Public Employees Insurance Program (PEIP)

Introduction and Summary of Benefit for PEIP – 2024 renewal

1/1/24 RENEWALS

- The renewal rates for January 2024 will be based on a combination of the group's claims and the overall pool. Group's credibility is based on enrollment size.
- PEIP will be offering the Blue Cross and HealthPartners network choices for 2024 (PreferredOne is no longer available). If you are currently participating with Preferred One you MUST complete a new enrollment form to be effective 1.1.24.
- The 2024 clinic directory will be available approximately 10.15.23 at www.innovomn.com. Please check to see if your clinic cost level has changed.
- Innovo Benefits Administration is easy to access on 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) or changing plan designs (High/Value/HSA). If you are changing clinics only, please call the customer service number on your ID card.

Plan Changes for 2024

There are a few plan revisions for 2024

- Enhanced coverage of infertility for Blue Cross members (similar to HealthPartners coverage)
- $0 or reduced office copays for mental health treatment (deductible applies only on the HSA plan).
- The HSA plan deductible increased due to IRS rules.
- The out of area benefits for members living out of state has been revised also.

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.

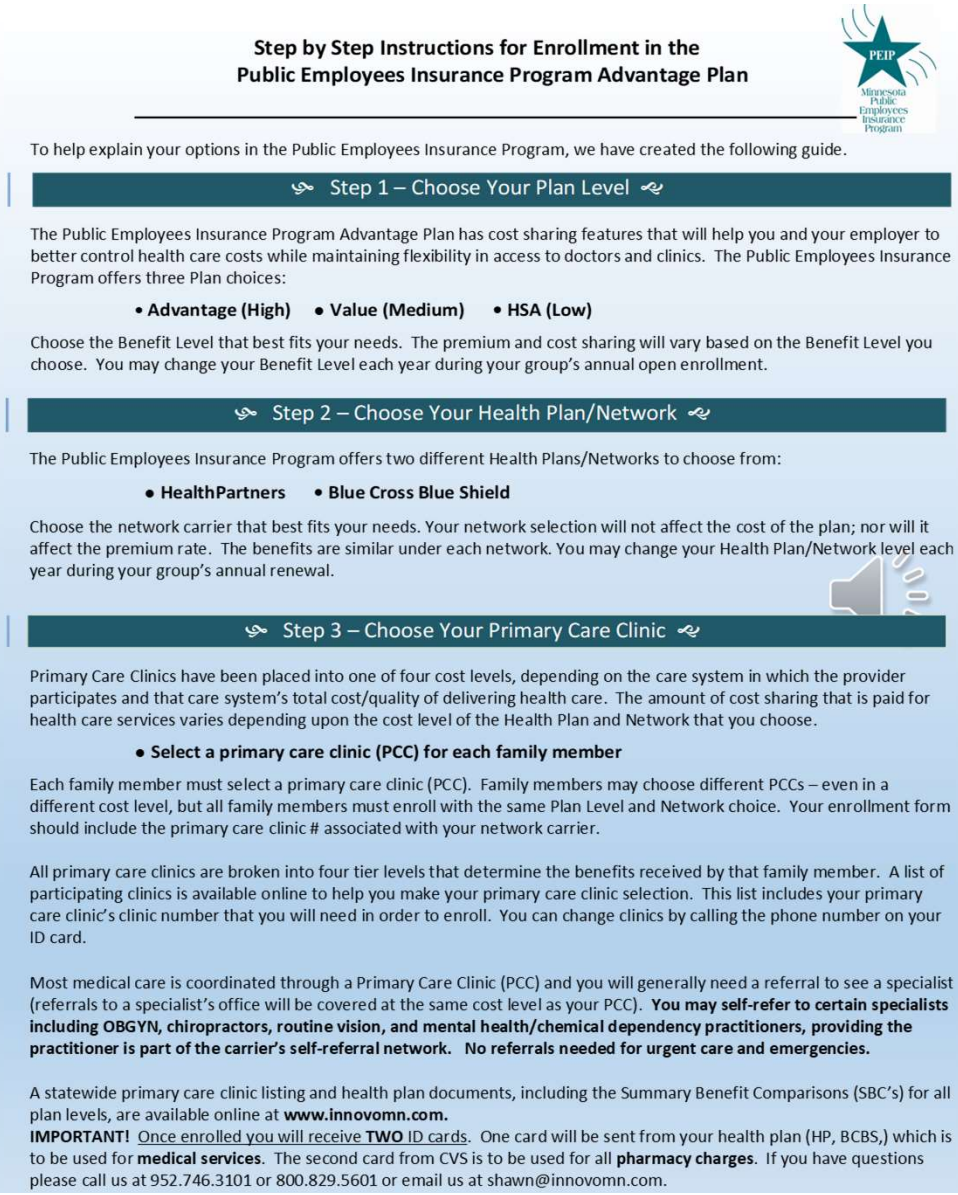
Innovo Benefits is the third party administrator for the PEIP program. Our core staff has worked with the PEIP program since it was created.

Our strength is vast **experience** and **dedication** to 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 300 employer groups covering 35,000 members.

Overview of PEIP Coverage

- Members have the choice of **three plan design options** and **two 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 both network carriers.
- CVS Caremark has a large 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 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.

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

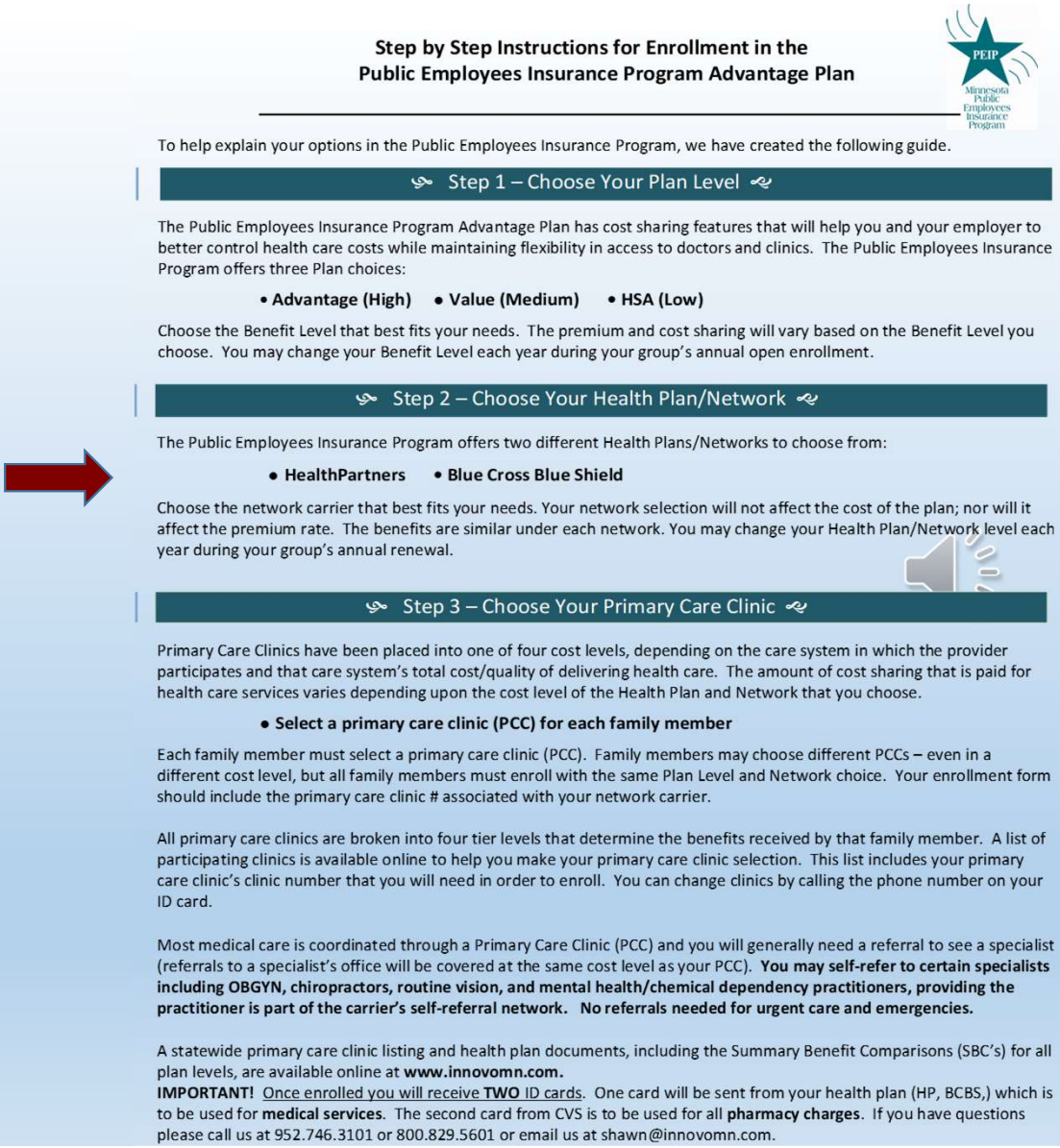
Advantage High is the highest level of benefits and the highest payroll deduction.

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

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Step 2 – Choose Your Health Plan/Network

The Public Employees Insurance Program offers two different Health Plans/Networks to choose from:

- **HealthPartners**
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Step 2 – Choose Your Health Plan/ Network

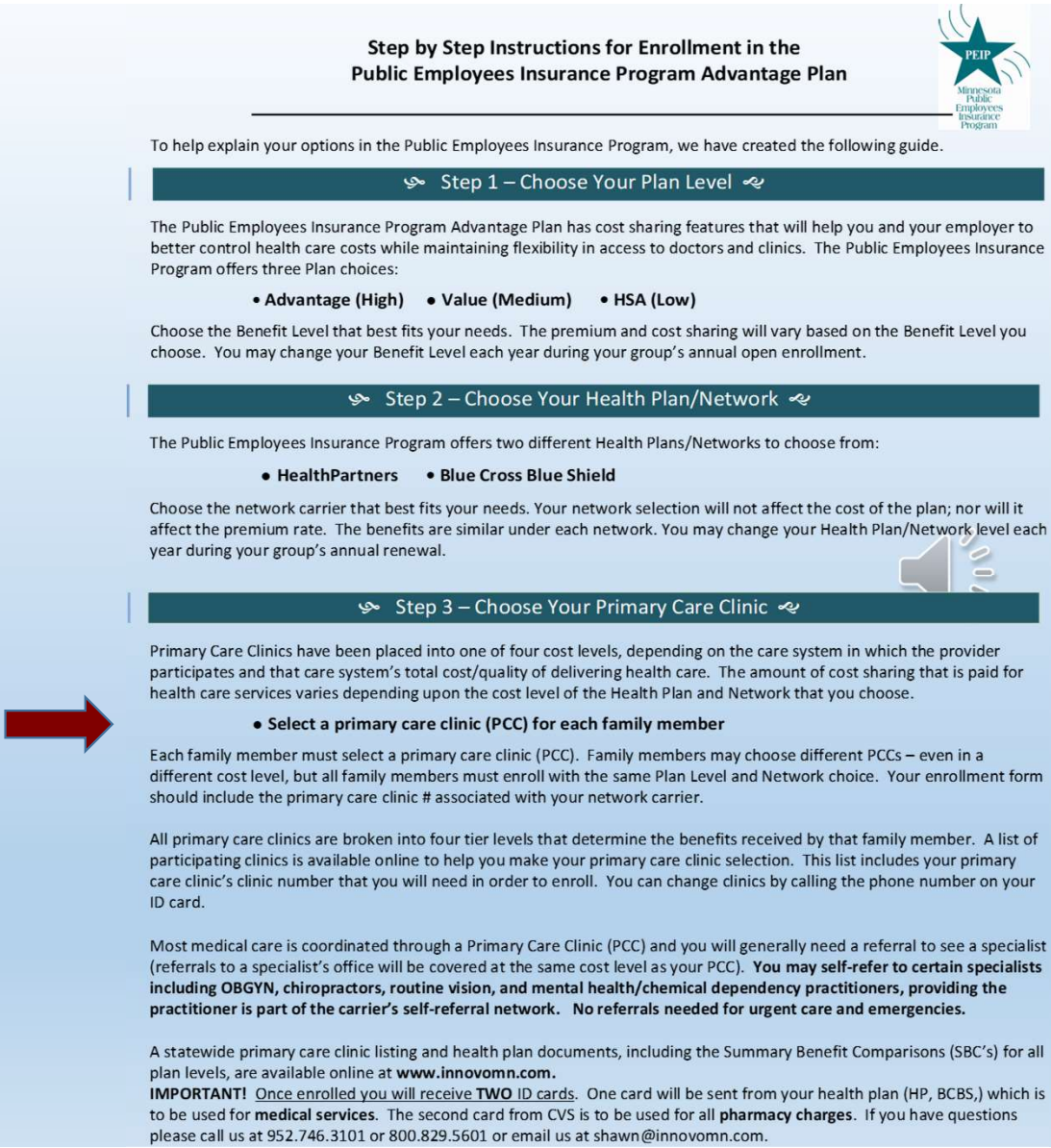
HealthPartners
Blue Cross Blue Shield

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

Both networks have the same plan design levels.

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

You can change your network each year during open enrollment.



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Step 3 – Choose Your Primary Care Clinic

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.

2024 clinic directory will be available at www.innovomn.com beginning in October.

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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**.

**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).

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

High Plan

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

Advantage High plan

Highest benefit level
(Highest payroll deduction)

Preventive Routine Care covered at 100%

Minnesota Public Employees Insurance Program (PEIP)
Advantage Health Plan High Option 2024 - 2025 Benefits Schedule

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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

Advantage High plan

Prescription Drugs

No Deductible
Copay per 30 day supply

Typically tiers are broken out …
Tier 1 – $18, generic & common name brand
Tier 2 – $30, name brand, some generic & specialty
Tier 3 – $55, 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 - $1,050/$2,100

Mail Order for 90 day medications for 2 copays (also available at retail CVS pharmacies)

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K. MRI/CT Scans	10% coinsurance annual deductible applies	15% coinsurance annual deductible applies	25% coinsurance annual deductible applies	30% coinsurance annual deductible applies

Advantage High plan

Your **Deductible** is based on your cost level.
CL 1 - $250/$500
CL2 – $400/$800

(Higher cost clinics, CL3 and CL4, will have higher deductibles.)
CL3 - $750/$1,500
CL4 - $1,500/$3,000

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

Deductibles are embedded.

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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

Advantage High 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.

Prosthetics and Durable Medical bypass the deductible with member paying only 20% copay (25% with CL4).

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

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
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

Advantage High 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 - $1,700/$3,400
CL2 - $1,700/$3,400

(Higher cost clinics, CL3 and CL4, will have higher OOP max.)
CL3 - $2,400/$4,800
CL4 - $3,600/$7,200

OOP Max is embedded.

Value Plan

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

Value Plan

Mid-range benefit level

Preventive Routine Care covered at 100%

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
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

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 90 day medications for 2 copays
(also available at retail CVS pharmacies)

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

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 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

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.

Prosthetics and Durable Medical bypass the deductible with member paying only 20% copay CL1, CL2. (25% CL3, 35% CL4).

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

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
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

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 Plan

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

HSA Plan

High deductible, lowest payroll deduction

HSA plan meets IRS rules for QHDHP and works differently than High & Value plan:

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

Preventive Routine Care covered at 100%

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
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)	$3,000	$3,000	$4,000	$5,000
Single Coverage	$5,000 per family member	$5,000 per family member	$6,900 per family member	$6,900 per family member
Family Coverage	$6,000 per family	$6,000 per family	$8,000 per family	$10,000 per family

HSA 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 90 day medications for 2 copays, after deductible is met (Also available at retail CVS pharmacies)

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

HSA 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, then member is only responsible for copayments or coinsurance.

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 *	$1,600	$2,000	$3,000	$4,000
Combined Medical/Pharmacy (single 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
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 ● 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

HSA 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 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
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)	$3,000	$3,000	$4,000	$5,000
Single Coverage	$5,000 per family member	$5,000 per family member	$6,900 per family member	$6,900 per family member
Family Coverage	$6,000 per family	$6,000 per family	$8,000 per family	$10,000 per family

HSA 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

- Out of area benefits

- PEIP has revised the out of area benefit plan. Members no longer need to "sign-up" to receive the benefits. Any care out of the service area, MN and bordering counties basically, is covered at cost level 3 for high and value plans, HSA remains the same deductible then 30% coinsurance. *Out of area deductibles are separate from in-area PEIP deductibles but do accumulate to out of pocket maximums. Always call the phone number on your ID card to verify benefits. Urgent care and emergency care are still covered at the cost level of your primary clinic.*

EMPLOYEE ENROLLMENT

EMPLOYER USE ONLY

❑ New Employee ❑ Annual Enrollment ❑ Late Entrant (Complete Health History Form)
Date of Hire ❑ COBRA ❑ Early Retiree
❑ Return from Leave ❑ 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)	**Benefit Level: (choose one):**	**Who do you wish to cover? Check all that apply.**
• HealthPartners • Blue Cross Blue Shield	• Advantage High Plan • Advantage Value Plan • Advantage HSA Plan	❑ Employee Only ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ 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				

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.

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 or BC)
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

- For 2024 both Blue Cross and HealthPartners are available for network selection, they are shown in the far left column as BC or HP
- If you are only changing clinics make sure you call the number on your ID card to make that change.
- Always check your ID card after open enrollment to make sure the information is correct.

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

Plan	County	City	State	Primary Care Clinic No.	Primary Care Clinic Name	Clinic Address	ZIP	Phone	Type PCC = Primary Care; PD=Pediatric	FT?	Care System	2023 Cost Level (2* means the clinic was moved to 2 for access)
BC	Ramsey	St. Paul	MN	003202595	M Health Fairview Clinic Highland Park	2270 Ford Parkway, #200	55116	651-696-5000	PCC	Y	FAI	3
HP	Ramsey	St. Paul	MN	776	M Health Fairview Clinic Highland Park	2270 Ford Parkway, #200	55116	651-696-5000	PCC	Y	FAI	2
BC	Ramsey	St. Paul	MN	003206824	M Health Fairview Clinic Midway	1390 University Ave W	55104	651-232-4800	PCC	Y	FAI	3
HP	Ramsey	St. Paul	MN	837	M Health Fairview Clinic Midway	1390 University Ave. West	55104	651-232-4800	PCC	Y	FAI	2
BC	Ramsey	St. Paul	MN	003206826	M Health Fairview Clinic Rice Street	980 Rice St	55117	651-326-9020	PCC	Y	FAI	3
HP	Ramsey	St. Paul	MN	843	M Health Fairview Clinic Rice Street	980 Rice St.	55117	651-326-9020	PCC	Y	FAI	2

Questions

PEIP website – www.innovomn.com

For questions regarding PEIP medical coverage, contact Innovo via phone or email.

952-746-3101 or 800-829-5601

M-F 7:30am – 4:30pm

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