If you have questions about this bulletin, please contact your agent or Blue Cross and Blue Shield of Minnesota (Blue Cross) account manager. 

Grandfathered Plans.

If you have questions about this bulletin, please contact your agent or Blue Cross and Blue Shield of Minnesota (Blue Cross) account manager.

Grandfathered Plans. You must complete and return the Premium Contribution Reporting Tool and the Plan Election Form. Details are described below:

Also be directed online to bluecrossmn.com.

2014 Contract Change of Coverage issued to each employee under the Plan. For the most current and detailed medical policy descriptions, members may please refer to the State of Minnesota’s information with your plan members as part of your annual health plan renewal process. The changes will also be reflected in the Plan Summary and Informational Leaflets that will be implemented with your health plan renewal on or after January 1, 2014.

Appropriate Options:

- Blue Cross / Blue Shield
- UnitedHealthcare
- HealthPartners
- Cigna

Please refer to the State of Minnesota’s information with your plan members as part of your annual health plan renewal process. The changes will also be reflected in the Plan Summary and Informational Leaflets that will be implemented with your health plan renewal on or after January 1, 2014.

Employee and their covered beneficiaries. You may receive a second bulletin later this year that outlines any part time eligible changes if they impact your health.

Endeared to your 2014 Group Renewal Bulletin, which outlines benefit clarifications, process modifications and other plan changes that may affect your.
Employer Notice of Employee Coverage Options

The notice of employee coverage options distribution date was pushed out to October 1, 2013 from the earlier effective date of March 1, 2013 (see below).

The purpose of Labor (DOL) released (1) model notice forms for employers to use for the notice to employees of affordable care act (ACA) employer notice.

All applicable ACA fees have been incorporated into the plans renewal rates.

Any applicable fee, if any, shall be paid by the period covered. Underwriting fee of $2.00 per member per year will apply to ACA that funds a


An annual fee of 1.9 percent of premium that applies to Health Insurance benefit plans for annuities premium.

A two-part premium underwriting fee of $2.00 per member for 2014, 2015 and 2016.

Electronic signatures are accepted.

An electronic copy of the form and the reporting tool can be found on our employer portal at employers.bluecross.com

Under terms and conditions, please complete the form, sign it, and email it to your Blue Cross account manager.

For the health of all.

For the health of all.

For the health of all.

Full and Complete Plan

Form the distribution.

Your plan or your plan will be considered non-grandfathered and all applicable health care reform provisions will be applied to your

Plan.

Form the health care reform provisions.

Notices must be received within 1 business day of the start date of your next plan.

Fully-Insured Grandfathered Plans:

Form the Premium Contribution Reporting Tool and submit it along with a signed

Form the health care reform provisions.

Notices must be received within 1 business day of the start date of your next plan.

Fully-Insured Grandfathered Plans: Must complete the Premium Contribution Reporting Tool and submit it along with a signed

Form the health care reform provisions.

Notices must be received within 1 business day of the start date of your next plan.
The guidance which includes the forms can be found at http://www.dol.gov/esa/ewr/newsroom/01-02.htm.

The Technical Release states that use of the model election notice, appropriately completed, will be considered by DOL to be

required.

Model COBRA Election Notice

The Technical Release states that employers must provide a notice of coverage options to each employee, regardless of plan

coverage eligibility.

The model notice forms explain the availability of coverage through exchanges and that an offer of employer coverage affects

the applicability of the model notice.

For employees who are current employees before October 1, 2013, employers must provide the notice not later than October

1, 2013.

The notice is required to be provided as soon as practicable, free of charge.

Timing of Notice: Employers are required to provide the notice to each new employee at the time of hiring beginning October

1, 2014.

Employers who are current employees before October 1, 2014, will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an

excludable from income for federal income tax purposes.

contribution (i.e., any health benefits plan offered by the employer and all or a portion of the contribution may be

excluded from income for federal income tax purposes).

The model notice states the employer that if the employer purchases a qualified health plan through an exchange and

the employee purchases a qualified health plan through an exchange, the employee may lose the employer

reduction under 42 U.S.C. § 18071 if the employee purchases a qualified health plan through an exchange and

costs, then the employee may be eligible for a premium tax credit under internal revenue code § 36B and a cost sharing

reduction under 42 U.S.C. § 36B.
A plan is not required to cover clinical trials conducted outside the state in which the qualified individual resides.

Note: The statute requires "out-of-network" with clinical trials conducted outside the state in which the qualified individual resides. Providers may not use an in-network clinical trial provider if the in-network provider is participating in the clinical trial and will accept the trial's standards of care.

Clinical Trials

A qualified individual is a plan member who is eligible to participate in an approved clinical trial protocol for the treatment of a qualified individual's covered condition.

2014 Group Renewal Bulletin

Fully Insured Groups

Blue Cross and Blue Shield of Minnesota
All changes under Preventive Health Benefits will be effective upon renewal or after January 1, 2014.

The out-of-pocket maximum will be adjusted for inflation in 2015 and later years.

<table>
<thead>
<tr>
<th>Preventive Health Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$12,700 for family coverage</td>
</tr>
<tr>
<td>$6,350 for single coverage</td>
</tr>
</tbody>
</table>

The IRS released the following HDHP out-of-pocket maximums for 2014:

- $12,700 for family coverage
- $6,350 for single coverage

An out-of-pocket maximum is an annual cap on the amount a member may pay out of pocket for covered health care costs for services from in-network providers, including deductibles, copays and coinsurance. It does not include the employee premium.

Out-individual and group health plans, including large group fully insured plans, these requirements do not apply to grandfathered plans.
<table>
<thead>
<tr>
<th>Waiting Period Options Available:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
</tr>
<tr>
<td>First day after the completion of the waiting period</td>
</tr>
<tr>
<td>First day of the month following completion</td>
</tr>
<tr>
<td>First day after the completion of the waiting period</td>
</tr>
<tr>
<td>First day of the month following completion</td>
</tr>
</tbody>
</table>

The table below outlines the waiting period options available:

- Groups that currently have a waiting period equal to or lower than 90 days may remain as-is for 2014.
- Groups that prefer to change the waiting period from 90 days to something less than 90 days, must contact their Blue Cross account manager to implement the change.
- Maximum of 90 days upon renewal in 2014.
- Groups that currently have a waiting period greater than 90 days will be required to change to the waiting period to 90 days.

To ensure all Blue Cross groups comply with this requirement, the following approach will apply:

- Insured Plans: This requirement must be met as groups renew in 2014.
- The Affordable Care Act (ACA) provides employers from applying an employee waiting period longer than 90 days.

### 90-Day Waiting Period Requirement

- **Women**
  - 
- **Men**
  - 
- **Other non-compliance benefit changes** (applied to both HCR and non-HCR preventive benefits):
  - 

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2014 Group Renewal Bulletin

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<table>
<thead>
<tr>
<th>Special Enrollment Triggering Event</th>
<th>Coverage Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee becomes entitled to Medicare</td>
<td>First day of the month following the event</td>
</tr>
<tr>
<td>Employee bankruptcy</td>
<td></td>
</tr>
<tr>
<td>Exceeding the plan's lifetime maximum</td>
<td></td>
</tr>
<tr>
<td>More outside HMO service area</td>
<td></td>
</tr>
<tr>
<td>Death of Employee</td>
<td></td>
</tr>
<tr>
<td>Loss of dependent child status</td>
<td></td>
</tr>
<tr>
<td>Legal separation or divorce</td>
<td></td>
</tr>
<tr>
<td>Termination of employment or reduction in coverage</td>
<td></td>
</tr>
<tr>
<td>Loss of eligibility for employer-sponsored coverage due to the time employees or eligible family members are no longer a reason to have a legal enrollment provision in the plan</td>
<td></td>
</tr>
<tr>
<td>Induced loss due to failure to pay premiums or</td>
<td></td>
</tr>
<tr>
<td>Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or)</td>
<td></td>
</tr>
</tbody>
</table>

Notice Period is 30 days except for Medicaid/CHIP events.

Open enrollment period or with a qualifying event. Qualifying or triggering events are listed below.

Due to the removal of the pre-existing condition limitation, there is no longer a reason to have a legal enrollment provision in the plan.

<table>
<thead>
<tr>
<th>Special Enrollment Period</th>
<th>First day after the completion of the waiting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 days</td>
<td></td>
</tr>
</tbody>
</table>

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The coverage must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee’s treating physician or mental health professional.

The diagnosis, evaluation, and assessment must include an assessment of the child’s developmental skills, functional behaviors, needs, and capacities.

(g) Medications
(h) Physical therapy
(i) Speech therapy
(j) Psychological services, including but not limited to, all types of applied behavior analysis, intensive early intervention and developmental services, including but not limited to, all types of special education, early intervention, or other services requested by the enrollee and covered by the plan.

Behavioral Health - Early Intensive Behavioral Intervention (EIBI)

Other Required Changes, Notifications and Reminders

<table>
<thead>
<tr>
<th>Month</th>
<th>60 days of the event</th>
<th>An individual gains or loses eligibility for Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>If application is received between the 1st and 15th of the month, coverage will be effective on the 1st of the following month.</td>
<td>If application is received between the 16th and the end of the month, coverage will be effective on the 1st of the following month.</td>
<td>If application is received between the 1st and 15th of the month, coverage will be effective on the 1st of the following month.</td>
</tr>
</tbody>
</table>

Date of birth, adoption or placement for adoption of

- Parenting or becoming a dependent due to birth or adoption of
- First day of the month following the event.

- Parenting or becoming a dependent due to marriage.
Identify all employees and dependents with a Massachusetts address during a calendar year.

Blue Cross offers the following service to groups. For clients purchasing this service, Blue Cross will provide the following:

- Account managers will be notified of changes to CMS in that plan year.
- If an employee does not offer prescription drug benefits to any Medicare-eligible individuals, the employer is not required to disclose the information.

Your Blue Cross account manager can provide information regarding the credibility of non-creditable or non-credible status of your plan.

CMS's govern the coverage.

Detailed instructions and requirements regarding member notification and CMS disclosure can be found at

CMS's govern the coverage.

There are two discloses (on Medicare-eligible members, and 2) Discloses to Medicare-eligible members.

Credible coverage for pharmacy benefits.

Inadvisable and other resources on the website will be removed, and the program will be fully discontinued after December 31.

In order to adapt to our needs, a decision has been made to discontinue the 2014 Group Renewal Bulletin.
Blue Cross® and Blue Shield® of Minnesota is a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

Then December 15, 2013. (Note: Changes received after December 31, 2013, will apply to the following tax year.) Completing a Change in Authorization Form. You will need to submit this form to your Blue Cross Representative no later than January 15, 2013. Your preference will be binding unless you notify us of a change by signing this form. You will be authorized Blue Cross to provide the MA Health Care Reform Form Filing Service for your group and need to complete the online forms located at employees.bluecrossmn.com under Forms and Guides. By completing and submitting this form, you will authorize us to process the MCC requirements for your group. Please review your group’s health plan(s) to understand the required elements of the MCC.

Action Required: To authorize this service and certify that your group’s health plan(s) meet the MCC requirements, you will need to complete the online forms located at employees.bluecrossmn.com under Forms and Guides. By completing and submitting this form, you will authorize us to process the MCC requirements for your group. Please review your group’s health plan(s) to understand the required elements of the MCC.

Fees: The fee for this service is $40 for each 1099-HC form issued to a Massachusetts resident. There is a minimum fee of $120 and a maximum fee of $10,000 per employer.

Completing Report for Auditing and Compliance Purposes: Prepare a report of all 1099-HC forms created, and submit this report to the MA DOF. We will provide you with a complete report for auditing and compliance purposes. The MA 1099-HC form is not required to be prepared and mailed to each eligible employee for income tax filing purposes. The MA 1099-HC form is not required. One 1099-HC form that meets the Massachusetts Department of Revenue (MA DOF) Reporting Requirements will be submitted for each Massachusetts resident who is eligible for a Blue Cross health plan.

For Medicare members, prepare and submit an annual report to the Blue Cross Medicare Provider of Services (MPO) for all Medicare members who are eligible for a Blue Cross health plan.