Red Wing Public Schools

ENROLLMENT GUIDE 2025

intellicents®

Pick the best benefits for you and your family

Red Wing Public Schools strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you are getting the most out of our benefits—that is why we have put together this Enrollment Guide.

This guide will outline all the different benefits offered, so you can identify which offerings are best for you and your family. If you have questions about any of the benefits mentioned in this guide, please contact Human Resources.

Table of Contents

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact Human Resources.

Contacts

Medical | Blue Cross Blue Shield

Customer Service:	**(866) 873-5943**
Network:	**Open Access Aware Limited Access High Value**
Policy Number:	**See ID Card**
Website:	**bluecrossmnonline.com**

Dental | Blue Cross Blue Shield

Customer Service:	**(866) 873-5943**
Network:	**United Concordia Advantage Plus AXS**
Policy Number:	**See ID Card**
Website:	**bluecrossmnonline.com**

Vision | Blue Cross Blue Shield

Customer Service:	**(866) 873-5943**
Network:	**Davis Vision**
Policy Number:	**See ID Card**
Website:	**bluecrossmnonline.com**

Kavira | Virtual Primary Care

Website: **https://www.kavirahealth.com**

Virtual and At-Home HealthCare | Kavira

Appointment Line:	**(763) 373-3856**
Website:	**Kavirahealth.com**

Life Insurance | Guardian

Customer Service:	**(800) 525-4542**
Policy Number:	**022403**
Website:	**guardianlife.com**

Long Term Disability | Guardian

Customer Service:	**(800) 538-4583**
Policy Number:	**022403**
Website:	**guardianlife.com**

VEBA, FSA | WEX

Customer Service:	**(866) 451-3399**
Website:	**wexinc.com**

Human Resources | Kelsie Kuyath

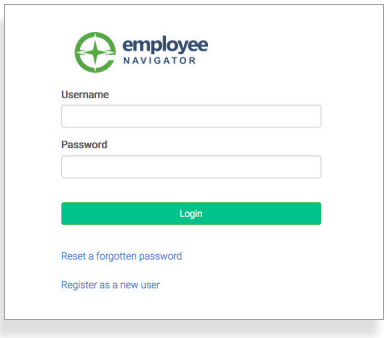
Phone:	**(651) 385-4511**
E-Mail:	**klkuyath@rwps.org**

Your *intellicents* Consulting Team

Lynn Kermes, AIF®, CPFA
Senior Consultant
lynn.kermes@intellicents.com
1-800-880-4015
507-377-2919

Logan Tufte
Relationship Manager
logan.tufte@intellicents.com
1-800-880-4015
507-377-2919

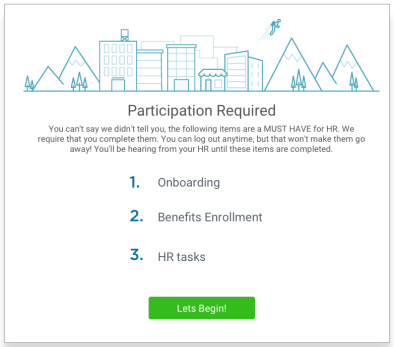
ENROLL IN YOUR BENEFITS: One step at a time



Step 1: Log In

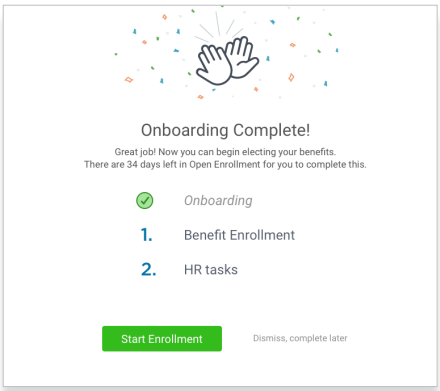
Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.
- **First time users:** You will be asked to enter a Company Identifier. Your Company Identifier is: RedWing



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

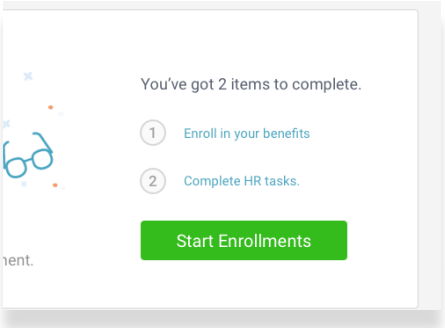


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**



Step 4: Start Enrollments

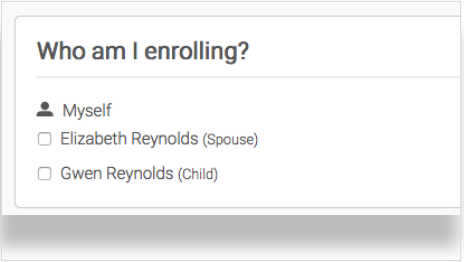
After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

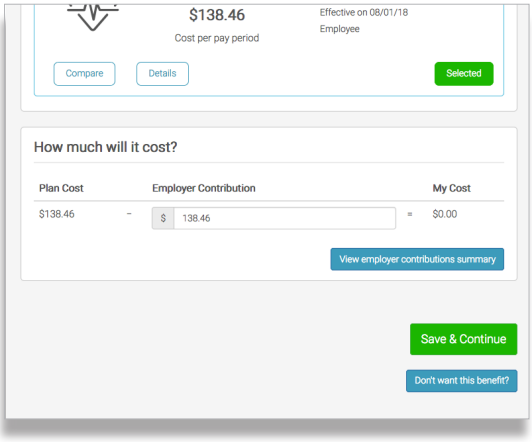
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

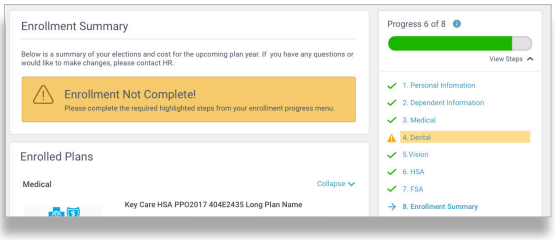


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

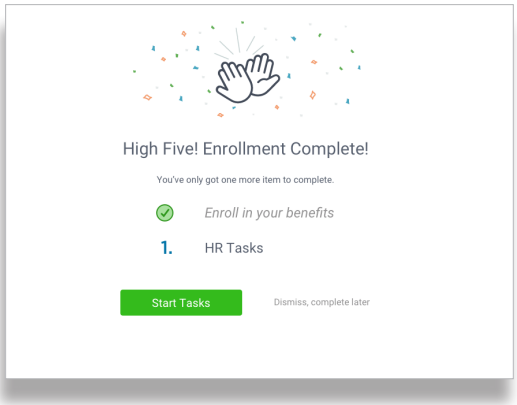


Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7

Health Insurance Networks

Employees of Red Wing Public Schools will have the choice between two medical insurance networks in 2025. Your medical network determines which hospitals and doctors are considered "in-network" and have enhanced coverage for you and your family.

1. **"Open Access Network"/Aware Network** – broadest medical coverage network in the State of Minnesota covering more than 98% of doctors and hospitals in Minnesota.
    - Available with $3,000, $5,000, and $7,000 plans.
    - You will also have national coverage covering 95% of doctors and 96% of hospitals nationwide through the BlueCard PPO.

2. **"Limited Access Network"/High Value Network (HVN)** – alternative, Limited access network that **excludes Mayo Clinic in Rochester, all satellite Mayo Clinic locations, the VA Clinic, and other providers**.
    - Emergency care is considered "in-network" at any provider.
    - Available with $3,000, $5,000, and $7,000 plans.
    - You also still have access to the BlueCard PPO - national coverage covering 95% of doctors and 96% of hospitals nationwide

Please note, the Limited Access/High Value network does not include Mayo as an in-network provider. If you elect either plan with this network, you will pay more for care a Mayo facility.

Network Comparison

	Aware Network	High Value Network
SOUTHEAST		
Allina	X	X
Children's Hospitals & Clinics	X	X
Gundersen Health System	X	X
Mankato Clinic LTD	X	X
Mayo Health System	X	
Northfield Hospital and Clinics	X	X
Olmsted Medical Center	X	X
Veterans Admin Medical Center	X	
Winona Health	X	X

	Aware Network	High Value Network
METRO		
Allina	X	X
Avera	X	
CentraCare Health	X	X
Children's Hospitals & Clinics	X	X
Entira	X	X
HealthPartners Health System	X	
Hennepin County Medical Center	X	X
M Health Fairview	X	X
Mankato Clinic Ltd	X	X
Mayo Health System	X	
North Memorial	X	X
Northfield Hospital and Clinic	X	X
Park Nicollet	X	
Ridgeview	X	X
St. Croix Regional Medical Center	X	X
University of Minnesota Physicians	X	X
Veterans Admin Medical Center	X	

Health Insurance Plans

	$3,000 Plan Open Access Aware Network		$5,000 Plan Open Access Aware Network	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Type				
Deductible Type	Embedded		Embedded	
Overall Deductible				
Individual	$3,000	$4,500	$5,000	$6,500
Family	$6,000	$9,000	$10,000	$13,000
Out-of-Pocket Limit				
Individual	$4,500	$6,000	$5,600	$8,000
Family	$9,000	$12,000	$11,200	$16,000
After Deductible is met, you owe				
Office visit for injury/illness	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Specialist visit	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Preventative	No Charge	40% after deductible	No Charge	40% after deductible
If you need immediate medical attention				
Emergency room services	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs				
Preferred generic drugs	20% after deductible	No Coverage	20% after deductible	No Coverage
Preferred brand drugs	20% after deductible	No Coverage	20% after deductible	No Coverage
Non-preferred drugs	30% after deductible	No Coverage	30% after deductible	No Coverage
Specialty drugs	20% after deductible	No Coverage	20% after deductible	No Coverage
This is a summary of benefit highlights only. See plan document for full plan details.				

Premium Summary

Please refer to your collective bargaining agreement for employee premium share amount.

Health Insurance – Open Access

	$7,000 Plan Open Access Aware Network	
	In-Network	Out-of-Network
Deductible Type		
Deductible Type	Embedded	
Overall Deductible		
Individual	$7,000	$10,000
Family	$14,000	$20,000
Out-of-Pocket Limit		
Individual	$7,000	$15,000
Family	$14,000	$30,000
After Deductible is met, you owe		
Office visit for injury/illness	0% after deductible	40% after deductible
Specialist visit	0% after deductible	40% after deductible
Urgent care	0% after deductible	40% after deductible
Preventative	No Charge	40% after deductible
If you need immediate medical attention		
Emergency room services	0% after deductible	20% after deductible
Prescription Drugs		
Preferred generic drugs	0% after deductible	No Coverage
Preferred brand drugs	0% after deductible	No Coverage
Non-preferred drugs	0% after deductible	No Coverage
Specialty drugs	0% after deductible	No Coverage
This is a summary of benefit highlights only. See plan document for full plan details.		
Premium Summary		
Please refer to your collective bargaining agreement for employee premium share amount.		

Health Insurance – High Value

	$3,000 Plan High Value (NO MAYO) Network		$5,000 Plan High Value (NO MAYO) Network	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Type				
Deductible Type	Embedded		Embedded	
Overall Deductible				
Individual	$3,000	$5,000	$5,000	$6,500
Family	$6,000	$10,000	$10,000	$13,000
Out-of-Pocket Limit				
Individual	$4,500	$10,000	$5,600	$10,000
Family	$9,000	$20,000	$11,200	$20,000
After Deductible is met, you owe				
Office visit for injury/illness	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Specialist visit	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Preventative	No Charge	40% after deductible	No Charge	40% after deductible
If you need immediate medical attention				
Emergency room services	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs				
Preferred generic drugs	20% after deductible	No Coverage	20% after deductible	No Coverage
Preferred brand drugs	20% after deductible	No Coverage	20% after deductible	No Coverage
Non-preferred drugs	30% after deductible	No Coverage	30% after deductible	No Coverage
Specialty drugs	20% after deductible	No Coverage	20% after deductible	No Coverage
This is a summary of benefit highlights only. See plan document for full plan details.				

Premium Summary

Please refer to your collective bargaining agreement for employee premium share amount.

Health Insurance – High Value

	$7,000 Plan High Value (NO MAYO) Network	
	In-Network	Out-of-Network
Deductible Type		
Deductible Type	Embedded	
Overall Deductible		
Individual	$7,000	$10,000
Family	$14,000	$20,000
Out-of-Pocket Limit		
Individual	$7,000	$15,000
Family	$14,000	$30,000
After Deductible is met, you owe		
Office visit for injury/illness	0% after deductible	40% after deductible
Specialist visit	0% after deductible	40% after deductible
Urgent care	0% after deductible	40% after deductible
Preventative	No Charge	40% after deductible
If you need immediate medical attention		
Emergency room services	0% after deductible	0% after deductible
Prescription Drugs		
Preferred generic drugs	0% after deductible	No Coverage
Preferred brand drugs	0% after deductible	No Coverage
Non-preferred drugs	0% after deductible	No Coverage
Specialty drugs	0% after deductible	No Coverage
This is a summary of benefit highlights only. See plan document for full plan details.		
Premium Summary		
Please refer to your collective bargaining agreement for employee premium share amount.		

kavira.

Kavira is a membership-based primary and urgent care clinic that provides everyday medical care, lab work, medications, tests, exams, and non-emergency imaging via virtual visits, in-person house and office visits, for you and your family.

What is included?

Free* Visits: Chat, Video, In-Person House and Office Visits

Medications: 300 free medications: our providers can diagnose, treat and prescribe

Labs: 30 free labs available; access to thousands of other heavily discounted labs

Who has Access: You, your spouse, and your children under the age of 26 have free* access to Kavira

Hours of Service: Weekdays available for House Visits and Telehealth from 8am-7pm; Weekends available for Telehealth-Only from 10am-2pm

kavira.

Services List

Acute Conditions We Treat:

- Asthma
- Athlete's foot
- Bronchitis
- Bug bites
- Cold sores
- Cough, cold & flu
- Diarrhea
- Ear concerns (pain, drainage, wax)
- Gout flare up
- Hand, foot, mouth
- Insomnia
- Muscle or joint pain
- Pink eye
- Rashes, skin conditions, burns
- Sprains and strains
- Sinus infection
- Sore throat
- Stitch removal
- UTI (female)
- Vaginitis (yeast or BV infection)
- Various viral illnesses
- Wart evaluation
- Many more

Chronic Conditions We Treat:

- Acne
- Anemia (mild) evaluation
- Anxiety / Mild-moderate depression
- Asthma
- Constipation
- Diabetes type 2
- Eczema
- Epi-pen refills
- Gout
- Hair Loss
- Heartburn (GERD)
- High cholesterol
- Hypertension
- Hypothyroidism
- Obesity
- Osteoarthritis
- Seasonal allergies

Preventive:

- Wellness exams
- Contraception
- Sports physicals
- Tobacco / nicotine cessation
- Wellness goals

Imaging (non-emergency):

- X-rays
- EKGs

Additional Services:

- 30 free labs
- 300 free Rxs

***Note**: This is not a comprehensive list of treatable conditions. Decisions to treat specific medical conditions will be based on patient medical history, complexity, and provider discretion. For the most up-to-date services list, please visit www.kavirahealth.com/services*

kavira.

Helpful Resources and FAQs

How do I learn more about the free labs and medications?

Visit our website at www.kavirahealth.com/labsandmeds

Who are my providers?

We have a team of Board-Certified Nurses and Nurse Practitioners. Our providers have specialties in family medicine, urgent care, pediatrics and behavioral health.

Who in my family can use this?

Your spouse and children (under the age of 26). If they are under the age of 18, we ask that you use the app and handle communication with providers. If they are between the ages of 18-26, we ask that you provide us with their information so that we can get them into our system.

I don’t have a smartphone

No problem! Give us a call or send us a text at (763) 373-3856. Or access our clinic through your browser.

Dental Insurance

	Low Plan - Freedom Standard In-Network	High Plan - Freedom Enhanced In-Network
Basic Information		
Deductible Per Person	$0	$25
Deductible Per Family	$0	$75
Deductible Waived for Preventative	Yes	Yes
Calendar Year Maximum Per Covered Person	$800	$1,000
Benefit Coverage		
Diagnostic & Preventive	80%	100%
Routine and Restorative Care	50%	80%
Major Restorative Services	50%	50%
Orthodontics		
Orthodontic Services	No coverage	50%
Orthodontia Dependent Child Coverage Age	N/A	Up to age 19
Orthodontia Lifetime Maximum	N/A	$1,000
Other Features		
Waiting Periods	No waiting periods	No waiting periods
Dental Dependent Child Coverage Age	Up to age 26	Up to age 26
Preventative Incentive	Preventive and diagnostic services are not applied to the annual maximum	
This is a summary of benefit highlights only. See plan document for full plan details.		
Premium Summary		
Please refer to your collective bargaining agreement for employee premium share amount.		

Vision Insurance

Voluntary Vision

In-Network

Basic Information	
Eye Exam	Covered 100% after a $10 Copay
Contact Lens Evaluation & Fitting	Covered 100% after a $10 Copay
Lenses	
Standard Plastic Lenses	Covered 100% after a $10 Copay
Frames	
Standard Frames	Davis Vision Exclusive Collection is Covered 100%; Frames at Visionworks are up to $200 plus 20% of remaining cost; Non-Davis Vision Exclusive Collection from other participating retailers pays up to $150 plus 20% of the remaining cost
Contact Lenses	
Elective Contact Lenses - Davis Vision Collection	Disposable: Up to 8 boxes/multi-packs; Non-disposable: Up to 4 boxes/multi-packs
Elective Contact Lenses - Non-Collection	Up to $150 plus 15% discount on remaining costs
Medically Necessary Contact Lenses	Covered 100%
Frequency of Services	
Exams	12 months
Frames	12 months
Lenses	12 months
Contact Lenses	12 months (in lieu of eyeglass lenses)
This is a summary of benefit highlights only. See plan document for full plan details.	

Premium Summary

Contract Type	Monthly Employee Premium 2025
Employee Only	$6.65
Employee + Spouse	$13.09
Employee + Child(ren)	$12.39
Family	$20.21

VEBA

What is a health reimbursement arrangement (VEBA)?

A benefit provided by your employer that sets money aside for you to spend on eligible healthcare expenses. Depending on how your employer set up your VEBA, you may have access to all or some of your funds at the beginning of the year. And you may be able to spend your funds on your spouse or dependents.

What does it cover?

There are thousands of eligible items, including:

Doctor visits and surgeries

Over-the-counter medications

Prescription drugs

Dental and orthodontia

Vision expenses

How do I get the most from my VEBA?

Spending funds
You can use your VEBA dollars on eligible healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Simply swipe your debit card at the point of purchase.

Online account and mobile app
You can log in to your online account or mobile app 24/7 and review your VEBA balance and submit out-of-pocket claims for reimbursement.

Text alerts
Sign up for text alerts in your online account and stay on top of your VEBA balance and debit card transactions.

VEBA

What is a health reimbursement arrangement (VEBA)?

A benefit provided by your employer that sets money aside for you to spend on eligible healthcare expenses. Depending on how your employer set up your VEBA, you may have access to all or some of your funds at the beginning of the year. And you may be able to spend your funds on your spouse or dependents.

What you need to know about your VEBA:

Funding

As soon as your employer funds the account, the money belongs to you.
Active employees and early retirees enrolled in the group medical plan may receive a base VEBA benefit of $900 per year at $75 per month.

Additional Funding

Eligible participants can earn an additional VEBA contribution of up to $900 annually through the district sponsored wellness program.

Total Funding

Between the $900 base contribution and the wellness program incentive, eligible members can receive up to $1,800 into their VEBA annually.

Reimbursement

VEBA funds can be used to pay for eligible medical expenses now or later, even in retirement.

Taxation

You don't pay taxes on account contributions, interest earned or on qualified withdrawals.

Growth

Your money can earn interest tax-free, from day one. After your Base Balance reaches $1,000, you can open a basic investment account with access to 30+ mutual funds.

Flexible Spending Accounts

What is a Flexible Spending Account (FSA)?

- Flexible Spending Accounts are personal expense accounts that allow you to set aside a portion of your salary pre-tax and use that money for eligible expenses. Using pre-tax dollars on those eligible expenses allows you to save 10 to 40% on these eligible costs, depending on your tax bracket.[1]
- You have two types of Flexible Spending Accounts available to you as an employee of Red Wing Public Schools:
    - Health Flexible Spending Account
    - Dependent Care Flexible Spending Account
- The district's Flexible Spending Accounts are administered by **WEX**.

Have questions?

Our Participant Services team is available Monday - Friday 6:00 a.m. to 9:00 p.m. Central time.

Questions when enrolled: 1-866-451-3399
Questions before you enroll: 1-844-561-1337
Email a question: customerservice@wexhealth.com
Submit a form: forms@wexhealth.com
Live chat: go to **www.wexinc.com**, hover over Solutions and select Participants/Employees.

[1] Depends on your income tax bracket. Consult a tax advisor for more information.

Medical FSA

Why should I choose a medical flexible spending account?

A medical FSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses. This saves you money by reducing your taxable income.

Funds on Day 1
Schedule that surgery, buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use your benefits debit card at the point of purchase.

Discount
Think of it like a discount on healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Dollars you contribute are taken out of your paycheck before tax which means a $100 purchase would actually cost you over $130 without a medical FSA.*

Plan ahead
Think about the money you spent on healthcare expenses last year. Plan ahead and set those funds aside in a medical FSA and save 30%.*

*Based on a 30% tax bracket.

What does it cover?

There are thousands of eligible items, including:

- Copays and coinsurance
- Doctor visits and surgeries
- Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- Prescription drugs
- Birthing and lamaze classes
- Dental and orthodontia
- Frames, contacts, prescription sunglasses, etc.

View our interactive eligible expense list at
www.wexinc.com/insights/benefits-toolkit/eligible-expenses/

Can I enroll?

Yes, as long as you or your spouse aren't actively enrolled and contributing to a health savings account (HSA).

Fast fact

Don't know how much to elect? Determine how much you spent on healthcare expenses last year and estimate the amount you'll spend this year using our eligible expense list. Any funds you contribute to the medical FSA must be spent by the end of the plan year.

Flexible Spending Account

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a medical FSA. The annual contribution limit is $3,300. We recommend reviewing how much you spend on eligiblehealthcare expenses every year to determine how much to elect.

Funds on day 1

All of your FSA dollars are available on the very first day of the plan year. For example, if you choose to contribute $1,200 to your FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all $1,200 on day 1! You can use your funds for expenses incurred by you, your spouse or eligible dependents.

Use-or-lose

Don't forget to spend your FSA dollars. You will forfeit any money left in your account at the end of the plan year. (Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.)

Changing your FSA election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event.

These events include:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status

If you experience a qualifying life event, contact your employer to make changes to your election.

Dependent Care FSA

Why should I choose a dependent care FSA?

A dependent care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year.

Save money
The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.

Save strategically
Submit all of your dependent care expenses at the end of the plan year for one lump sum reimbursement to give yourself a hard-earned "bonus".

What does it cover?

The list includes, but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before- or after-school care
- Disabled dependent and/or spouse care
- Elder care

Fast Fact

For recurring costs, submit our Recurring Dependent Care Form. It makes claim filing simple because you only need to submit one form once in order to get reimbursed each pay period. You can find the form on the back of this handout.

DCA Open Enrollment (video)

View our interactive eligible expense list at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**

Can I enroll?

You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.

Dependent Care FSA

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a dependent care flexible spending account (dependent care FSA). The annual contribution limit is:

Per household: $5,000 **Per person (if married and filing separately): $2,500**

Although most people incur more than the limit per year, we recommend reviewing how much you spend on eligible dependent care expenses every year to determine your election.

Funds available as you contribute

Funds will be available to you as they're deducted from your paycheck and contributed to the plan. This means when payroll is processed and your paycheck is available to you, your dependent care FSA contributions will be applied to your account and available for reimbursement.

Use-or-lose

Don't forget to spend your FSA dollars. If you have not used all of your FSA dollars before the end of the plan year, you will forfeit any money left in your account. (Employees have a "grace period" of 75 days after 12/31/2024 to continue to submit reimbursement for 2024 FSA expenses.)

Fast Fact

A great way to set it and forget it is to use our Recurring Dependent Care Form that allows you to submit one claim for the entire year and you will be reimbursed after each payroll.

Changing your dependent care FSA election

In order to make changes to your election after open enrollment, you need to experience a qualifying life event. These events include:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status
- Change in daycare providers
- Child turning age 13
- Increase or decrease in the cost of qualifying daycare expenses
- Judgement, decree or order requiring a change in coverage

If you experience a qualifying life event, contact your employer to make changes to your election.

Life Insurance

Guardian®

Employer Paid Base Life and AD&D

Basic Information	
Life Benefit Amount	Please refer to your collective bargaining agreement for Life Benefit Amount.
Beneft Maximum	100% of Life Benefit
Guarantee Issue Amount	100% of Life Benefit
AD&D Benefit Maximums	
Loss of Life	100% of Life Benefit
Other Loss	Percentage of Life Benefit Depending on Type of Loss
Other Features	
Waiver of Premium	Included
Accelerated Benefits	Included
Conversion	Included
Reduction Schedule	None
This is a summary of benefit highlights only. See plan document for full plan details.	

Premium Summary
This is an employer paid benefit.

Voluntary Life Insurance

Guardian®

Voluntary Life and AD&D	
Basic Information	
Employee Life	$20,000 - $500,000; increments of $5,000
Spousal Life	$5,000 - $250,000; increments of $5,000 Not to exceed 100% of Employee life amount
Dependent Child(ren) Life	$1,000 - $20,000; increments of $1,000 Not to exceed 100% of Employee life amount
Guarantee Issue Amounts	
Employee Amount	Under Age 65: $150,000 Age 65-70: $50,000 Age 70+: $10,000
Spousal Amount	Under Age 65: $30,000 Age 65-70: $10,000 Age 70+: $0
Dependent Child(ren) Amount	$20,000
Other Features	
Waiver of Premium	Included
Accelerated Benefits	Included
Conversion	Included
Portability	Included
Premium Summary	
Please see Voluntary Life Rates on Preceeding Page	

Voluntary Life Insurance Rates

Employee	
Age	**Monthly Premium (Per every $1,000)**
Under 30	$0.082
30-34	$0.085
35-39	$0.106
40-44	$0.142
45-49	$0.209
50-54	$0.329
55-59	$0.517
60-64	$0.842
65-69	$1.809
70+	$3.294

Spouse	
Spouse Coverage rates based on employee age	**Monthly Premium (Per every $1,000)**
Under 30	$0.082
30-34	$0.085
35-39	$0.106
40-44	$0.142
45-49	$0.209
50-54	$0.329
55-59	$0.517
60-64	$0.842
65-69	$1.809
70+	$3.294

Child Life	
Age	**Monthly Premium (Per every $1,000)**
14 Days -26 Years	0.194

Long Term Disability

Guardian®

Employer Paid Long Term Disability	
Basic Information	
Long Term Disability Insurance protects your income should you suffer a serious illness or injury and cannot work	
Benefit Percentage	66.6%
Monthly Benefit Maximum	Varies by contract: Please refer to your collective bargaining agreement for Monthly Benefit Maximum.
Elimination Period	90 days
Benefit Duration	
Own Occupation	24 Months
Any Occupation	To Social Security Normal Retirement Age (SSNRA)
Specific Disability Provisions	
Chemical Dependency	24 Months
Mental / Nervous	24 Months
Recurring Disability	Included - 6 Months
This is a summary of benefit highlights only. See plan document for full plan details.	
Premium Summary	
This is an employer paid benefit.	

Scan the QR Code below to see the Aflac Insurance Plans

Aflac helps with expenses health insurance doesn't cover, so you can care about everything else.

Or, visit your benefits page at:
www.aflacenrollment.com/REDWINGPUBLICSCHOOLS/AGC000107000354910

Z2300116QR

EXP 9/24

Red Wing Public Schools ISD 256
Aware $3,000 Deductible PPO
01/01/2025

Coinsurance reflects member responsibility

	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Calendar Year deductible The in- and out-of-network deductibles cross apply.	Medical and prescription combined $3,000 individual $6,000 family	Medical and prescription combined $4,500 individual $9,000 family
Coinsurance Level – What the member pays	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Calendar Year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $4,500 individual $9,000 family	Medical and prescription combined $6,000 individual $12,000 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%	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Omada® • diabetes and cardiovascular disease prevention program	0%	No coverage
Physician services • e-visits (in-network: first three visits free) • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • allergy injections and serum • Urgent Care professional services	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Hospital Inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	

	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Durable Medical Equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Bariatric surgery	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Assisted Fertilization	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Behavioral health (mental health and substance abuse services)		
• inpatient professional services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
• outpatient professional services (office visits)	Deductible then 20% coinsurance	Deductible then 40% coinsurance
• outpatient hospital/facility services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Prescription drugs –Select Network		
retail (31-day limit)		
FlexRx preferred drug list		
• open plan design	Deductible then 20% coinsurance	No coverage
• preferred generic	Deductible then 30% coinsurance	No coverage
• non-preferred generic	Deductible then 20% coinsurance	No coverage
• preferred brand	Deductible then 30% coinsurance	No coverage
• non-preferred brand		
• specialty	Deductible then 20% coinsurance	No coverage
90dayRx – Mail order & Retail pharmacy (90-day limit)		
FlexRx preferred drug list		
• open plan design	Deductible then 20% coinsurance	No coverage
• preferred generic	Deductible then 30% coinsurance	No coverage
• non-preferred generic	Deductible then 20% coinsurance	No coverage
• preferred brand	Deductible then 30% coinsurance	No coverage
• non-preferred brand		
	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 **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

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 poviders
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 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.
The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

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.

BlueCross BlueShield Minnesota

Red Wing Public Schools ISD 256
Aware $5,000 Deductible PPO
01/01/2025

Coinsurance reflects member responsibility

	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Calendar Year deductible The in- and out-of-network deductibles cross apply.	Medical and prescription combined $5,000 individual $10,000 family	Medical and prescription combined $6,500 individual $13,000 family
Coinsurance Level – What the member pays	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Calendar Year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $5,600 individual $11,200 family	Medical and prescription combined $8,000 individual $16,000 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%	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Omada® • diabetes and cardiovascular disease prevention program	 0%	 No coverage
Physician services • e-visits (in-network: first three visits free) • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • allergy injections and serum • Urgent Care professional services	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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)	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Hospital Inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	

	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Durable Medical Equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Bariatric surgery	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Assisted Fertilization	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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 **90dayRx – Mail order & Retail pharmacy** (93-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand	 Deductible then 20% coinsurance Deductible then 30% coinsurance Deductible then 20% coinsurance Deductible then 30% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 30% coinsurance Deductible then 20% coinsurance Deductible then 30% coinsurance	 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 **bluecrossmnonline.com** and select “Prescriptions,” then see “frequently asked questions.”	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.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 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 **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

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.

BlueCross BlueShield Minnesota

Red Wing Public Schools ISD 256
Aware Network $7,000 Deductible PPO
01/01/2025

Coinsurance reflects member responsibility

	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Calendar year deductible The in- and out-of-network deductibles cross apply.	Medical and prescription combined $7,000 individual $14,000 family	Medical and prescription combined $10,000 individual $20,000 family
Coinsurance Level – What the member pays	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Calendar Year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $7,000 individual $14,000 family	Medical and prescription combined $15,000 individual $30,000 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%	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Omada® • diabetes and cardiovascular disease prevention program	 0%	 No coverage
Physician services • e-visits (in-network: first three visits free) • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • allergy injections and serum • Urgent Care professional services	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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)	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Hospital Inpatient services	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	

	In network* MN Network: Aware National Network: BlueCard PPO	Out of network**
Durable Medical Equipment	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Bariatric surgery	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Assisted Fertilization	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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 **90dayRx – Mail order & Retail pharmacy** (93-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 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 **bluecrossmnonline.com** and select “Prescriptions,” then see “frequently asked questions.”	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.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 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 **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

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.

Red Wing Public Schools ISD 256
High Value Network $3,000 Deductible PPO
01/01/2025

Coinsurance reflects member responsibility

	In network* MN Network: High Value National Network: BlueCard PPO	Out of network**
Calendar Year deductible The in- and out-of-network deductibles do not cross apply.	Medical and prescription combined $3,000 individual $6,000 family	Medical and prescription combined $5,000 individual $10,000 family
Coinsurance Level – What the member pays	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Calendar Year out-of-pocket maximum The in- and out-of-pocket maximums do not cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $4,500 individual $9,000 family	Medical and prescription combined $10,000 individual $20,000 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%	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Omada® • diabetes and cardiovascular disease prevention program	0%	No coverage
Physician services • e-visits (in-network: first three visits free) • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • allergy injections and serum • Urgent Care professional services	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Hospital Inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	

	In network* MN Network: High Value National Network: BlueCard PPO	Out of network**
Durable Medical Equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Bariatric surgery	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Assisted Fertilization	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Behavioral health (mental health and substance abuse services)		
• inpatient professional services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
• outpatient professional services (office visits)	Deductible then 20% coinsurance	Deductible then 40% coinsurance
• outpatient hospital/facility services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Prescription drugs –Select Network		
retail (31-day limit)		
FlexRx preferred drug list		
• open plan design	Deductible then 20% coinsurance	No coverage
• preferred generic	Deductible then 30% coinsurance	No coverage
• non-preferred generic	Deductible then 20% coinsurance	No coverage
• preferred brand	Deductible then 30% coinsurance	No coverage
• non-preferred brand		
• specialty	Deductible then 20% coinsurance	No coverage
90dayRx – Mail order & Retail pharmacy (90-day limit)		
FlexRx preferred drug list		
• open plan design	Deductible then 20% coinsurance	No coverage
• preferred generic	Deductible then 30% coinsurance	No coverage
• non-preferred generic	Deductible then 20% coinsurance	No coverage
• preferred brand	Deductible then 30% coinsurance	No coverage
• non-preferred brand		
	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 **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

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 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.
The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program

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.

BlueCross BlueShield Minnesota

Red Wing Public Schools ISD 256
High Value Network $5,000 Deductible PPO
01/01/2025

Coinsurance reflects member responsibility

	In network* MN Network: High Value National Network: BlueCard PPO	Out of network**
Calendar Year deductible The in- and out-of-network deductibles do not cross apply.	Medical and prescription combined $5,000 individual $10,000 family	Medical and prescription combined $6,500 individual $13,000 family
Coinsurance Level – What the member pays	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Calendar Year out-of-pocket maximum The in- and out-of-pocket maximums do not cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $5,600 individual $11,200 family	Medical and prescription combined $10,000 individual $20,000 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%	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Omada® • diabetes and cardiovascular disease prevention program	 0%	 No coverage
Physician services • e-visits (in-network: first three visits free) • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • allergy injections and serum • Urgent Care professional services	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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)	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Hospital Inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	

	In network* MN Network: High Value National Network: BlueCard PPO	Out of network**
Durable Medical Equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Bariatric surgery	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Assisted Fertilization	Deductible then 20% coinsurance	Deductible then 40% coinsurance
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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 **90dayRx – Mail order & Retail pharmacy** (93-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand	 Deductible then 20% coinsurance Deductible then 30% coinsurance Deductible then 20% coinsurance Deductible then 30% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 30% coinsurance Deductible then 20% coinsurance Deductible then 30% coinsurance	 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 **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.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 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 **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

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.

BlueCross BlueShield Minnesota

Red Wing Public Schools ISD 256
High Value Network $7,000 Deductible PPO
01/01/2025

Coinsurance reflects member responsibility

	In network* MN Network: High Value National Network: BlueCard PPO	Out of network**
Calendar year deductible The in- and out-of-network deductibles do not cross apply.	Medical and prescription combined $7,000 individual $14,000 family	Medical and prescription combined $10,000 individual $20,000 family
Coinsurance Level – What the member pays	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Calendar Year out-of-pocket maximum The in- and out-of-pocket maximums do not cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $7,000 individual $14,000 family	Medical and prescription combined $15,000 individual $30,000 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%	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Omada® • diabetes and cardiovascular disease prevention program	 0%	 No coverage
Physician services • e-visits (in-network: first three visits free) • retail health clinic (office visit) • physician office visits • office and outpatient lab services • office and outpatient lab diagnostic imaging • allergy injections and serum • Urgent Care professional services	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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)	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Hospital Inpatient services	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Hospital Outpatient services • facility lab services • facility diagnostic imaging • chemotherapy and radiation therapy • scheduled outpatient surgery • urgent care services (facility services)	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
Emergency care • emergency room (facility charges) • professional charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	

	In network* MN Network: High Value National Network: BlueCard PPO	Out of network**
Durable Medical Equipment	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Bariatric surgery	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Assisted Fertilization	Deductible then 0% coinsurance	Deductible then 40% coinsurance
Behavioral health (mental health and substance abuse services) • inpatient professional services • outpatient professional services (office visits) • outpatient hospital/facility services	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 Deductible then 40% coinsurance Deductible then 40% coinsurance Deductible then 40% coinsurance
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 **90dayRx – Mail order & Retail pharmacy** (93-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • non-preferred generic • preferred brand • non-preferred brand	 Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance Deductible then 0% coinsurance	 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 **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.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 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 **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

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.

BlueCross BlueShield Minnesota

BLUE CROSS DENTAL – FREEDOM STANDARD PLAN

Red Wing Public Schools LOW Plan 1/1/2025

	FREEDOM Standard
Plan benefits	**Equal coinsurance in and out of network***
Calendar year deductible Deductible does not apply to preventive and diagnostic services or services covered at 100%	**Individual/Family:** $0/$0
Annual maximum per member Preventive Incentive: Preventive and diagnostic services are not applied to the annual maximum	$800
PREVENTIVE AND DIAGNOSTIC	
Exams and cleanings	80%
Fluoride treatments	80%
X-rays (bitewings and full mouth)	80%
Sealants	80%
BASIC RESTORATIVE	
Amalgam (silver) and composite (white) fillings	50%
Surgical/non-surgical periodontics Includes treatment of gum disease	50%
Endodontics Includes root canal	50%
Simple extractions	50%
Complex oral surgery	50%
General anesthesia	50%
Repairs Includes bridges and dentures	50%
MAJOR	
Inlays, onlays, crowns Every five years for the same tooth	50%
Prosthetics Includes bridges and dentures	50%
TMD (temporomandibular disorder)	50%
ORTHODONTICS – *Optional***	
Diagnostic, active, retention, treatment	No coverage

This plan provides dental coverage only. Your dental plan's benefit booklet will contain more details on standard plan exclusions and frequency limitations.

Blue Cross Dental plans include coverage for certain pediatric dental services. This plan is not exchange-certified and does not qualify as the pediatric dental essential health benefit under the Affordable Care Act.

Discounts may apply. Network dentists may elect to discount non-covered services. Consult our online provider directory at **bluecrossmn.com/findadentist** to search for a dentist. Dentists with a "**$ave!**" symbol next to their name accept allowances for services not covered by the benefit plan, including services rendered after the annual maximum has been exceeded; not available in all areas.

United Concordia Companies, Inc. is an independent company providing dental benefit management services and access to the Advantage Plus AXS network.

*When you receive services from nonparticipating providers, you are responsible for the difference between the allowed amount and the billed charge.

<**Plans with orthodontic benefits are available to groups of 10 to 24 enrolling subscribers who did not have pervious orthodontic coverage after 12 months of Blue Cross Dental plan coverage.>

Each provider in the network is an independent contractor and is not our agent. If you receive services from a nonparticipating provider, you will be responsible for the difference between what Blue Cross will reimburse and what the provider bills.

BLUE CROSS DENTAL – FREEDOM ENHANCED PLAN

Red Wing Public Schools HIGH Plan 1/1/2025

	FREEDOM Enhanced
Plan benefits	**Equal coinsurance in and out of network***
Calendar year deductible Deductible does not apply to preventive and diagnostic services or services covered at 100%	**Individual/Family:** $25/$75
Annual maximum per member Preventive Incentive: Preventive and diagnostic services are not applied to the annual maximum	$1000
Orthodontic lifetime maximum Dependent children to age 19	$1000
PREVENTIVE AND DIAGNOSTIC	
Exams and cleanings	100%
Fluoride treatments	100%
X-rays (bitewings and full mouth)	100%
Sealants	100%
BASIC RESTORATIVE	
Amalgam (silver) and composite (white) fillings	80%
Surgical/non-surgical periodontics Includes treatment of gum disease	80%
Endodontics Includes root canal	80%
Simple extractions	80%
Complex oral surgery	80%
General anesthesia	80%
Repairs Includes bridges and dentures	80%
MAJOR	
Inlays, onlays, crowns Every five years for the same tooth	50%
Prosthetics Includes bridges and dentures	50%
TMD (temporomandibular disorder)	50%
ORTHODONTICS – *Optional***	
Diagnostic, active, retention, treatment	50%

This plan provides dental coverage only. Your dental plan's benefit booklet will contain more details on standard plan exclusions and frequency limitations.

Blue Cross Dental plans include coverage for certain pediatric dental services. This plan is not exchange-certified and does not qualify as the pediatric dental essential health benefit under the Affordable Care Act.

Discounts may apply. Network dentists may elect to discount non-covered services. Consult our online provider directory at **bluecrossmn.com/findadentist** to search for a dentist. Dentists with a "**$ave!**" symbol next to their name accept allowances for services not covered by the benefit plan, including services rendered after the annual maximum has been exceeded; not available in all areas.

United Concordia Companies, Inc. is an independent company providing dental benefit management services and access to the Advantage Plus AXS network.

*When you receive services from nonparticipating providers, you are responsible for the difference between the allowed amount and the billed charge.

<**Plans with orthodontic benefits are available to groups of 10 to 24 enrolling subscribers who did not have pervious orthodontic coverage after 12 months of Blue Cross Dental plan coverage.>

Each provider in the network is an independent contractor and is not our agent. If you receive services from a nonparticipating provider, you will be responsible for the difference between what Blue Cross will reimburse and what the provider bills.

2025 Blue Cross Vision
Premier Enhanced Exam and Eyewear – Option 1

BlueCross BlueShield Minnesota

	In-network benefit	Out-of-network reimbursements
EYE EXAMS – One exam every 12 months		Eye exam: $40
Eye exam Includes dilation when recommended by eye care professional	100% after $10 copay	Frames: $50
PRESCRIPTION GLASSES – Benefit available for eyeglass lenses *or* contact lenses once every 12 months		Lenses: - Single vision: $40 - Bifocal/progressive: $60 - Trifocal: $80 - Lenticular: $100
Lenses* Single vision, lined bifocal, trifocal, lenticular, polycarbonate (dependent children)	100% after $10 copay	
Frames	1 every 12 months	
Davis Vision Exclusive Collection** - Fashion level - Designer level - Premier level	 100%; no copay 100%; no copay 100%; no copay	Contact lenses: - Elective: $105 - Visually required: $225
Non-Davis Vision Exclusive Collection†† - Visionworks stores - Frames available from other participating retailers	 No copay: plan pays up to $200 plus 20% discount on remaining costs*** No copay: plan pays up to $150 plus 20% discount on remaining costs***	*Your plan covers a wide variety of lenses. Be sure the lenses you choose are covered by your plan. You'll have to pay the full cost for lenses your plan doesn't cover.
EYE GLASS ENHANCEMENTS		Your eyecare/eyewear provider can assist you with this, or you can contact customer service at the number on your vision member ID card.
- Tinting of plastic lenses	Member pays $0	**Davis Vision Exclusive Collection available at most participating independent provider offices. Collection is subject to change.
- Scratch-resistant coating	Standard: $0 / Premium: $30	***Additional discount not available at Costco, Walmart, Sam's Club or at participating online retail providers.
- Polycarbonate lenses - Dependent children, monocular patients and those with a prescription of +/-6.00 diopters or greater	 Member pays $0	†Available at most participating independent provider offices. Collection is subject to change.
- Adults	Member pays $30	††Available at participating retail providers.
- Ultraviolet coating	Member pays $12	†††Visually required (also known as medically necessary) means that optimal visual correction cannot be achieved with prescription eyeglasses but can be achieved with contact lens wear. Conditions that may commonly justify visually required lenses include keratoconus, anisometropia, aniseikonia, high astigmatism, pathological myopia, post-traumatic disorders, aphakia, aniridia, and certain corneal conditions.
- Antireflective coating	Standard: $35 / Premium: $48 / Ultra: $60 / Ultimate: $85	
- Blue light filtering	Member pays $15	
- Progressive lenses	Standard: $50 / Premium: $90 / Ultra: $140 / Ultimate: $175	
- High-index lenses	Member pays $55 / $120	
- Polarized lenses	Member pays $75	
- Plastic photochromic lenses	Member pays $65	
- Scratch protection plan	Single vision: $20 / Multifocus vision: $40	
CONTACT LENSES – Benefit available for eyeglass lenses *or* contact lenses once every 12 months		
Collection contact lenses† - Disposable - Non-disposable	 up to 8 boxes up to 4 boxes	
- Evaluation, fitting and follow-up care	100% after $10 copay	
Non-collection contact lens allowance††	Plan pays up to $150 plus 15% discount on remaining costs***	
- Evaluation, fitting and follow-up care for standard lenses	100% after $10 copay	
- Evaluation, fitting and follow-up care for specialty lenses	$10 copay; after copay, plan pays up to $60 plus 15% discount on remaining costs***	
Visually required contact lenses††† (preauthorization required) - Materials - Evaluation, fitting and follow-up care	 100% 100%	

This plan provides vision coverage only. Your vision plan's benefit booklet will contain more details on standard plan exclusions and frequency limitations.

Davis Vision is an independent company providing vision benefit management services and access to their network.

Each provider in the network is an independent contractor and is not our agent. If you receive services from a nonparticipating provider, you will be responsible for the difference between what Blue Cross will reimburse and what the provider bills.