2024-2025 SEGIP Out-of-Area Benefits Schedule for the Minnesota Advantage and High Deductible Health Plans

Benefit Provision	MN Advantage Health Plan	MN Advantage High Deductible Health Plan (HDHP)
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 Annual Deductible	$0 copay Not subject to Annual Deductible
B. Annual First Dollar Deductible Single Family	$750 $1,500	$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	$70 copay per visit Annual deductible applies	30% coinsurance Annual deductible applies
C1. Outpatient office visits for mental health and substance use disorder	$50 copay per visit Annual deductible applies	30% coinsurance Annual deductible applies
C2. Urgent Care clinic visits (in- and 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
D. Convenience Clinics	$0 copay Not subject to Annual 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
F. Inpatient Hospital	$500 copay Annual deductible applies	30% coinsurance Annual deductible applies
G. Outpatient Surgery	$250 copay Annual deductible applies	30% coinsurance Annual deductible applies
H. Hospice and Skilled Nursing Facility	$0 copay Not subject to Annual Deductible	30% coinsurance Annual deductible applies
I. Prosthetics and Durable Medical Equipment	20% coinsurance not subject to Annual 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	30% coinsurance Annual deductible applies
K. MRI/CT scans	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	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 - $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	N/A
O. *Plan Maximum Out-of-Pocket Expense (single/family) (Including prescription drugs for HDHP plan)	$1,700 / 3,400 (cost levels 1, 2) $2,400 / 4,800 (cost level 3) $3,600 / 7,200 (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 SEGIP deductibles (except for urgent care) 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 HDHP 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.