High Value Gold $1,000 Plan 664

High Value Network

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

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.	$1,000 per person $2,000 family	$10,000 per person $20,000 family
Your coinsurance The percent you pay after your deductible is met.	30%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in medical and prescription drug deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply to the in-network out-of-pocket maximum.	$7,000 per person $14,000 family	$30,000 per person $60,000 family
Preventive care (including vision screening) **Well baby care** (ages 0 to 6, including vision screening) **Prenatal care**	0% (no deductible) 0% (no deductible) 0% (no deductible)	50% after deductible 0% (no deductible) 0% (no deductible)
Visits to: • health care provider's office • mental health or substance abuse provider's office • specialist • retail health clinic • urgent care • e-visits	$35 copay $35 copay $70 copay $35 copay $35/$70 copay First 5 e-visits free (no copay), then $35/$70 copay	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	30% after deductible	50% after deductible
Prescription drugs Classic pharmacy network with BasicRx Insulin listed on Tier 1 and Tier 2 are covered at $0 member cost-sharing	Tier 1: $20 copay Tier 2: $75 copay Tier 3: $150 copay Tier 4: 30% per prescription	No coverage
Maternity (labor, delivery and post-delivery care)	30% after deductible	50% after deductible
Emergency care • physician • facility	30% after deductible 30% after deductible	
Ambulance	30% after deductible	
Outpatient facility services • physician • facility • lab, pathology, advanced and standard imaging	30% after deductible 30% after deductible 30% after deductible	50% after deductible 50% after deductible 50% after deductible
Inpatient facility services (including Mental Health and Substance Abuse) • physician • facility	30% after deductible 30% after deductible	50% after deductible 50% after deductible
Skilled Nursing facility services 120 days per period of confinement	30% after deductible	50% after deductible
Chiropractic, physical, occupational and speech therapy (habilitative and rehabilitative)	30% after deductible	50% after deductible
Hospice and Home Infusion Therapy	30% after deductible	No coverage
Home Health Care 120 visits per calendar year	30% after deductible	No coverage
Durable Medical Equipment	30% after deductible	50% after deductible
Eyewear for members age 18 and younger • lenses and one pair of standard collection frames or contact lenses	30% 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**.

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 Plus' 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.

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**.
For a list of drugs on your specified Preferred drug list, visit **bluecrossmn.com/smallgroupdruglist2024** 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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