BlueCard PPO Plan

BlueCross BlueShield Minnesota

Benefit Summary | Effective Dates January 1, 2024 – December 31, 2024

Key Benefits	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Calendar-year deductible The in- and out-of-network maximums accumulate separately. Any dollars paid toward the deductible the last three months of the calendar year will apply to the deductible for the next calendar year.	Medical $1,500 individual $3,000 family	Medical $2,500 individual $5,000 family
Coinsurance Level The percent you pay after your deductible is met.	20%	20%
Calendar-year out-of-pocket maximum The medical in- and out-of-network maximums accumulate separately The prescription in- and out-of-network maximums cross apply Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical $2,500 individual $5,000 family Prescription $1,000 individual $2,000 family	Medical $4,000 individual $8,000 family Prescription $1,000 individual $2,000 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% 0% after the deductible 0% after the deductible 0% after the deductible 0% after the deductible
Physician services • e-visits • retail health clinic (office visit) • physician office visits • office, outpatient, and inpatient lab services • office, outpatient, and inpatient diagnostic imaging • allergy injections and serum • Urgent Care professional services	 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 0% 20% after the deductible	 20% after the deductible 20% after the deductible 20% after the deductible 20% after the in-network deductible 20% after the in-network deductible 20% after the deductible 20% after the in-network deductible
Other professional services • chiropractic manipulation (office visit) • chiropractic therapy • home health care • hospice care • physical therapy, occupational therapy, speech therapy (office visit) • physical therapy, occupational therapy, speech therapy (therapy)	 20% after the deductible 20% after the deductible 20% after the deductible 0% 20% after the deductible 20% after the deductible	 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible
Inpatient Facility Services	20% after the deductible	20% after the deductible
Outpatient Facility Services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible	 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible

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Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	20% after the deductible 20% after the deductible 20% after the deductible	
Durable Medical Equipment	20% after the deductible	20% after the deductible
Bariatric surgery	20% after the deductible	No coverage
Assisted fertilization	20% after the deductible	20% after the deductible
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services	 20% after the deductible 20% after the deductible 20% after the deductible	 20% after the deductible 20% after the deductible 20% after the deductible
Preventive drug benefit	0% after the deductible	No coverage
Prescription drugs – Select Network • **retail** (31-day limit) **FlexRx preferred drug list** open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand **Specialty drug list** • Specialty preferred • Specialty non-preferred • **90dayRx – Mail order pharmacy** (93-day limit) **FlexRx preferred drug list** Open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand • **90dayRx – Retail pharmacy** (93-day limit) **FlexRx preferred drug list** open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand	 100% after $20 copay 100% after $20 copay 100% after $20 copay 100% after $75 copay Member pays 20% up to $300 per script Member pays 40% per script 100% after $40 copay 100% after $40 copay 100% after $40 copay 100% after $150 copay 100% after $40 copay 100% after $40 copay 100% after $40 copay 100% after $150 copay	 40% 40% 40% 40% No coverage No coverage No coverage No coverage No coverage No coverage No coverage No coverage No coverage No coverage
	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.