Preferred Plan
HVN $0 Deductible 0% Coinsurance Copay Plan

BlueCross BlueShield Minnesota

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

Key Benefits	In network* MN Network: HighValue National Network: BlueCard PPO	Out of network**
Calendar-year deductible The in- and out-of-network maximums accumulate separately.	Medical $0 individual $0 family	Medical and prescription combined $750 individual $2,100 family
Coinsurance Level The percent you pay after your deductible is met.	0%	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 $3,000 individual $6,000 family	Medical and prescription combined $6,000 individual $12,000 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 • 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 • 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	 $10 copay $10 copay $25 copay 0% 0% 0% $40 copay $40 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 $80 copay
Other professional services • chiropractic manipulation (office visit) • chiropractic therapy • home health care • physical therapy, occupational therapy, speech therapy (office visit) • physical therapy, occupational therapy, speech therapy (therapy)	 $25 copay 0% 0% $25 copay $25 copay	 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible
Inpatient Facility Services	$250 copay	40% after the deductible
Outpatient Facility Services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	 0% 0% 0% $100 copay 0%	 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible 40% after the deductible
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	$150 copay 0% 0%	
Durable Medical Equipment	0%	40% after the deductible

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Behavioral health (mental health and substance abuse services)		
• inpatient professional services	0%	40% after the deductible
• outpatient professional services (office visits)	$25 copay	40% after the deductible
• outpatient hospital/facility services	0%	40% after the deductible
Prescription drugs – Select Network		
• **retail** (31-day limit)		
FlexRx preferred drug list		
• open plan design		
• preferred generic	$10 copay	No coverage
• non-preferred generic	$15 copay	No coverage
• preferred brand	$25 copay	No coverage
• non-preferred brand	$35 copay	No coverage
Specialty drug list	20% to a maximum of $200 per prescription	No coverage
• **90dayRx – Mail order pharmacy** (90-day limit)		
FlexRx preferred drug list		
• open plan design		
• preferred generic	$30 copay	No coverage
• non-preferred generic	$45 copay	No coverage
• preferred brand	$75 copay	No coverage
• non-preferred brand	$105 copay	No coverage
• **90dayRx – Retail pharmacy** (90-day limit)		
FlexRx preferred drug list		
• open plan design		
• preferred generic	$30 copay	No coverage
• non-preferred generic	$45 copay	No coverage
• preferred brand	$75 copay	No coverage
• non-preferred brand	$105 copay	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. 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** or call Blue Cross customer service at the number on the back of your member ID card.