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

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

Step 1 – Choose Your Plan Level

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

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

Choose the Benefit Level that best fits your needs. The premium 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 network selection will not affect the cost of the plan; nor will it affect the premium rate. The benefits are similar under each network. You may change your Health Plan/Network level each year during your group's annual renewal.

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/quality of delivering health care. The amount of cost sharing that is paid for health care services varies depending upon the cost level of the Health Plan and Network that you choose.

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

Each family member must select a primary care clinic (PCC). Family members may choose different PCCs – even in a different cost level, but all family members must enroll with the same Plan Level and Network choice. Your enrollment form should include the primary care clinic # associated with your network carrier.

All primary care clinics are broken into four tier levels that determine the benefits received by that family member. A list of participating clinics is available online to help you make your primary care clinic selection. This list includes your primary care clinic's clinic number that you will need in order to enroll. You can change clinics by calling the phone number on your ID card.

Most medical care is coordinated through a Primary Care Clinic (PCC) and you will generally need a referral to see a specialist (referrals to a specialist's office will be covered at the same cost level as your PCC). **You may self-refer to certain specialists including OBGYN, chiropractors, routine vision, and mental health/chemical dependency practitioners, providing the practitioner is part of the carrier's self-referral network. No referrals needed for urgent care and emergencies.**

A statewide primary care clinic listing and health plan documents, including the Summary Benefit Comparisons (SBC's) 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 **medical services**. The second card from CVS is to be used for all **pharmacy charges**. If you have questions please call us at 952.746.3101 or 800.829.5601 or email us at shawn@innovomn.com.

Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan High Option 2024 - 2025 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 & out of network)	$30 copay per visit annual deductible applies	$35 copay per visit annual deductible applies	$65 copay per visit annual deductible applies	$85 copay per visit annual deductible applies
• Outpatient office visits for mental health and chemical dependency	$0 copay per visit not subject to deductible	$0 copay per visit not subject to deductible	$50 copay per visit annual deductible applies	$70 copay per visit annual deductible applies
D. Network Convenience Clinics & Online Care	Nothing	Nothing	Nothing	Nothing
E. Emergency Care (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	$1,700 / 3,400	$2,400 / 4,800	$3,600 / 7,200

- Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.
- This chart applies only to in-service area coverage. Out of service area coverage is available outside the Advantage Plan's service area. Out of service area claims are subject to a $750 single or $1,500 family deductible (separate and distinct from the deductibles listed in section B above). Claims will be processed at the levels above under Cost Level 3 that will apply to the out-of-pocket maximums described in section O above. 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 Value Option 2024 - 2025 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)	$600 / 1,200	$850 / 1,700	$1,300 / 2,600	$2,100 / 4,200
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 network)	$35 copay per visit annual deductible applies	$40 copay per visit annual deductible applies	$100 copay per visit annual deductible applies	$125 copay per visit annual deductible applies
• Outpatient office visits for mental health and chemical dependency	$0 copay per visit not subject to deductible	$0 copay per visit not subject to deductible	$80 copay per visit annual deductible applies	$105 copay per visit annual deductible applies
D. Network Convenience Clinics and Online Care	Nothing	Nothing	Nothing	Nothing
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	$225 copay not subject to deductible	$250 copay not subject to deductible	$275 copay not subject to deductible	$500 copay not subject to deductible
F. Inpatient Hospital Copay	$150 copay annual deductible applies	$325 copay annual deductible applies	$750 copay annual deductible applies	30% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$100 copay annual deductible applies	$175 copay annual deductible applies	$350 copay annual deductible applies	35% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing	Nothing
I. Prosthetics and Durable Medical Equipment	20% coinsurance	20% coinsurance	25% coinsurance	35% 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	15% coinsurance annual deductible applies	25% coinsurance annual deductible applies	35% coinsurance annual deductible applies
K. MRI/CT Scans	10% coinsurance annual deductible applies	15% coinsurance annual deductible applies	25% coinsurance annual deductible applies	35% 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
	10% coinsurance
	annual deductible applies
		10% coinsurance
		annual deductible applies
			20% coinsurance
			annual deductible applies
				35% 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.	$25 tier one $45 tier two $70 tier three	$25 tier one $45 tier two $70 tier three	$25 tier one $45 tier two $70 tier three	$25 tier one $45 tier two $70 tier three
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (single/family)	$1,250 / 2,500	$1,250 / 2,500	$1,250 / 2,500	$1,250 / 2,500
O. Plan Maximum Out-of-Pocket Expense (excluding prescription drugs) (single/family)	$2,600 / 5,200	$2,600 / 5,200	$3,800 / 7,600	$4,800 / 9,600

- Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.

- This chart applies only to in-service area coverage. Out of service area coverage is available outside the Advantage Plan's service area. Out of service area claims are subject to a $1,300 single or $2,600 family deductible (separate and distinct from the deductibles listed in section B above). Claims will be processed at the levels above under Cost Level 3 that will apply to the out-of-pocket maximums described in section O above. 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 2024 - 2025 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**)	$1,600	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**family coverage**)	$3,200 per family member $3,400 per family	$3,200 per family member $4,000 per family	$4,800 per family member $6,000 per family	$6,400 per family member $8,000 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 & 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 chemical dependency	$0 copay per visit annual deductible applies	$0 copay per visit annual deductible applies	$85 copay per visit annual deductible applies	$110 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 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
  • Other diagnostic or treatment related outpatient services
	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**	$3,000	$3,000	$4,000	$5,000
Family Coverage	$5,000 per family member $6,000 per family	$5,000 per family member $6,000 per family	$6,900 per family member $8,000 per family	$6,900 per family member $10,000 per family

- Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network is covered as described in sections C and E above.

- This chart applies only to in-service area coverage. Out of service area coverage is available outside the Advantage Plan's service area. Members pay a $1,600 single or $3,400 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.

*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.

Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan 2024-2025 Out-of-Area Benefits Schedule

Benefit Provision	Advantage High	Advantage Value	Advantage HSA
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	30% coinsurance annual deductible applies
B. Annual First Dollar Deductible (single/family)	$750 / 1,500	$1,300 / 2,600	Single $1,600 Family $3,200 per family member $3,400 family
C. Office visits for Illness/Injury, for Outpatient Physical, Occupational or Speech Therapy, and Urgent Care within the service area • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency • Urgent Care clinic visits (in or out of network)	$65 copay per visit annual deductible applies	$100 copay per visit annual deductible applies	30% coinsurance annual deductible applies
• Outpatient office visits for mental health and chemical dependency	$50 copay per visit annual deductible applies	$80 copay per visit annual deductible applies	30% coinsurance annual deductible applies
D. Convenience Clinics	Nothing	Nothing	30% coinsurance annual deductible applies
E. Emergency Care (in or out of network) • Emergency care received in a hospital emergency room	$150 copay not subject to deductible	$275 copay not subject to deductible	Covered at in-network levels
F. Inpatient Hospital Copay	$500 copay annual deductible applies	$750 copay annual deductible applies	30% coinsurance annual deductible applies
G. Outpatient Surgery Copay	$250 copay annual deductible applies	$350 copay annual deductible applies	30% coinsurance annual deductible applies
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	30% coinsurance annual deductible applies
I. Prosthetics and Durable Medical Equipment	20% coinsurance	25% coinsurance	30% 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
K. MRI/CT Scans	25% 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
	20% coinsurance
	annual deductible applies
		20% coinsurance
		annual deductible applies
			30% 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	$25 tier one $45 tier two $70 tier three	$25 tier one $40 tier two $65 tier three Annual deductible applies
N. Plan Maximum Out-of-Pocket Expense for Prescription Drugs (single/family)	$1,050 / 2,100	$1,250 / 2,500	n/a
O. *Plan Maximum Out-of-Pocket Expense (single/family) (Excluding prescription drugs for High and Value plans) (Including prescription drugs for HSA plan)	$1,700 / 3,400 (cost levels 1, 2) $2,400 / 4,800 (cost level 3) $3,600 / 7,200 (cost level 4)	$2,600 / 5,200 (cost levels 1, 2) $3,800 / 7,600 (cost level 3) $4,800 / 9,600 (cost level 4)	$3,000 / 6,000 (cost levels 1, 2) $4,000 / 8,000 (cost level 3) $5,000 / 10,000 (cost level 4)

Out-of-area coverage is available outside the Advantage Plan's service area. Out of area deductibles are separate from in-area PEIP deductibles but do accumulate to out of pocket maximums.

**Your out-of-pocket maximum will be the Plan Maximum Out of Pocket Expense (Letter O) of the PCC you choose. For HSA Family coverage, there is an embedded $5,000 (cost level 1, 2) or $6,900 (cost level 3, 4) per family member Out-of-Pocket Maximum. The Family Out-of-Pocket Maximum shown above is the maximum amount that a family will pay in any one calendar year for all family members.*