

High Deductible Health Plan

Aware HDHP \$1,650 Deductible 20% Coinsurance



Minnesota

Plan

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

Key benefits	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Calendar-year deductible The in- and out-of-network accumulate separately.	Medical and prescription combined \$1,650 individual \$3,300 family	Medical and prescription combined \$4,850 individual \$9,700 family
Coinsurance Level The percent you pay after your deductible is met.	20%	40%
Calendar-year out-of-pocket maximum 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 \$6,000 individual \$12,000 family	Medical and prescription combined \$12,000 individual \$24,000 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% 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible
Physician services <ul style="list-style-type: none"> • e-visits • retail health clinic (office visit) • physician office visits • office lab services • office diagnostic imaging • allergy injections and serum • specialist office visits • Urgent Care professional services 	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	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 40% 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) 	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
Inpatient facility services	20% after the deductible	40% after the deductible
Outpatient facility services <ul style="list-style-type: none"> • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services) 	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
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) 	20% after the deductible 20% after the deductible 20% after the deductible	
Durable Medical Equipment	20% after the deductible	40% after the deductible

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Behavioral health (mental health and substance abuse services) <ul style="list-style-type: none"> inpatient professional services outpatient professional services (office visits) outpatient professional services (office – other services) outpatient hospital/facility services 	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
Prescription drugs – Select Network <ul style="list-style-type: none"> retail (31-day limit) FlexRx preferred drug list <ul style="list-style-type: none"> open plan design preferred generic non-preferred generic preferred brand non-preferred brand Specialty drug list <p>20% to a maximum of \$200 per prescription</p> 90dayRx – Mail order pharmacy (90-day limit) FlexRx preferred drug list <ul style="list-style-type: none"> open plan design preferred generic non-preferred generic preferred brand non-preferred brand 90dayRx – Retail pharmacy (90-day limit) FlexRx preferred drug list <ul style="list-style-type: none"> open plan design preferred generic non-preferred generic preferred brand non-preferred brand 	\$10 copay after the deductible \$15 copay after the deductible \$25 copay after the deductible \$35 copay after the deductible \$30 copay after the deductible \$45 copay after the deductible \$75 copay after the deductible \$105 copay after the deductible \$30 copay after the deductible \$45 copay after the deductible \$75 copay after the deductible \$105 copay after the deductible	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
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 not Medicare Part D creditable.

Non-embedded deductible – The plan begins paying benefits that require cost sharing when the entire family deductible is met. The deductible can be met by one or a combination of several family members. The individual deductible applies to single coverage only.

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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