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MEMO

TO: **Nine Mile Creek Watershed District Board of Managers**

FROM: **Randy Anhorn**

DATE: **November 2, 2020**

RE: **2021 Employee Health Insurance Recommendation**

Background

The District has been contracting with Blue Cross Blue Shield (BCBS) to provide health insurance to its employees since January 1, 2015.

In recent years, the an annual deductible (or maximum out-of-pocket amount) of our the health savings account (HSA) plan, known as BlueAccess HSA Gold 653, had an annual deductible (or maximum out-of-pocket amount) has risen from $2,000 for individuals and $4,000 for families in 2017 to $2,500/$5,000 this year (up from $2,350/$4,700 last year). Per District policy, the District covers 100 percent of the employee cost and 75 percent of the family cost for insurance and in the past the Board has elected to cover the full deductible coverage for each employee enrolling in the plan by providing an annual deposit into each employee's HSA account ($2,350 in 2020).

In addition, 2021 monthly premiums for the BCBS package are set to increase by 5% over 2020 (after an 8% increase in 2020).

Because of the continual increases in rates and deductible amounts, I asked our insurance brokerage firm, Morgan Planning Group, do a comparison of our current health insurance to other options out there. Attached is a table comparing our 2020 BCBS benefits and rates to the 2021 BCBS option along with comparable options for HealthPartners, Medica and United Health Group.

After consultation with staff, to ensure that that the primary doctors that each is currently seeing would be in the network of the chosen option, and a representative of Morgan Planning Group, I am recommending switching the District 2021 health insurance from BCBS Blue Access HSA Gold to HealthPartners 2400-100 HSA - Open Access.

As you can see from the attached table, this will result in a savings of $313/month from the BCBS 2021 rates.

I have also attached the summary of benefits for both the BCBS and Health Partner plan options.

Request

Authorize the administrator to initiate the process of switching the District's employee health insurance plan from BCBS to the HealthPartners 2400-100 HSA - Open Access option.

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Renewal Effective Date: 2021-01-01
00208611

	Blue Cross Blue Shield of		Blue Cross Blue Shield of		HealthPartners		Medica		UnitedHealthcare	
	BlueAccess HSA Gold $2350		BlueAccess HSA Gold $2500		2400-100 HSA Gold SE Open		Medica Choice Passport MN		CC8Y w/273 PKG MN004 MN005	
Plan Design	In Network*	Out of Network	In Network*	Out of Network	In Network*	Out of Network	In Network*	Out of Network	In Network*	Out of Network
Deductible										
Individual	$2,350	$10,000	$2,500	$10,000	$2,400	$10,000	$2,400	$10,000	$2,500	$10,000
Family	$4,700	$20,000	$5,000	$20,000	$4,800	$20,000	$4,800	$20,000	$5,000	$20,000
Out of Pocket (OOP)										
Individual	$2,350	$30,000	$2,500	$30,000	$2,400	$30,000	$3,000	NA	$2,500	$20,000
Family	$4,700	$60,000	$5,000	$60,000	$4,800	$60,000	$6,000	NA	$5,000	$40,000
Coinsurance	0%	50%	0%	50%	0%	50%	0%	50%	0%	50%
Physician Services										
In Office	0%	50%	0%	50%	0%	50%	0%	50%	0%	See Benefit Brochure
Specialist Copay	0%	50%	0%	50%	0%	50%	0%	50%	See Benefit Brochure	See Benefit Brochure
Hospital Services										
Inpatient Facility	0%	50%	0%	50%	0%	50%	0%	50%	See Benefit Brochure	See Benefit Brochure
Inpatient Physician	0%	50%	0%	50%	0%	50%	0%	50%	See Benefit Brochure	See Benefit Brochure
Emergency Room Copay	0%	0%	0%	0%	0%	0%	0%	0%	See Benefit Brochure	See Benefit Brochure
Urgent Care	0%	50%	0%	50%	0%	0%	0%	0%	See Benefit Brochure	See Benefit Brochure
Preventive Care	No Charge	50%	No Charge	50%	No Charge	50%	No Charge	50%	See Benefit Brochure	See Benefit Brochure
Prescription Drugs	In Network: 0% / 0% / 0% / 0%		0% / 0% / 0% / 0%		0% / 0% / NA / 0%		$0/$50/$100/0%		NA / NA / NA / NA (Rx Ded: Med	
Network	BlueAccess		Blue Access		Open Access		Choice		CHOICE PLUS	

Employee Only	2		$589.52	$619.13	$575.97	$591.43	$588.96
Employee Spouse	0		$1,179.04	$1,238.26	$1,151.95	$1,182.85	$1,177.93
Employee Child	1		$1,149.56	$1,207.31	$1,123.15	$1,153.28	$1,148.48
Employee Family	1		$1,945.42	$2,043.14	$1,900.71	$1,951.71	$1,943.58
Monthly Total	4	0	$4,274.02	$4,488.71	$4,175.80	$4,287.85	$4,269.98

*For 3 tier plans, the 'In Network' field is pulled from the 'Designated Network' cell from the SBC files .

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			Blue Cross Blue Shield of		Blue Cross Blue Shield of		HealthPartners		Medica		UnitedHealthcare	
			BlueAccess HSA Gold $2350		BlueAccess HSA Gold $2500		2400-100 HSA Gold SE Open		Medica Choice Passport MN		CC8Y w/273 PKG MN004 MN005	
Increase							-2.30%		0.32%		-0.09%	
			Current		Renewal		Aca		Aca		Aca	
Sniegowski, Erica	08/09/1981	Employee	$497.66	$1,706.26	$520.42	$1,774.86	$484.14	$1,651.14	$497.13	$1,695.44	$495.06	$1,688.38
Sniegowski, Joel	10/27/1981	Spouse	$497.66		$520.42		$484.14		$497.13		$495.06	
Sniegowski, Jacob	07/29/2010	Dependent	$355.47		$367.01		$341.43		$350.59		$349.13	
Sniegowski, William	06/21/2012	Dependent	$355.47		$367.01		$341.43		$350.59		$349.13	
Werner Foley, Lauren	11/19/1991	Employee	$434.15	$434.15	$461.45	$461.45	$429.28	$429.28	$440.80	$440.80	$438.96	$438.96
Zembal, Gael	02/10/1990	Employee	$446.93	$446.93	$468.05	$468.05	$435.42	$435.42	$447.10	$447.10	$445.24	$445.24
Anhorn, Randall	01/26/1963	Employee	$931.81	$1,686.68	$1,004.96	$1,784.35	$934.91	$1,659.97	$959.99	$1,704.50	$955.99	$1,697.40
Anhorn, Elise	12/16/1998	Dependent	$399.40		$412.38		$383.63		$393.92		$392.28	
Anhorn, Alex	08/22/2002	Dependent	$355.47		$367.01		$341.43		$350.59		$349.13	
Monthly Admin. Fee												
Monthly Total		4	$4,274.02		$4,488.71		$4,175.81		$4,287.84		$4,269.98	
Increase					5.02%		-2.30%		0.32%		-0.09%	

*For 3 tier plans, the 'In Network' field is pulled from the 'Designated Network' cell from the SBC files .

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,400 Individual/$4,800 Family contract Out-of-network: $10,000 Individual/$20,000 Family contract	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and benefits with no charge are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network medical/pharmacy: $2,400 Individual/$4,800 Family contract Out-of-network medical/pharmacy: $30,000 Individual/$60,000 Family contract	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/openaccess or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/genericsadvantagerx	Generic drugs	Formulary: 0% coinsurance Non-formulary: Not covered	Formulary: 50% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail/ 93 day supply mail order Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month.
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	0% coinsurance	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
	Emergency medical	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			network deductible.
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	120 visit limit
	Rehabilitation services	0% coinsurance	50% coinsurance	None
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 120 day maximum per calendar year
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	0% coinsurance	Not covered	Limit of one pair of eyeglasses or contact lenses per year.
	Children's dental check-up	No charge	50% coinsurance	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery
- Dental care (Adult)
- Hearing aids(Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at 1-800-883-2177, or the MN Dept of Commerce at 651-539-1600 /1-800-657-3602, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at 1-800-883-2177 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,400**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,400**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,400**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,400**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

BlueCross BlueShield Minnesota

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 1/1/2021

BlueAccess HSA Gold $2,500 Plan 653

Coverage for: Individual and family | Plan Type: HSA

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossmnonline.com or call 1-888-279-4210. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-888-279-4210 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500/single medical and drug in-network $5,000/family medical and drug in-network $10,000/single medical and drug out-of-network $20,000/family medical and drug out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has a non-embedded deductible. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The single deductible applies to single coverage only.
Are there services covered before you meet your deductible?	Yes. Well-child care, prenatal care and in-network preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500/single medical and drug in-network $5,000/family medical and drug in-network $30,000/singlel medical and drug out-of-network $60,000/family medical and drug out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. This plan has a non-embedded out-of-pocket limit. If you have other family members on this plan, the overall family out-of-pocket limit must be met. The single out-of-pocket limit applies to single coverage only.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use an in-network provider?	Yes. The Aware network is your in-network. See www.bluecrossmn.com/awarenetwork or call 1-888-279-4210 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as laboratory work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copay and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition. A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A mail service pharmacy dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is	Tier 1 prescription drugs: designated preventive drugs (other than ACA preventive drugs) in the following categories: diabetes, hypertension, cholesterol lowering	No charge/retail No charge/mail service No charge/90dayRx retail	Not covered	Covers up to a 31-day supply (retail prescription); 93-day supply (mail order prescription and 90dayRx retail prescription). Some over-the-counter drugs can be obtained with a prescription at the preventive level of benefits. Tier 1 and Tier 2 of the prescription drug list are covered at zero cost-sharing. The value of drug coupons you use will not count towards cost-sharing or out-of-pocket limits.
	Tier 2 prescription drugs	0% coinsurance/retail 0% coinsurance/mail service 0% coinsurance/90dayRx retail	Not covered	
	Tier 3 prescription drugs	0% coinsurance/retail 0% coinsurance/mail service 0% coinsurance/90dayRx retail	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
available at www.bluecrossmn.com/basicrxsmallgrouphsa2021	Tier 4 prescription drugs	0% coinsurance/retail 0% coinsurance/mail service 0% coinsurance/90dayRx retail	Not covered	
	Tier 5 prescription drugs: specialty drugs	0% coinsurance	Not covered	Covers up to a 31-day supply (participating specialty drug network supplier prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance for outpatient hospital facility services 0% coinsurance for ambulatory surgery center services	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance for outpatient hospital facility services 0% coinsurance for ambulatory surgery center services	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	0% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use services	Outpatient services	0% coinsurance	50% coinsurance	Services for marriage/couples counseling are not covered.
	Inpatient services including residential adult mental health treatment	0% coinsurance	50% coinsurance	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: 0% coinsurance	Prenatal care: No charge Postnatal care: 50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
	Home health care	0% coinsurance	Not covered	In-network: 120 visits per person per benefit period.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	0% coinsurance for occupational therapy 0% coinsurance for physical therapy 0% coinsurance for speech therapy	50% coinsurance for occupational therapy 50% coinsurance for physical therapy 50% coinsurance for speech therapy	None
	Habilitation services	0% coinsurance for occupational therapy 0% coinsurance for physical therapy 0% coinsurance for speech therapy	50% coinsurance for occupational therapy 50% coinsurance for physical therapy 50% coinsurance for speech therapy	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Combined in-network and out-of-network: 120 days per person per benefit period.
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Age 0 through 5: No charge Age 6 through 18: 50% coinsurance	None
	Children's glasses	0% coinsurance	Not covered	Maximum of one standard frame and one pair of lenses or one pair of contact lenses or one year supply of disposable contact lenses per calendar year for members age 18 and younger.
	Children's dental check-up	Not covered	Not covered	No coverage for these services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (except as specified in plan benefits)
- Bariatric surgery
- Cosmetic surgery (except as specified in plan benefits)
- Dental care (except as specified in plan benefits)
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids for individuals 18 years of age or younger (as required by state law)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (as required by state law)
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-2198, or call 1-800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/. Other coverage options may be available to you too, including buying individual insurance coverage through MNsure/the Marketplace. For more information about MNsure/the Marketplace, visit www.mnsure.org or call 1-855-366-7873.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Customer Service at www.bluecrossmnonline.com or call 1-888-279-4210 or the Minnesota Department of Commerce by calling (651) 539-1600 or toll-free 1-800-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through MNsure/the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through MNsure/the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copay	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,560

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,300
Copay	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,320

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copay	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,500

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness plan, please refer to your plan document.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination Practices

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လၢ TTYအဂိၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.