Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan HSA-Compatible 2026 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	Nothing	Nothing	Nothing	Nothing
immunizations				
Prenatal and postnatal care and exams				
Adult immunizations				
Routine eye and hearing exams				
B. Annual First Dollar Deductible *	\$1,750	\$2,250	\$3,250	\$4,250
Combined Medical/Pharmacy (single coverage)				
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	\$45 copay per visit	\$55 copay per visit	\$105 copay per visit	\$130 copay per visit
 Outpatient visits in a physician's office 	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
Chiropractic services	arridar deductible applies	ailitual deductible applies	ailitual deductible applies	ariridal deddclible applies
 Urgent Care clinic visits (in- or out-of-service- area / in- or out-of-network) 				
Outpatient office visits for mental health and	\$0 copay per visit	\$0 copay per visit	\$75 copay per visit	\$100 copay per visit
substance use disorder	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
D. Network Convenience Clinics & Online Care	\$0 copay	\$0 copay	\$0 copay	\$0 copay
dillion dillion di dillion	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
E. Emergency Care (in- or out-of-service-area / in-				, , , , , , , , , , , , , , , , , , ,
or out-of-network)	\$250 copay	\$300 copay	\$350 copay	\$600 copay
Emergency care received in a hospital	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
emergency room	arriadi doddonolo applico	armaar adaddibio apprico	amidal doddololo applico	armaar adadabib appride
F. Inpatient Hospital Copay	\$400 copay	\$650 copay	\$1,500 copay	50% coinsurance
1. Inpution ricopital copus	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
G. Outpatient Surgery Copay	\$250 copay	\$400 copay	\$800 copay	50% coinsurance
G. Outpatient Surgery Copay	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing after	Nothing after	Nothing after	Nothing after
n. Hospice and Skilled Nursing Facility	annual deductible	annual deductible	annual deductible	annual deductible
I. Prosthetics and Durable Medical	20% coinsurance	25% coinsurance	30% coinsurance	50% coinsurance
Equipment	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
J. Lab (including allergy shots), Pathology,	arriual acadelible applies	armaar acaactible applies	arridar deddelible applies	armaar acaacable applies
and X-ray (not included as part of preventive	20% coinsurance	25% coinsurance	30% coinsurance	50% coinsurance
care and not subject to office visit or facility	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
copayments) K. MRI/CT Scans	20% coinsurance	25% coinsurance	30% coinsurance	50% coinsurance
R. WRI/CT Scalls	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
1 Other	armual deductible applies	armual deductible applies	armual deductible applies	arinual 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	20% coinsurance	25% coinsurance	30% coinsurance	50% coinsurance
Dialysis	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
Day treatment for mental health and				
chemical dependency				
Other diagnostic or treatment related				
outpatient services				
M. Prescription Drugs	\$30 tier one	\$30 tier one	\$30 tier one	\$30 tier one
30-day supply of Tier 1, Tier 2, or Tier 3	\$50 tier two	\$50 tier two	\$50 tier two	\$50 tier two
prescription drugs, including insulin; or a	\$75 tier three	\$75 tier three	\$75 tier three	\$75 tier three
3-cycle supply of oral contraceptives.	annual deductible applies	annual deductible applies	annual deductible applies	annual deductible applies
N. Plan Maximum Out-of-Pocket Expense**	arridal doddolible applies	amual acadelible applies	amuai acaaciibie applies	arridar deddelible applies
(including prescription drugs) Single Coverage	\$3,250	\$3,250	\$4,250	\$5,250
Family Coverage	\$5,250 per family member	\$5,250 per family member	\$7,250 per family member	\$7,250 per family member
Combined in- and out-of-area services for both	\$6,500 per family	\$6,500 per family	\$8,500 per family	\$10,500 per family
single and family coverage				
		DEID Adventore Plan's convice area A	lambara nav a \$1.750 aingle or \$4.000	

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.