

2025 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 or have questions on 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 <u>not</u> 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	\$500 individual; \$1,000 family	
Annual Out-of-Pocket Maximum (OOP) • Deductibles and out-of-pocket maximums do <u>not</u> 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 <ul style="list-style-type: none"> Deductibles and out-of-pocket maximums do <u>not</u> 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) <ul style="list-style-type: none"> Deductibles and out-of-pocket maximums do <u>not</u> 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 <ul style="list-style-type: none"> routine physicals, immunizations, vaccinations, cancer screenings, well-childcare up to age 6, preventive vision and hearing exam 	0%	50% after deductible
Physician Services <ul style="list-style-type: none"> maternal care, prenatal maternal care, delivery and postpartum primary care office visits specialist office visits urgent care diagnostic imaging/x-ray lab services inpatient and outpatient professional services telehealth visits with Doctor on Demand (DoD) 	<i>First two office visits** in a calendar year are member-paid 0%: no deductible. 0% after a \$35 copay thereafter</i> 0% 0% after a \$35 copay 0% after \$35 copay 0% after \$55 copay 0% after \$55 copay 20% after deductible 20% after deductible 20% after deductible 0%, no deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
Other Provider Services <ul style="list-style-type: none"> chiropractic care speech, occupational and physical therapy home health care 	<i>First two office visits** in a calendar year will be member-paid 0%: no deductible. 0% after a \$35 copay thereafter</i> 20% after deductible 0% after a \$35 copay 20% after deductible	50% after deductible 50% after deductible 50% after deductible
Chronic Condition Management <i>Evidence Based Services (Visits, Lab & X-Ray) member-paid at 0% in-network for the following conditions:</i> <ul style="list-style-type: none"> diabetes (drugs and supplies) high blood pressure cholesterol lowering 	0% 0% 0%	50% after deductible 50% after deductible 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 <ul style="list-style-type: none"> outpatient surgery, preadmission tests, radiation therapy, chemotherapy, or kidney dialysis lab or x-rays 	20% after deductible 20% after deductible	50% after deductible 50% after deductible
Emergency Care and Ambulance Services	20% after deductible	
Behavioral Health (mental health and chemical dependency) <ul style="list-style-type: none"> inpatient outpatient facility professional 	<i>First two office visits** in a calendar year will be member-paid 0%; no deductible. 0% after a \$35 copay thereafter</i> 20% after deductible 20% after deductible 0% after \$35 copay	50% after deductible 50% after deductible 50% after deductible
Prescription Drugs*** <ul style="list-style-type: none"> Retail (31-day supply) Mail order or 90dayRx retail 	Tier 1 \$15/Tier 2 \$100/Tier 3 \$50/Tier 4 \$100 Tier 1 \$45 /Tier 2 \$300/Tier 3 \$150/Tier 4 \$300	No coverage No coverage
KeyRx Value Based Benefit Design (VBBD) Drug List <ul style="list-style-type: none"> 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

2025 Coupe Health Plan (Aware®/BlueCard® PPO Network)

	In-Network Tier 1	In-Network Tier 2	In-Network Tier 3	Out-of-Network
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			No coverage
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	\$45	\$45	\$45	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
Prescription Drugs**	31-day retail	Mail Order		90-Day Retail
• Tier 1 (Generic Drugs)	\$5	\$15		\$15
• Tier 2 (Non-Preferred Generic)	\$25	\$75		\$75
• Tier 3 (Preferred Brand)	\$15	\$45		\$45
• Tier 4 (Non-Preferred Brand)	\$25	\$75		\$75
• Specialty Drugs – mail order only, 30-day supply maximum***		\$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 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.

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