MANAGEMENT AND BUDGET
STATE EMPLOYEE GROUP INSURANCE PROGRAM

Health Insurance Open Enrollment 2023

Open Enrollment Summary for Retirees

Effective January 1, 2023

Open Enrollment WebEx meetings

Tuesday, October 25, 2022, from 10:00 am to 12:00 noon

Thursday, October 27, 2022, from 1:00 pm to 3:00 pm

Tuesday, November 1, 2022, from 1:00 pm to 3:00 pm

Thursday, November 3, 2022, from 10:00 am to 12:00 noon

Open Enrollment for Retirees

Open Enrollment is held from October 27 - November 16, 2022.

Retirees may change plan administrators.

- The BlueCross BlueShield Coordinated Plan premiums will remain unchanged (0% increase).
- HealthPartners Medicare Group Solution Plan premiums will remain unchanged (0% increase).
- UCare Medicare Group premiums will remain unchanged (0% increase).
- The Minnesota Advantage Plan premiums will increase by 2.0%.

Steps for a successful Open Enrollment

Review the information in this booklet.

Changes in the Minnesota Advantage Plan and Senior Plans for the 2023 plan year are highlighted in this booklet and posted on the SEGIP website available at: mn.gov/mmb/segip.

Review the plan administrator availability.

You may choose any plan available in the county in which you live. Page 9 of this booklet.

Review the 2023 insurance rate table.

It lists the premium costs for each of the state's health plans. It also shows how premiums are combined for retirees and spouses under and over age 65 and retirees who attain age 65 and move into the Senior Plan and have a spouse remaining in the Minnesota Advantage Plan. Page 10 of this booklet.

Check your MN Advantage Health Plan Primary Care Clinic (PCC) for its cost level for the 2023 Plan Year.

Clinics can change cost levels throughout the plan year. The same clinic may be listed at a different cost level depending on the plan administrator selected. The 2023 Clinic Directory is available on the SEGIP website at: mn.gov/mmb/segip. To access it, click on the "Open Enrollment" tab. If you want to keep your current health plan administrator, but change clinics, call your plan administrator using the phone number listed on page 23 of this booklet clinic changes are immediate, be specific about the requested effective date, January 1, 2023). To change from one plan administrator to another, you must complete and return both an Enrollment form and a Disenrollment form found at the back of this booklet by November 16, 2022.

Complete and mail your applications if you want to make changes.

Complete the Enrollment and Disenrollment forms in this booklet and mail them to the appropriate plan administrator listed on page 23. If enrolling in Senior Plans, you will receive additional enrollment forms from your new plan administrator at your home address. These must also be completed and returned to your new plan administrator as quickly as possible (before December 31, 2022). If your Senior Plan Forms are not received before December 31, 2022, you will not have coverage on January 1, 2023.

Open Enrollment applications must be postmarked by November 16, 2022.

If you do not want to make changes, you do not have to complete the applications. You will continue the medical coverage with your current plan administrator.

Exclusive Retiree Meetings

Open Enrollment WebEx meetings

Tuesday, October 25, 2022, from 10:00 am to 12:00 noon

Thursday, October 27, 2022, from 1:00 pm to 3:00 pm

Tuesday, November 1, 2022, from 1:00 pm to 3:00 pm

Thursday, November 3, 2022, from 10:00 am to 12:00 noon

Gathering Open Enrollment Information

Retiree meetings.

Retiree Open Enrollment WebEx meetings will be held on October 25 and 27, and the following week, on November 1 and 3, 2022 (see times listed on page 24). All meetings will be held on WebEx and can be accessed by going to the SEGIP Open Enrollment page here: mn.gov/mmb/segip. Details about the retiree WebEx meetings can also be found on the Minnesota Retired State Employees Association (MRSEA) website at: www.mrsea.org. To join a WebEx meeting, click on the link provided on the SEGIP website for the meeting you wish to attend.

Via the Internet.

The SEGIP website mn.gov/mmb/segip provides links to the provider directories published by the three Minnesota Advantage Health Plan administrators: BlueCross BlueShield, HealthPartners, and PreferredOne. A list of participating doctors and clinics, accessible through the Minnesota Advantage Health Plan, is available to help you make your Primary Care Clinic (PCC) selection. This list also includes the PCC number you need to write on your form to enroll. Each plan administrator has a unique number for the PCCs. To access it, click on the "Open Enrollment" tab.

Via the phone.

You may call the plan administrators directly if you have questions. Each health insurance plan administrator will provide a list of its participating clinics specific to your area and clinic numbers for the Minnesota Advantage Health Plan. BlueCross BlueShield Coordinated Plan, HealthPartners Medicare Group Solution, and the UCare Medicare Group will provide directories for the plans to members age 65 and greater. The plan administrators' phone numbers are listed on page 23 of this booklet.

SEGIP's Open Enrollment Service Center.

For answers to questions about rates, eligibility, and coverage or help with enrollment issues, call SEGIP's Open Enrollment Service Center through November 18, 2022. SEGIP representatives are available Monday through Friday from 7:00 a.m. to 4:00 p.m. Offices will be closed Friday, November 11, 2022, in observance of the Veterans' Holiday. Call 651-355-0100, or 1-800-664-3597 in greater Minnesota. Members with hearing or speech disabilities may contact SEGIP via their preferred telecommunications relay service.

An Overview of Your Health Benefits

As a state retiree, you and your eligible dependents receive health insurance benefits through the State Employee Group Insurance Program (SEGIP).

Open Enrollment will be held from October 27 – November 16, 2022. This booklet is designed to help you make decisions about the SEGIP health benefits that you will receive during the next plan year. Use it to learn about the Minnesota Advantage Health Plan design, changes in the MN Advantage Plan, Senior Plans, and costs that may impact your selection of health plan administrator. After Open Enrollment, you are encouraged to keep this booklet as a reference guide. Use it in conjunction with your Plan Summary or Certificate of Coverage to gain a greater understanding of your benefits.

SEGIP will host four WebEx meetings for retirees. Check page 24 of this booklet for dates and times. **You do not need to pre-register to attend a retiree WebEx meeting.** Retiree WebEx meetings are also listed on the SEGIP website at: mn.gov/mmb/segip and the MRSEA website at: www.mrsea.org.

Medicare Part D (Prescription Drug Coverage)

CAUTION: Members enrolling in the age 65 and over plans (Senior Plans) should NOT apply for or purchase Medicare Part D from another Part D plan administrator for prescription drug coverage. Enrolling in Part D with an insurance company that is different from your SEGIP group plan administrator will terminate your participation in the SEGIP Senior Plans. As you approach age 65, Medicare beneficiaries will see marketing materials from several different insurance companies and pharmacies offering prescription coverage. If you purchase that coverage, you will **permanently lose** medical insurance coverage in the state's retiree group!

- If you reach age 65 and enroll in Medicare Parts A and B while you are participating in SEGIP as a retiree, your enrollment in Medicare Part D will be handled by enrolling with your plan administrator's Senior Plan (BlueCross BlueShield participants enroll in the Coordinated Plan, HealthPartners participants enroll in HealthPartners Medicare Group Solution and PreferredOne participants enroll in UCare Medicare Group).

  Retirees under age 65 in the Minnesota Advantage Health Plan have existing prescription drug coverage that, on average, is as good as, if not better than Medicare Part D. This is important. It ensures that you will not be penalized with a higher premium or Part D penalty if you join a Medicare prescription plan after Medicare Part D was first made available to you. A disclosure is available on the SEGIP website.

- **SEGIP Plan Benefit:** The pharmacy benefit of the Senior Plans will include and coordinate with Medicare Part D. Participants in the Senior Plans do not pay a separate Part D premium to Medicare (unless your income is above a certain level as determined by Medicare) or to a Part D plan administrator. The Medicare Part D benefit and premium are built into the premium paid directly to BlueCross BlueShield Coordinated Plan, HealthPartners Medicare Group Solution, and UCare Medicare Group.

  Enrollment: New members to any of the Senior Plans that coordinate with Medicare must immediately complete the Senior Plan's enrollment form and Medicare Part D form sent to their home address by the

plan administrator. Participants who turn 65 during the year and continue coverage in SEGIP must also complete and return both the Senior Plan enrollment form and the Medicare Part D form before the month in which they turn 65 to ensure timely coverage upon turning age 65.

Premiums

The 2023 premiums will change:

- 2.0% increase for the Minnesota Advantage Health Plan.
- 0% (no change) for UCare Medicare Group. Remains $350.00 per month.
- 0% (no change) for the HealthPartners Medicare Group Solution. Remains $325.60 per month.
- 0% (no change) for BlueCross BlueShield Coordinated Plan. Remains $355.00 per month.

Remember to update your auto payment amounts through your bank. Likewise, you may also provide updated monthly premium amounts to MSRS, if you have a monthly reimbursement deposited to your bank account.

What's New – Minnesota Advantage Health Plan

For retirees under age 65: Minnesota Advantage Health Plan – HealthPartners Enhanced Fertility Benefit

Effective January 1, 2023: The Minnesota Advantage Health Plan will include an enhanced fertility benefit available only through HealthPartners. The benefit covers services to diagnose infertility and provide professional fertility treatment, limited to a lifetime maximum benefit of $30,000 and a lifetime limit of two assisted reproductive technology cycles. For more information, visit: https://mn.gov/mmb/segip/benefits/medical/

For retirees under age 65: Minnesota Advantage Health Plan – Travel Benefit

Effective September 1, 2022: The Minnesota Health Advantage Plan now offers a travel benefit to help defray some of the cost of traveling to receive a necessary medical service when the service is not offered or provided within 100 miles of your home. Eligible members may receive help paying for lodging and transportation related to receiving a service available under the health plan. For more information, visit: https://mn.gov/mmb/segip/travel-benefit/

Primary Care Clinics and Provider Quality

There are changes to the 2023 Primary Care cost levels. Check your current Primary Care Clinic's (PCC) cost level at mn.gov/mmb/segip on the Open Enrollment tab. Quality of care information is provided through Minnesota HealthScores for most of Minnesota's PCCs. Minnesota HealthScores is a nonprofit organization that monitors and reports how well physician groups deliver preventive care and manage a variety of health conditions.

Turning 65 in 2023

If you or your spouse will be turning age 65 in 2023, you should also review the Senior Plans. The MN Advantage Plan administrator that you have in place when you turn age 65 determines the Senior Plan that you will be eligible to enroll with for the remainder of the 2023 plan year. Turning age 65 and your Medicare eligibility do not allow you to access a Senior Plan affiliated with a different plan administrator.

Under 65, Advantage Plan Primary Care Clinics

Check with your plan administrator during Open Enrollment to see if your Primary Care Clinic will participate in the plan administrator's provider network for the new insurance year. The Clinic Directory for the Minnesota Advantage Health Plan is available on the SEGIP website. If under age 65, you should confirm the cost level of your MN Advantage Plan's PCC for the upcoming year, as there are changes to the 2023 Clinic Cost Levels.

If your current clinic will be available in 2023, and you do not want to change plan administrators, you do not need to do anything during this Open Enrollment period. You will continue to participate with your current plan administrator in 2023. If you will keep the same plan administrator, but need to change your Primary Care clinic, call your plan administrator to change the clinic. Clinic changes can now be made effective immediately. Be sure to request the effective date you'd like the change (for example January 1, 2023).

Changes you make to your health insurance plan administrator will be effective from January 1, 2023, through December 31, 2023.

Other Enrollment Notes

Medicare participation.

To enter a senior plan, you must be age 65 and enrolled in:

- Medicare A
- Medicare B

When you enroll in a Senior Plan you will be asked if you are enrolled in Medicare Parts A and B. You must be enrolled in Medicare A and B and provide this information to ensure claims will be processed correctly. If you are changing plan administrators and are age 65 or greater, you must enroll with the new plan's Part D drug benefit. The plan will send you enrollment forms that must be completed immediately to ensure that your new senior plan enrollment takes effect on January 1, 2023.

BlueCross BlueShield, HealthPartners, and PreferredOne will send plan membership cards to your home before 2023. Check your membership cards closely to ensure that all information is correct, including the Primary Care Clinic. If there are errors, call your plan administrator immediately.

Important Plan Statements

- The state expects to continue the State Employee Group Insurance Program indefinitely. However, the state reserves the right to change or discontinue all or any part of the program, consistent with the state's rights and obligations under the law and collective bargaining agreements.
- The Plan assumes fraud or intentional misrepresentation if a participant enrolls a dependent who does not meet the Plan's definition of dependent. Upon 30-day notice, coverage will be rescinded to the effective date of coverage. You will be liable for all claims paid by the Plan on behalf of an ineligible dependent.

Health Plans offered

BlueCross BlueShield Plans

- Minnesota Advantage Health Plan – BlueCross BlueShield (under age 65)
- Senior Plan - Coordinated Plan (age 65 and over and a Medicare A & B enrollee)

HealthPartners Plans

- Minnesota Advantage Health Plan – HealthPartners (under age 65)
- Senior Plan - HealthPartners Medicare Group Solution (age 65 or over and a Medicare A & B enrollee)

PreferredOne Plans

- Minnesota Advantage Health Plan – PreferredOne (under age 65)
- Senior Plan - UCare Medicare Group (age 65 or over and a Medicare A & B enrollee)

You may receive information about other plans offered by some of the same insurance companies or plan administrators that offer the plans we have just listed. Be cautious. Plans not listed in this book are not state-sponsored. If you enroll in a plan that is not state-sponsored, you forfeit your membership in the State Employee Group Insurance Program (SEGIP) and will never be able to re-enroll in the state group medical insurance.

Note: if you and your dependents are all under age 65, you must all enroll in the same plan with the same insurance plan administrator. If you and your spouse or dependents are in different age groups (one is age 65 or older; one is under age 65) or you have other insurance-eligible dependents under age 65, you must select plans appropriate by age group. Both age-appropriate plans must be offered by the same insurance plan administrator. (For example, a retiree who is age 67 may be enrolled in UCare. The under age 65 spouse, of this member and dependent children (under the age of 26) would participate in Minnesota Advantage Health Plan with PreferredOne.)

You may only change plan administrators during Open Enrollment. Upon turning age 65, you will have the opportunity to enroll in the senior plan affiliated with your current Minnesota Advantage Health Plan administrator. Those approaching age 65 should receive an enrollment kit or packet for the senior plan affiliated with their current plan administrator thirty (30) to sixty (60) days before the month in which they reach age 65.

Cost

You pay the full cost of retiree health coverage for yourself and your insurance-eligible dependents. Since you are a member of the State Employee Group Insurance Program (SEGIP), you receive the privilege of group rates for high-quality plans. This makes your health care coverage more affordable for a very good plan, with a low out-of-pocket maximum than if you were to purchase similar coverage on your own. Your monthly cost varies depending on which plan you choose and whether you cover a spouse, the age of your spouse, and whether you cover other eligible dependents. The Minnesota Advantage Health Plan rates and Senior Plan rates are listed in the table on page 10.

Eligibility

If you and/or your spouse are Medicare-eligible and age 65 or older, you must be enrolled in Medicare Part A (hospital insurance) and Part B (supplemental medical insurance). Your Part D (prescription drug coverage) is included with your state group plan administrator and enrollment will be coordinated through your SEGIP senior plan for those ages 65 and older.

Participants in the state's retiree health insurance program may change plan administrators during Open Enrollment. It is important for you to carefully consider your option to continue your state-sponsored health insurance. If you turn 65 in 2023 you will be offered enrollment in the senior plan affiliated with your current MN Advantage Plan insurance plan administrator. **If you decide not to continue, you and/or your dependents will not be eligible to re-enroll in the state's health plans.**

Family coverage

When you retired and became eligible to continue your participation in SEGIP's retiree plans, your eligible dependents were also able to maintain coverage.

If you chose coverage for yourself but not your dependent(s) when you retired, you may still be able to add your dependent(s) later. You may add dependent coverage if your eligible dependents, including your spouse if they either:

- Lose other group coverage, or
- If you become newly married after retirement

At either time, **you must submit an *Application to Change Insurance Coverage* (Qualifying Status Change form) to the State Employee Group Insurance Program (SEGIP)** within 30 days of the event. Contacting SEGIP before the event is encouraged and necessary for retirees adding a spouse who is age 65 or greater. A marriage certificate and other documents will be required to verify the marriage date. When losing other group coverage, you must send written verification on company letterhead from your dependent's employer. The employer's letter must state the exact date of the event that is causing the loss of group coverage. It must also state the current coverage and the date their current coverage ends.

Adding new dependents will require that you verify your dependent status. The policyholder verifies the dependent status for newly added dependents by submitting specific documents. Failure to provide documentation will result in the removal of coverage.

Surviving spouses and dependents

A spouse who was covered by the state's retiree plans at the time of the retiree's death may continue participation in SEGIP indefinitely. Dependent children who were covered at the time of the retiree's death may continue participation until the end of the month in which they turn age 26.

COBRA Qualified Events – Dependent

If you have maintained coverage for a dependent child who reaches age 26, contact SEGIP before their 26th birthday to ensure that a COBRA offer will be provided to your dependent. Additionally, if you divorce after retirement, contact SEGIP to provide this information and inquire about continuation options no later than 60 days from the date of divorce.

Availability by County

UCare Medicare Group Wisconsin Counties

Ashland	Juneau
Barron	La Crosse
Bayfield	Monroe
Buffalo	Pepin
Burnett	Pierce
Chippewa	Polk
Crawford	Richland
Douglas	Sawyer
Dunn	Sauk
Eau Claire	St. Croix
Grant	Trempealeau
Iowa	Vernon
Jackson	Washburn

2023 Monthly Rates	Section 1		Section 2					Section 3			
	Retiree under 65	Retirees 65 & over	One dependent under age 65 (spouse or child)	A spouse under 65 and 1 or more children	One or more eligible children/ no spouse	Spouse 65 & over	Spouse 65 or over and 1 or more children	Surviving Spouse or one dependent under 65	Surviving Spouse 65 and over	Two or more surviving dependents under 65	Surviving Spouse 65 & over and one or more dependent
Minnesota Advantage Health Plan – BlueCross BlueShield	$770.04	—	$1,494.40	$1,494.40	$1,494.40	—	$1,494.40	$770.04	—	$2,264.44	—
BlueCross BlueShield Coordinated Plan	—	$355.00	$770.04 *	—	—	$355.00	—	—	$355.00	—	$1,849.40
Minnesota Advantage Health Plan - HealthPartners	$770.04	—	$1,494.40	$1,494.40	$1,494.40	—	$1,494.40	$770.04	—	$2,264.44	—
HealthPartners Medicare Group Solution	—	$325.60	$770.04 *	—	—	$325.60	—	—	$325.60	—	$1,820.00
Minnesota Advantage Health Plan - PreferredOne	$770.04	—	$1,494.40	$1,494.40	$1,494.40	—	$1,494.40	$770.04	—	$2,264.44	—
UCare Medicare Group	—	$350.00	$770.04 *	—	—	$350.00	—	—	$350.00	—	$1,844.40

Note: Add Section 1 to Section 2 to arrive at the total cost for family coverage. For survivors of retirees, choose the appropriate rate under Section 3. Rates are subject to change on January 1, 2023.

- **A single remaining dependent continues coverage in the Minnesota Advantage Health Plan and is allowed to pay the equivalent of a single premium*

Plan Summaries

The next section of this booklet provides summaries of each SEGIP health plan offered to retirees.

- Retirees and dependents under age 65 should refer to pages 12 through 15 for plan features and types of services covered under the Minnesota Advantage Health Plan.
- Retirees and/or dependents age 65 and greater who are Medicare eligible will find plan summaries and a comparison chart on pages 16 through 22.
- For definitions of some of the terms used in these descriptions, refer to the glossary on pages 25 and 26.

This booklet does not describe all procedures and requirements established by the plan administrators to ensure quality and efficiency. For example, the booklet may state coverage is 100 percent for a certain service, but coverage may also require the plan administrator's prior approval. You should familiarize yourself with how your plan works, in addition to its benefit levels and provider network. Each plan's Certificate of Coverage or Summary of Benefits describes these features. The Minnesota Advantage Health Plan Summary will be available on the SEGIP website after January 1, 2023. The age 65 and over plan certificates will be made available electronically after January 1, 2023.

Provider Networks

Most health plans have a network of physicians, hospitals, and other health care providers through which you receive your care. To be sure that a particular doctor or other health care provider will be in your plan's network for the 2023 insurance year, call the plan's customer service number (see pages 23 and 24).

Medicare Coordination

All SEGIP Senior Plans are coordinated with Medicare Parts A, B, and D for people age 65 or older. Medicare-eligible retirees and spouses age 65 and older are **required to enroll in Medicare Part A and Part B to participate in the state's group insurance plans**. Enrollment in Medicare Part D (prescription drugs) is included with the state group plan administrator you have chosen for all medical benefits. Your enrollment in Part D will be coordinated through the plan administrator with which you participate.

Important note

The following descriptions are meant only to highlight the benefits provided by each plan. Refer to the Certificate of Coverage or Summary of Benefits for complete descriptions of all benefits and benefit exclusions. If there are differences between this document and the plans' Certificates of Coverage or Summary of Benefits, the Certificates of Coverage or Summary of Benefits will govern.

Minnesota Advantage Health Plan (under age 65)

Minnesota Advantage Health Plan is the medical benefits program for all retirees and dependents under age 65

All state of Minnesota retirees and eligible dependents under age 65 who receive medical coverage under the State Employee Group Insurance Program (SEGIP) are enrolled in the benefits program called the Minnesota Advantage Health Plan (referred to as Advantage Plan).

MN Advantage Plan features

The Minnesota Advantage Health Plan include:

- Cost-sharing features that help you better control health care costs while maintaining flexibility in accessing doctors and clinics.
- A uniform and comprehensive set of benefits across all plan administrators.
- Out-of-pocket expense maximums for both prescription drugs and medical services that protect you from financial hardship.
- No copays are charged for preventive care, like annual check-ups, etc.
- Most medical care is coordinated through your Primary Care Clinic (PCC) and you will generally need a referral to see a specialist.
- You may self-refer to certain specialists including:
    - Obstetricians/gynecologists
    - Chiropractors
    - Mental health/chemical dependency practitioners
    - Routine eye exam providers

Access to this specialty care still depends on your plan network and possibly your PCC. Contact your plan administrator to verify clinic cost level participation.

- You may change your clinic and cost level as often as monthly.
- Referrals for office visits to a specialist are covered at the same level as your PCC office visits.
- Choose a plan administrator that is available in the county in which you live.

Creditable coverage for prescription drugs

It has been determined that the prescription drug coverage offered through the Minnesota Advantage Health Plan is creditable. This means the amount that the Minnesota Advantage Health Plan expects to pay, on average, for prescription drugs is the same as or greater than what standard Medicare prescription drug coverage will pay. This is important because if you are now eligible or become eligible for Medicare Part D, but enroll at a future date, you will not pay extra for that coverage. A disclosure is available to you on the SEGIP website at: mn.gov/mmb/segip.

How does the MN Advantage Plan work?

Under the MN Advantage Plan, you will share in the cost of specific medical services you obtain by paying out-of-pocket amounts (annual deductibles, office visit copays, coinsurance).

Health care providers have been placed into one of four cost levels. The cost level in which each provider is placed depends on the care system in which the provider participates and that care system's total cost of delivering health care. Participants pay the least out-of-pocket costs when using cost level 1 or 2 clinics.

Clinics have changed cost levels for 2023. To check the cost level of your clinic, refer to the Advantage Clinic Directory on the SEGIP website at mn.gov/mmb/segip. To access it, click on the Open Enrollment tab. Then click on the 2023 Advantage Clinic Directory or call your insurance plan administrator listed on pages 23 and 24.

The amount of cost-sharing that will be paid when using health care services varies depending on the cost level of the Primary Care Clinic that is chosen. **Primary Care Clinics in cost levels 1 and 2 provide the best value with the lowest possible out-of-pocket costs**.

Members in cost level 1 or 2 have annual out-of-pocket maximums set at the lowest amounts available under the plan: $1,700 for single coverage and $3,400 for family coverage. Participants opting for coverage in a cost level 3 or 4 clinic will have higher out-of-pocket costs, as the delivery of care under these cost levels has higher costs. Participants in cost level 3 will share in their cost of care up to the out-of-pocket maximum of $2,400 for single coverage and $4,800 for family coverage. Participants using cost level 4 clinics will share in the cost of their care to a maximum of $3,600 for single coverage and $7,200 for family coverage. Once you've reached your annual out-of-pocket maximum, the Advantage Plan will pay all remaining medical costs allowed under the plan for that year.

CVS Caremark is the Pharmacy Benefits Manager for all participants of the Minnesota Advantage Health Plan regardless of the plan administrator selected. Under the SEGIP plan, most drugs are covered under one of three tiers, regardless of the PCC selected. The formulary may be accessed at www.caremark.com. The out-of-pocket maximum is $1,050 for single coverage and $2,100 for family coverage, regardless of the cost level of a participant's Primary Care Clinic.

2023 Minnesota Advantage Health Plan Schedule of Benefits

2023 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, 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)	$35 copay per visit Annual deductible applies	$40 copay per visit Annual deductible applies	$70 copay per visit Annual deductible applies	$90 copay per visit Annual deductible applies
D. **In-network Convenience Clinics & Online Care** (deductible waived)	$0 copay	$0 copay	$0 copay	$0 copay
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** (waived for admission to Center of Excellence)	$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, 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 visits 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** A 30-day supply of Tier 1, Tier 2, or Tier 3 prescription drugs, including insulin, or a 3-cycle supply of oral contraceptives Note: all Tier 1 generic and select branded oral contraceptives are covered at no cost.	$18 / 30 / 55	$18 / 30 / 55	$18 / 30 / 55	$18 / 30 / 55
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

This chart applies only to in-network coverage. Point-of-Service (POS), coverage is available only to members whose permanent residence is outside both the State of Minnesota and the Advantage plan's service area. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave (including sabbatical), and college students. It also applies to dependent children and spouses permanently residing outside the service area. Members enrolled in this category pay a $350 single or $700 family deductible (separate and distinct from the deductibles listed in section B above) and 30 percent coinsurance to the out-of-pocket maximum described in Section O above. Members pay the drug copayment described in Section M above to the out-of-pocket maximum described in Section N. This benefit must be requested.

The Advantage Plan offers a standard set of benefits regardless of the selected plan administrator. There are differences in how each plan administrator administers the benefits, including the transplant benefit, in the referral and diagnosis coding patterns of primary care clinics, and the definition of Allowed Amount.

Coordinated Plan (age 65 and over)

This is a BlueCross BlueShield of Minnesota Plan available for those who are:

- Age 65 and older.
- Enrolled in Medicare Parts A and B.
- Enrolled in Medicare Part D which is included and coordinated through this plan.

Requires immediate completion and return of forms to the plan. There are two forms entitled, "Enrollment Form for State of Minnesota Coordinated Plan" and, "MedicareBlue^{SM} Rx (PDP) Participant Enrollment Form)." Forms will be mailed directly to your home address.

General plan features

The Coordinated Plan is available in all Minnesota counties and worldwide.

As a member of the Coordinated Plan, you are free to choose any health care provider that accepts Medicare assignment. However, when you use providers that participate with BlueCross BlueShield Plans (BCBS), your claims will be filed for you and the BCBS payment will be made directly to the provider. In addition, BCBS providers have agreed to accept the allowed amount as payment in full. You are only responsible for any deductible, coinsurance, and copays for eligible services.

Health care providers who do not participate with BCBS may charge more for services than the allowed amount. When you use a provider who does not participate with BCBS you are responsible for the deductible, copays or coinsurance, and any eligible charges that exceed the allowed amount. You may also have to file your claims.

Some deductibles specified in the Coordinated Plan are based on 2023 Medicare deductibles which are subject to change for 2023 through action by the federal government. Be aware that such changes could take place without warning.

Inpatient admissions

Inpatient services:

- General hospital
- Skilled nursing facilities
- Mental health
- Chemical dependency

The Coordinated Plan will process at 80% of the first $3,000 of total eligible expenses, then 100% for a semi-private room up to 365 days, following your $200 annual deductible.

- **Deductible:** A deductible applies to the first $200.
- **Coinsurance:** After the $200 inpatient deductible, each participant is responsible for 20% of the first $3,000 ($600) of the total eligible expenses.
- Eligible expenses of more than $3,000 each calendar year are covered at 100%.
- **Inpatient services out-of-pocket maximum:** $800 per participant per calendar year ($200 deductible plus 20% of the next $3,000).

Emergency services

After the Medicare Part B annual deductible, 100% coverage. The plan requires participants to pay the Medicare Part B deductible of $233.00 for 2022. The 2023 Medicare Part B deductible is not released for the plan year 2023 as of the writing of this booklet.

Health care services

There is an annual outpatient deductible for all medical (Medicare Part B) services. After the deductible is met, services will be covered as follows:

- **Preventive care:** 100% coverage. Preventive care is not subject to the deductible.
- **Physician services:** 100% coverage.
- **Eye and hearing exams:** One routine exam per calendar year. 100% coverage of the allowed amount. The Medicare Part B deductible does not apply.
- **Hospital outpatient and surgery center:** 100% coverage.
- **Outpatient mental health services:** 100% coverage.
- **Outpatient chemical dependency services**: 100% coverage.
- **Chiropractic services**: 100% coverage.
- **Physical, speech, and occupational therapy (in an outpatient hospital):** 100% coverage.
- **Home health care:** 100% of the Medicare-approved amount for medically necessary skilled care.

Prescriptions and products

Prescription Drugs: 30-day supply, including insulin.

- $10 copay for **generic drugs.**
- $30 copay for **preferred brand drugs.**
- $50 copay for **brand-name drugs.**
- $50 copay for **specialty drugs.**
- 25% coinsurance for **supplemental drugs.** These are certain classes of drugs not covered by Medicare.
- SEGIP Retirees pay the appropriate copay while in the donut hole or medication gap. SEGIP Retirees do NOT pay a greater percentage of drug costs while in the donut hole.
- **Catastrophic prescription drug coverage:** If out-of-pocket expenses total $7,400 prescription drug copay changes to the greater of 5% coinsurance or a $4.15 copay for generics (including brand drugs treated as generic) and $10.35 for other drugs for the remainder of the year.
- **Mail Order/Preferred Extended Supply:** (90-day supply). Generic Drugs - $20 copay, Preferred Brand Drugs - $60 copay, Non-Preferred Brand Drugs - $100 copay, Specialty Drugs - $100 copay.

Prosthetics and durable medical equipment

100% coverage after the annual Medicare Part B deductible.

Hearing aids: 80% coverage for hearing aids and accessories every three years. Coverage does not apply to upgrades. You pay all charges that exceed the allowed amount when you use a nonparticipating provider. Check your Certificate of Coverage for more information.

Fitness Program

SilverSneakers®

HealthPartners Medicare Group Solution

(age 65 and over)

The HealthPartners Medicare Group Solution is available for those who are:

- Age 65 and older
- Enrolled in Medicare Parts A and B
- Enrolled in Medicare Part D which is included and coordinated through this plan.

Requires immediate completion and return of forms to the plan. The form is entitled “2023 HealthPartners® Medicare Group Solution Enrollment Form.” You may also see references to "Journey” on your forms. **Forms will be mailed directly to your home address.**

General plan features

HealthPartners Medicare Group Solution aligns the HealthPartners Journey Group Medicare Advantage (PPO) plan and HealthPartners Retiree national Choice (RNC) (PDP) plan. HealthPartners enrolls retirees in one of the plans based on their county of residence.

Members living in the Journey Group Service area (70 MN counties) will be enrolled in the HealthPartners Journey Group Plan (a Medicare Advantage Plan). Retirees living outside of the Journey Group service area will be enrolled in the Retiree National Choice Plan (RNC).

As a member of the HealthPartners Medicare Group Solution, you can use any provider who accepts Medicare and your insurance across the United States. The Journey Group plan has a network that includes all major care groups in Minnesota. Plus, there’s no additional cost sharing for out-of-network providers. That means retirees pay the same cost-sharing whether they see in-network or out-of-network providers. The RNC plan doesn’t have a medical network.

Telehealth coverage includes Virtuwell, e-visits, scheduled telephone visits, and video visits.

Travel Coverage

- Broad-based travel benefits are available for up to 9 consecutive months. You can use any provider who accepts Medicare and your insurance across the United States and access to a national pharmacy network.
- Urgent and emergency coverage worldwide.
- Assist America provides worldwide emergency travel logistics including experienced clinicians to help with assessing your need for medical care, coordinating transport, or even lost medications.

Inpatient admissions

- **General hospital**: $100 copay, then 100% coverage.
- **Skilled nursing facilities:** 100% coverage for rehabilitative care for up to 100 days per benefit period.
- **Mental health and Chemical dependency**: $100 copay and then 100% coverage for unlimited days.

Emergency services

- **The United States and US territories:** $50 copay for emergency room services (waived if admitted). 100% coverage for ambulance service.

- **Outside the United States and US territories:** 20% coinsurance. **Ambulance Benefit:** 20% coinsurance for one-way (limited to a ground ambulance to the nearest appropriate facility).

Health care services

There is a $3,400 out-of-pocket maximum expense for health care services.

- **Preventive care:** 100% coverage.
- **Physician services:** 100% coverage after a $15 copay
- **Eye and hearing exams:** 100% coverage.
- **Hospital outpatient and surgery center:** 100% coverage.
- **Outpatient mental health services:** 100% coverage after a $15 copay; $7.50 copay for group therapy.
- **Outpatient chemical dependency services:** 100% coverage after a $15 copay.
- **Chiropractic services:** 100% coverage after a $15 copay, when meeting Medicare guidelines.
- **Physical, speech, and occupational therapy:** $15 copay, then 100% for physical, occupational, or speech therapy.
- **Home health care:** 100% coverage. Must meet Medicare guidelines (no coverage beyond Medicare).
- **Online Care:** You pay nothing for online care visits to virtuwell at virtuwell.com.

Prescriptions and products

Prescription drugs: 30-day supply in the initial coverage and coverage gap phases

- $10 copay for generic and **preferred generic drugs.**
- $30 copay for a **preferred brand.**
- $50 copay for **non-preferred brand.**
- $50 copay for **specialty drugs.**

Catastrophic coverage:

- Generics $4.15 or 5%
- Brands $10.35 or 5%

You pay whichever is greater (not to exceed the copays in the Initial Coverage phase).

Mail order prescription options: A three-month supply of drugs available for only two copays at a preferred mail order pharmacy.

Prosthetics and durable medical equipment:

90% coverage, including test strips and syringes for people with diabetes. (No more than a 90-day supply will be covered and dispensed at a time.)

Hearing Aid benefit: Up to two TruHearing-branded hearing aids every year (one per ear per year). Covered at 100% of the charges incurred, subject to $99/$199/$499 copayment per aid. Includes professional exam, unlimited follow-up visits, and a risk free trial period.

Fitness Program

SilverSneakers® program at no cost.

UCare Medicare Group (age 65 and over)

The UCare Medicare Group is offered through PreferredOne. It is for those who are:

- Age 65 and older.
- Enrolled in Medicare Parts A and B.
- Enrolled in Medicare Part D which is included and coordinated through this plan.

Requires immediate completion and return of forms to the plan. The form is entitled, "UCare Medicare Group Enrollment Request Form." Forms will be mailed directly to your home address.

General plan features

Health care services are provided through the UCare network of physicians, clinics, pharmacies, and other health care providers. UCare Medicare Group is available in all counties in Minnesota and 26 western Wisconsin counties listed on page 9 of this booklet.

New for 2023; In addition to the in-network providers in Minnesota and Wisconsin, you also have access to out-of-state providers with the MultiPlan Medicare Advantage national network at in-network cost sharing.

Referrals are not needed for specialty care. UCare also provides coverage for services obtained outside the UCare network. Physician office visits out of network will be covered with the same copays as in network office visits.

As a UCare member, you select the clinic of your choice. Family members may choose different clinics.

Point of Service

Routine and non-emergency physician services outside of the UCare Medicare Group network in the United States are covered at 80% to a maximum benefit of $100,000. The participant pays 20% to a maximum out-of-pocket of $7,500 for eligible expenses per calendar year. The participant would be responsible for all charges above $100,000. Physician office visits out of network will be covered with the same copays as in-network office visits.

Inpatient admissions

- **General hospital:** 100% coverage after a $100 copay per admission.
- **Skilled nursing facilities:** 100% coverage for rehabilitative care up to 100 days. Must meet current Medicare coverage requirements. **No 3-day hospitalization stay is required.**
- **Mental health:** 100% coverage, after a $100 copay per admission.
- **Each Medicare-covered Opioid treatment program service:** 0% coinsurance for each service
- **Chemical dependency:** 100% coverage.

Emergency/urgent care services

- **In and out of area emergencies:** $50 copay, 100% coverage thereafter. Copay waived upon hospital admission. Worldwide coverage.
- **Urgent care:** $20 copay, 100% coverage thereafter.
- **Ambulance**: 100% coverage after $100 copay.

Health care services

There is a $3,000 out-of-pocket maximum expense for in-network health care services.

- **Preventive care:** 100% coverage.
- **Physician services:** 100% coverage after a $15 copay per visit.
- **Eye and hearing exams:** 100% coverage.
- **Hospital outpatient and surgery center:** 100% coverage.
- **Outpatient mental health services:** 100% coverage after a $15 copay per visit
- **Outpatient chemical dependency services:** 100% coverage after a $15 copay per visit.
- **Opioid Treatment Program:** $0 copay for each Medicare-covered opioid treatment program service.
- **Chiropractic services:** 100% coverage for Medicare-approved services. Must use a UCare Medicare Group affiliated chiropractor.
- **Physical, speech, and occupational therapy:** 100% coverage after a $15 copay per visit.
- **Home health care:** 100% coverage.

Prescriptions and Products

Prescription drugs: 30-day supply in the initial coverage and coverage gap phases

- **$10 copay** for generic drugs.
- **$30 copay** per prescription for preferred brand-name drugs.
- **$50 copay** per prescription for brand-name drugs.
- **$50 copay** for specialty drugs.
- SEGIP Retirees pay the appropriate copay while in donut hole or gap. SEGIP Retirees do NOT pay a greater percentage of drug costs while in the donut hole.
- Mail order or Preferred Pharmacy network which includes CVS/Target, Costco, Cub, Sam's Club/Walmart, and others: 90-day supply for 2 copays
- **Catastrophic prescription drug coverage:** If out-of-pocket expenses total $7,400 the prescription drug copay changes to the greater of 5% coinsurance or a $4.15 copay for generics (including brand drugs; treated as generic) and $10.35 for other drugs for the remainder of the year.
- $75 every six months for over-the-counter OTC items available by mail order, online or in-store. Purchase at participating retail locations.

Prosthetics and durable medical equipment

- 100% coverage for prosthetics.
- 80% coverage for durable medical equipment, including glucose monitors, test strips, and Lancets for people with diabetes. **Syringes and insulin are covered as prescription drugs.**
- 100% coverage for Part B diabetic supplies.
- Up to two TruHearing-branded hearing aids every year. Limited to TruHearing's Advanced and Premium hearing aids. Must see a TruHearing provider. $499 copay per aid for Advanced aids, $799 copay per aid for Premium Aids.
- $200 toward eyeglass frames and lenses once each calendar year.

Fitness Program

- One Pass Fitness Program®
- UCare health Club Savings Program

Comparison Chart for Senior Plans

2023 Benefit	BCBS Coordinated Plan	HP Medicare Group Solution	UCare Medicare Group
Extended Absence or Point of Service	Worldwide coverage	National coverage for up to 9 months and worldwide coverage for emergencies	Worldwide coverage for emergencies. May be outside the service area for up to 6 months.
Inpatient Admissions General Hospitalization	$200 deductible + 20% of the first $3000 ($600) = $800 per patient per calendar year	$100 copay per admission then 100% coverage	$100 copay per admission, then 100% coverage.
Emergency Services	After Medicare B annual deductible, 100% coverage	$50 copay, waived if admitted	$50 copay, waived if admitted
Out of Pocket Maximum	$800 inpatient, Medicare B deductible and 20% on hearing aids	$3,400	$3,000
Preventative care	100% Coverage (no deductible)	100% Coverage	100% Coverage
Eye & Hearing Exam	100% (no deductible) for one routine exam per year	100% Coverage	100% Coverage
Physicians Service	Medicare B deductible, then 100%	$15 copay, then 100% coverage	$15 copay, then 100% coverage
Hospital Outpatient and Surgery Center	After Medicare B annual deductible, 100% coverage	100% Coverage	100% Coverage
Outpatient Mental Health	After Medicare B annual deductible, 100% coverage	$15 copay or $7.50 copay for group then 100% Coverage	$15 copay per visit, then 100% coverage
Outpatient Chemical Dependency	After Medicare B annual deductible, 100% coverage	$15 copay, then 100% coverage	$15 copay per visit, then 100% coverage AND $0 copay for each Medicare-covered opioid treatment program service
Chiropractic	After Medicare B annual deductible, 100% coverage	$15 copay, then 100% coverage, subject to Medicare guidelines	100% Coverage for Medicare-approved services at UCare Medicare Group Chiropractor.
Physical Therapy	After Medicare B annual deductible, 100% coverage	$15 copay, then 100% coverage	100% coverage outpatient setting, after a $15 copay per visit
Occupational Therapy	After Medicare B annual deductible, 100% coverage	$15 copay, then 100% coverage	100% coverage outpatient setting, after a $15 copay per visit
Speech Therapy	After Medicare B annual deductible, 100% coverage	$15 copay, then 100% coverage	100% Coverage outpatient setting after $15 copay per visit
Home Health –skilled care meeting Medicare-approved guidelines	After Medicare B annual deductible, 100% coverage	100% Coverage	100% Coverage
30-day Prescriptions	Copay coverage thru the gap	Copay coverage thru the gap	Copay coverage thru the gap
30-day Prescriptions	$10 Generic	$10 Generic	$10 Generic
30-day Prescriptions	$30 Preferred Brand	$30 Preferred Brand	$30 Preferred Brand Name
30-day Prescriptions	$50 Brand Name	$50 Non-Preferred Brand	$50 Brand Name
30-day Prescriptions	$50 for Specialty drugs	$50 for Specialty drugs	$50 for Specialty drugs
30-day Prescriptions	25% for supplementary drugs	n/a	Supplemental Rx Covered
Mail Order Available	Yes	Yes	Yes
Prosthetics	100% after the annual Medicare B deductible	90% coverage	100% coverage
Durable Medical Equipment	100% after the annual Medicare B deductible	90% coverage	80% and 100% for Part B diabetic supplies
Hearing Aid	80% for hearing aids and accessories every 3-yrs any vendor (upgrades not covered)	$99 copay, $199 copay per aid for TruHearing Advanced Aids, $499 copay per aid for TruHearing	$499 copay per aid for TruHearing Advanced aids, $799 copay per aid for TruHearing Premium Aids.
Eyeglasses	eyewear discounts available	Eyewear discounts available. 100% coverage for eyeglasses after cataract	$200 allowance toward eyewear per year

Other information

Health Plan addresses and phone numbers

Plan administrator	Address	Phone Numbers
Minnesota Advantage Health Plan - BlueCross BlueShield, Coordinated Plan	BlueCross BlueShield of Minnesota P.O. Box 64560 St. Paul, MN 55164-9756 www.bluecrossmn.com/segip	(800) 262-0819 771 - TTY
Medicare Blue RX	www.YourMedicareSolutions.com	(877) 838-3827 711 - TTY
National PPO for Advantage - Blue Cross Blue Card	www.bluecrossmn.com/segip	(800) 810-2583
Minnesota Advantage Health Plan – HealthPartners	HealthPartners - Individuals MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 www.healthpartners.com/segip/	(952) 883-7900 (888) 343-4404 (952) 883-5127 - TTY
HealthPartners Medicare Group Solution	HealthPartners Attn: Riverview Membership Accounting MS 21103R P.O. Box 9463 Minneapolis, MN 55440-9463 www.healthpartners.com/segipmedicare	(952) 883-7373 (877) 816-9539 711 - TTY
National PPO for Advantage – HealthPartners	www.healthpartners.com/segip/	(888) 343-4404
Minnesota Advantage Health Plan – PreferredOne	PreferredOne Administrative Services 6105 Golden Hills Drive Golden Valley, MN 55416 www.preferredone.com/segip	(763) 847-4477 (800) 997-1750 (763) 847-4013 - TTY
National PPO for Advantage – PreferredOne	www.preferredone.com/segip/find-a-doctor	(763) 847-4477 (800) 997-1750
UCare Medicare Group	UCare Attn: Group UCare Medicare Group 500 Stinson Boulevard NE Minneapolis, MN 55413 Groupsales@ucare.org www.ucare.org	(612) 676-6900 (877) 598-6574 (612) 676-6810 - TTY (800) 688-2534 - TTY

Plan administrator	Address	Phone Numbers
CVS Caremark	CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 www.caremark.com	(844) 345-3234 (toll free)
Employee Insurance, State Employee Group Insurance Program **MMB**	MMB - Employee Insurance 400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155 mn.gov/mmb/segip	(651) 355-0100 (800) 664-3597
Medicare	www.Medicare.gov	(800) MEDICARE ((800) 633-4227) (877) 468-2048 TTY/TDD
Social Security	www.socialsecurity.gov	(800) 772-1213 (800) 325-0778

Exclusive Retiree WebEx Meetings

No pre-registration is required. contact SEGIP with any questions about these meetings.

Date	Time	Location
October 25, 2022	10:00 a.m. - 12:00 noon	WebEx
October 27, 2022	1:00 p.m. - 3:00 p.m.	WebEx
November 1, 2022	1:00 p.m. - 3:00 p.m.	WebEx
November 3, 2022	10:00 a.m. - 123:00 noon.	WebEx

Glossary

Advantage Value for Diabetes: A program that gives Minnesota Advantage Health Plan members diagnosed with diabetes access to reduced out-of-pocket costs for high-value medical and pharmacy services that are primarily for diabetes. Eligible medical services include physician office visits, dietitian office visits, diabetic retinal eye exams, lab tests, diabetic testing supplies, and pharmacist consults. Eligible pharmacy services include diabetic testing supplies as well as diabetes, hypertension, cholesterol, and depression medications.

Allowed amount: A set amount which an insurance company (often referred to as a plan) agrees to pay for a particular service or product provided by a doctor or health care provider. Under some plans, there may be a difference in the insurance company's allowed amount and the health care provider's fee for a particular service or product. In some of these cases, the insured person is responsible for paying the difference.

Brand name drugs: Prescription drugs that are sold under a trademarked brand name.

Certificate of Coverage: A document available to plan participants describing details of coverage. Insured plans call this a certificate of coverage and self-insured plans call this a summary of benefits.

Coinsurance: This is a percentage of the cost that is charged for certain services after the deductible has been paid. For example, a coinsurance level of 90% means that the member first pays the deductible, then the plan would pay 90% of the costs and the member would pay the remaining 10% of the costs. Once the employee costs reach the out-of-pocket limit, the plan would pay all costs for the rest of the plan year.

Copay: A flat dollar amount that is charged every time a service is provided. For example, under Advantage, members will be charged an office visit copay for most visits to the doctor's office. (Copays will not be charged for preventive care under Advantage, such as annual check-ups, etc.)

Creditable Coverage: Prescription drug coverage that is on average at least as good as the standard Medicare prescription drug coverage.

Deductible: An annual amount that must be paid each year before the plan starts paying for services. A "$400 deductible" for example, means that the member would pay the first $400 per year for certain services before the plan would begin covering the cost of services.

Dependent: Generally, the spouse/children of a covered person, as defined in the insurance policy or plan.

Effective date: The date on which an insurance policy or plan goes into effect and coverage begins.

Eligible expenses: Medical expenses for which a health plan will provide benefits. Some health providers may charge more than what an insurance plan considers eligible. In these cases, the covered person is responsible for paying the additional costs.

Family coverage: Health insurance for the retiree and one or more eligible dependents.

Formulary: A drug formulary is a listing of preferred high-quality, cost-effective drugs selected by a professional committee of physicians and pharmacists.

Generic: A drug that has been on the market long enough that no single manufacturer has an exclusive right to making and marketing.

In-network: The group of health care providers with whom a plan has contracted to provide services to members of the plan. Ask if a provider is still participating with your plan before you seek services because Networks may change during the year.

Medicare: The federal government's plan for paying certain hospital and medical expenses for those individuals who qualify and are enrolled in the Medicare plan, primarily those 65 and over. Benefits are provided regardless of income level. The program is government-subsidized and government-operated.

Medicare Part A: Medicare Part A, hospital insurance, generally pays for inpatient hospital services and post-hospital care.

Medicare Part B: Medicare Part B, Supplementary Medical Insurance, pays for medically necessary doctors' services, outpatient hospital services, and other medical services and supplies not covered by Part A.

Medicare Part D: Medicare Part D pays for prescription drug coverage for qualified Medicare beneficiaries.

Open Enrollment: The period during which participants in the State Employee Group Insurance Program have an opportunity to change from one plan to another.

Out-of-pocket costs: Fees or charges, in the form of deductibles, copays, and co-insurance, that an insured person is required to pay for products or services.

Outpatient services: Treatment that does not require hospitalization.

Plan administrator: An organization, such as an insurance company, that provides or administers programs that arrange for health, life, or other insurance services. All the companies that offer health, dental, life, and optional insurance plans through the State Employee Group Insurance Program may be called plan administrators. Examples are BlueCross BlueShield, HealthPartners, PreferredOne, and UCare Medicare Group.

Preferred brand: A group of brand-name drugs that the pharmacy benefit manager has selected to be the most effective for the price.

Preferred Provider Organization (PPO): A group of physicians and hospitals that contract with an insurance company to provide medical services.

Prescription Drug Plan (PDP): Private risk-bearing entity providing stand-alone Medicare Part D coverage.

Primary care: Routine medical care, normally provided in a doctor's office, by an internist, family or general practitioner, obstetrician-gynecologist, osteopath, or pediatrician.

Provider: A doctor, therapist, chiropractor, or other licensed medical practitioner. A participating provider is a provider who contracts with a plan to provide services to members of the health or dental insurance plan.

Summary of Benefits: A document available to plan participants describing details of coverage. Insured plans call this a certificate of coverage and self-insured plans call this a summary of benefits.

NOTICE OF INTENT TO COLLECT PRIVATE DATA

Minnesota Management and Budget (MMB) administers the State Employee Group Insurance Program (SEGIP). As an individual seeking to or participating in a group insurance program, you are asked to provide certain data for the purpose of the administration of group insurance benefits. This notice explains why MMB is requesting private data, how the data will be used, who has access to the data, and what may happen if you do not provide the requested data.

Use of Data. The data requested by MMB may be used for the following purposes:

- To determine eligibility for group insurance benefits
- To administer group insurance benefits
- As required by State and federal law, rule, or regulation

Right of Refusal. You are not required to provide any of the requested data, however, if you do not provide the requested data, group insurance program benefits may be denied or delayed for you, your spouse, or your dependent(s), as applicable.

Access to Data. The data that you provide may be shared with:

- Authorized personnel whose jobs reasonably require access
- Insurance and service providers, and other contracted vendors
- Any other person or entity authorized by federal or state law to access the data, including but not limited to the Office of the Legislative Auditor, the Minnesota Department of Health, the Minnesota Department of Commerce, or others as authorized by a court order

The parents of a minor may access private data about the minor unless there is a law, court order, or other legally binding instrument that blocks the parent from accessing the data.