

# Broad Plan

## Aware \$600 Deductible 20% Coinsurance Copay Plan



Benefit Summary | Effective Dates January 1, 2025 – December 31, 2025

Key Benefits	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
<b>Calendar-year deductible</b> The in- and out-of-network maximums accumulate separately.	Medical \$600 individual \$1,200 family	Medical and prescription combined \$1,800 individual \$3,600 family
<b>Coinsurance Level</b> The percent you pay after your deductible is met.	20%	40%
<b>Calendar-year out-of-pocket maximum</b> The in- and out-of-pocket maximums accumulate separately. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined \$4,500 individual \$9,000 family	Medical and prescription combined \$9,000 individual \$18,000 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% 0% 0% 0% 0% 0%	0% 0% 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible
<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 lab services</li> <li>• office diagnostic imaging</li> <li>• allergy injections and serum</li> <li>• specialist office visits</li> <li>• Urgent Care professional services</li> </ul>	\$10 copay \$10 copay \$30 copay 0% 0% 0% \$50 copay \$50 copay	40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible \$100 copay
<b>Other professional services</b> <ul style="list-style-type: none"> <li>• chiropractic manipulation (office visit) and 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>	\$30 copay 20% after the deductible \$30 copay \$30 copay	40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible
<b>Inpatient Facility Services</b>	20% after the deductible	40% after the deductible
<b>Outpatient Facility 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>	20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible	40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible
<b>Emergency care</b> <ul style="list-style-type: none"> <li>• emergency room (facility charges)</li> <li>• professional charges</li> <li>• ambulance (medically necessary transport to the nearest facility equipped to treat the condition)</li> </ul>	\$150 copay 0% 0%	

Key Benefits	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
<b>Durable Medical Equipment</b>	20% after the deductible	40% after the deductible
<b>Behavioral health (mental health and substance abuse services)</b> <ul style="list-style-type: none"> <li>inpatient professional services</li> <li>outpatient professional services (office visits)</li> <li>outpatient hospital/facility services</li> </ul>	20% after the deductible \$30 copay 20% after the deductible	40% after the deductible 40% after the deductible 40% after the deductible
<b>Prescription drugs – Select Network</b> <ul style="list-style-type: none"> <li>retail (31-day limit)</li> </ul> <b>FlexRx preferred drug list</b> <ul style="list-style-type: none"> <li>open plan design</li> <li>preferred generic</li> <li>non-preferred generic</li> <li>preferred brand</li> <li>non-preferred brand</li> </ul> <b>Specialty drug list</b> <ul style="list-style-type: none"> <li>90dayRx – Mail order pharmacy (90-day limit)</li> </ul> <b>FlexRx preferred drug list</b> <ul style="list-style-type: none"> <li>open plan design</li> <li>preferred generic</li> <li>non-preferred generic</li> <li>preferred brand</li> <li>non-preferred brand</li> </ul> <ul style="list-style-type: none"> <li>90dayRx – Retail pharmacy (90-day limit)</li> </ul> <b>FlexRx preferred drug list</b> <ul style="list-style-type: none"> <li>open plan design</li> <li>preferred generic</li> <li>non-preferred generic</li> <li>preferred brand</li> <li>non-preferred brand</li> </ul>	\$10 copay \$15 copay \$25 copay \$35 copay  20% to a maximum of \$200 per prescription  \$30 copay \$45 copay \$75 copay \$105 copay  \$30 copay \$45 copay \$75 copay \$105 copay	No coverage No coverage No coverage No coverage  No coverage  No coverage No coverage No coverage No coverage  No coverage No coverage No coverage No coverage
<b>Important Information About Your Pharmacy Benefits</b>	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 <a href="http://bluecrossmn.com">bluecrossmn.com</a> 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](http://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](http://bluecrossmn.com) or call Blue Cross customer service at the number on the back of your member ID card.

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