

## Advantage High Deductible Health Plan (HDHP)

2020-2021 Benefit Provisions	Cost Level 1-You Pay	Cost Level 2-You Pay	Cost Level 3-You Pay	Cost Level 4-You Pay
Preventive Care Services	Nothing	Nothing	Nothing	Nothing
Annual First Dollar Deductible *				
Combined Medical/Pharmacy (single coverage)	\$1,500	\$2,000	\$3,000	\$4,000
(family coverage)	\$2,800 per family member \$3,000 per family	\$3,200 per family member \$4,000 per family	\$4,800 per family member \$6,000 per family	\$6,400 per family member \$8,000 per family
Annual Out-of-Pocket Maximum** (including prescription drugs) (single coverage)	\$3,000	\$3,000	\$4,000	\$5,000
(family coverage)	\$5,000 per family member \$6,000 per family	\$5,000 per family member \$6,000 per family	\$6,900 per family member \$8,000 per family	\$6,900 per family member \$10,000 per family
Office Visits***	\$45 copay per visit after deductible	\$55 copay per visit after deductible	\$105 copay per visit after deductible	\$130 copay per visit after deductible
In-network Convenience Clinics and Online Care	\$0 after deductible	\$0 after deductible	\$0 after deductible	\$0 after deductible
Emergency (emergency care received in a Hospital emergency room)	\$150 copay after deductible	\$150 copay after deductible	\$150 copay after deductible	50% coinsurance after deductible
Inpatient Hospital	\$400 copay after deductible	\$650 copay after deductible	\$1,500 copay after deductible	50% coinsurance after deductible
Outpatient Surgery	\$250 copay after deductible	\$400 copay after deductible	\$800 copay after deductible	50% coinsurance after deductible
Hospice and Skilled Nursing Facility	Nothing after annual deductible	Nothing after annual deductible	Nothing after annual deductible	Nothing after annual deductible
Prosthetics and Durable Medical Equipment; Lab, Pathology, and X-ray; MRI/CT Scans; Other (e.g., Ambulance, Home Health Care, Outpatient Hospital (non-surgical))	20% coinsurance after deductible	25% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible
Prescription Drugs****	\$30 / \$50 / \$75 after deductible	\$30 / \$50 / \$75 after deductible	\$30 / \$50 / \$75 after deductible	\$30 / \$50 / \$75 after deductible

\*The family Deductible is the maximum amount that a family has to 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.

\*\*The family Out-of-Pocket Maximum is the maximum amount that a family has to pay in any one calendar year. The per-family member embedded Out-of-Pocket Maximum is the maximum amount that a family has to pay in any one calendar year on behalf of any individual family member.

\*\*\*Office visits for illness/injury, for outpatient physical, occupational or speech therapy, and urgent care within the service area, including outpatient visits in a physician's office, chiropractic services, outpatient mental health and chemical dependency.

\*\*\*\*30-day supply of Tier 1, Tier 2, or Tier 3 Prescription Drugs, including insulin; or a 3-cycle supply of oral contraceptives.

This chart applies only to in-network coverage. Point of Service (POS) 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 the Advantage HDHP. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and college students. It is also available to dependent children and spouses permanently residing outside the service area. These Members pay a \$1500 single or \$3000 family Deductible and 30% Coinsurance to the \$3000/\$6000 Out-of-Pocket Maximums described above. This benefit must be requested.