High Value Silver $4,500 Rx Copay Plan 583

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

Key benefits	In network MN Network: High Value National Network: BlueCard® PPO	Out of network
What you will pay	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.
Your deductible 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 $4,500 per person $9,000 family	Medical deductible only $10,000 per person $20,000 family
Deductible type	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.	
Your coinsurance The percent of the allowed amount that you pay after your deductible is met.	30%	50%
Your out-of-pocket maximum 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 $7,000 per person $14,000 family	Medical & Rx combined $30,000 per person $60,000 family
Preventive care		
• well-child care to age 6	0% (no deductible)	0% (no deductible)
• prenatal care	0% (no deductible)	0% (no deductible)
• preventive medical evaluations age 6 and older; cancer screening; preventive hearing and vision exams; immunizations and vaccinations	0% (no deductible)	50% after the deductible
Physician Services		
• e-visits	First five E-visits are 0% (no deductible): subsequent visits are 30% after the deductible	50% after the deductible
• retail health clinic (office visit)	30% after the deductible	50% after the deductible
• physician office visits	30% after the deductible	50% after the deductible
• office and outpatient lab services	30% after the deductible	50% after the deductible
• office and outpatient lab diagnostic imaging	30% after the deductible	50% after the deductible
• office and outpatient allergy injections and serum	30% after the deductible	50% after the deductible
• specialist office visits	30% after the deductible	50% after the deductible
• urgent care professional services	30% after the deductible	50% after the deductible
Other professional services		
• chiropractic manipulation (office visit)	30% after the deductible	50% after the deductible
• chiropractic therapy	30% after the deductible	50% after the deductible
• physical therapy, occupational therapy, speech therapy (office visit)	30% after the deductible	50% after the deductible
• physical therapy, occupational therapy, speech therapy (therapy)	30% after the deductible	50% after the deductible
Inpatient facility services	30% after the deductible	50% after the deductible
Outpatient facility services		
• facility lab services	30% after the deductible	50% after the deductible
• facility diagnostic imaging	30% after the deductible	50% after the deductible
• surgery and anesthesia	30% after the deductible	50% after the deductible
• urgent care services (facility services)	30% after the deductible	50% after the deductible

Key benefits	In network MN Network: High Value National Network: BlueCard® PPO	Out of network
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	30% after the deductible 30% after the deductible 30% after the deductible	
Home Health Care Limit: 120 visits per calendar year combined with Private Duty Nursing	30% after the deductible	No Coverage
Durable Medical Equipment	30% after the deductible	50% after the deductible
Bariatric surgery	No Coverage	
Reproductive treatment	No Coverage	
Pediatric Eyewear 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
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits/office therapy) • outpatient professional services (all other services)	 30% after the deductible 30% after the deductible 30% after the deductible	 50% after the deductible 50% after the deductible 50% after the deductible
• outpatient hospital/facility services	30% after the deductible	50% after the deductible
Prescription drugs – Classic Pharmacy Network (31-day limit) **BasicRx drug list** • Tier 1 • Tier 2 • Tier 3 • Tier 4	 $20 copay $60 copay $180 copay $575 copay	 No Coverage No Coverage No Coverage No Coverage
90dayRx – Mail order pharmacy (93-day limit) or **Retail pharmacy** (93-day limit) **BasicRx drug list** • Tier 1 • Tier 2 • Tier 3 • Tier 4	 $60 copay $180 copay $540 copay No Coverage	 No Coverage No Coverage No Coverage No Coverage
Important information about your pharmacy benefits	For a list of drugs on your specified Preferred drug list, visit **bluecrossmn.com/smallgroupdruglist2025** 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.** 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.