Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan 2020-2021 Benefits Schedule
Out-of-Network Summary

2020-2021 Benefit Provision	Advantage High	Advantage Value	Advantage HSA
A. Preventive Care Services • Routine medical exams, cancer screening • Child health preventive services, routine immunizations • Prenatal and postnatal care and exams • Adult immunizations • Routine eye and hearing exams	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
B. Annual First Dollar Deductible (single/family)	*$350/$700*	*$350/$700*	*Single $1,500* *Family $2,800 per family member $3,000 family*
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care within the service area • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency • Urgent Care clinic visits (in or out of network)	*30% coinsurance annual deductible applies (except urgent care which is paid at in-network levels)*	*30% coinsurance annual deductible applies (except urgent care which is paid at in-network levels*	*30% coinsurance annual deductible applies*
D. Convenience Clinics	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	*Covered at in-network levels*	*Covered at in-network levels*	*Covered at in-network levels*
F. Inpatient Hospital Copay	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
G. Outpatient Surgery Copay	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
H. Hospice and Skilled Nursing Facility	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
I. Prosthetics and Durable Medical Equipment	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
J. Lab (including allergy shots), **Pathology, and X-ray** (not included as part of preventive care and not subject to office visit or facility copayments)	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*
K. MRI/CT Scans	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*

L. Other expenses not covered in A – K above, including but not limited to:
• **Ambulance**
• **Home Health Care**
• **Outpatient Hospital Services** (non-surgical)
  • Radiation/chemotherapy
  • Dialysis
  • Day treatment for mental health and chemical dependency
  • Other diagnostic or treatment related outpatient services
	30% coinsurance annual deductible applies	*30% coinsurance annual deductible applies*	*30% coinsurance annual deductible applies*

M. Prescription Drugs 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives.	*$18 tier one* *$30 tier two* *$55 tier three*	*$25 tier one* *$45 tier two* *$70 tier three*	*$25 tier one* *$40 tier two* *$65 tier three* *Annual deductible applies*
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)	*$1,050/$2,100*	*$1,250/$2,500*	*n/a*
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	*$1,700/$3,400 (cost level 1, 2)* *$2,400/$4,800 (cost level 3)* *$3,600/$7,200 (cost level 4)*	*$2,200/$4,400 (cost level 1, 2)* *$3,200/$6,400 (cost level 3)* *$4,200/$8,400 (cost level 4)*	*$3,000 single (cost level 1, 2)* *$4,000 single (cost level 3)* *$5,000 single (cost level 4)* *$6,000 family* (cost level 1,2)* *$8,000 family* (cost level 3)* *$10,000 family* (cost level 4)*

Out-of-Network coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and all dependent children, including college students, and spouses living out of area). Out of Network Deductibles are separate from in-network PEIP deductibles, but do accumulate to out of pocket maximums.

**Your out of pocket maximum will be the Plan Maximum Out of Pocket Expense (Letter O) of the PCC you choose. For HSA Family coverage, there is an embedded $5,000 (cost level 1, 2) or $6,850 (cost level 3, 4) per family member Out-of-Pocket Maximum. The Family Out of Pocket Maximum shown above is the maximum amount that a family will pay in any one calendar year for all family members.*

You will choose a network PCC for all covered members. Anytime you (or your dependents) are back in the service area, the traditional benefits levels are available. *Be sure to contact your carrier and inform them of your (or your dependent's out of network address to activate this coverage.) A standard set of benefits is offered in all PEIP Advantage Plans. There are still some differences from plan to plan in the way that benefits are administered, in the referral and diagnosis coding patterns of clinics both in and out of network. This is an overview of benefits. Please refer to your plan document for actual coverage.*