2024/2025 Minnesota Advantage High Deductible Health Plan (HDHP) Schedule of Benefits

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 * Combined Medical/Pharmacy -**Single Coverage** **Family Coverage**	$1,600 $3,200 per family member $3,400 per family	$2,000 $3,200 per family member $4,000 per family	$3,000 $4,800 per family member $6,000 per family	$4,000 $6,400 per family member $8,000 per family
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 or out of network/in or out of service area)	$45 copay per visit Annual deductible applies	$55 copay per visit Annual deductible applies	$105 copay per visit Annual deductible applies	$130 copay per visit Annual deductible applies
C1. Outpatient office visits for mental health and substance use disorder	$0 copay per visit Annual deductible applies	$0 copay per visit Annual deductible applies	$85 copay per visit Annual deductible applies	$110 copay per visit Annual deductible applies
D. Network Convenience Clinics & Online Care	$0 copay Annual deductible applies	$0 copay Annual deductible applies	$0 copay Annual deductible applies	$0 copay Annual deductible applies
E. Emergency Care (in or out of network/in or out of service area) Emergency care received in a hospital emergency room	$250 copay Annual deductible applies	$300 copay Annual deductible applies	$350 copay Annual deductible applies	$600 copay Annual deductible applies
F. Inpatient Hospital	$400 copay Annual deductible applies	$650 copay Annual deductible applies	$1,500 copay Annual deductible applies	50% coinsurance Annual deductible applies
G. Outpatient Surgery	$250 copay Annual deductible applies	$400 copay Annual deductible applies	$800 copay Annual deductible applies	50% coinsurance Annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing after Annual deductible	Nothing after Annual deductible	Nothing after Annual deductible	Nothing after Annual deductible
I. Prosthetics and Durable Medical Equipment	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies	30% coinsurance Annual deductible applies	50% 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	50% coinsurance Annual deductible applies
K. MRI/CT Scans	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies	30% coinsurance Annual deductible applies	50% 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
		25% coinsurance
		Annual deductible applies
			30% coinsurance
			Annual deductible applies
				50% 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 - $30 Tier 2 - $50 Tier 3 - $75 Annual deductible applies	Tier 1 - $30 Tier 2 - $50 Tier 3 - $75 Annual deductible applies	Tier 1 - $30 Tier 2 - $50 Tier 3 - $75 Annual deductible applies	Tier 1 - $30 Tier 2 - $50 Tier 3 - $75 Annual deductible applies
N. Plan Maximum Out-of-Pocket Expense (including prescription drugs) - **Single Coverage** **Family Coverage**	$3,000 $5,000 per family member $6,000 per family	$3,000 $5,000 per family member $6,000 per family	$4,000 $6,900 per family member $8,000 per family	$5,000 $6,900 per family member $10,000 per family

This chart applies only to in-service area coverage. Out-of-service area coverage is available outside the Minnesota Advantage High Deductible Health Plan's service area. Members pay a $1,600 single or $3,400 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance that will apply to the out-of-pocket maximums described in section N above. Members pay the drug copayment described in section M above to the out-of-pocket maximum described in section N.

Urgent Care and Emergency Care received in-service area or out-of-service area or in or out-of-network claims will process based on C and E above. Deductible will be applied to in-service area benefit.

* The family Deductible is the maximum amount that a family must pay in deductible expenses in any one calendar year. The family Deductible is not the amount of expenses a family must incur before any family member can receive benefits. Individual family members only need to satisfy their individual deductible once to be eligible for benefits. Once the family Deductible has been met, deductible expenses for the family are waived for the balance of the year.