

**Minnesota Public Employees Insurance Program (PEIP)**  
**Advantage Health Plan 2020 - 2021 Benefits Schedule**  
**High Option**

Benefit Provision	Cost Level 1 – You Pay	Cost Level 2 – You Pay	Cost Level 3 – You Pay	Cost Level 4 – You Pay
<b>A. Preventive Care Services</b> <ul style="list-style-type: none"> <li>• Routine medical exams, cancer screening</li> <li>• Child health preventive services, routine immunizations</li> <li>• Prenatal and postnatal care and exams</li> <li>• Adult immunizations</li> <li>• Routine eye and hearing exams</li> </ul>	Nothing	Nothing	Nothing	Nothing
<b>B. Annual First Dollar Deductible *</b> (single/family)	\$250 / 500	\$400 / 800	\$750 / 1,500	\$1,500 / 3,000
<b>C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care</b> <ul style="list-style-type: none"> <li>• Outpatient visits in a physician's office</li> <li>• Chiropractic services</li> <li>• Outpatient mental health and chemical dependency</li> <li>• Urgent Care clinic visits (in &amp; out of network)</li> </ul>	\$30 copay per visit annual deductible applies	\$35 copay per visit annual deductible applies	\$65 copay per visit annual deductible applies	\$85 copay per visit annual deductible applies
<b>D. Network Convenience Clinics &amp; Online Care</b>	Nothing	Nothing	Nothing	Nothing
<b>E. Emergency Care</b> (in or out of network) <ul style="list-style-type: none"> <li>• Emergency care received in a hospital emergency room</li> </ul>	\$100 copay annual deductible applies	\$100 copay annual deductible applies	\$100 copay annual deductible applies	25% coinsurance annual deductible applies
<b>F. Inpatient Hospital Copay</b>	\$100 copay annual deductible applies	\$200 copay annual deductible applies	\$500 copay annual deductible applies	25% coinsurance annual deductible applies
<b>G. Outpatient Surgery Copay</b>	\$60 copay annual deductible applies	\$120 copay annual deductible applies	\$250 copay annual deductible applies	25% coinsurance annual deductible applies
<b>H. Hospice and Skilled Nursing Facility</b>	Nothing	Nothing	Nothing	Nothing
<b>I. Prosthetics and Durable Medical Equipment</b>	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance annual deductible applies
<b>J. Lab</b> (including allergy shots), <b>Pathology, and X-ray</b> (not included as part of preventive care and not subject to office visit or facility copayments)	10% coinsurance annual deductible applies	10% coinsurance annual deductible applies	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies
<b>K. MRI/CT Scans</b>	10% coinsurance annual deductible applies	15% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies
<b>L. Other expenses not covered in A – K above, including but not limited to:</b> <ul style="list-style-type: none"> <li>• Ambulance</li> <li>• Home Health Care</li> <li>• Outpatient Hospital Services (non-surgical) <ul style="list-style-type: none"> <li>• Radiation/chemotherapy</li> <li>• Dialysis</li> <li>• Day treatment for mental health and chemical dependency</li> <li>• Other diagnostic or treatment related outpatient services</li> </ul> </li> </ul>	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies
<b>M. Prescription Drugs</b> 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	\$18 tier one \$30 tier two \$55 tier three	\$18 tier one \$30 tier two \$55 tier three	\$18 tier one \$30 tier two \$55 tier three
<b>N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs</b> (excludes PKU & Infertility) (single/family)	\$1,050 / 2,100	\$1,050 / 2,100	\$1,050 / 2,100	\$1,050 / 2,100
<b>O. Plan Maximum Out-of-Pocket Expense</b> (excluding prescription drugs) (single/family)	\$1,700 / 3,400	\$1,700 / 3,400	\$2,400 / 4,800	\$3,600 / 7,200

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 outside both 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 enrolled in this category pay a \$350 single or \$700 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 O 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.

\* This Plan uses an **embedded deductible**: If any family member reaches the individual deductible then the deductible is satisfied for that family member. If any combination of family members reaches the family deductible, then the deductible is satisfied for the entire family.