

**Willmar Public School**  
**Aware VEBA \$6350 Deductible 0% Coinsurance**  
**July, 1 2023**

Coinsurance reflects member responsibility

|                                                                                                                                                                                                                                                                                                                                                                                                         | In network*<br>MN Network: Aware<br>National Network: BlueCard PPO                                                                                                                                                                                                                                                | Out of network**                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Calendar-year deductible</b><br><br>The in- and out-of-network maximums accumulate separately.                                                                                                                                                                                                                                                                                                       | Medical and prescription<br>\$6,350 individual<br>\$12,700 family                                                                                                                                                                                                                                                 | Medical and prescription<br>\$8,250 individual<br>\$16,500 family                                                                                                                                                                                                                        |
| <b>Coinsurance Level – What the member pays</b>                                                                                                                                                                                                                                                                                                                                                         | Deductible then 0% coinsurance                                                                                                                                                                                                                                                                                    | Deductible then 20% coinsurance                                                                                                                                                                                                                                                          |
| <b>Calendar-year out-of-pocket maximum</b><br>The in- and out-of-pocket maximums accumulate separately.<br><br>Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.                                                                                                                                                                               | Medical and prescription<br>\$6,350 individual<br>\$12,700 family                                                                                                                                                                                                                                                 | Medical and prescription<br>\$10,000 individual<br>\$20,000 family                                                                                                                                                                                                                       |
| <b>Benefit payment levels</b>                                                                                                                                                                                                                                                                                                                                                                           | Payment for participating network providers as described. Most payments are based on allowed amount.                                                                                                                                                                                                              | If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.                                                                                                      |
| <b>Preventive care</b> <ul style="list-style-type: none"> <li>• well-child care to age 6</li> <li>• prenatal care</li> <li>• preventive medical evaluations age 6 and older</li> <li>• cancer screening</li> <li>• preventive hearing and vision exams</li> <li>• immunizations and vaccinations</li> </ul>                                                                                             | 0%<br>0%<br>0%<br>0%<br>0%<br>0%                                                                                                                                                                                                                                                                                  | 0%<br>0%<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance                                                                                                                                     |
| <b>Omada®</b> <ul style="list-style-type: none"> <li>• diabetes and cardiovascular disease prevention program (Generic Program)</li> </ul>                                                                                                                                                                                                                                                              | 0%                                                                                                                                                                                                                                                                                                                | No coverage                                                                                                                                                                                                                                                                              |
| <b>Physician services</b> <ul style="list-style-type: none"> <li>• e-visits</li> <li>• retail health clinic (office visit)</li> <li>• physician office visits</li> <li>• office and outpatient lab services</li> <li>• office and outpatient lab diagnostic imaging</li> <li>• allergy injections and serum</li> <li>• specialist office visits</li> <li>• Urgent Care professional services</li> </ul> | 5 free E-visit; subsequent visits<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance | Deductible then 20% coinsurance<br><br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance |
| <b>Other professional services</b> <ul style="list-style-type: none"> <li>• chiropractic manipulation (office visit)</li> <li>• chiropractic therapy</li> <li>• home health care</li> <li>• physical therapy, occupational therapy, speech therapy (office visit)</li> <li>• physical therapy, occupational therapy, speech therapy (therapy)</li> </ul>                                                | Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br><br>Deductible then 0% coinsurance                                                                                                                                        | Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br><br>Deductible then 20% coinsurance                                                                                                          |
| <b>Hospital Inpatient services</b>                                                                                                                                                                                                                                                                                                                                                                      | Deductible then 0% coinsurance                                                                                                                                                                                                                                                                                    | Deductible then 20% coinsurance                                                                                                                                                                                                                                                          |
| <b>Hospital Outpatient services</b> <ul style="list-style-type: none"> <li>• facility lab services</li> <li>• facility diagnostic imaging</li> <li>• chemotherapy and radiation therapy</li> <li>• scheduled outpatient surgery</li> <li>• urgent care services (facility services)</li> </ul>                                                                                                          | Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance                                                                                                                                            | Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance                                                                                                              |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | In network*<br>MN Network: Aware<br>National Network: BlueCard PPO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Out of network**                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Emergency care</b><br>• emergency room (facility charges)<br>• professional charges<br>• ambulance (medically necessary transport to the nearest facility equipped to treat the condition)                                                                                                                                                                                                                                                                                                                          | Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                             |
| <b>Durable Medical Equipment</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Deductible then 0% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Deductible then 20% coinsurance                                                                                                                                                                                             |
| <b>Bariatric surgery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | No Coverage                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | No Coverage                                                                                                                                                                                                                 |
| <b>Assisted fertilization</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Deductible then 0% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Deductible then 20% coinsurance                                                                                                                                                                                             |
| <b>Behavioral health (mental health and substance abuse services)</b><br>• inpatient professional services<br>• outpatient professional services (office visits)<br>• outpatient hospital/facility services                                                                                                                                                                                                                                                                                                            | Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance                                                                                                                       |
| <b>Prescription drugs – Select Network</b><br><b>Retail</b> (31-day limit)<br><b>FlexRx preferred drug list</b><br><br>• preferred generic<br>• non-preferred generic<br>• preferred brand<br>• non-preferred brand<br><br><b>Specialty drug list</b><br>• specialty drug<br><br><b>90dayRx – Mail order pharmacy</b> (90-day limit) or <b>Retail pharmacy</b> (90-day limit)<br><b>FlexRx preferred drug list</b><br><br>• preferred generic<br>• non-preferred generic<br>• preferred brand<br>• non-preferred brand | Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br><br>Deductible then 0% coinsurance<br><br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance<br>Deductible then 0% coinsurance                                                                                                                                                                                                                                                                      | Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br>Deductible then 20% coinsurance<br><br>No coverage<br><br>No coverage<br>No coverage<br>No coverage<br>No coverage |
| <b>Important Information About Your Pharmacy Benefits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 90dayRx applies to participating retail and/or mail service pharmacy only.<br>Identified specialty drugs purchased through a specialty pharmacy network supplier are eligible for coverage (no coverage for specialty drugs purchased through a nonparticipating specialty pharmacy supplier).<br>The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available.<br>The drug list uses a step therapy program. Sign in at <a href="https://bluecrossmn.com">bluecrossmn.com</a> and select "Prescriptions," then see "frequently asked questions." |                                                                                                                                                                                                                             |

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit [bluecrossmn.com](https://bluecrossmn.com).

**\*Lowest out-of-pocket costs:** in-network providers

**Highest out-of-pocket costs:** out-of-network **nonparticipating** providers (You are responsible for the difference between Blue Cross' allowed amount and the amount billed by nonparticipating providers. 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 plan is Medicare Part D creditable.

**Embedded deductible** – The plan begins paying benefits that require cost sharing for the first family member who meets the individual 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.

This is only a summary. Read your benefit booklet for more information about what is and isn't covered. Services that aren't covered include those that are cosmetic, investigative, not medically necessary or covered by workers' compensation or no-fault insurance.

For more information, visit [bluecrossmn.com](https://bluecrossmn.com) or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

8/2/2021



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