

Copay Plan (All Employee Groups)

Benefit Summary | Effective Dates July 1, 2024 – June 30, 2025

Key Benefits	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Customer Service: 1-866-873-5943	Employee Pays	Employee Pays
Calendar-year deductible (January – December) The in- and out-of-network maximums cross apply.	Medical \$400 individual \$1,000 family	Medical and prescription \$800 individual \$2,000 family
Coinsurance Level The percent you pay after your deductible is met.	0%	20%
Calendar-year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical \$700 individual \$1,400 family Prescription \$500 individual \$750 family	Medical \$1,050 individual \$2,100 family Prescription \$500 individual \$750 family
Benefit payment levels	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.
Preventive care <ul style="list-style-type: none"> well-child care to age 6 prenatal care preventive medical evaluations age 6 and older cancer screening preventive hearing and vision exams immunizations and vaccinations 	0% 0% 0% 0% 0% 0%	0% 0% 0% 0% 0% 0%
Physician services <ul style="list-style-type: none"> e-visits retail health clinic (office visit) physician office visits office and outpatient lab services office and outpatient MRI/CT/PET office and outpatient diagnostic imaging allergy injections and serum specialist office visits Urgent Care professional services 	0% 0% 100% after \$35 (\$55*) copay 0% 0% after the deductible 0% 0% 100% after \$35 (\$55*) copay 100% after \$35 (\$55*) copay	20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible
Other professional services <ul style="list-style-type: none"> chiropractic manipulation (office visit) chiropractic therapy home health care physical therapy, occupational therapy, speech therapy (office visit) physical therapy, occupational therapy, speech therapy (therapy) 	100% after \$35 (\$55*) copay 100% after \$35 (\$55*) copay 100% after \$35 (\$55*) copay 100% after \$35 (\$55*) copay 100% after \$35 (\$55*) copay	20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible
Inpatient Facility Services	0% after the deductible	20% after the deductible

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Outpatient Facility Services <ul style="list-style-type: none"> • facility lab services • facility MRI/CT/PET • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services) 	0% 0% after the deductible 0% 0% after the deductible 0% after the deductible 0%	20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible
Emergency care <ul style="list-style-type: none"> • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition) 	\$75 copay 0% 0% after the deductible	
Durable Medical Equipment	0% after the deductible	20% after the deductible
Behavioral health (mental health and substance abuse services) <ul style="list-style-type: none"> • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services 	0% after the deductible 100% after \$35 (\$55*) copay 100% after \$35 (\$55*) copay	20% after the deductible 20% after the deductible 20% after the deductible
Prescription drugs – Select Network <ul style="list-style-type: none"> • retail (31-day supply or 100 units. Whichever is greater) FlexRx preferred drug list <ul style="list-style-type: none"> • open plan design • generic • non-preferred generic • preferred brand • non-preferred brand Specialty drug list <ul style="list-style-type: none"> • Specialty <ul style="list-style-type: none"> • 90dayRx – Mail order pharmacy (102-day limit) FlexRx preferred drug list <ul style="list-style-type: none"> • open plan design • generic • non-preferred generic • preferred brand • non-preferred brand <ul style="list-style-type: none"> • 90dayRx – Retail pharmacy (102-day limit) FlexRx preferred drug list <ul style="list-style-type: none"> • open plan design • generic • non-preferred generic • preferred brand • non-preferred brand 	100% after \$8 copay 100% after \$40 copay 100% after \$20 copay 100% after \$40 copay 100% after \$40 copay 100% after \$16 copay 100% after \$80 copay 100% after \$40 copay 100% after \$80 copay 100% after \$16 copay 100% after \$80 copay 100% after \$40 copay 100% after \$80 copay	20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible No coverage No coverage No coverage No coverage No coverage No coverage No coverage No coverage No coverage
Important Information About Your Pharmacy Benefits	90dayRx applies to participating retail and/or mail service pharmacy only. 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). The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available. The drug list uses a step therapy program. Sign in at bluecrossmn.com for more information.	

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.

***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.

For more information, visit bluecrossmn.com or call Blue Cross customer service at the number on the back of your member ID card.

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*Non-Preferred Benefit. Completing the wellness incentive program results in the Preferred Benefit.