School District 622
NORTH ST. PAUL | MAPLEWOOD | OAKDALE
Ready for tomorrow

BlueCross BlueShield Minnesota

Nutrition Services VEBA Plan

Benefit Summary | Effective Dates July 1, 2026 – June 30, 2027

Key Benefits	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Customer Service: 1-866-873-5943	Employee Pays	Employee Pays
Plan-year deductible (July – June) The in- and out-of-network maximums cross apply.	Medical and prescription $1,350 ($1,600*) individual $2,700 ($3,200*) family	Medical and prescription $1,350 ($1,600*) individual $2,700 ($3,200*) family
Coinsurance Level The percent you pay after your deductible is met.	0%	20%
Plan-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 and prescription $1,350 ($1,600*) individual $2,700 ($3,200*) family	Medical and prescription $3,650 ($3,900*) individual $6,800 ($7,300*) 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		
• well-child care to age 6	0%	0%
• prenatal care	0%	0%
• preventive medical evaluations age 6 and older	0%	0%
• cancer screening	0%	0%
• preventive hearing and vision exams	0%	0%
• immunizations and vaccinations	0%	0%
Physician services		
• e-visits	0% after the deductible	20% after the deductible
• retail health clinic (office visit)	0% after the deductible	20% after the deductible
• physician office visits	0% after the deductible	20% after the deductible
• office and outpatient lab services	0% after the deductible	20% after the deductible
• office and outpatient MRI/CT/PET	0% after the deductible	20% after the deductible
• office and outpatient diagnostic imaging	0% after the deductible	20% after the deductible
• allergy injections and serum	0% after the deductible	20% after the deductible
• specialist office visits	0% after the deductible	20% after the deductible
• Urgent Care professional services	0% after the deductible	20% after the deductible
Other professional services		
• chiropractic manipulation (office visit)	0% after the deductible	20% after the deductible
• chiropractic therapy	0% after the deductible	20% after the deductible
• home health care	0% after the deductible	20% after the deductible
• physical therapy, occupational therapy, speech therapy (office visit)	0% after the deductible	20% after the deductible
• physical therapy, occupational therapy, speech therapy (therapy)	0% 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 • facility lab services • facility MRI/CT/PET • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	0% after the deductible 0% after the deductible 0% after the deductible 0% after the deductible 0% after the deductible 0% 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
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	0% after the deductible 0% after the deductible 0% after the deductible	
Durable Medical Equipment	0% after the deductible	20% after the deductible
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services	0% after the deductible 0% after the deductible 0% after the deductible	20% after the deductible 20% after the deductible 20% after the deductible
Prescription drugs – Select Network • **retail** (31-day limit) **FlexRx preferred drug list** • closed plan design • generic • preferred brand	0% after the deductible 0% after the deductible	20% after the deductible 20% after the deductible
Specialty drug list • Specialty	0% after the deductible	No coverage
• **90dayRx – Mail order pharmacy** (93-day limit) **FlexRx preferred drug list** • closed plan design • generic • preferred brand	0% after the deductible 0% after the deductible	No coverage No coverage
• **90dayRx – Retail pharmacy** (93-day limit) **FlexRx preferred drug list** • closed plan design • generic • preferred brand	0% after the deductible 0% after the deductible	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.