Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan High Option 2027 Benefits Schedule

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 * (single/family)	$250 / 500	$400 / 800	$750 / 1,500	$1,500 / 3,000
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-service-area / in- or out-of-network)	$35 copay per visit annual deductible applies	$40 copay per visit annual deductible applies	$70 copay per visit annual deductible applies	$90 copay per visit annual deductible applies
• Outpatient office visits for mental health and substance use disorder	$0 copay per visit not subject to deductible	$0 copay per visit not subject to deductible	$40 copay per visit annual deductible applies	$60 copay per visit annual deductible applies
D. Network Convenience Clinics & Online Care	Nothing	Nothing	Nothing	Nothing
E. Emergency Care (in service area / in or out of network) • Emergency care received in a hospital emergency room	$100 copay not subject to deductible	$125 copay not subject to deductible	$150 copay not subject to deductible	$350 copay not subject to deductible
F. Inpatient Hospital Copay	$100 copay annual deductible applies	$200 copay annual deductible applies	$500 copay annual deductible applies	25% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$60 copay annual deductible applies	$120 copay annual deductible applies	$250 copay annual deductible applies	25% 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	25% 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)	10% coinsurance annual deductible applies	10% coinsurance annual deductible applies	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies
K. MRI/CT Scans	10% coinsurance annual deductible applies	15% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% 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 chemical dependency
  • Other diagnostic or treatment related outpatient services
	5% coinsurance
	annual deductible applies
		5% coinsurance
		annual deductible applies
			20% coinsurance
			annual deductible applies
				25% 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.	$18 tier one $30 tier two $55 tier three	$18 tier one $30 tier two $55 tier three	$18 tier one $30 tier two $55 tier three	$18 tier one $30 tier two $55 tier three
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (single/family)	$1,050 / 2,100	$1,050 / 2,100	$1,050 / 2,100	$1,050 / 2,100
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$1,700 / 3,400 Combined in- and out-of-area services	$1,700 / 3,400 Combined in- and out-of-area services	$2,400 / 4,800 Combined in- and out-of-area services	$3,600 / 7,200 Combined in- and out-of-area services

Important note: this chart describes coverage within the PEIP Advantage Plan's service area. Covered out-of-area services have a different cost-sharing structure: claims will be processed at Cost Level 3 with the out-of-pocket maximums described in section O above, and with a separate out-of-area deductible ($750 single/$1,500 family). Most care must be received within the national network of the selected plan administrator.

Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.

This Plan uses an embedded deductible: if any family member reaches the individual deductible, then the deductible is satisfied for that family member. If any combination of family members reaches the family deductible, then the deductible is satisfied for the entire family.