Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan 2017 - 2018 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 • 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 * (single/family)	$150/300	$250/500	$550/1,100	$1,250/2,500
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 or out of network)	$25 copay per visit annual deductible applies	$30 copay per visit annual deductible applies	$60 copay per visit annual deductible applies	$80 copay per visit annual deductible applies
D. Convenience Clinics	$10 copay	$10 copay	$10 copay	$10 copay
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	$100 copay annual deductible applies	$100 copay annual deductible applies	$100 copay annual deductible applies	25% coinsurance annual deductible applies
F. Inpatient Hospital Copay	$100 copay annual deductible applies	$200 copay annual deductible applies	$500 copay annual deductible applies	25% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$60 copay annual deductible applies	$120 copay annual deductible applies	$250 copay annual deductible applies	25% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing	Nothing
I. Prosthetics and Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	25% 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)	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies
K. MRI/CT Scans	5% coinsurance annual deductible applies	10% coinsurance annual deductible applies	20% coinsurance annual deductible applies	25% 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
	5% coinsurance
	annual deductible applies
		5% coinsurance
		annual deductible applies
			20% coinsurance
			annual deductible applies
				25% 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.	$14 tier one $25 tier two $50 tier three	$14 tier one $25 tier two $50 tier three	$14 tier one $25 tier two $50 tier three	$14 tier one $25 tier two $50 tier three
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes infertility) (single/family)	$800/1,600	$800/1,600	$800/1,600	$800/1,600
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$1,200/2,400	$1,200/2,400	$1,600/3,200	$2,600/5,200

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 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 college students. It is also available to all dependent children and spouses permanently residing outside the service area. These members pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance 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.

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, including the transplant benefits, are administered, 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.*

Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan 2017 - 2018 Benefits Schedule

Value Option

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 * (single/family)	$500/1,000	$700/1,400	$1,100/2,200	$1,800/3,600
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 or out of network)	$30 copay per visit annual deductible applies	$35 copay per visit annual deductible applies	$95 copay per visit annual deductible applies	$120 copay per visit annual deductible applies
D. Convenience Clinics	$15 copay	$15 copay	$15 copay	$15 copay
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	$125 copay annual deductible applies	$125 copay annual deductible applies	$125 copay annual deductible applies	30% coinsurance annual deductible applies
F. Inpatient Hospital Copay	$150 copay annual deductible applies	$325 copay annual deductible applies	$750 copay annual deductible applies	30% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$100 copay annual deductible applies	$175 copay annual deductible applies	$350 copay annual deductible applies	35% coinsurance 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 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 annual deductible applies	10% coinsurance annual deductible applies	20% coinsurance annual deductible applies	35% coinsurance annual deductible applies
K. MRI/CT Scans	10% coinsurance annual deductible applies	10% coinsurance annual deductible applies	20% coinsurance annual deductible applies	35% 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
	10% coinsurance
	annual deductible applies
		10% coinsurance
		annual deductible applies
			20% coinsurance
			annual deductible applies
				35% 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.	$20 tier one $40 tier two $65 tier three	$20 tier one $40 tier two $65 tier three	$20 tier one $40 tier two $65 tier three	$20 tier one $40 tier two $65 tier three
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes Infertility) (single/family)	$1,000/2,000	$1,000/2,000	$1,000/2,000	$1,000/2,000
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$2,200/4,400	$2,200/4,400	$3,200/6,400	$4,200/8,400

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 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 college students. It is also available to all dependent children and spouses permanently residing outside the service area. These members pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance 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.

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, including the transplant benefits, are administered, 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.*

Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan 2017 - 2018 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**)	$2,600 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 or out of network)	$40 copay per visit annual deductible applies	$50 copay per visit annual deductible applies	$100 copay per visit annual deductible applies	$120 copay per visit annual deductible applies
D. Convenience Clinics	$20 copay annual deductible applies	$20 copay annual deductible applies	$20 copay annual deductible applies	$20 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.	$25 tier one $40 tier two $65 tier three annual deductible applies	$25 tier one $40 tier two $65 tier three annual deductible applies	$25 tier one $40 tier two $65 tier three annual deductible applies	$25 tier one $40 tier two $65 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	$6,850 per family member $8,000 per family	$6,850 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 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 college students. It is also available to all dependent children and spouses permanently residing outside the service area. These 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 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.

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, and in the referral and diagnosis coding patterns of primary care clinics.

**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.*