Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan 2024-2025 Out-of-Area Benefits Schedule

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	Nothing	Nothing	30% coinsurance annual deductible applies
B. Annual First Dollar Deductible (single/family)	$750 / 1,500	$1,300 / 2,600	Single $1,600 Family $3,200 per family member $3,400 family
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, within the service area • Outpatient visits in a physician's office • Chiropractic services	$65 copay per visit annual deductible applies	$100 copay per visit annual deductible applies	30% coinsurance annual deductible applies
• Outpatient office visits for mental health and substance use disorder	$50 copay per visit annual deductible applies	$80 copay per visit annual deductible applies	30% coinsurance annual deductible applies
• Urgent Care clinic visits (in-service-area / in- & out-of-network)	$65 copay per visit annual deductible applies	$100 copay per visit annual deductible applies	Covered at in-network and in-service-area levels
D. Convenience Clinics	Nothing	Nothing	30% coinsurance annual deductible applies
E. Emergency Care (in-service-area / in- or out-of-network) • Emergency care received in a hospital emergency room	$150 copay not subject to deductible	$275 copay not subject to deductible	Covered at in-network and in-service-area levels
F. Inpatient Hospital Copay	$500 copay annual deductible applies	$750 copay annual deductible applies	30% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$250 copay annual deductible applies	$350 copay annual deductible applies	30% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	30% coinsurance annual deductible applies
I. Prosthetics and Durable Medical Equipment	20% coinsurance	25% coinsurance	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)	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies
K. MRI/CT Scans	25% coinsurance annual deductible applies	25% 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
	20% coinsurance
	annual deductible applies
		20% 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	$30 tier one $50 tier two $75 tier three Annual deductible applies
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (single/family)	$1,050 / 2,100	$1,250 / 2,500	n/a
O. *Plan Maximum Out-of-Pocket Expense (single/family) (Excluding prescription drugs for High and Value plans) (Including prescription drugs for HSA plan)	$1,700 / 3,400 (cost levels 1, 2) $2,400 / 4,800 (cost level 3) $3,600 / 7,200 (cost level 4)	$2,600 / 5,200 (cost levels 1, 2) $3,800 / 7,600 (cost level 3) $4,800 / 9,600 (cost level 4)	$3,000 / 6,000 (cost levels 1, 2) $4,000 / 8,000 (cost level 3) $5,000 / 10,000 (cost level 4)

Out-of-area coverage is available outside the Advantage Plan's service area. Out-of-area deductibles are separate from in-area 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 $6,900 (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.*