Public Employees Insurance Program (PEIP)

Introduction and Summary of Benefits for PEIP
2022 renewal groups and new enrollees

January 1, 2022 Renewals

- The rates for 2022 increased by about 9%, this is higher than our historical average (about 3.6%) due to a spike in post COVID voluntary surgeries and rare Rx claims (one time).
- The 2022 clinic directory will be available October 15th at www.innovomn.com. Please check to see if your clinic has changed.
- Innovo Benefits Administration is excited to introduce to you our PEIP Online Enrollment Portal. Access the Online Enrollment Portal by visiting – https://www.mnpeip.com. Please consult with your HR Office prior to submitting changes online.
- No member action is required unless you are changing Networks (BC/HP/P1) or changing plan designs (High/Value/HSA). If you are just changing clinics, that can only be done by calling the phone number on your ID card.

Underwriting Guidelines

- The goal of the program is to pool all claims from all groups to spread risk over a very large member base.
- As in the past, groups renewing for the first time may see percentage changes different from the pool average if the are being placed in a premium tier for the first time (one time event).
- Renewing groups that have experienced much higher claims, or much lower claims than other groups in their premium tier for an extended period (3-4 years) may be moved up, or down one tier level. Thus, a handful of groups may see rate changes above or below the pool average for that renewal. This will only affect a small number of groups.
- As always, the PEIP underwriters will make any changes necessary to protect the financial stability of the pool.

Plan Changes for 2022

There are a few plan changes for 2022, we are glad to announce these positive changes.

1. 3D mammograms may be obtained as preventive care.

2. In addition to an annual routine eye visit (preventive with no copay or coinsurance), an office visit to an in-network eye care provider for eye injury or illness will be covered at the cost level of the member's PCC without needing a referral.

3. Emergency room copayments have increased for cost levels 2 thru 4 but are excluded from the deductible in the High and Value plans.

Public Employees Insurance Program (PEIP) & Innovo

The Public Employee Insurance Program (PEIP) is a state of Minnesota health plan available to cities, counties and school districts. PEIP is able to leverage off the state employee plan and use the negotiating clout of their size to offer very **low administrative costs** and **multiple network** carriers to our member groups.

Deloitte, the world's largest professional services organization, handles the financials, underwriting, and consulting.

Innovo Benefits is the third-party administrator for the PEIP program. Our core staff has worked with the PEIP program since it was created.

Our strength is vast **experience** and **dedication** in servicing the PEIP program. Our 30 years of experience has proven to be vital in dealing with the myriad of issues that arise in servicing our employers and members.

The PEIP pool has grown to approximately 450 employer groups covering 50,000 members.

Overview of PEIP Coverage

- Members have the choice of **three plan design options** and **three network carriers**
- Primary Care Clinic model where clinics are broken down into 4 tiers or **cost levels (CL).**
- Each family member can choose their own **primary care clinic (PCC)** and your benefit level is based on the cost level of your PCC choice. More efficient, lower cost clinics provide the highest benefit levels.
- Generally, all routine and non-emergency care flows through your primary care, **referrals** are typically required for care outside your PCC.
- **Prescription drugs** are through the CVS Caremark network for all three network carriers.
- CVS Caremark has a huge network of pharmacies throughout the state/country.
  - You do <u>not</u> have to use a CVS Retail pharmacy.

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 three different Health Plans/Networks to choose from:

- **HealthPartners**
- **Blue Cross Blue Shield**
- **Preferred One**

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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.

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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, POne) 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.

Step by Step Instructions *will guide you through the enrollment steps and provide information you need to make election choices.*

Step 1 – Choose Your Plan Level

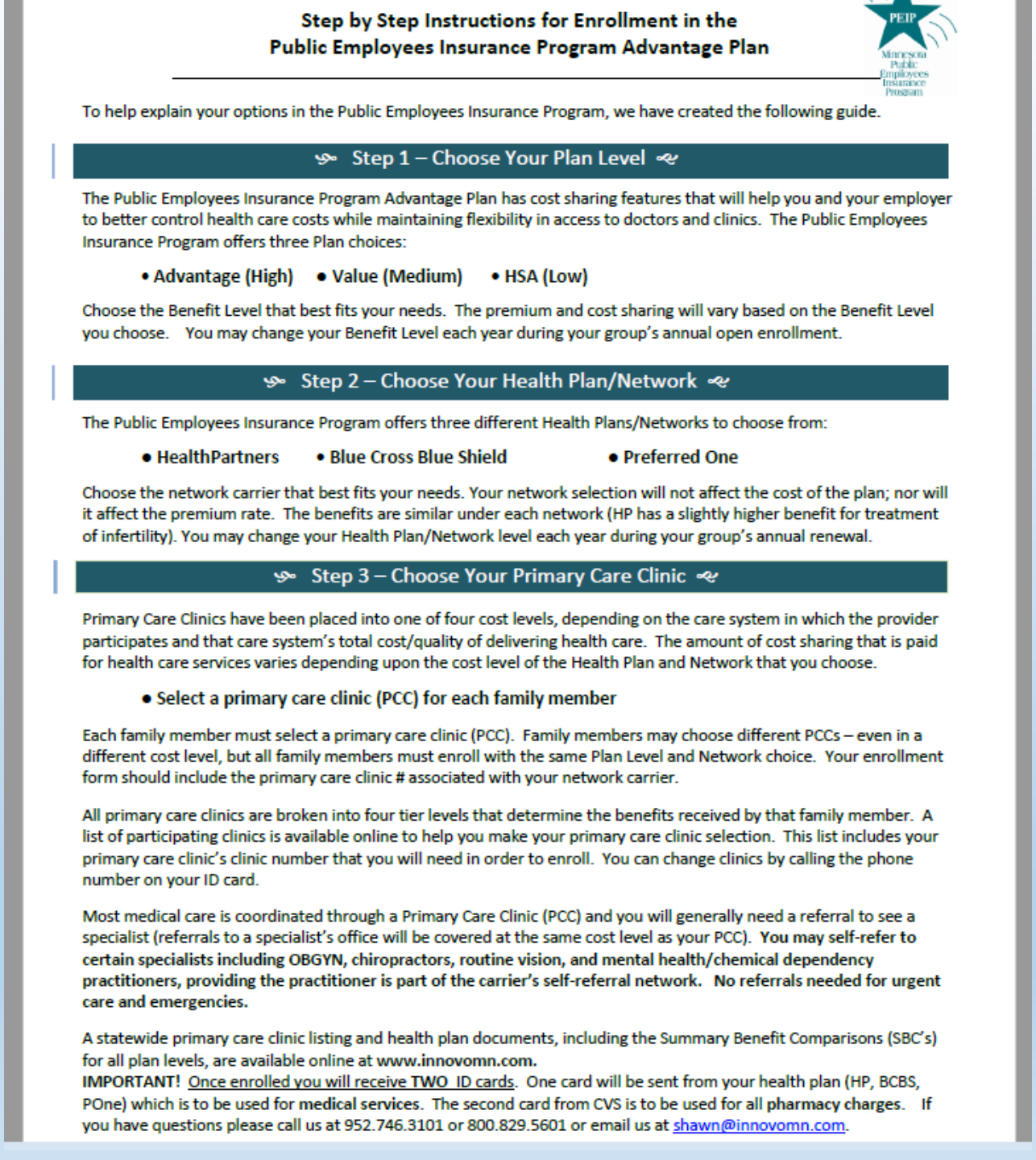
Advantage High is the highest level of benefits and the highest payroll deduction.

Value is a mid-rage option with a little higher deductible and out of pocket expenses but lower payroll deduction.

HSA option has highest deductible and out of pocket expenses and the lowest payroll deduction.

One plan is selected for employee + 1 and family coverage.

You can change your plan level each year during open enrollment.



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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 (HP has a slightly higher benefit for treatment of infertility). You may change your Health Plan/Network level each year during your group's annual renewal.

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Step 2 – Choose Your Health Plan/ Network

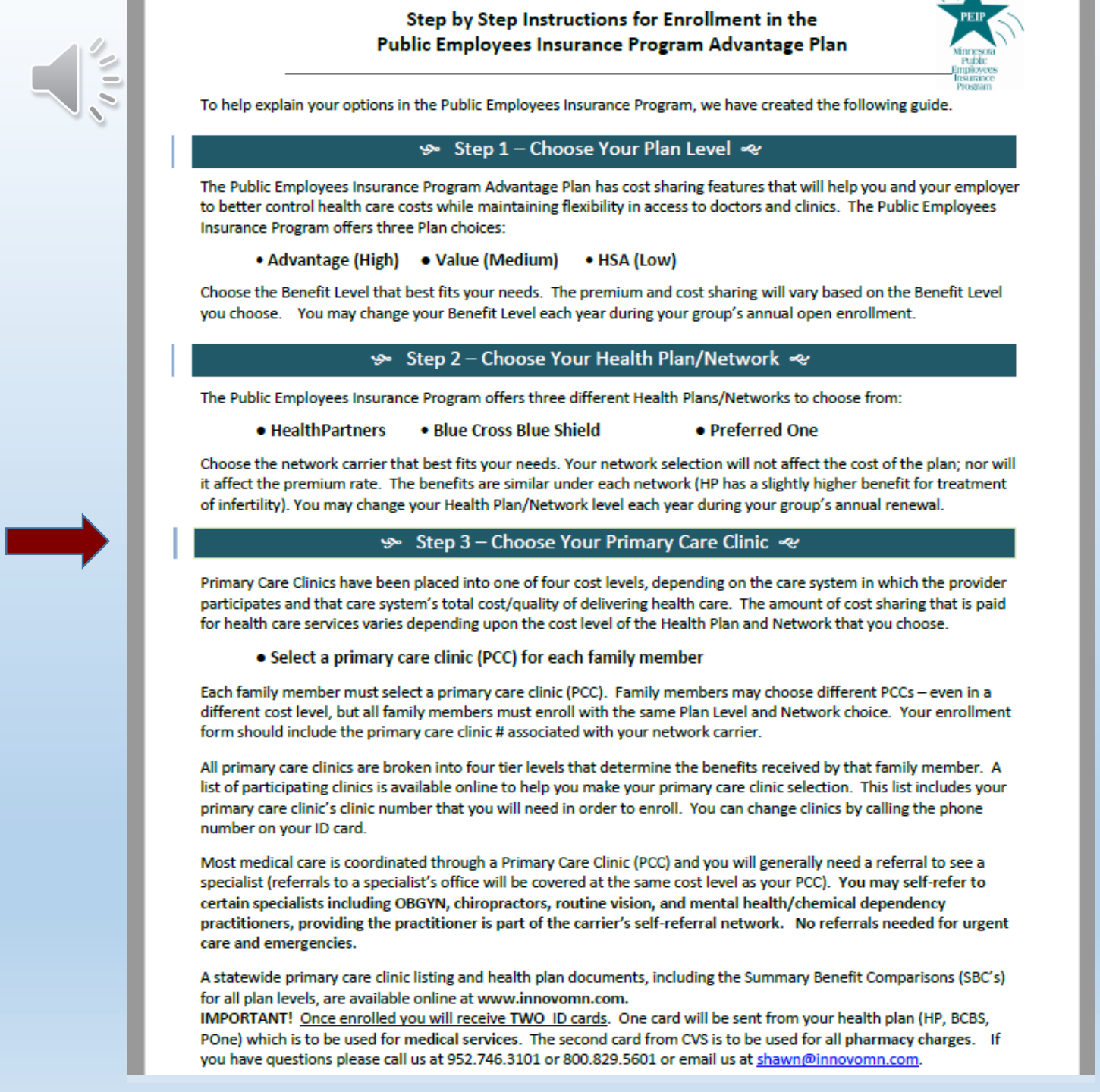
HealthPartners
Blue Cross Blue Shield
PreferredOne

Network selection does not affect the cost of the plan or your premium rate.

All three Networks have the same plan design and cover the same eligible benefits. Exception: HealthPartners includes certain treatment for infertility.

One network is selected for employee + 1 and family coverage.

You can change your network each year during open enrollment.



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Primary Care Clinics (PCC) are placed in four cost levels, based on the care system and overall cost/quality of their delivery of care.

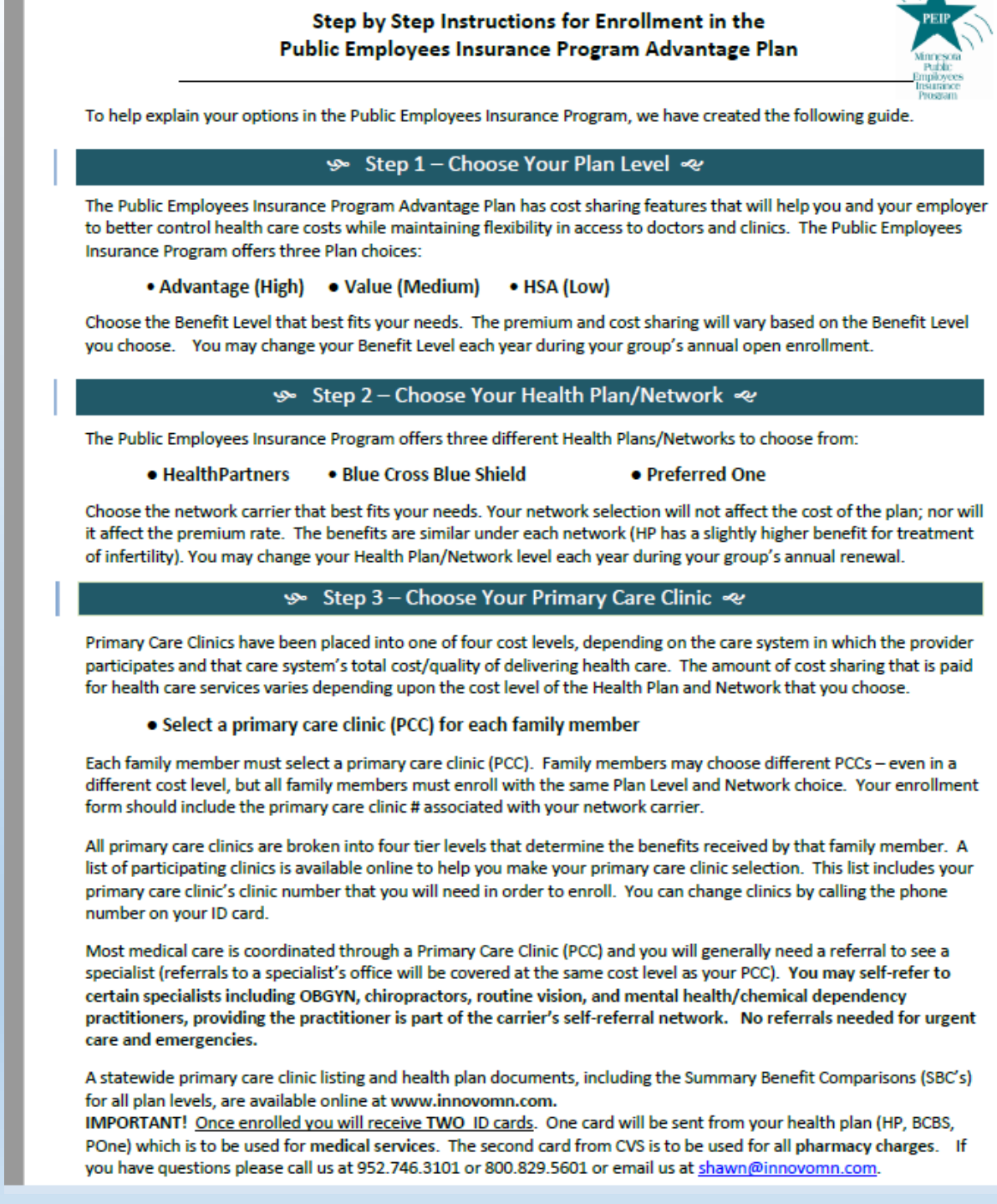
Your final benefit level is based on the on the cost level of the primary clinic you choose related to your Health Plan and Network choice.

You will choose a primary care clinic (PCC) for each family member.

PCC does not need to be the same for each family member, nor the same Cost Level.

PCC can be changed monthly by calling your network carrier customer service number on the back of your ID card.

2022 clinic directory is available at www.innovomn.com.



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Specialists

Referrals to specialists are covered at the same cost level as your PCC.

Members can Self-Refer* to specialists for **OBGyn, Mental Health, Chemical Dependency, Chiropractic Care and Routine Vision**. New in 2022, treatment of eye care problems (beyond basic exam) may also be self-referred.

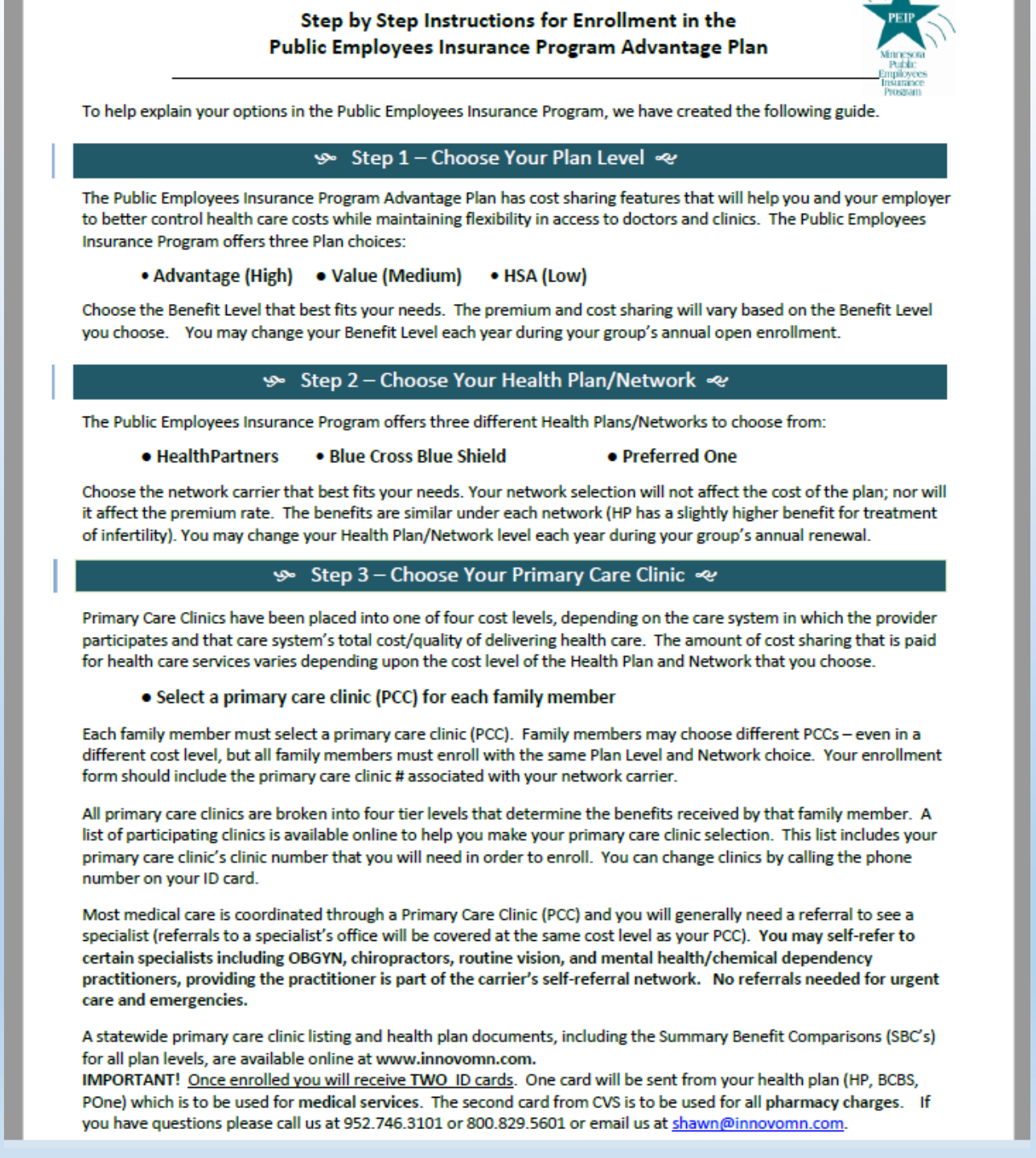
**Practitioners must participate in your network carrier's self-referral network.*

No referrals are needed for Urgent Care or Emergency Services.

CVS Caremark (PBM)

CVS Caremark is the pharmacy benefit manager for PEIP and provides services for all three networks.

- has a **nationwide** network of more than 68,000 participating **retail** pharmacies.
- PEIP includes both CVS and **non**-CVS pharmacies. Pharmacy locator tool at www.innovomn.com
- Convenient access to retail, specialty services and mail order delivery options.



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PEIP Plan Documents and Information

Once enrolled, you will receive two ID cards.

1) One ID card is for medical and will come from your network choice (HP, BC, P1).

2) The second ID card is for all pharmacy services and will come from CVS Caremark.

All PEIP plan documents and tools are posted on the PEIP website at **www.innovomn.com.**

The website includes Plan Summaries and Plan Documents, Statewide Clinic Directory, Summary Benefit Comparisons (SBC's), Pharmacy Tools and informative Q&A.

PEIP Customer Service is available from: 7:30am to 4:30pm

952-746-3101
800-829-5601

Or eMail your question to

service@innovomn.com

Value Plan

No voice on the next 5 slides.

Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan
2022 - 2023 Benefits Schedule
Value Option

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 • Outpatient mental health and chemical dependency • 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
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	$250 copay	$275 copay	$500 copay
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 (excludes PKU & Infertility) (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

Value Plan

Mid-range benefit level

Preventive Routine Care covered at 100%

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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

Value Plan

Prescription Drugs

No Deductible
Copay per 30-day supply

Typically, tiers are broken out …
Tier 1 – $25, generic & common name brand
Tier 2 – $45, name brand, some generic & specialty
Tier 3 – $70, typically specialty medications
(If medications are less than the copay, only pay the price of medication.)

Formulary tools for pricing covered meds at www.innovomn.com

RX Out of Pocket Max - $1,250/$2,500

Mail Order for maintenance medications provides a 90 day supply for 2 copays (also available at retail pharmacies)

Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan
2022 - 2023 Benefits Schedule
Value Option

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 • Outpatient mental health and chemical dependency • 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
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	$250 copay	$275 copay	$500 copay
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 (excludes PKU & Infertility) (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

Value Plan

Your **Deductible** is based on your cost level.
CL 1 - $600/$1,200
CL2 – $850/$1,700

(Higher cost clinics, CL3 and CL4, will have higher deductibles.)
CL3 - $1,300/$2,600
CL4 - $2,100/$4,200

Medical Deductible is paid in full by the member **first**, then member is only responsible for copayments or coinsurance.

Deductibles are embedded.

Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan
2022 - 2023 Benefits Schedule
Value Option

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 • Outpatient mental health and chemical dependency • 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
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	$250 copay	$275 copay	$500 copay
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 (excludes PKU & Infertility) (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

Value Plan

After the deductible has been satisfied, member only pays copayments or coinsurance for services.

Copayment is a flat dollar amount for visit or service.

Coinsurance is a % amount of the bill.

Emergency Room, Prosthetics and Durable Medical bypass the deductible with member paying only copayment or coinsurance.

Network Convenience Clinics & Online Care, Hospice – no deductible, no copay

Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan
2022 - 2023 Benefits Schedule
Value Option

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 • Outpatient mental health and chemical dependency • 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
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	$250 copay	$275 copay	$500 copay
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 (excludes PKU & Infertility) (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

Value Plan

Medical Out of Pocket Maximum

Once the deductible, copays and coinsurance expenses for medical total a certain level, the plan covers 100% of eligible medical expenses for the remaining contract year.

Your Medical OOP Max is based on your cost level.
CL1 - $2,600/$5,200
CL2 - $2,600/$5,200

(Higher cost clinics, CL3 and CL4, will have higher OOP max.)
CL3 - $3,800/$7,600
CL4 - $4,800/$9,600

OOP Max is embedded.

HSA/HRA Plan

Minnesota Public Employees Insurance Program (PEIP)

Advantage Health Plan 2022 - 2023 Benefits Schedule - HSA Compatible

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 *	$1,500	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**single coverage**)	$2,800 per family member $3,000 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
Combined Medical/Pharmacy (**family coverage**)				
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 • Outpatient mental health and chemical dependency • 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
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

HSA/HRA Plan

High deductible, lowest payroll deduction

HAS/HRA plan meets IRS rules for QHDHP and works differently than High & Value plan:

- Medical and Prescription Drugs are combined
- Deductible must be satisfied first before member moves into copayments or coinsurance

Preventive Routine Care covered at 100%

Minnesota Public Employees Insurance Program (PEIP)

Advantage Health Plan 2022 - 2023 Benefits Schedule - HSA Compatible

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 *	$1,500	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**single coverage**)	$2,800 per family member $3,000 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
Combined Medical/Pharmacy (**family coverage**)				
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 • Outpatient mental health and chemical dependency • 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
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

HSA/HRA Plan

Prescription Drugs

After Deductible, Copay per 30 day supply

Typically, tiers are broken out …
Tier 1 – $30, generic & common name brand
Tier 2 – $50, name brand, some generic & specialty
Tier 3 – $75, typically specialty medications

(If medications are less than the copay, only pay the price of medication.)

Formulary tools for pricing covered meds at www.innovomn.com

Mail Order for maintenance medications provides a 90 day supply for 2 copays after deductible is met.
(also available at retail pharmacies)

Minnesota Public Employees Insurance Program (PEIP)

Advantage Health Plan 2022 - 2023 Benefits Schedule - HSA Compatible

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 *	$1,500	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**single coverage**)	$2,800 per family member $3,000 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
Combined Medical/Pharmacy (**family coverage**)				
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 • Outpatient mental health and chemical dependency • 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
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

HSA/HRA Plan

Your **Deductible** is based on your cost level.
CL 1 - $1,500/$3,000
CL2 – $2,000/$4,000

(Higher cost clinics, CL3 and CL4, will have higher deductibles.)
CL3 - $3,000/$6,000
CL4 - $4,000/$8,000

Note: Family Coverage has an embedded individual deductible.

Deductible is paid in full by the member **first** for medical and prescription drugs, before moving into copayments or coinsurance level of benefits.

Minnesota Public Employees Insurance Program (PEIP)

Advantage Health Plan 2022 - 2023 Benefits Schedule - HSA Compatible

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 *	$1,500	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**single coverage**)	$2,800 per family member $3,000 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
Combined Medical/Pharmacy (**family coverage**)				
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 • Outpatient mental health and chemical dependency • 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
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

HSA/HRA Plan

After the deductible has been satisfied, member only pays copayments or coinsurance for services.

Copayment is a flat dollar amount for visit or service.

Coinsurance is a % amount of the bill.

Minnesota Public Employees Insurance Program (PEIP)

Advantage Health Plan 2022 - 2023 Benefits Schedule - HSA Compatible

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 *	$1,500	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (**single coverage**)	$2,800 per family member $3,000 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
Combined Medical/Pharmacy (**family coverage**)				
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 • Outpatient mental health and chemical dependency • 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
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

HSA/HRA Plan

Medical & RX Out of Pocket Maximum Combined

Once the deductible, copays and coinsurance expenses for medical and prescription drugs total a certain level, the plan covers 100% of eligible expenses for the remaining contract year.

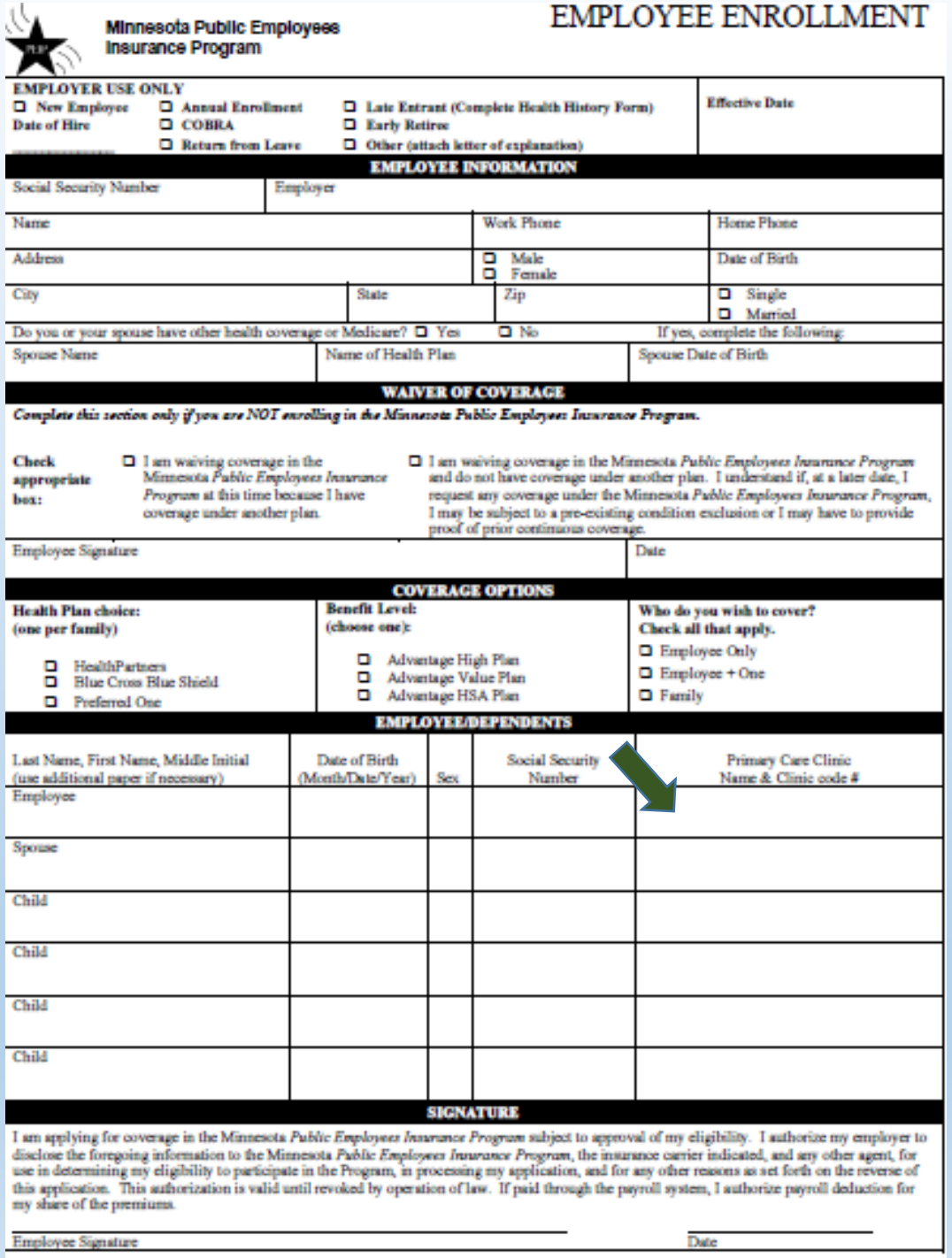
Your Medical & RX OOP Max is based on your cost level.
CL1 - $3,000/$6,000
CL2 - $3,000/$6,000

(Higher cost clinics, CL3 and CL4, will have higher OOP max.)
CL3 - $4,000/$8,000
CL4 - $5,000/$10,000

Note: Family Coverage has an embedded individual out of pocket maximum.

Out of Area Coverage
(Point of Service, POS)

- For members with a permanent residence outside the PEIP service area. Coverage includes students and dependents living away from home.
- Members would enroll in in-network coverage choosing a PCC. In-network coverage would apply when at home. Emergency and Urgent Care, and prescription drugs are covered anywhere. If additional coverage is desired, qualified members can enroll in POS.
- There is no additional premium.
- POS Coverage
  - Advantage High and Value – Separate $350 single/$500 family deductible. 30% coinsurance. OOP Max is combined with in-network OOP Max.
  - HSA – Separate $1,500 single/$3,000 family deductible. 30% coinsurance. OOP Max is combined with in-network OOP Max.



Minnesota Public Employees Insurance Program

EMPLOYEE ENROLLMENT

EMPLOYER USE ONLY

☐ New Employee Date of Hire ☐ Annual Enrollment ☐ COBRA ☐ Return from Leave ☐ Late Entrant (Complete Health History Form) ☐ Early Retiree ☐ Other (attach letter of explanation)

Effective Date

EMPLOYEE INFORMATION

Social Security Number | Employer

Name | Work Phone | Home Phone

Address | ☐ Male ☐ Female | Date of Birth

City | State | Zip | ☐ Single ☐ Married

Do you or your spouse have other health coverage or Medicare? ☐ Yes ☐ No If yes, complete the following:

Spouse Name | Name of Health Plan | Spouse Date of Birth

WAIVER OF COVERAGE

Complete this section only if you are NOT enrolling in the Minnesota Public Employees Insurance Program.

Check appropriate box: ☐ I am waiving coverage in the Minnesota *Public Employees Insurance Program* at this time because I have coverage under another plan. ☐ I am waiving coverage in the Minnesota *Public Employees Insurance Program* and do not have coverage under another plan. I understand if, at a later date, I request any coverage under the Minnesota *Public Employees Insurance Program*, I may be subject to a pre-existing condition exclusion or I may have to provide proof of prior continuous coverage.

Employee Signature | Date

COVERAGE OPTIONS

Health Plan choice: (one per family)
☐ HealthPartners
☐ Blue Cross Blue Shield
☐ Preferred One

Benefit Level: (choose one):
☐ Advantage High Plan
☐ Advantage Value Plan
☐ Advantage HSA Plan

Who do you wish to cover? Check all that apply.
☐ Employee Only
☐ Employee + One
☐ Family

EMPLOYEE/DEPENDENTS

Last Name, First Name, Middle Initial (use additional paper if necessary)	Date of Birth (Month/Date/Year)	Sex	Social Security Number	Primary Care Clinic Name & Clinic code #
Employee				
Spouse				
Child				
Child				
Child				
Child				

SIGNATURE

I am applying for coverage in the Minnesota *Public Employees Insurance Program* subject to approval of my eligibility. I authorize my employer to disclose the foregoing information to the Minnesota *Public Employees Insurance Program*, the insurance carrier indicated, and any other agent, for use in determining my eligibility to participate in the Program, in processing my application, and for any other reasons as set forth on the reverse of this application. This authorization is valid until revoked by operation of law. If paid through the payroll system, I authorize payroll deduction for my share of the premiums.

Employee Signature | Date

Health Enrollment Form

(if your group uses paper forms)

1 Complete Employee Information Section

2 **Skip.** *Only complete 'other health coverage' section if you or your dependents will be double covered while on PEIP.*

3 Choose your health plan network (HP, BC, P1)
Choose your plan level (High, Value, HSA)
Choose your coverage level.

4 Complete information for all family members.

Be sure to include the **name** and **PCC #** for all family members.

(Match PCC # to the health plan network you choose.)

5 Sign and date your enrollment form.

Tips

- Benefits are on a calendar year basis. Deductibles and out of pocket maxs will reset each January. (*Carry forward credit may be applied to new groups enrolling during the calendar year.)*
- Any prior referrals you received from your doctor will need to be refreshed/resubmitted at your PCC for PEIP.
- Any Prescriptions (Rx) that can be filled in late December will help make the transition to a new plan go more smoothly.
- To avoid delays in your enrollment, please type or print clearly on your form.
- Below is an illustration of important clinic directory information and where to find it.

- *Be sure to note the **cost level** and correct **PCC #** that matches your Network Carrier **(HP, BC, P1)** when enrolling.*

ID	City	State	PCC Number	Clinic	Clinic Address	PCC = Primary Care Clinic	Care System	2021 Cost Level
HP	St. Paul	MN	537	HealthPartners Clinic Midway	451 N Dunlap St	PCC	HPR	1
HP	St. Paul	MN	776	M Health Fairview Clinic - Highland Park	2155 Ford Pkwy., Suite A	PCC	FAI	2
P1	St. Paul	MN	FP160	M Health Fairview Clinic - Highland Park	2155 Ford Pkwy., Suite A	PCC	FAI	2
BC	St. Paul	MN	003202595	M Health Fairview Clinic - Highland Park	2155 Ford Pkwy., Suite A	PCC	FAI	3
HP	Minneapolis	MN	486	Park Nicollet Clinic - Minneapolis	2001 Blaisdell Ave. S.	PCC	PKN	1
P1	Minneapolis	MN	PN115	Park Nicollet Clinic - Minneapolis	2001 Blaisdell Ave. S.	PCC	PKN	1
BC	Minneapolis	MN	003200844	Park Nicollet Clinic - Minneapolis	2001 Blaisdell Ave. S.	PCC	PKN	2

INNOVO BENEFITS

PEIP Customer Service

Innovo Benefits Administration / PEIP

Phone: (952) 746-3101 / 800 829-5601

Email: service@innovomn.com
shawn@innovomn.com

7805 Telegraph Road, Suite 110
Bloomington, MN, 55438