

# 2020 Minnesota Advantage Health Plan Schedule of Benefits

2020 - 21 Benefit Provision	Cost Level 1 - You Pay	Cost Level 2 - You Pay	Cost Level 3 - You Pay	Cost Level 4 - You Pay
<b>A. Preventive Care Services</b> <ul style="list-style-type: none"> <li>Routine medical exams, cancer screening</li> <li>Child health preventive services, routine immunizations</li> <li>Prenatal and postnatal care and exams</li> <li>Adult immunizations</li> <li>Routine eye and hearing exams</li> </ul>	Nothing	Nothing	Nothing	Nothing
<b>B. Annual First Dollar Deductible (single/family)</b>	<del>\$150/300</del> <del>\$250/500</del>	<del>\$250/500</del> <del>\$400/800</del>	<del>\$550/1,100</del> <del>\$750/1500</del>	<del>\$1,250/2,500</del> <del>\$1500/3000</del>
<b>C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care</b> <ul style="list-style-type: none"> <li>Outpatient visits in a physician's office</li> <li>Chiropractic services</li> <li>Outpatient mental health and chemical dependency</li> <li>Urgent Care clinic visits (in &amp; out of network)</li> </ul>	<del>\$25/30</del> <del>30/35*</del> copay per visit Annual deductible applies	<del>\$ 30/35</del> <del>35/40*</del> copay per visit Annual deductible applies	<del>\$60/65</del> <del>65/70*</del> copay per visit Annual deductible applies	<del>\$80/85</del> <del>85/90*</del> copay per visit Annual deductible applies
<b>D. In-network Convenience Clinics &amp; Online Care (deductible waived)</b>	\$0 copay	\$0 copay	\$0 copay	\$0 copay
<b>E. Emergency Care (in or out of network)</b> <ul style="list-style-type: none"> <li>Emergency care received in a hospital emergency room</li> </ul>	\$100 copay Annual deductible applies	\$100 copay Annual deductible applies	\$100 copay Annual deductible applies	25% coinsurance Annual deductible applies
<b>F. Inpatient Hospital Copay (waived for admission to Center of Excellence)</b>	\$100 copay Annual deductible applies	\$200 copay Annual deductible applies	\$500 copay Annual deductible applies	25% coinsurance Annual deductible applies
<b>G. Outpatient Surgery Copay</b>	\$60 copay Annual deductible applies	\$120 copay Annual deductible applies	\$250 copay Annual deductible applies	25% coinsurance Annual deductible applies
<b>H. Hospice and Skilled Nursing Facility</b>	Nothing	Nothing	Nothing	Nothing
<b>I. Prosthetics, Durable Medical Equipment</b>	20% coinsurance	20% coinsurance	20% coinsurance	25% coinsurance Annual deductible applies
<b>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)</b>	510% coinsurance Annual deductible applies	510% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
<b>K. MRI/CT Scans</b>	510% coinsurance Annual deductible applies	4015% coinsurance Annual deductible applies	2025% coinsurance Annual deductible applies	2530% coinsurance Annual deductible applies
<b>L. Other expenses not covered in A-K above, including but not limited to:</b> <ul style="list-style-type: none"> <li>Ambulance</li> <li>Home Health Care</li> <li>Outpatient Hospital Services (non-surgical) <ul style="list-style-type: none"> <li>Radiation/chemotherapy</li> <li>Dialysis</li> <li>Day treatment for mental health and chemical dependency</li> <li>Other diagnostic or treatment related outpatient services</li> </ul> </li> </ul>	5% coinsurance Annual deductible applies	5% coinsurance Annual deductible applies	20% coinsurance Annual deductible applies	25% coinsurance Annual deductible applies
<b>M. Prescription Drugs</b> 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.	<del>\$14/25/50</del> <del>\$18/30/55</del>	<del>\$14/25/50</del> <del>\$18/30/55</del>	<del>\$14/25/50</del> <del>\$18/30/55</del>	<del>\$14/25/50</del> <del>\$18/30/55</del>
<b>N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, Infertility, growth hormones) (single/family)</b>	<del>\$800/4,600</del> <del>\$1050/2100</del>	<del>\$800/4,600</del> <del>\$1050/2100</del>	<del>\$800/4,600</del> <del>\$1050/2100</del>	<del>\$800/4,600</del> <del>\$1050/2100</del>
<b>O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)</b>	<del>\$1,200/2,400</del> <del>\$1700/3400</del>	<del>\$1,200/2,400</del> <del>\$1700/3400</del>	<del>\$1,600/3,200</del> <del>\$2400/4800</del>	<del>\$2,600/5,200</del> <del>\$3600/7200</del>

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## STATE OFFER – Medical plan design

Average actuarial value of 92.05%

\$30.3 million in saving on entire population (18 months)

8% premium increases in 2020-21 (down from 9.3%)

### Projected 2020 monthly premiums\*

Employee share	
Employee	\$35.08
Family	\$239.36

*\*May change slightly due to rounding and other factors*

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## STATE OFFER – 92% actuarial value plan design

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## STATE OFFER – Dental benefits

### Costs are shared between agencies and employees

Employee share of dependent premium (50%) is unchanged. Agency share also remains at 50%.

Employee share of single premium (\$13.50) is unchanged. Agency share of single premium goes up.

### Projected 2020 monthly premiums\*

Employee share	
Employee	\$13.50
Dependent	\$40.68
Family	\$54.18

*\*May change slightly due to rounding and other factors*

### Current 2019 premiums, for reference

Employee share	
Employee	\$13.50
Dependent	\$39.02
Family	\$52.52