Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan 2020 - 2021 Benefits Schedule - HSA Compatible

Benefit Provision	**Cost Level 1** – You Pay	**Cost Level 2** – You Pay	**Cost Level 3** – You Pay	**Cost Level 4** – You Pay
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	Nothing	Nothing	Nothing	Nothing
B. Annual First Dollar Deductible * Combined Medical/Pharmacy (**single coverage**)	$1,500	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**family coverage**)	$2,800 per family member $3,000 per family	$3,200 per family member $4,000 per family	$4,800 per family member $6,000 per family	$6,400 per family member $8,000 per family
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency • Urgent Care clinic visits (in & out of network)	$45 copay per visit annual deductible applies	$55 copay per visit annual deductible applies	$105 copay per visit annual deductible applies	$130 copay per visit annual deductible applies
D. Network Convenience Clinics & Online Care	$0 copay annual deductible applies	$0 copay annual deductible applies	$0 copay annual deductible applies	$0 copay annual deductible applies
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	$150 copay annual deductible applies	$150 copay annual deductible applies	$150 copay annual deductible applies	50% coinsurance annual deductible applies
F. Inpatient Hospital Copay	$400 copay annual deductible applies	$650 copay annual deductible applies	$1,500 copay annual deductible applies	50% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$250 copay annual deductible applies	$400 copay annual deductible applies	$800 copay annual deductible applies	50% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing after annual deductible	Nothing after annual deductible	Nothing after annual deductible	Nothing after annual deductible
I. Prosthetics and Durable Medical Equipment	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies	50% 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)	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies	50% coinsurance annual deductible applies
K. MRI/CT Scans	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies	50% 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
	20% coinsurance
	annual deductible applies
		25% coinsurance
		annual deductible applies
			30% coinsurance
			annual deductible applies
				50% 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.	$30 tier one $50 tier two $75 tier three annual deductible applies	$30 tier one $50 tier two $75 tier three annual deductible applies	$30 tier one $50 tier two $75 tier three annual deductible applies	$30 tier one $50 tier two $75 tier three annual deductible applies
N. Plan Maximum Out-of-Pocket Expense** (including prescription drugs) **Single Coverage**	$3,000	$3,000	$4,000	$5,000
Family Coverage	$5,000 per family member $6,000 per family	$5,000 per family member $6,000 per family	$6,900 per family member $8,000 per family	$6,900 per family member $10,000 per family

Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.

This chart applies only to in-network coverage. Point of Service coverage is available only to members whose permanent residence is both outside the State of Minnesota and the Advantage Plan's service area. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to dependent children and spouses permanently residing outside the service area. Members pay a $1,500 single or $3,000 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance that will apply to the out-of-pocket maximums described in section N above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N. This benefit must be requested.

The PEIP Advantage Plans offer a standard set of benefits regardless of the selected carrier. There are some differences in the way each carrier administers the benefits, including the transplant benefits, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.

The family Deductible is the **maximum amount that a family has to pay in deductible expenses in any one calendar year. The family Deductible is **not** the amount of expenses a family must incur before any family member can receive benefits. Individual family members only need to satisfy their individual deductible once to be eligible for benefits. Once the family Deductible has been met, deductible expenses for the family are waived for the balance of the year.*

***The family Out-of-Pocket Maximum is the **maximum amount** that a family has to pay in any one calendar year. The per-family member embedded Out-of-Pocket Maximum is the maximum amount that a family has to pay in any one calendar year on behalf of any individual family member.*