

Minnesota Public Employees Insurance Program (PEIP)

Advantage Health Plans 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	\$0 copay not subject to deductible	\$0 copay not subject to deductible	\$0 copay not subject to deductible
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 - 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- & out-of-network)	covered at in-network and in-service-area selected PCC levels	covered at in-network and in-service-area selected PCC levels	covered at in-network and in-service-area selected PCC levels
D. Convenience Clinics	\$0 copay not subject to deductible	\$0 copay not subject to deductible	30% coinsurance annual deductible applies
E. Emergency Care (in- or out-of-network) Emergency care received in a hospital emergency room	covered at in-network and in-service-area selected PCC levels	covered at in-network and in-service-area selected PCC levels	covered at in-network and in-service-area selected PCC levels
F. Inpatient Hospital	\$500 copay annual deductible applies	\$750 copay annual deductible applies	30% coinsurance annual deductible applies
G. Outpatient Surgery	\$250 copay annual deductible applies	\$350 copay annual deductible applies	30% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	\$0 copay not subject to deductible	\$0 copay not subject to deductible	30% coinsurance annual deductible applies
I. Prosthetics and Durable Medical Equipment	20% coinsurance not subject to deductible	25% coinsurance not subject to deductible	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 substance use disorder - 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.	Tier 1 - \$18 Tier 2 - \$30 Tier 3 - \$55	Tier 1 - \$25 Tier 2 - \$45 Tier 3 - \$70	Tier 1 - \$30 Tier 2 - \$50 Tier 3 - \$75 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 Primary Care Clinic 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.