STATE OFFER – 92% actuarial value plan design

2020 Minnesota Advantage Health Plan Schedule of Benefits

2020 - 21 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	~~$250/500~~ $400/800	~~$550/1,100~~ $750/1500	~~$1,250/2,500~~ $1500/3000
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)	~~$25/30~~30/35* copay per visit Annual deductible applies	$ ~~30/35~~35/40* copay per visit Annual deductible applies	~~$60/65~~65/70* copay per visit Annual deductible applies	~~$80/85~~85/90* copay per visit Annual deductible applies
D. In-network Convenience Clinics & Online Care (deductible waived)	$0 copay	$0 copay	$0 copay	$0 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 (waived for admission to Center of Excellence)	$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, 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~~10% coinsurance Annual deductible applies	~~5~~10% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
K. MRI/CT Scans	~~5~~10% coinsurance Annual deductible applies	~~10~~15% coinsurance Annual deductible applies	~~20~~25% coinsurance Annual deductible applies	~~25~~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
	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 Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.	~~$14/25/50~~$18/30/55	~~$14/25/50~~$18/30/55	~~$14/25/60~~$18/30/55	~~$14/25/60~~$18/30/55
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)	~~$800/1,600~~$1050/2100	~~$800/1,600~~$1050/2100	~~$800/1,600~~$1050/2100	~~$800/1,600~~$1050/2100
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	~~$1,200/2,400~~$1700/3400	~~$1,200/2,400~~$1700/3400	~~$1,600/3,200~~$2400/4800	~~$2,600/5,200~~$3600/7200