Minnesota Advantage Health Plan 2016-2017 Benefits Schedule

(As of 6/28/15)

2016-17 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)	~~$75/150~~$150/300	~~$180/360~~$250/500	~~$400/800~~$550/1100	~~$1000/2000~~$1250/2500
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)	$~~18/23*~~25/30 copay per visit Annual deductible applies	$~~23/28~~30/35 copay per visit Annual deductible applies	$~~36/41*~~60/65 copay per visit Annual deductible applies	$~~55/60*~~80/85 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 (copay waived for procedures at designated Centers 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% 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	$~~12/$18/$38~~14/25/50	$~~12/$18/$38~~14/25/50	$~~12/$18/$38~~14/25/50	$~~12/$18/$38~~14/25/50
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)	$800/$1600	$800/$1600	$800/1600	$800/$1600
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$~~1100/2200~~1200/2400	$~~1100/2200~~1200/2400	$~~1500/3000~~1600/3200	$~~2500/5000~~2600/5200

**The level of the office visit copayment for the employee and his or her family is dependent upon whether the employee has completed the Health Assessment in each Open Enrollment period, and opted-in for any indicated health coaching. Employees who have completed the Health Assessment and opted-in for health coaching are entitled to the lower copayment. Employees hired after the close of Open Enrollment will be entitled to the lower copayment.*

This chart applies only to in-network coverage. Point of Service (POS) 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 all dependent children, including college students, and spouses living out of area. These members pay a $350 single or $700 family deductible and 30% coinsurance to the out-of-pocket maximum 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.

Out-of-network emergency and urgent care are covered at the in-network level.

A standard set of benefits is offered in all SEGIP Advantage Plans. There are still some differences from plan to plan in the way that benefits, including the transplant benefit, are administered, in the referral and diagnosis coding patterns of primary care clinics, and in the definition of Allowed Amount.