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

To help explain your enrollment in the Public Employees Insurance Program, we have created the following guide.

Step 1 – Choose Your Plan Level

The Public Employees Insurance Program has cost sharing features that will help you and your employer better control health care costs while maintaining flexibility in access to doctors and clinics. The Public Employees Insurance Program offers two plan choices:

- **Advantage (High)**
- **HSA (Low)**

Choose the benefit level that best fits your needs. The premium rate and cost sharing will vary based on the benefit level you choose. You may change your benefit level each year during your group's annual open enrollment.

Step 2 – Choose Your Health Plan/Network

The Public Employees Insurance Program offers two different health plans/networks to choose from:

- **HealthPartners**
- **Blue Cross Blue Shield**

Choose the network carrier that best fits your needs. Your health plan/network selection will not affect the premium rate of the plan, and the benefits are similar under each option. You may change your health plan/network each year during your group's annual open enrollment.

Step 3 – Choose Your Primary Care Clinic

Primary care clinics have been placed into one of four cost levels, depending on the care system in which the provider participates and that care system's total cost of delivering health care. The amount of cost sharing for health care services under your plan is dependent on the cost level of the primary care clinic you have assigned. A lower cost level generally corresponds to a richer benefit, which means lower deductibles, copays, coinsurance, and out-of-pocket maximums.

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

Each family member must select a primary care clinic. Family members may choose different primary care clinics – even in different cost levels, but all family members must enroll with the same plan and network carrier choice.

A list of participating clinics is available online to help you make your primary care clinic selection. This list includes the PCC Number of your clinic that must be indicated on your enrollment form. Be sure to choose the PCC Number that corresponds with your network carrier selection. Primary care clinic assignments can be changed throughout the year. To do so, contact your network carrier directly by calling the number on your medical ID card.

Most medical care is coordinated through your primary care clinic and you will generally need a referral to see a specialist (referrals to a specialist are covered at the same cost level as your PCC). **You may self-refer to certain specialists including OBGYN, chiropractors, vision care, and mental health/chemical dependency practitioners, provided the practitioner is part of your network carrier's self-referral network. No referrals are needed for urgent care and emergency room visits.**

A statewide primary care clinic listing and health plan documents, including the Summary Benefit Comparisons (SBCs) for all plan levels, are available online at www.innovomn.com.

IMPORTANT! Once enrolled you will receive **TWO** ID cards. One card will be sent from your health plan (HP, BCBS) which is to be used for all **medical claims**. The second card from CVS Caremark is to be used for all **pharmacy claims**. If you have questions, please call us at 952-746-3101 or 800-829-5601 or email us at service@innovomn.com.

Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan High Option 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 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 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 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.