PUBLIC EMPLOYEES INSURANCE PROGRAM (PEIP)

Questions & Answers 2026

Plan documents and other resources available online at www.innovomn.com

Q1. What is the Advantage Health Plan and how does it work?

A1. The State of Minnesota introduced the Advantage Health Plan in 2002 to manage rising healthcare costs while maintaining broad provider access for state employees. In 2007, the Public Employees Insurance Program (PEIP) adopted the model to extend these benefits to public employers, where it has continued to deliver strong results.

The plan uses a tiered cost-level system for primary care clinic groups. Clinics are assigned to one of four cost levels based on actual, risk-adjusted costs and geographic accessibility. More efficient clinics are placed in lower cost levels. Members who choose lower-cost level clinics benefit from reduced out-of-pocket costs, including deductibles, copays, coinsurance, and out-of-pocket maximums. This creates a financial incentive to select cost-efficient providers.

Advantage follows a primary care clinic-driven, referral-based model. Most care is coordinated through a designated clinic, and referrals are typically required for services outside that clinic. Employees and their families can choose any clinic within their network and may change their clinic assignment during the year.

This structure supports flexibility, informed provider choice, and cost-effective care.

Q2. What plan designs are available with PEIP?

A2. PEIP offers two distinct plan designs to meet the diverse needs of public employees.

- The PEIP **Advantage High Plan** provides more comprehensive coverage with lower out-of-pocket costs when receiving care. It comes with a higher monthly premium and is a good fit for members who expect to use healthcare services more frequently and prefer predictable costs.
- The PEIP **HSA-Compatible Plan** features a lower monthly premium but higher out-of-pocket costs. It is compatible with a Health Savings Account (HSA), making it a good option for members who expect lower healthcare usage and want to manage expenses through an HSA.

Note: Plan availability depends on your employer's decision to offer one or both options. Please confirm with your employer which plans are available to you.

Q3. What network carrier choices are available under PEIP?

A3. PEIP offers access to two network carriers: **HealthPartners** and **Blue Cross Blue Shield**.

Members must choose one network carrier during open enrollment, and all covered family members must be enrolled with the same carrier. The choice of carrier does not affect the monthly premium rate. Your selected carrier will process claims according to the plan design you choose – either the Advantage High Plan or the HSA-Compatible Plan.

Q4. How are primary care clinic cost levels determined, and why does PEIP use a tiered model?

A4. Primary care clinics are assigned to one of four cost levels based on a risk-adjusted analysis of their efficiency, overall care delivery costs, and geographic access. Risk adjustment accounts for differences in patient health status to ensure fairness. More efficient, lower-cost clinics are placed in lower cost levels.

PEIP uses this tiered model to help members understand cost differences and to encourage providers to manage expenses. It also reduces claims costs by incenting members to use the most efficient clinics. This approach has delivered strong results, including favorable renewals and consistently low fixed costs.

Q5. What do the four cost levels mean, and how do they affect my benefits?

A5. Primary care clinics are grouped into four cost levels based on their total cost of delivering health care. Level 1 includes the most cost-efficient clinics. Level 2 includes the next most cost-efficient clinics, and some less cost-efficient clinics are placed in this level to ensure statewide access (marked with an asterisk in the directory). Levels 3 and 4 include clinics with higher costs, with Level 4 representing the least cost-efficient providers. Without Level 4, access to these providers would be unsustainable.

Your benefit level is determined by the cost level of your assigned primary care clinic. Lower cost levels generally offer richer benefits, including lower deductibles, copays, coinsurance, and out-of-pocket maximums. Premiums remain the same across all levels.

Q6. Can clinic cost levels change?

A6. Yes. Cost levels are reviewed annually. A clinic's cost level may only increase mid-year if it changes its care system affiliation. If this happens, affected members will be notified.

Q7. How do I find my clinic's cost level?

A7. The PEIP clinic directory can be accessed online at www.innovomn.com.

Q8. Can I change my clinic assignment during the year?

A8. Yes. You may change your primary care clinic at any time by contacting your network carrier using the phone number on your medical ID card. Changes are typically effective immediately, but always confirm with your carrier.

Q9. How do I see specialists under PEIP? What cost level will I receive?

A9. Most care is coordinated through your primary care clinic. You will typically need a referral from your clinic to see a specialist. Once referred, specialist services are covered at the same cost level as your assigned clinic.

For certain types of specialty care, such as OBGYN, chiropractic, vision, mental health, and substance abuse, you may self-refer if the practitioner is part of your network carrier's self-referral network. See Q10 for more details.

Q10. What is a self-referral under PEIP?

A10. Self-referring allows members to access certain specialty care services without needing a referral from their primary care clinic. These services include OBGYN care, chiropractic care, vision care, mental health services, and substance abuse treatment.

Access to self-referral providers depends on your network carrier (HealthPartners or BCBS) and whether the provider is included in that carrier's self-referral network. Benefits for these services are provided at the cost level of your assigned primary care clinic. To find eligible providers, visit www.innovomn.com and use the network carrier links to search within each provider directory.

Q11. Is a referral required for urgent care and emergency room services? How are these services covered?

A11. No referral is required for urgent care or emergency room services. These services are covered according to the cost level of your assigned primary care clinic, regardless of where they are received.

Q12. What is a deductible?

A12. A deductible is the amount you must pay out-of-pocket before your plan begins covering services. Under the PEIP Advantage High Plan, this applies to most services except preventive care and prescription drugs. Under the HSA-Compatible Plan, it applies to all services except preventive care. If you only use preventive care, you won't pay the deductible. This feature helps keep premiums affordable and encourages cost awareness.

Q13. What is a copay?

A13. A copay is a fixed dollar amount you pay for certain healthcare services. Under PEIP, copay amounts vary based on the cost level of the primary care clinic you are assigned to. Generally, the higher the clinic's cost level designation, the higher the copay. Copays apply to services such as office visits, emergency room visits, inpatient admissions, outpatient surgery, and prescription drugs.

Q14. What is coinsurance?

A14. Coinsurance is a percentage of the cost you pay for certain services after meeting your deductible. Like copays, coinsurance amounts vary depending on the cost level of your assigned clinic. Higher cost level clinics typically result in higher coinsurance. Coinsurance is generally less common than copays and applies to services such as lab work, pathology, x-rays, and durable medical equipment.

Q15. Are there caps on cost-sharing (deductibles, copays, and coinsurance)?

A15. Yes. PEIP includes out-of-pocket maximums. Under the Advantage High Plan, there is one cap for medical services and another for prescription drug coverage. The HSA-Compatible Plan has a single combined maximum. Once you reach the cap, you pay no additional cost-sharing for the rest of the year for covered services.

Q16. I went to my doctor for a yearly routine examination. I had concerns about a health condition and my doctor ordered additional tests. I was charged a copay for the visit. Is this correct?

A16. Yes. The routine preventive portion of the exam is covered at 100 percent with no copay. However, any additional tests related to a health condition are not considered preventive care, so a copay applies.

Q17. I have diabetes and need to see my doctor four times per year. Will I have to pay a copay for these visits?

A17. Yes. Preventive care generally includes one routine physical exam per year. Visits related to an illness or condition, such as diabetes, are not considered preventive care, so copays apply.

Q18. Are there any other costs or exclusions under PEIP?

A18. PEIP generally does not cover non-network services unless they are urgent or emergency care. The network includes providers available through your primary care clinic and network carrier, including referred specialists. Urgent and emergency care received outside the service area is covered as if it were in-network.

Q19. What out-of-network benefits are available to people who live out of state and outside the service area of the network carriers?

A19. Employees and dependents who live outside Minnesota and its bordering counties are eligible for Out-of-Area Coverage under PEIP. This includes early retirees, employees on sabbatical, and college students. Coverage depends on the plan option selected.

Under the High Plan, the out-of-area deductible is $750 for single coverage and $1,500 for family coverage. After meeting the deductible, services are covered at Cost Level 3. Under the HSA-Compatible Plan, the out-of-area deductible is $1,750 for single coverage and $4,000 for family coverage, which includes a $3,500 embedded deductible per family member. After meeting the deductible, members pay 30 percent coinsurance.

Out-of-area deductibles are separate from in-area deductibles but count toward the overall out-of-pocket maximums. Urgent and emergency services received out-of-area are covered at the same cost level as the member's assigned in-area primary care clinic.

Important: To receive coverage, the provider must participate in your network carrier's national network. Always call the number on your medical ID card to verify benefits before receiving care.

Q20. What benefits do students who live in-state and within the service area of the network carriers receive?

A20. For students attending school within the plan's service area, the employee must choose a network carrier that offers primary care clinics in both the employee's and the student's locations. Employees and dependents can select their own clinics and do not need to choose the same clinic or benefit level.

If a student temporarily moves between school and home, they may change their primary care clinic assignment at any time by contacting their network carrier. Benefits will be based on the cost level of the clinic the student has assigned at the time of service. For simple care needs, online care is also a convenient option for students while away at school.

Q21. Where can I find a detailed description of my coverage?

A21. A Summary of Benefits will be provided to each employee during enrollment. Plan documents are also available online at www.innovomn.com.

Q22. How are prescription drugs covered under PEIP?

A22. Prescription drug coverage under PEIP is administered by CVS Caremark, the pharmacy benefit manager (PBM) for the program. Members have access to a nationwide network of over 68,000 participating retail pharmacies, which includes both CVS and non-CVS locations. To find a participating pharmacy, members can use the pharmacy locator available at www.innovomn.com.

PEIP uses a three-tier formulary, and prescription drugs are covered based on a copay structure that varies by tier. Each member receives two ID cards: one from their medical network carrier (HealthPartners or BCBS) and a separate pharmacy ID card from CVS Caremark.

Coverage details depend on the plan option selected. Under the PEIP Advantage High Plan, there is no deductible for prescription drug coverage, and prescription costs apply toward a separate pharmacy out-of-pocket maximum. The HSA-Compatible Plan requires members to meet a combined medical and pharmacy deductible, and all prescription drug costs count toward the combined out-of-pocket maximum.

Q23. Is there a mail order program for prescriptions?

A23. Yes. PEIP offers a mail order program for certain maintenance medications. The program is administered by CVS Caremark. Contact your pharmacy to confirm availability.

Q24. What are online clinics and how do they work?

A24. PEIP offers access to online clinic services that allow members to consult with a doctor or certified nurse practitioner 24 hours a day, seven days a week. These professionals can diagnose conditions, create personalized treatment plans, and prescribe medications when needed.

Doctor On Demand and Virtuwell are available to all members, regardless of which network carrier they choose. Teladoc is available exclusively through HealthPartners. These services are designed to treat over 50 routine conditions such as colds, flu, allergies, ear, eye, and sinus infections, skin conditions, and lice. Online clinics offer a convenient, confidential, and cost-effective way to receive care.

Q25. What are convenience clinics and how do I find them?

A25. Convenience clinics offer walk-in services in retail settings and provide care for minor ailments similar to urgent care centers, often at a lower copay or out-of-pocket cost. Availability depends on the network carrier and the member's location, and not all areas of the state have convenience clinics.

To verify access to a specific convenience clinic, members should call the number on their ID card. For members enrolled in the HSA-Compatible plan, copays for convenience clinic services apply only after the deductible has been met.

Q26. Does PEIP offer a Health Club Benefit?

A26. No. Effective January 1, 2020, PEIP discontinued the health club reimbursement program due to several key factors. First, Blue Cross Blue Shield could no longer offer its fitness center reimbursement, making it impossible to provide a consistent experience across all network carriers. Second, program usage was low, with only 9.4 percent of eligible contract holders receiving a reimbursement during the quarter ending June 30, 2019. Third, an IRS ruling clarified that monetary incentives are taxable, reducing the value of the benefit to members by about one third. Finally, the administrative burden of processing the fitness award for tax purposes created challenges for employer groups, network carriers, and PEIP staff.

Q27. How do I access member ID information, order new ID cards, or inquire about claims?

A27. Members can contact their network carrier using the member services numbers below to request ID information, order new ID cards, or speak with member services about claims. Members can also create an online account to access digital ID cards, view claims, and manage other benefits.

- **Blue Cross Blue Shield:**
  - (866) 286-2948
  - https://www.bluecrossmn.com/peip
- **HealthPartners:**
  - (800) 883-2177
  - https://www.healthpartners.com/peip
- **CVS Caremark (Pharmacy):**
  - (844) 205-8475
  - https://www.caremark.com

Please Note: *The questions and answers in this document are for informational purposes only. For more detailed information, please refer to the official plan documents posted on www.innovomn.com. The actual payment amount for any claim will be determined by the health plan based on the information submitted by the provider of services.*

PEIP is proudly administered by Innovo Benefits Administration. For questions, feedback, or requests for assistance, please use the contact information below:

Phone: 952-746-3101 or 800-829-5601
Email: service@innovomn.com
Customer Service Hours: Monday–Friday, 7:30 AM–4:30 PM