RAMSEY COUNTY

Only In-Network is Shown	Current Distinctions Plan - HealthPartners			2024 Plan Designs - BCBS: PREFERRED PLAN		BROAD PLAN		HIGH-DEDUCTIBLE PLAN	
Description of Services	In-Network		Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	**Broad National Network**		**Out-of-Network**	**Narrow Network**	**Out-of-Network**	**Broad National Network**	**Out-of-Network**	**Broad National Network**	**Out-of-Network**
Annual Deductible									
Single	$25		$750	$0	$750	$600	$1,800	$1,600 (Minimum Allowed)	$4,800
Family	$75		$2,100	$0	$2,100	$1,200	$3,600	$3,200 (Minimum Allowed)	$9,600
Out-of-Pocket Maximum (Rx + Med)									
Single	$2,400		$3,500	$3,000	$6,000	$4,500	$9,000	$6,000	$12,000
Family	$4,800		$8,500	$6,000	$12,000	$9,000	$18,000	$12,000	$24,000
Savings Account								HSA Eligible	
Health Savings Account	None		None	None	None	None	None	(County contribution - bargained)	
Professional Services									
Preventive Care	100% coverage		No Coverage	100% coverage (no deductible)	No Coverage	100% coverage (no deductible)	No Coverage	100% coverage (no deductible)	No Coverage
Primary Care Office Visit	**Healthy Benefits** Level 1: $25 after ded Level 2: $40 after ded	**No Healthy Benefits** Level 1: $45 after ded Level 2: $60 after ded	35%	$25 copay (no deductible)	40%	$30 Copay (no deductible)	40%	20% after deductible	40%
Specialist Office Visit	Level 1: $25 after ded Level 2: $40 after ded	Level 1: $45 after ded Level 2: $60 after ded	35%	$40 copay (no deductible)	40%	$50 Copay (no deductible)	40%	20% after deductible	40%
Urgent Care	$40 after ded	$60 after ded	$60 after ded	$40 copay (no deductible)	$80 copay (no deductible)	$50 Copay (no deductible)	$100 copay (no deductible)	20% after deductible	40%
Convenience Clinics	$10 after ded	$20 after ded	35%	$10 copay (no deductible)	40%	$10 Copay (no deductible)	40%	20% after deductible	40%
Hospital Services									
Inpatient Hospital Visit	Level 1: $125 after ded Level 2: $275 after ded		35%	$250 copay (no deductible)	40%	20% after deductible	40%	20% after deductible	40%
Outpatient Visit	Level 1: $125 after ded Level 2: $275 after ded		35%	$100 copay (no deductible)	40%	20% after deductible	40%	20% after deductible	40%
Emergency Room	$100 after deductible		$100 after deductible	$150 copay (no deductible)	$150 copay (no deductible)	$150 copay (no deductible)	$150 copay (no deductible)	20% after deductible	20% after deductible
Prescription Drugs Generic/ Brand/ Non-Brand (Non-Formulary)/ Specialty	$12/ $35/ $35/ 20% ($200 max)		35%	$10/ $25/ $35/ 20% ($200 max) (no deductible)	40%	$10/ $25/ $35/ 20% ($200 max) (no deductible)	40%	Deductible then $10/ $25/ $35/ 20% ($200 max)	40%