

# High Value Gold \$500 Plan 556



Benefit Summary for Small Group | January 1, 2025 – December 31, 2025

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Key benefits	In network MN Network: High Value National Network: BlueCard® PPO	Out of network
<b>What you will pay</b>	You will pay the least when seeing an in-network provider.	You will pay the most when seeing an out-of-network or non-participating provider.
<b>Your deductible</b> The amount you pay per calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply to the in-network deductible.	Medical deductible only \$500 per person \$1,000 family	Medical deductible only \$10,000 per person \$20,000 family
<b>Deductible type</b>	Embedded – 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.	
<b>Your coinsurance</b> The percent of the allowed amount that you pay after your deductible is met.	30%	50%
<b>Your out-of-pocket maximum</b> The maximum amount you pay per calendar year in medical and prescription drug deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply to the in-network out-of-pocket maximum.	Medical & Rx combined \$5,250 per person \$10,500 family	Medical & Rx combined \$30,000 per person \$60,000 family
<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; cancer screening; preventive hearing and vision exams; immunizations and vaccinations</li> </ul>	0% (no deductible) 0% (no deductible) 0% (no deductible)	0% (no deductible) 0% (no deductible) 50% 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 and outpatient lab services</li> <li>• office and outpatient lab diagnostic imaging</li> <li>• office and outpatient allergy injections and serum</li> <li>• specialist office visits</li> <li>• urgent care professional services</li> </ul>	First five E-visits are 0% (no deductible); subsequent visits are \$35/\$70 copay, 0% (no deductible)  \$35 copay \$35 copay 30% after the deductible 30% after the deductible 30% after the deductible \$70 copay \$35/\$70 copay	50% after the deductible  50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible
<b>Other professional services</b> <ul style="list-style-type: none"> <li>• chiropractic manipulation (office visit)</li> <li>• chiropractic therapy</li> <li>• physical therapy, occupational therapy, speech therapy (office visit)</li> <li>• physical therapy, occupational therapy, speech therapy (therapy)</li> </ul>	\$35 copay 30% after the deductible \$35 copay  30% after the deductible	50% after the deductible 50% after the deductible 50% after the deductible  50% after the deductible
<b>Inpatient facility services</b>	30% after the deductible	50% 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>• surgery and anesthesia</li> <li>• urgent care services (facility services)</li> </ul>	30% after the deductible 30% after the deductible 30% after the deductible 30% after the deductible	50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible

Key benefits	In network	Out of network
	MN Network: High Value National Network: BlueCard® PPO	
<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>		30% after the deductible 30% after the deductible 30% after the deductible
<b>Home Health Care</b> Limit: 120 visits per calendar year combined with Private Duty Nursing	30% after the deductible	No Coverage
<b>Durable Medical Equipment</b>	30% after the deductible	50% after the deductible
<b>Bariatric surgery</b>	No Coverage	
<b>Reproductive treatment</b>	No Coverage	
<b>Pediatric Eyewear</b> Limit: Maximum of one standard frame and one pair of lenses or one pair of contact lenses or one year supply of disposable contact lenses per cal year for members age 18 and younger.	30% after the deductible	No Coverage
<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/office therapy)</li> <li>• outpatient professional services (all other services)</li> <li>• outpatient hospital/facility services</li> </ul>	30% after the deductible \$35 copay 30% after the deductible 30% after the deductible	50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible
<b>Prescription drugs – Classic Pharmacy Network</b> (31-day limit) <b>BasicRx drug list</b> <ul style="list-style-type: none"> <li>• Tier 1</li> <li>• Tier 2</li> <li>• Tier 3</li> <li>• Tier 4</li> </ul> <b>90dayRx – Mail order pharmacy</b> (93-day limit) or <b>Retail pharmacy</b> (93-day limit) <b>BasicRx drug list</b> <ul style="list-style-type: none"> <li>• Tier 1</li> <li>• Tier 2</li> <li>• Tier 3</li> <li>• Tier 4</li> </ul>	\$20 copay \$75 copay \$150 copay 30% (no deductible)  \$60 copay \$225 copay \$450 copay 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>	For a list of drugs on your specified Preferred drug list, visit <a href="https://bluecrossmn.com/smallgroupdruglist2025">bluecrossmn.com/smallgroupdruglist2025</a> or contact Customer Service.	

This is only a summary of covered benefits. For detailed information about what is and isn't covered refer to plan benefit booklet or visit [bluecrossmn.com](https://bluecrossmn.com). Services not covered include custodial care or rest cures, bariatric surgery, infertility, adult eyewear, adult dental services, services that are experimental, not medically necessary or received while on military duty and certain services for the treatment of autism.

Each healthcare provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.