2025 Medical Plan Renewal - Negotiated

				CURRENT			NEGOTIATED RENEWAL		
Carrier Name				BlueCross BlueShield of Minnesota			BlueCross BlueShield of Minnesota		
Plan Name				T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	T25075 Aware HSA $3,300 Ded 0% Coins	T25111 Aware $1,000 Ded 30% Coins	T25032 Aware $500 Ded 20% Coins
PLAN DESIGN*									
In-Network Benefits				Aware Network	Aware Network	Aware Network	Aware Network	Aware Network	Aware Network
Deductible Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Calendar Year (CY) Deductible (Individual / Family)				$3,200 / $6,400	$1,000 / $3,000	$500 / $1,500	$3,300 / $6,600	$1,000 / $3,000	$500 / $1,500
Out-of-Pocket Max Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)				$3,200 / $6,400	$5,000 / $10,000	$2,000 / $4,000	$3,300 / $6,600	$5,000 / $10,000	$2,000 / $4,000
Coinsurance (member pays after deductible)				0%	30%	20%	0%	30%	20%
Preventive Care				Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Primary Care Visit				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Specialist Visit				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Urgent Care				0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	Office visits: $40 Copay ; All other services: 30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Emergency Room				0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible	0% after deductible	30% after deductible	Office visits: $25 Copay ; All other services: 20% after deductible
Inpatient Hospital				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Outpatient Surgery				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Chiropractic (visit limits may apply)				0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible	0% after deductible	Spinal Manipulation: $40 Copay; Other Chiropractic: 30% after deductible	Spinal Manipulation: $25 Copay; Other Chiropractic: 30% after deductible
Phys/Occ/Speech Therapy (visit limits may apply)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Diagnostic Test (X-ray, blood work)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Imaging (CT/PET scan, MRI)				0% after deductible	30% after deductible	20% after deductible	0% after deductible	30% after deductible	20% after deductible
Prescription Drug Benefit									
Retail				31 Days	31 Days	31 Days	31 Days	31 Days	31 Days
Tier I / Tier II / Tier III / Tier IV				0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120	0% after deductible	$20 / $50 / $75 / $120	$20 / $50 / $75 / $120
Specialty				0% after deductible	30% to max $500	20% to max $500	0% after deductible	30% to max $500	20% to max $500
Mail Order				90 Days	90 Days	90 Days	90 Days	90 Days	90 Days
Tier I / Tier II / Tier III / Tier IV				0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360	0% after deductible	$60 / $150 / $225 / $360	$60 / $150 / $225 / $360
Out-of-Network Benefits									
Deductible Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Deductible (Individual / Family)				$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000	$5,000 / $10,000
Out-of-Pocket Max Type				Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
CY Out-of-Pocket Max (Individual / Family)				$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000	$10,000 / $20,000
Coinsurance (member pays after deductible)				50%	50%	50%	50%	50%	50%
COST ANALYSIS									
PEPM Rates - Enrollment per Renewal	Plan 1	Plan 2	Plan 3	T24075 HSA $3,200	T24111 $1,000	T24032 $500 Ded	T25075 Aware HSA $3,300 Ded 0% Coins	T25111 Aware $1,000 Ded 30% Coins	T25032 Aware $500 Ded 20% Coins
Employee (EE) Only	46	2	11	$759.18	$834.18	$945.28	$798.38	$864.10	$985.84
EE + Family	38	1	3	$2,026.94	$2,227.18	$2,523.80	$2,131.59	$2,307.06	$2,632.11
Total Enrollment	**84**	**3**	**14**						
Estimated Monthly Premium				$111,946	$3,896	$17,969	$117,726	$4,035	$18,741
Estimated Annual Premium				**$1,343,352**	**$46,746**	**$215,634**	**$1,412,711**	**$48,423**	**$224,887**
Dollar Difference from Current							**$69,359**	**$1,677**	**$9,253**
Percent Change from Current							**5.2%**	**3.6%**	**4.3%**
Total Combined Annual Cost									
				CURRENT			NEGOTIATED RENEWAL		
Estimated Annual Premium				**$1,605,732**			**$1,686,021**		
Dollar Difference from Current							**$80,289**		
Percent Change from Current							**5.0%**		
PLAN PROVISIONS									
Rate Guarantee				1 Year rate guarantee ending 12/31/2024			2026 Rate Cap of 15%		

**NOTE: Benefit deviations from Current are identified in blue font*