PUBLIC EMPLOYEES INSURANCE PROGRAM (PEIP)
ADVANTAGE HEALTH PLAN

2025 Questions & Answers

(Information Also Available Online @ www.innovomn.com)

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

A1. The State of Minnesota implemented Advantage in 2002 to address rapidly rising health care costs and to maintain access to as many health care providers for state employees as possible. The PEIP Advantage Plan was first offered in 2007 to all public employers. PEIP has had great success with the Advantage program.

Under Advantage, primary care clinic systems available to employees are placed in cost levels according to their actual, risk-adjusted costs of delivering care and to meet geographic access needs. Employees and their family members are free to select providers of their choice in their area, and to change their selection during the year within the same health carrier. The amount employees and family members pay out-of-pocket for copays, deductibles, and coinsurance varies according to the cost level of the provider used. The lower the cost level of the provider, the lower the out-of-pocket costs for Advantage members.

This award winning plan design and structure gives members flexibility and choice while taking advantage of best practices in provider competition and managing the cost of care.

Q2. Why are there four Advantage provider cost levels?

A2. Advantage places health care providers in cost levels based on their actual costs of delivering care and to meet geographic access needs. The purpose of the cost levels is to help inform employees and their families of differences in the cost of healthcare delivery, and to create incentives for providers to control costs. The premium for each plan level does not change but employees pay different levels of copays, deductibles, and coinsurance depending on the cost level of the provider they use.

Cost level four reflects the fact that a number of clinic systems have much higher costs than others. Without cost level four, it likely would not be possible to continue offering the highest cost providers to employees. Cost level four preserves the availability of these highest cost providers. Employees are free to choose any cost level provider, including those in cost level four. There is no difference in monthly premium, but employees will continue to pay less out-of-pocket in deductibles, copayments, etc. when using a provider with a lower cost level, and more when choosing a higher cost level provider.

Q3. How are the cost levels of the clinics determined?

A3. The cost levels of the clinics are determined based on an analysis of their actual costs of delivering care and to meet geographic access needs. In the analysis, the results are "risk adjusted," which means that differences in patient populations have been taken into account to help ensure that providers do not appear to be more expensive simply because they are caring for patients who are more ill than others.

The very lowest cost clinics were put into level one. The next lowest group of clinics is in level two, and the highest cost clinics are in levels three and four. In order to provide access statewide to a level two option for all employees, some higher cost clinics or clinic groups were moved to level two, identified by * in the clinic directory. Also, a few differences exist in the cost level placement of individual clinics, depending on their health carrier affiliation(s) or as a result of some administrative limitations among the health carriers. Finally, some clinic groups have negotiated lower reimbursements in exchange for being offered at a lower cost level.

It is important for you check the most current clinic listing to verify your clinic's cost level during the open enrollment.

Q4. How often will the cost level of the clinics change? Can they change mid-year?

A4. The cost levels of clinic groups will be re-evaluated once per year. The cost level of a clinic could only increase to a higher level mid-year if the clinic changes its care system affiliation. If this were to occur, members of the clinic would be notified.

Q5. How do I find out what cost level my clinic is in?

A5. You can view the 2025 state-wide clinic listings at www.innovomn.com.

Q6. What is a "first dollar deductible"?

A6. A form of employee cost sharing called a "first dollar deductible" is a set amount that is paid annually before the plan benefits take effect. Once the deductible is paid, it is not charged again during that calendar year.

The deductible applies to all services except preventive care and prescription drugs for the Advantage plan option. For the HAS plan, the deductible applies to all services except preventive care. It is called a "first dollar deductible" because the deductible must be paid first before the plan benefits take effect. If employees do not receive health care services during the calendar year, or if they receive only preventive services, they pay no deductible.

The purpose of the deductible is to help keep monthly premiums more affordable and to create greater awareness of the costs of health care services. This is a typical feature in many health plans.

Q7. What is the copay in the Advantage Plan?

A7. A co-payment (copay) is a flat dollar amount that is charged every time certain services are provided. Under Advantage, the amount of the copay varies, depending on the "cost level" of the primary care clinic that the employee or their family members are enrolled in – generally, the higher the cost level of the primary care clinic, the higher the copay. Under Advantage, copays are charged for the following types of services:

- Office visits
- Emergency room visits
- Inpatient admissions
- Outpatient surgery
- Prescription drugs

Q8. What is coinsurance? What coinsurance will I have to pay with the Advantage Plan?

A8. Coinsurance is a percentage of the eligible cost that is charged for certain services after the annual deductible is paid. As with the copays and deductibles described above, the amount of coinsurance varies with the cost level of the primary care clinic. Coinsurance is in effect most often with cost level 4 providers.

Q9. Are there caps on the cost-sharing (copays, deductibles, and coinsurance) that I have to pay? What are the caps?

A9. There are caps known as the "out-of-pocket maximums." There are two separate caps, one for prescription drugs, and one for all other services. The HSA compatible version of Advantage has a single combined out-of-pocket maximum. Once the out-of-pocket maximum is reached for the year, the employee pays no more cost sharing.

Q10. Are there any other costs with Advantage? What is not covered?

A10. Advantage generally does not pay for "non-network" services unless they are considered urgent or emergency care services. The "network" refers to the health care providers available to the employee through their primary care clinic and health carrier, including any referrals that are provided by the primary care clinic. Advantage pays Urgent care, and emergency costs as if you were treated through your network provider.

Q11. What are the rules for choosing a health carrier and primary care clinic under Advantage?

A11. The following requirements apply:

- All members of a family must select the same health Network.

• Family members may choose different primary care clinics in different cost levels.

• Employees and dependents can change clinics every month if they are not changing cost levels, subject to the health carrier's rules. To make a clinic change, employees call the carrier directly. Changes will be effective on the next 1st of the month after the call is made.

• Employees are encouraged to choose a clinic in the area in which they live or work so that they can access care easily.

Q12. If the premium is the same for each health carrier, and my clinic is available in more than one network, how should I choose a health carrier?

A12. Employees have a number of factors to consider when deciding on a health carrier. All dependents must be enrolled with the employee's health carrier; so employees will need to determine which carrier offers the primary care clinic of his/her dependents' choices.

Other factors to consider include the cost level and referral patterns of health carriers and particular specialist networks such as OB/GYNs, chiropractors, mental health providers, substance abuse professionals and routine vision services.

Q13. How do I see specialists under Advantage? What cost level will I receive?

A13. All care is coordinated through your primary care clinic (PCC). Generally, you will need a referral from your primary care clinic to see a specialist. Once referred, specialist services are covered at the same level as your primary care. For some specialty care, such as OB/GYN, chiropractic, routine vision, substance abuse and mental health, you may self-refer, providing the practitioner is within the self-referral network of the carrier you choose. See the Q and A's below for more information.

Q14. How do I see an OB/GYN?

A14. If you enroll in Blue Cross Blue Shield, you have access to all the OB/GYNs listed with the Blue Cross network of OB/GYNs. If you enroll in Health Partners (HP) you have access to all the OB/GYNs listed with the HealthPartners network. The benefits received at the OB/GYN will be at the cost level of the primary care clinic (PCC) you select.

Q15. How can I see a chiropractor and mental health providers?

A15. You may self-refer to certain chiropractors and mental health providers. Access to these providers depends on the carrier and the primary care clinic chosen. If you enroll in Blue Cross Blue Shield, you can self-refer to any chiropractor or mental health provider listed in the Blue Cross network. If you enroll in HealthPartners, you can self-refer to any chiropractor or mental

health provider listed in the HealthPartners network. The benefits received at the chiropractic or mental health clinics will be at the cost level of the primary care clinic (PCC) you select. The www.innovomn.com website has carrier links where you can search for providers within each network.

Q16. Can I change network health carriers at any time?

A16. No. Employees can only change health carriers at open enrollment or if they move out of the service area of their health carrier. You can change clinics during the year by calling the number on your ID card.

Q17. What out-of-network benefits are available to people who live out of state and out of the service area of the health carriers?

A17. Employees and their dependents who live outside the State and the Advantage Service Area (includes early retirees, employees on sabbatical, college students): These individuals are eligible for the Point-of-Service (POS) benefit. There is a separate deductible and coinsurance amounts with this coverage. Individuals using POS benefits are not required to choose an out of area provider, but may receive discounted services by utilizing their health carrier's national preferred provider organization (PPO).

Q18. What benefits do students who live in state and within the service area of the health carriers receive?

A18. If the eligible student is to receive services, the employee will need to choose a health carrier that offers primary care clinics for both the employee's and the student's locations. Employees and dependents can choose their own clinics – they do not need to choose the same clinic or clinics within the same cost level. Students who are eligible dependents living in the state and within the service area of the health carrier will receive the benefits at the cost level of the clinic they have enrolled in. A great idea for simple care situations is using online care for students away at school.

Q19. Where do employees get a detailed description of their coverage?

A19. The Summary of Benefits will be available to every employee as they enroll in the plan. Plan Documents are also available on the PEIP website at www.innovomn.com.

Q20. Is there a mail order program for prescriptions?

A20. Yes. You can receive up to a 90-day supply of certain maintenance medications through mail-order pharmacies. For mail order, you pay two copays for a 90-day supply of these drugs;

the plan pays 100% of the balance. Certain pharmacies may also give the 90-day supply for 2 copays, call them and ask. The plan is administered by CVS-Caremark.

Q21. I went to my doctor for a yearly routine examination. I have had some concerns with a health condition that I have. I talked to my doctor about these and he ordered some additional tests. I was charged a copay for the visit. Is this correct?

A21. Yes. The routine preventive portion of the examination is covered at 100% without a copay. However, additional tests that are related to your health condition are not considered preventive care, and the copay will apply.

Q22. I have diabetes so I need to see my doctor for care related to my condition four times per year. Will I have to pay the copay for these visits?

A22. Yes. Preventive care is generally one routine physical examination per year. Check-ups relating to an illness or injury are not considered preventive, and the copay will apply.

Q23. Does Advantage offer a Health Club Benefit? What is the benefit?

A23. Effective January 1, 2020 PEIP will no longer offer the health club reimbursement program. Among the reasons we are ending the programs are:

1. Because Blue Cross is no longer able to offer its fitness center reimbursement program, we would be unable to continue to provide a consistent member experience across all three carriers (HP/BC).
2. Only 9.4% of eligible contract holders received a health club reimbursement during the quarter ending June 30, 2019.
3. The IRS ruling that clarified that monetary incentives are taxable has reduced the benefit to the member by about one third.
4. The work required to include the fitness award for tax purposes has placed a large burden on employer groups, the carriers, and PEIP staff.

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

A24. PEIP Advantage includes services from two online clinics. Members can use either online clinic service – no matter what carrier network you choose.

www.Virtuwell.com –Available to members under both networks

www.doctorondemand.com-Available to members under both networks

Online clinics allow members to consult with a doctor or certified nurse practitioner online 24 hours a day, seven days a week. These health care professionals can make a diagnosis, create a

personalized treatment plan or send a prescription, if needed, for over 50 routine conditions such as colds, flu, allergies, ear/eye/sinus infections, skin conditions, lice, etc. It's easy, confidential and cost effective for the member.

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

A25. Convenience clinics provide walk-in services in a retail setting. Locations vary based on the carrier network you choose and the area in which you live. Not all areas of the state have convenience clinics. If available, convenience clinics provide routine services for minor ailments, similar to urgent care centers, but at a lower copay or out of pocket expense.

Call the number on your ID card to verify access to a specific convenience clinic.

Note: All HSA-compatible plan copays are after the deductible has been met.

Please Note: These questions and answers are informational only. The Summary of Benefits includes more detailed information. The actual amount of payment for any claim will be determined by the health plan based on the information submitted by the provider of services.