# Minnesota Public Employees Insurance Program (PEIP)
# Advantage Health Plan Value Option 2024 - 2025 Benefits Schedule

| 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**<br>• Routine medical exams, cancer screening<br>• Child health preventive services, routine immunizations<br>• Prenatal and postnatal care and exams<br>• Adult immunizations<br>• Routine eye and hearing exams | Nothing | Nothing | Nothing | Nothing |
| **B. Annual First Dollar Deductible** * (single/family) | $600 / 1,200 | $850 / 1,700 | $1,300 / 2,600 | $2,100 / 4,200 |
| **C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care**<br>• Outpatient visits in a physician's office<br>• Chiropractic services<br>• Urgent Care clinic visits (in-service-area / in- or out-of-network) | $35 copay per visit<br>annual deductible applies | $40 copay per visit<br>annual deductible applies | $100 copay per visit<br>annual deductible applies | $125 copay per visit<br>annual deductible applies |
| • Outpatient office visits for mental health and substance use disorder | $0 copay per visit<br>not subject to deductible | $0 copay per visit<br>not subject to deductible | $80 copay per visit<br>annual deductible applies | $105 copay per visit<br>annual deductible applies |
| **D. Network Convenience Clinics and Online Care** | Nothing | Nothing | Nothing | Nothing |
| **E. Emergency Care** (in-service-area / in- or out-of-network)<br>• Emergency care received in a hospital emergency room | $225 copay<br>not subject to deductible | $250 copay<br>not subject to deductible | $275 copay<br>not subject to deductible | $500 copay<br>not subject to deductible |
| **F. Inpatient Hospital Copay** | $150 copay<br>annual deductible applies | $325 copay<br>annual deductible applies | $750 copay<br>annual deductible applies | 30% coinsurance<br>annual deductible applies |
| **G. Outpatient Surgery Copay** | $100 copay<br>annual deductible applies | $175 copay<br>annual deductible applies | $350 copay<br>annual deductible applies | 35% coinsurance<br>annual deductible applies |
| **H. Hospice and Skilled Nursing Facility** | Nothing | Nothing | Nothing | Nothing |
| **I. Prosthetics and Durable Medical Equipment** | 20% coinsurance | 20% coinsurance | 25% coinsurance | 35% coinsurance<br>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) | 10% coinsurance<br>annual deductible applies | 15% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies | 35% coinsurance<br>annual deductible applies |
| **K. MRI/CT Scans** | 10% coinsurance<br>annual deductible applies | 15% coinsurance<br>annual deductible applies | 25% coinsurance<br>annual deductible applies | 35% coinsurance<br>annual deductible applies |
| **L. Other expenses not covered in A – K above, including but not limited to:**<br>• **Ambulance**<br>• **Home Health Care**<br>• **Outpatient Hospital Services** (non-surgical)<br>  ◦ Radiation/chemotherapy<br>  ◦ Dialysis<br>  ◦ Day treatment for mental health and chemical dependency<br>  ◦ Other diagnostic or treatment related outpatient services | 10% coinsurance<br>annual deductible applies | 10% coinsurance<br>annual deductible applies | 20% coinsurance<br>annual deductible applies | 35% coinsurance<br>annual deductible applies |
| **M. Prescription Drugs**<br>30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin; or a 3-cycle supply of oral contraceptives. | $25 tier one<br>$45 tier two<br>$70 tier three | $25 tier one<br>$45 tier two<br>$70 tier three | $25 tier one<br>$45 tier two<br>$70 tier three | $25 tier one<br>$45 tier two<br>$70 tier three |
| **N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs** (single/family) | $1,250 / 2,500 | $1,250 / 2,500 | $1,250 / 2,500 | $1,250 / 2,500 |
| **O. Plan Maximum Out-of-Pocket Expense** (excluding prescription drugs) (single/family) | $2,600 / 5,200<br>Combined in- and out-of-area services | $2,600 / 5,200<br>Combined in- and out-of-area services | $3,800 / 7,600<br>Combined in- and out-of-area services | $4,800 / 9,600<br>Combined in- and out-of-area services |

Important note: this chart describes coverage within the PEIP Advantage Plan's service area. Covered out-of-area services have a different cost-sharing structure: claims will be processed at Cost Level 3 with the out-of-pocket maximums described in section O above, and with a separate out-of-area deductible ($1,300 single/$2,600 family). Most care must be received within the national network of the selected plan administrator.

Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.

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.