deductible is met
Imaging tests (for example, MRIs, CT or CAT scans, PET scans)	30% after deductible is met	50% after deductible is met
Eyewear for children For one pair of lenses and one pair of frames for members age 18 and under	30% after deductible is met	50% after deductible is met
Dental for children For members age 18 and under as required by health care reform.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.

For January 1, 2014, to December 31, 2014. **(AABV)**

Your out-of-pocket costs depend on the network status of your health care provider. To check provider 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.

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Plan Highlights

BlueCross BlueShield Minnesota

BLUEBASIC HSA $5,350/$10,700 embedded deductible and no coinsurance

Plan 617

For small businesses with one to 50 employees

Consumer Value® network

Your costs	In Consumer Value network	Out of network
Your deductible What you pay for covered health care services each calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply in network.	$5,350 per person $10,700 per family	$10,000 per person $20,000 per family
Your coinsurance The percent you pay for your covered health care services after you meet your deductible.	0%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply in network.	$5,350 per person $10,700 per family	unlimited

Key benefits Includes care for mental health and substance abuse	You pay	
	In Consumer Value network	Out of network
Preventive care/tests	$0 (no deductible)	50% after deductible is met
Prenatal and well-child care	$0 (no deductible)	$0 (no deductible)
Prescription drugs GenRx with open formulary	0% after deductible is met	0% after deductible is met
Visits to • Health care provider's office, retail health clinic or urgent care clinic • Specialist	0% after deductible is met	50% after deductible is met
Chiropractic, physical, occupational and speech therapies	0% after deductible is met	50% after deductible is met
Online Care Anywhere® e-visit	0% after deductible is met	50% after deductible is met
Emergency care	0% after deductible is met	0% after deductible is met

Key benefits Includes care for mental health and substance abuse	You pay	
	In Consumer Value network	Out of network
Hospital visit (outpatient) • Facility • Physician	0% after deductible is met	50% after deductible is met
Hospital stay (inpatient) • Facility • Physician	0% after deductible is met	50% after deductible is met
Diagnostic tests (X-rays, blood work)	0% after deductible is met	50% after deductible is met
Imaging tests (for example, MRIs, CT or CAT scans, PET scans)	0% after deductible is met	50% after deductible is met
Eyewear for children For one pair of lenses and one pair of frames for members age 18 and under	0% after deductible is met	50% after deductible is met
Dental for children For members age 18 and under as required by health care reform.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.	This coverage is included, but you may opt out if you have dental coverage certified by MNsure.

For January 1, 2014, to December 31, 2014. **(AABT)**

Your out-of-pocket costs depend on the network status of your health care provider. To check provider 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.

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