Step-by-Step Instructions for Enrollment in the Public Employees Insurance Program

This guide explains how the Public Employees Insurance Program (PEIP) works and the choices you'll make when you enroll.

Step 1 – Choose Your Benefit Level

You can choose between two benefit levels. Your premium and how much you pay for medical care will depend on the option you choose:

- **Advantage** (High): Higher premiums, but generally lower costs when you receive medical care.
- **HSA** (Low): Lower premiums, but generally higher costs when you receive medical care.

Choose the option that works best for you and your family. Your premium and how much you pay for medical care will depend on the option you choose. You may change your benefit level each year during your group's annual open enrollment.

Step 2 – Choose Your Plan Administrator/Provider Network

You can choose between two plan administrators/provider networks:

- **HealthPartners**
- **Blue Cross Blue Shield (BCBS)**

Both options have similar benefits, and your choice does not change your premium. Choose the provider network that includes the doctors and clinics you prefer. You may change your plan administrator/provider network each year during your group's annual open enrollment.

Step 3 – Choose a Primary Care Clinic

- **Select a primary care clinic (PCC) for each family member**

Each person covered by your plan must choose a primary care clinic (PCC). Family members can choose different clinics – even in different cost levels – but everyone in your family must have the same benefit level and the same plan administrator/provider network.

Clinic cost levels: Primary care clinics are placed into one of four cost levels based on the health care system they belong to and that system's overall cost of providing care. Your clinic's cost level affects how much you pay for medical care. In general, a lower cost level means better benefits for you, such as lower deductibles, copays, coinsurance, and out-of-pocket maximums.

A list of participating clinics is available online. When you enroll, enter your clinic's PCC Number on your enrollment form. Important: be sure the PCC Number matches the plan administrator/provider network you selected. You can change your primary care clinic during the year by contacting your plan administrator directly using the phone number on your medical ID card.

Additional Information

Referrals: Most care is coordinated through your primary care clinic, and you'll generally need a referral to see a specialist (referrals are covered at the same cost level as your primary care clinic). You may self-refer to certain specialists – including OB/GYN, chiropractic, vision care, and mental health/substance use disorder providers – within your plan administrator's self-referral network. No referral is needed for urgent care or emergency room visits.

Plan documents: A statewide primary care clinic listing and health plan documents, including Summary of Benefits and Coverage (SBC) documents for each benefit level, are available online at www.innovomn.com.

ID cards: Once enrolled, you will receive two ID cards – one from your plan administrator (HealthPartners or BCBS) for medical claims, and one from CVS Caremark for pharmacy claims.

Questions? Call us at 952-746-3101 or 800-829-5601, or email service@innovomn.com.

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.

Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan HSA-Compatible 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 * Combined Medical/Pharmacy (**single coverage**)	$1,750	$2,250	$3,250	$4,250
Combined Medical/Pharmacy (**family coverage**)	$3,500 per family member $4,000 per family	$3,750 per family member $4,500 per family	$5,250 per family member $6,500 per family	$6,750 per family member $8,500 per family
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- or out-of-service-area / in- or out-of-network)	$45 copay per visit annual deductible applies	$55 copay per visit annual deductible applies	$105 copay per visit annual deductible applies	$130 copay per visit annual deductible applies
• Outpatient office visits for mental health and substance use disorder	$0 copay per visit annual deductible applies	$0 copay per visit annual deductible applies	$75 copay per visit annual deductible applies	$100 copay per visit annual deductible applies
D. Network Convenience Clinics & Online Care	$0 copay annual deductible applies	$0 copay annual deductible applies	$0 copay annual deductible applies	$0 copay annual deductible applies
E. Emergency Care (in- or out-of-service-area / in- or out-of-network) • Emergency care received in a hospital emergency room	$250 copay annual deductible applies	$300 copay annual deductible applies	$350 copay annual deductible applies	$600 copay annual deductible applies
F. Inpatient Hospital Copay	$400 copay annual deductible applies	$650 copay annual deductible applies	$1,500 copay annual deductible applies	50% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$250 copay annual deductible applies	$400 copay annual deductible applies	$800 copay annual deductible applies	50% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing after annual deductible	Nothing after annual deductible	Nothing after annual deductible	Nothing after annual deductible
I. Prosthetics and Durable Medical Equipment	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies	50% 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)	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies	50% coinsurance annual deductible applies
K. MRI/CT Scans	20% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies	50% 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
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	20% coinsurance
	annual deductible applies
		25% coinsurance
		annual deductible applies
			30% coinsurance
			annual deductible applies
				50% 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.	$30 tier one $50 tier two $75 tier three annual deductible applies	$30 tier one $50 tier two $75 tier three annual deductible applies	$30 tier one $50 tier two $75 tier three annual deductible applies	$30 tier one $50 tier two $75 tier three annual deductible applies
N. Plan Maximum Out-of-Pocket Expense** (including prescription drugs) **Single Coverage**	$3,250	$3,250	$4,250	$5,250
Family Coverage Combined in- and out-of-area services for both single and family coverage	$5,250 per family member $6,500 per family	$5,250 per family member $6,500 per family	$7,250 per family member $8,500 per family	$7,250 per family member $10,500 per family

This chart applies only to in-service area coverage. Out-of-service area coverage is available outside the PEIP Advantage Plan's service area. Members pay a $1,750 single or $4,000 family deductible (separate and distinct from the deductibles listed in section B above) and 30% coinsurance that will apply to the out-of-pocket maximums described in section N above. Members pay the drug copayment described at section M above to the out-of-pocket maximum described at section N.

Emergency Care and Urgent Care received in-service area or out-of-service area or in or out-of-network claims will process based on C and E above. Deductible will be applied to in-service area benefit.

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