

Minnesota Advantage Health Plan Benefits Schedule 2009

2008-2009 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 <ul style="list-style-type: none"> ● 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)	\$50/100	\$140/280	\$350/700	\$600/1200
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care within the service area <ul style="list-style-type: none"> ● Outpatient visits in a physician's office ● Chiropractic services ● Outpatient mental health and chemical dependency 	\$17/22* copay per visit annual deductible applies	\$22/27* copay per visit annual deductible applies	\$27/32* copay per visit annual deductible applies	\$37/42* copay per visit annual deductible applies
D. Convenience Clinics	\$10 copay	\$10 copay	\$10 copay	\$10 copay
E. Emergency Care (in service area) <ul style="list-style-type: none"> ● Emergency care received in a hospital emergency room 	\$75 copay annual deductible applies	\$75 copay annual deductible applies	\$75 copay annual deductible applies	25% coinsurance annual deductible applies
F. Inpatient Hospital Copay	\$85 copay annual deductible applies	\$180 copay annual deductible applies	\$450 copay annual deductible applies	25% coinsurance annual deductible applies
G. Outpatient Surgery Copay	\$55 copay annual deductible applies	\$110 copay annual deductible applies	\$220 copay annual deductible applies	30% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing	Nothing
I. Prosthetics and Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	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)	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	10% coinsurance annual deductible applies	30% coinsurance annual deductible applies
K. MRI/CT Scans	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	10% coinsurance annual deductible applies	30% coinsurance annual deductible applies
L. Other expenses not covered in A – K above, including but not limited to: <ul style="list-style-type: none"> ● Ambulance ● Home Health Care ● Outpatient Hospital Services (non-surgical) <ul style="list-style-type: none"> ● Radiation/chemotherapy ● Dialysis ● Day treatment for mental health and chemical dependency ● Other diagnostic or treatment related 	5% coinsurance annual deductible applies	5% coinsurance annual deductible applies	10% 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.	\$10/\$16/\$36	\$10/\$16/\$36	\$10/\$16/\$36	\$10/\$16/\$36
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	\$1100/2200	\$1100/2200	\$1100/2200

*The level of the office visit copayment for the employee and his or her family is dependent upon whether you have completed the Health Assessment in each Open Enrollment. Employees who have completed the Health Assessment and agreed to a follow-up call from a health coach are entitled to the lower copayment. Employees hired after the close of Open Enrollment will be entitled to the lower copayment.

Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network: the plan covers 80% of the first \$2000 of eligible charges, then 100% per calendar year.

Out-of-Network 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 maximums 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.

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 are administered, including the transplant benefit, and in the referral and diagnosis coding patterns of primary care clinics, and the definitions of allowed amount.