2024/2025 Minnesota Advantage Health Plan Schedule of Benefits

2024/2025 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)	$250 / 500	$400 / 800	$750 / 1,500	$1,500 / 3,000
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 • Urgent Care clinic visits (in service area/in or out of network)	$35 copay per visit Annual deductible applies	$40 copay per visit Annual deductible applies	$70 copay per visit Annual deductible applies	$90 copay per visit Annual deductible applies
C1. Office visits for mental health and Substance Use Disorder Outpatient office visits only	$0 copay per visit Not subject to Annual deductible	$0 copay per visit Not subject to Annual deductible	$50 copay per visit Annual deductible applies	$70 copay per visit Annual deductible applies
D. Convenience Clinics and Online Care	$0 copay Not subject to Annual deductible	$0 copay Not subject to Annual deductible	$0 copay Not subject to Annual deductible	$0 copay Not subject to Annual deductible
E. Emergency Care (in service area/in or out of network) Emergency care received in a hospital emergency room	$100 copay Not subject to Annual deductible	$125 copay Not subject to Annual deductible	$150 copay Not subject to Annual deductible	$350 copay Not subject to Annual deductible
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 Not subject to Annual deductible	20% coinsurance Not subject to Annual deductible	20% coinsurance Not subject to Annual deductible	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)	10% coinsurance Annual deductible applies	10% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
K. MRI/CT Scans	10% coinsurance Annual deductible applies	15% 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	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.	Tier 1 - $18 Tier 2 - $30 Tier 3 - $55	Tier 1 - $18 Tier 2 - $30 Tier 3 - $55	Tier 1 - $18 Tier 2 - $30 Tier 3 - $55	Tier 1 - $18 Tier 2 - $30 Tier 3 - $55
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (single/family)	$1,050 / 2,100	$1,050 / 2,100	$1,050 / 2,100	$1,050 / 2,100
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$1,700 / 3,400 Combined in and out of area services	$1,700 / 3,400 Combined in and out of area services	$2,400 / 4,800 Combined in and out of area services	$3,600 / 7,200 Combined in and out of area services

Important note: this chart describes coverage **within the Minnesota 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 ($750 single/$1,500 family). Most care must be received within the national network of the selected plan administrator.

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