ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	BRONZE BASIC	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	$5,500 $11,000	$11,000 $22,000
Prescription Drug Deductible Individual Family	$200 $400	Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	$2,850 $5,700	$5,700 $11,400
Health Care Out-of-Pocket Maximum Individual Family	$8,550 $17,100	$17,100 $34,200
COPAYMENTS/COINSURANCE		
Coinsurance	50%	50%
Adult and Child Preventive Services	100%	50% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	Combined total of 1 visit @ 100% coinsurance, then 50% coinsurance after deductible	50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible
Inpatient Hospital Services	$400 copayment, then 50% coinsurance after deductible	$400 copayment, then 50% coinsurance after deductible
Emergency Room	$350 copayment, then 50% coinsurance after deductible	$350 copayment, then 50% coinsurance after deductible
Prenatal Care	Deductible; 50% applies to first visit; 100% thereafter	50% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	Deductible: $200 per individual/ $400 per family per plan year; then 50% coinsurance	Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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Major medical plans not available in the state of Minnesota.
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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	BRONZE PREFERRED	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $4,000 $8,000	 $8,000 $16,000
Prescription Drug Deductible Individual Family	 $50 $100	Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $3,450 $7,000	 $7,000 $14,000
Health Care Out-of-Pocket Maximum Individual Family	 $7,900 $15,800	 $15,800 $31,600
COPAYMENTS/COINSURANCE		
Coinsurance	70%	50%
Adult and Child Preventive Services	100%	50% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $40 $75 $60	 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible
Inpatient Hospital Services	$400 copayment per visit, then 70% coinsurance after deductible	$400 copayment per visit, then 50% coinsurance after deductible
Emergency Room	$300 copayment per visit, then 70% coinsurance after deductible	$300 copayment per visit, then in-network deductible, 70% coins.
Prenatal Care	$40 PCP/ $60 specialist copay for first visit, then 100% thereafter	50% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $25 $55 $80 $50/$110/$160	Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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Major medical plans not available in the state of Minnesota.
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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	SILVER BALANCED	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
Prescription Drug Deductible Individual Family	 $50 $100	 Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $5,600 $11,200	 $11,300 $22,600
Health Care Out-of-Pocket Maximum Individual Family	 $7,150 $14,300	 $14,300 $28,600
COPAYMENTS/COINSURANCE		
Coinsurance	70%	50%
Adult and Child Preventive Services	100%	50% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $60 $75 $75	 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible
Inpatient Hospital Services	$300 copayment per visit, then 70% coinsurance after deductible	$300 copayment per visit, then 50% coinsurance after deductible
Emergency Room	$200 copayment, then 70% coinsurance after deductible	$200 copayment, then in-network deductible, 70% co-ins
Prenatal Care	$60 PCP/$75 specialist copay for initial visit, then 100% thereafter	50% coinsurance after deductible
Postnatal Care	70% coinsurance after deductible	50% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $20 $50 $80 $40/$100/$160	 Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	SILVER BASIC	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Prescription Drug Deductible Individual Family	 $75 $150	Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $3,775 $7,550	 $7,700 $15,400
Health Care Out-of-Pocket Maximum Individual Family	 $6,850 $13,700	 $13,700 $27,400
COPAYMENTS/COINSURANCE		
Coinsurance	70%	50%
Adult and Child Preventive Services	100%	50% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $30 $75 $60	 50% coinsurance after deductible 50% coinsurance after deductible 50% coinsurance after deductible
Inpatient Hospital Services	$300 copayment, then 70% coinsurance after deductible	$300 copayment, then in-network deductible, 70% coins.
Emergency Room	$250 copayment, then 70% coinsurance after deductible	$250 copayment, then 50% coinsurance after deductible
Prenatal Care	$30 PCP/ $60 Specialist for initial visit; 100% thereafter	50% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	Deductible: $75 per individual/ $150 per family per plan yer; then 70% coinsurance	Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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Major medical plans not available in the state of Minnesota.
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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	SILVER CHOICE	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $2,000 $4,000	 $4,000 $8,000
Prescription Drug Deductible Individual Family	 $50 $100	 Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $4,800 $9,600	 $9,700 $19,400
Health Care Out-of-Pocket Maximum Individual Family	 $6,850 $13,700	 $13,700 $27,400
COPAYMENTS/COINSURANCE		
Coinsurance	80%	60%
Adult and Child Preventive Services	100%	60% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $30 $50 $50	 60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible
Inpatient Hospital Services	$300 copayment, then 80% coinsurance after deductible	$300 copayment, then 60% coinsurance after deductible
Emergency Room	$200 copayment, then 80% coinsurance after deductible	$200 copayment, then in-network deductible, 80% coins.
Prenatal Care	$30 PCP/ $50 specialist copay for initial visit, then 100% thereafter	60% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $20 $50 $80 $40/$100/$160	 Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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Major medical plans not available in the state of Minnesota.
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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	GOLD BALANCED	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $500 $1,000	 $1,500 $3,000
Prescription Drug Deductible Individual Family	 $50 $100	 Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $6,600 $13,200	 $19,950 $39,900
Health Care Out-of-Pocket Maximum Individual Family	 $7,150 $14,300	 $21,450 $42,900
COPAYMENTS/COINSURANCE		
Coinsurance	80%	60%
Adult and Child Preventive Services	100%	60% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $25 $45 $45	 60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible
Inpatient Hospital Services	$300 copayment, then 80% coinsurance after deductible	$300 copayment, then 60% coinsurance after deductible
Emergency Room	$150 copayment, then 80% coinsurance after deductible	$150 copayment per visit, then in-network deductible, 80% coins.
Prenatal Care	$25 PCP/ $45 Specialist copay for initial visit, 100% thereafter	60% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $20 $45 $75 $40/$90/$150	 Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	GOLD BASIC	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $1,000 $2,000	 $2,000 $4,000
Prescription Drug Deductible Individual Family	 $50 $100	 Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $4,700 $9,500	 $9,500 $19,000
Health Care Out-of-Pocket Maximum Individual Family	 $5,750 $11,500	 $11,500 $23,000
COPAYMENTS/COINSURANCE		
Coinsurance	80%	60%
Adult and Child Preventive Services	100%	60% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $25 $45 $45	 60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible
Inpatient Hospital Services	$300 copayment, then 80% coinsurance after deductible	$300 copayment, then 60% coinsurance after deductible
Emergency Room	$200 copayment, then 80% coinsurance after deductible	$200 copayment, then in-network deductible, 80% coins.
Prenatal Care	$25 PCP/ $45 Specialist for intial visit, then 100% thereafter	60% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $20 $45 $75 $40/$90/$150	 Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	GOLD PREFERRED	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
Prescription Drug Deductible Individual Family	 $50 $100	 Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $1,200 $2,400	 $2,500 $5,000
Health Care Out-of-Pocket Maximum Individual Family	 $2,750 $5,500	 $5,500 $11,000
COPAYMENTS/COINSURANCE		
Coinsurance	80%	60%
Adult and Child Preventive Services	100%	60% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $20 $40 $30	 60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible
Inpatient Hospital Services	$300 copayment, then 80% coinsurance after deductible	$300 copayment, then 60% coinsurance after deductible
Emergency Room	$150 copayment, then 80% coinsurance after deductible	$150 copayment, then in-network deductible, 80% coins.
Prenatal Care	$20 PCP/$30 Specialist copay for initial visit; 100% thereafter	60% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $20 $45 $75 $40/$90/$150	 Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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Major medical plans not available in the state of Minnesota.
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ELEVANTA® HEALTH

2021-2022 MAJOR MEDICAL PPO PLANS

	PLATINUM CHOICE	
BENEFITS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES (PER YEAR)		
Medical Deductible Individual Family	 $500 $1,000	 $1,000 $2,000
Prescription Drug Deductible Individual Family	 $50 $100	 Not Covered
OUT-OF-POCKET MAXIMUM (PER YEAR)		
Coinsurance/Copay Out-of-Pocket Maximum Individual Family	 $500 $1,000	 $1,100 $2,200
Health Care Out-of-Pocket Maximum Individual Family	 $1,050 $2,100	 $2,100 $4,200
COPAYMENTS/COINSURANCE		
Coinsurance	80%	60%
Adult and Child Preventive Services	100%	60% coinsurance after deductible
Office Visit Copays Primary Care Physician Urgent Care Services Specialist Office Visit	 $20 $40 $30	 60% coinsurance after deductible 60% coinsurance after deductible 60% coinsurance after deductible
Inpatient Hospital Services	$200 copayment, then 80% coinsurance after deductible	$200 copayment, then 60% coinsurance after deductible
Emergency Room	$150 copayment, then 80% coinsurance after deductible	$150 copayment, then in-network deductible; 80% coins.
Prenatal Care	$20 PCP/ $30 Specialist for initial visit; then 100% thereafter	60% coinsurance after deductible
Prescription Drug Copays Generic Preferred Brand Drug Non-Preferred Brand Drug Mail Order Generic/Preferred/Non-Preferred	 $10 $30 $55 $20/$60/$110	 Not Covered
Basic Term Life Insurance	$10,000 employee-only	

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