$1,500-$25-20% Copay

Benefit Summary | January 1, 2026 – December 31, 2026

Key benefits	In network	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 and amounts paid in-network DO NOT apply to the out of network deductible.	Medical deductible only $1,500 $4,500	Medical deductible only $5,000 $10,000
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.	20%	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 and amounts paid in-network DO NOT apply to the out of network out-of-pocket maximum.	Medical & Rx combined $4,000 $8,000	Medical & Rx combined $10,000 $20,000
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% 50% after the deductible
Physician services • e-visits • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • office and outpatient allergy injections and serum • specialist office visits • urgent care professional services	 First five E-visits are 0% (no deductible): subsequent E-visits are $20 copay, 0% (no deductible) $25 copay $25 copay 20% after the deductible 20% after the deductible 20% after the deductible $25 copay $25 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 50% after the deductible
Other professional services • chiropractic manipulation (office visit) • chiropractic therapy • home health care • physical therapy, occupational therapy, speech therapy (office visit) • physical therapy, occupational therapy, speech therapy (therapy)	 $25 copay 20% after the deductible 20% after the deductible $25 copay 20% after the deductible	 50% after the deductible 50% after the deductible No Coverage 50% after the deductible 50% after the deductible
Inpatient facility services	20% after the deductible	50% after the deductible

Key benefits	In network	Out of network
Outpatient facility services • facility lab services • facility diagnostic imaging • surgery and anesthesia • urgent care services (facility services)	 20% after the deductible 20% after the deductible 20% after the deductible 20% after the deductible	 50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible
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	50% after the deductible
Bariatric surgery	No Coverage	
Reproductive treatment	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) • outpatient hospital/facility services	 20% after the deductible $25 copay 20% after the deductible 20% after the deductible	 50% after the deductible 50% after the deductible 50% after the deductible 50% after the deductible
Prescription drugs – Classic Pharmacy Network **Retail** (31-day limit) **KeyRx drug list** • Tier 1 – Preferred generics • Tier 2 – Non-preferred generics • Tier 3 – Preferred brands • Tier 4 – Non-preferred brands **Specialty drug list**	 $20 copay $50 copay $75 copay $120 copay 20% to a maximum of $550 per prescription	 No Coverage No Coverage No Coverage No Coverage No Coverage
90dayRx – Mail order pharmacy (90-day limit) or **Retail pharmacy** (90-day limit) **KeyRx drug list** • Tier 1 – Preferred generics • Tier 2 – Non-preferred generics • Tier 3 – Preferred brands • Tier 4 – Non-preferred brands	 $60 copay $150 copay $225 copay $360 copay	 No Coverage No Coverage No Coverage No Coverage
Important information about your pharmacy benefits	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. More information about prescription drug coverage is available at **bluecrossmn.com.**	

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.** Members can also call Blue Cross customer service at the number on the back of their member ID card.

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.