2024 MEDICAL PLAN OPTIONS

Medical and pharmacy plan resources can be found at **bluecrossmn.com/associate** or by calling customer service at (651) 662-8304, toll free at 1-800-469-1110 (PPO and HSA plans only). If enrolled in the Coupe Health Plan, call the Health Valet Team at 1-833-749-1969 or HealthValet@CoupeHealth.com.

HSA Plan (Aware®/BlueCard® PPO Network or NetworkBlue*)

	In-Network* What you will pay	Out-of-Network* What you will pay
Annual Deductible • Deductibles and out-of-pocket maximums do not cross apply	$3,500 individual; $7,000 family. Includes prescription drugs.	$7,000 individual; $14,000 family. Includes prescription drugs.
Annual Employer Contribution towards Deductible	$750 individual; $1,500 family	
Annual Out-of-Pocket Maximum (OOP) • Deductibles and out-of-pocket maximums do not cross apply	$7,000 individual; $14,000 family. Includes prescription drugs.	$14,000 individual; $28,000 family. Includes prescription drugs.
Preventive Care • routine physicals, immunizations, vaccinations, cancer screenings, well-childcare up to age 6, preventive vision and hearing exam	0%	40% after deductible
Physician Services • maternal care, prenatal • maternal care, delivery and postpartum • primary care office and associated lab/ X-ray services • specialist office visits and associated lab and X-ray • urgent care • inpatient professional services • outpatient professional services • telehealth visits with Doctor on Demand (DoD)	0% 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible
Other Provider Services • chiropractic care • speech, occupational and physical therapy • home health care	20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible
Medical Equipment and Supplies	20% after deductible	40% after deductible
Inpatient Hospital Services	20% after deductible	40% after deductible
Outpatient Hospital Services • outpatient surgery, preadmission tests, radiation therapy, chemotherapy, or kidney dialysis • lab or X-rays	20% after deductible 20% after deductible	40% after deductible 40% after deductible
Emergency Care • emergency room and physician charges	20% after deductible	
Ambulance Services	20% after deductible	
Behavioral Health (mental health and chemical dependency) • inpatient • outpatient facility • professional	20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible
Prescription Drugs** • Retail (31-day limit) • Mail order or 90dayRx retail (in-network only)	20% after deductible 20% after deductible	No coverage No coverage
Specialty Pharmacy Drugs	20% after deductible. 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.	

*If you live outside of the state of Florida, this plan uses the Aware® Network within MN and surrounding counties and BlueCard® PPO when traveling outside the service area. If you live in the state of Florida, your network is NetworkBlue for services obtained within the state of Florida and BlueCard® PPO when traveling outside the state of Florida. **The Pharmacy Network through Prime Therapeutics is the Essential Pharmacy Network (E). There is no drug coverage at out-of-network pharmacies. The Formulary (Drug List) is KeyRx and there is no coverage for drugs that are not on the KeyRx formulary. Review your Benefit Booklet about what is and is not covered.

PPO Plan (High Value Network*)

	In-Network* What you will pay	Out-of-Network* What you will pay
Annual Deductible • Deductibles and out-of-pocket maximums do not cross apply. Copays do not apply towards deductible	$1,000 individual; $2,000 family	$2,000 individual; $4,000 family
Annual Out-of-Pocket Maximum (OOP) • Deductibles and out-of-pocket maximums do not cross apply. Includes deductible, coinsurance, and copays	$3,000 individual; $6,000 family. Includes prescription drugs.	$6,000 individual; $12,000 family. Includes prescription drugs.
Preventive Care • routine physicals, immunizations, vaccinations, cancer screenings, well-childcare up to age 6, preventive vision and hearing exam	0%	50% after deductible
Physician Services	*First two office visits** in a calendar year are member-paid 0%: no deductible. 0% after a $35 copay thereafter*	
• maternal care, prenatal	0%	50% after deductible
• maternal care, delivery and postpartum	0% after a $35 copay	50% after deductible
• primary care office visits	0% after $35 copay	50% after deductible
• specialist office visits	0% after $55 copay	50% after deductible
• urgent care	0% after $55 copay	50% after deductible
• diagnostic imaging/x-ray	20% after deductible	50% after deductible
• lab services	20% after deductible	50% after deductible
• inpatient and outpatient professional services	20% after deductible	50% after deductible
• telehealth visits with Doctor on Demand (DoD)	0%, no deductible	50% after deductible
Other Provider Services	*First two office visits** in a calendar year will be member-paid 0%: no deductible. 0% after a $35 copay thereafter*	
• chiropractic care	20% after deductible	50% after deductible
• speech, occupational and physical therapy	0% after a $35 copay	50% after deductible
• home health care	20% after deductible	50% after deductible
Chronic Condition Management *Evidence Based Services (Visits, Lab & X-Ray) member-paid at 0% in-network for the following conditions*:		
• diabetes (drugs and supplies)	0%	50% after deductible
• high blood pressure	0%	50% after deductible
• cholesterol lowering	0%	50% after deductible
Medical Equipment and Supplies	20% after deductible	50% after deductible
Inpatient Hospital Services	20% after deductible	50% after deductible
Outpatient Hospital Services		
• outpatient surgery, preadmission tests, radiation therapy, chemotherapy, or kidney dialysis	20% after deductible	50% after deductible
• lab or x-rays	20% after deductible	50% after deductible
Emergency Care and Ambulance Services	20% after deductible	
Behavioral Health (mental health and chemical dependency)	*First two office visits** in a calendar year will be member-paid 0%; no deductible. 0% after a $35 copay thereafter*	
• inpatient	20% after deductible	50% after deductible
• outpatient facility	20% after deductible	50% after deductible
• professional	0% after $35 copay	50% after deductible
Prescription Drugs* **		
• Retail (31-day supply)	Tier 1 $15/Tier 2 $100/Tier 3 $50/Tier 4 $100	No coverage
• Mail order or 90dayRx retail	Tier 1 $45 /Tier 2 $300/Tier 3 $150/Tier 4 $300	No coverage
KeyRx Value Based Benefit Design (VBBD) Drug List • diabetes (drugs and supplies) • high blood pressure • cholesterol lowering	0%	No coverage
Specialty Pharmacy Drugs - Does not apply towards deductible, does apply toward out-of-pocket maximum.	20% to maximum of $200 per script purchased using the specialty pharmacy network supplier are eligible for coverage. No coverage for specialty drugs purchased through a non-participating specialty pharmacy supplier.	

*This plan uses the High Value network within MN and bordering counties, and BlueCard® PPO while traveling outside the service area. **Office visits may include medical history/examination, counseling, coordination of care, nature of presenting problem, and the physician's time. ***The Pharmacy Network through Prime Therapeutics is the Essential Pharmacy Network (E). There is no drug coverage at out-of-network pharmacies. The Formulary (Drug List) is KeyRx and there is no coverage for drugs that are not on the KeyRx formulary.

Coupe Health Plan (Aware®/BlueCard® PPO Network)

	In-Network Tier 1	In-Network Tier 2	In-Network Tier 3	Out-of-Network
	What you will pay			
Annual Deductible	$0			
Coinsurance	Plan pays 100%			
Annual Out-of-Pocket Maximum (OOP) – Medical and Drugs • Individual • Family	$2,000 $4,000 ***No out-of-network coverage except for emergency services**			
Preventive	$0			
Primary care office visit	$15	$25	$40	No coverage
Specialist office visit	$35	$45	$75	No coverage
Advance Imaging (MRI, MRA, CAT, PET Scans)	$170	$230	$380	No coverage
Routine Diagnostic Labs	$10	$15	$25	No coverage
Diagnostic Radiology	$50	$65	$110	No coverage
Diagnostic Lab	$50	$65	$110	No coverage
Urgent Care	$35	$45	$75	No coverage
Outpatient Surgery	$550	$740	$1,235	No coverage
Emergency Room/Emergency Services*	$325			
Ambulance*	$325			
Outpatient Therapies (PT, OT, ST)	$35	$45	$75	No coverage
Inpatient Hospital Stay	$1,035	$1,380	$2,000	No coverage
Home Health Care	$35	$45	$75	No coverage
Hospice	$185	$245	$410	No coverage
Skilled Nursing Facility	$930	$1,240	$2,000	No coverage
Durable Medical Equipment	$75	$100	$170	No coverage
Behavioral Health (mental health and chemical dependency) • Office visits • Outpatient facility • Inpatient facility	$15 $550 $1,035	$25 $740 $1,380	$40 $1,235 $2,000	No coverage No coverage No coverage
Prescription Drugs**	**Tier 1 30-day retail**	**Tier 2 30-day Retail**	**Tier 1/Tier 2 90-day Retail**	**Mail Order 90-day**
• Generic Drugs • Preferred Brand • Non-Preferred Brand • Specialty Drugs – mail order only, 30-day supply maximum***	$5 $15 $25 Mail Order Only	$10 $20 $30 Mail Order Only	$15/$30 $45/$60 $75/$90 Mail Order Only	$10 $30 $50 $30***

This plan uses the Aware®/BlueCard® PPO Network. Your cost of services is based on which tier provider you utilize. *There is no coverage when services are received out-of-network except for emergency services. For more information, review your Coupe benefit booklet, call the Health Valet Team at 1-833-749-1969, or email HealthValet@CoupeHealth.com.

**The PrecisionOne Pharmacy Network is offered by MedOne, an independent company that provides pharmacy benefit management services. There is no coverage at out-of-network pharmacies. There is no coverage for drugs that are not on the Performance formulary. Review your Benefit Booklet about what is and is not covered.

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