Get ready

It’s time to shop for your new plan

MyRetiree Health

MEDICARE TRANSITION SERVICES
A non-governmental program

Dickinson

myretireehealth.net/retiree

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WELCOME TO YOUR ENROLLMENT GUIDE

Visit our website: myretireehealth.net/retiree
Create an account, then start shopping.

Or call **1-888-787-8945 (TTY: 711)**
Monday through Friday, 9 AM to 6 PM ET.

One of our licensed sales agents will be happy to walk you through your options. They'll help you find the best plan for your needs.

Get ready to enroll

This guide will help you prepare as you start shopping for your new health plan through the MyRetiree Health exchange. Shopping for health plans through an individual exchange may be different from what you're used to. But we're here to walk you through it, step by step.

Contents:

- Important dates to remember
- How the MyRetiree Health exchange works
- Types of health plans available
- Exploring the website
- How to shop for plans
- Frequently asked questions (FAQs)
- Worksheet: Compare plans
- Glossary of health plan terms

Important dates to remember

Today

Plan information is available, and you can enroll.

You have a Special Election Period (SEP) to choose another Medicare health or prescription drug plan. This SEP started October 1, 2024 and ends February 28, 2025.

If you want to choose a new plan for 2025 through the **MyRetiree Health Exchange**, you must do so by December 31, 2024 to assure that plan coverage will begin on January 1, 2025.

Seven to 10 days after your enrollment is approved

You'll get an enrollment confirmation from your new insurance carrier. This will include information about your plan and your ID card.

January 1, 2025

This is when your current group coverage will end. To avoid a gap in coverage, you should enroll in your new plan before this date.

How the MyRetiree Health exchange works

Today, you have group coverage offered through Dickinson College. Dickinson College selects the insurance carrier(s) and plan(s) you can enroll in. With MyRetiree Health, now the choice is yours. You decide what plan works best for you.

You'll find a variety of medical and prescription drug plan options on MyRetiree Health exchange. And you'll find educational videos and tools to help you choose a plan that best fits your needs.

MyRetiree health has licensed advisors to walk you through the process step by step. They're not paid to promote any plan or insurance carrier. They simply want to help you find the plan the best meets your health needs and budget.

MyRetiree health advisors can help you evaluate your plan options. Then when you're ready to enroll, they can help with that too.

On the MyRetiree Health exchange, you can:

Learn — watch educational videos, get healthy living tips, find information about how to plan for retirement and more.

Shop — see plan recommendations based on your needs.

Compare — view plans side by side to compare costs and coverage.

Estimate costs — use the payment estimator tool to calculate your medical costs for the year. This will help give you an idea on the type of health plan you'll need.

Enroll — once you pick your plan, you can sign up online or by phone.

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Enjoy more flexibility and freedom

You choose the plan that best suits you. Our payment estimator tool can give you an idea of the type of coverage you'll need. That way, you can choose your plan based on your unique health needs.

Types of health plans available

Knowing the basics beforehand can help make choosing a new health plan a little easier. You can shop for a new health plan on the MyRetiree Health exchange starting October 1, 2024.

What's Medicare?

Medicare is a federal health insurance program for:

- People age 65 or older
- Certain younger people with disabilities
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) or amyotrophic lateral sclerosis (ALS)

There are four parts to Medicare

The following information goes into more detail on each part.

Medicare Part A
(hospital coverage)

Part A typically covers:

- Inpatient care in a hospital
- Inpatient care in a skilled nursing facility (not custodial or long-term care)
- Home health care
- Hospice care

Medicare Part B
(medical coverage)

Part B typically covers:

- Preventive services
- Doctor's services
- Outpatient medical and surgical services and supplies
- Clinical lab tests
- Diabetes testing supplies

Medicare Part C
(Medicare Advantage plans)

Medicare Advantage plans usually offer more benefits than Original Medicare, but you may have to pay extra for these benefits. Extra coverage may include things like vision, hearing, dental, and other health and wellness programs.

With Medicare Advantage, most plans have physicians, nurses and social workers as part of their core clinical team, all dedicated to you. These providers help you achieve an optimal level of health through advocacy, coaching and care coordination.

In general, Medicare Advantage:

- Includes all Part A and Part B benefits and services
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Is run by Medicare-approved private insurance companies
- May include extra benefits and services not covered by Original Medicare

Medicare Advantage plans include:

- Health maintenance organizations (HMOs)
- Preferred provider organizations (PPOs)
- Private fee-for-service (PFFS) plans
- Medicare medical savings account (MSA) plans

You can get more details on these plans under “Medicare Advantage plans.”

Medicare Part D
(prescription drug coverage)

Part D coverage is available on its own or as part of many Medicare Advantage plans. These plans can also be added to:

- Original Medicare (Parts A and B)
- Medicare Supplement plans (Medigap)
- Some PFFS plans
- Medicare MSA plans
- Some Medicare cost plans

Types of Medicare plans

Let's take a look at the types of Medicare plans that may be available on the MyRetiree Health exchange.

Medicare Advantage plans

Medicare Parts A and B only cover so much. That's where Medicare Advantage plans come in. Depending on the plan, Medicare Advantage plans can help you pay for other things like eyewear, hearing aids, emergency medical care outside the U.S. and more. You must be enrolled in Medicare Parts A and B to enroll in a Medicare Advantage plan.

Here are the most common types of Medicare Advantage plans:

- **HMO plans** — These plans provide coverage through a network of doctors and hospitals. Typically, you must use network providers unless it's an emergency. If you don't, your care may not be covered.
- **PPO plans** — These plans provide coverage through a network of doctors and hospitals. In a PPO plan, you can see a doctor in or out of network. Typically, it costs more to get care out of network.
- **HMO point-of-service (HMO POS) plans** — These plans provide coverage through a network of doctors and hospitals. You may be able to see a doctor out of the network for some services. The POS option provides more choice and flexibility. But some services aren't available outside the network of contracted providers.

Medicare Supplement (Medigap) plans

A Medicare Supplement (Medigap) plan can help you pay for some of the health care costs not covered by Original Medicare (Parts A and B). This includes copayments, coinsurance and deductibles.

Here are some important things to know about Medicare Supplement plans:

- You must be enrolled in Medicare Parts A and B to enroll in this plan
- Medicare Supplement plans are given plan letters to differentiate them, for example Plan C
- Coverage for each plan letter is the same nationwide (except in Massachusetts, Minnesota, and Wisconsin). This means you'll get the same benefits for each plan letter no matter what state you live in.
- Medicare Supplement plans don't cover Prescription Drugs
- Enrollment in a Medicare Supplement plan is subject to underwriting. There can be exceptions if you enroll when you're first eligible for Medicare or if your former employer stops providing you group retiree coverage.

Prescription Drug Plans

Medicare Prescription Drug Plans (Part D) are often referred to as PDPs. Medicare PDPs have a group — or network — of pharmacies. The plans contract with these pharmacies to accept what the plan covers and pays.

You can buy a Medicare PDP in two ways:

1. As part of a Medicare Advantage plan that includes prescription drug coverage (MAPD). If you enroll in an MAPD plan, you typically only pay one premium that includes your medical and prescription drug coverage.

2. As a stand-alone Medicare PDP. You'll typically pay a monthly premium for your prescription drug coverage. Your premium may also vary based on your income. You pay this in addition to the Part B premium.

If you don't sign up for a Medicare Part D prescription drug plan when you're first eligible, you may need to pay a late enrollment penalty (LEP). The LEP is an amount added to your Medicare Part D monthly premium. The amount varies based on how long you went without Part D or creditable prescription drug coverage.

Income-Related Monthly Adjustment Amount (IRMAA) is an extra amount charged by Medicare Part B and Part D to those with higher incomes. It affects less than five percent of people with Medicare. The Social Security Administration (SSA) uses your income tax information from two years ago to determine if you owe an IRMAA in addition to your monthly premium.

Exploring the website

The MyRetiree Health exchange website makes it easy for you to understand your options. You can now log in to the website and start shopping for your new health plan. The first time you visit the website, you'll need to create an account.

Important note: Each Medicare-eligible family member will need to create their own account. This means each person will have their own login and password.

How to create an account

Step 1: Go to **myretireehealth.net/retiree**.

Step 2: Select "**create a new account**" and follow the prompts.

Step 3: Now you're registered. Next, you can start shopping for your health plan.

We're here to help if you're having trouble creating your account.

Give us a call at **1-888-787-8945 (TTY: 711)**, Monday through Friday, 9 a.m. – 6 p.m. ET.

Once you log in

After you log in, you'll be taken to the homepage of the website. From here, you can:

- View your account information
- Explore our gallery of videos that cover topics related to managing your health

Learn more about our easy-to-use tools

These tools can help you make informed decisions about your health care needs. They can also give you an estimate of what your annual costs could be for each plan. These tools are available to you once you log in to our retiree benefits website.

Out-of-pocket estimate

You can begin to get an idea of what each plan will cost you with this tool. It starts by asking you simple, confidential questions about your expected medical needs. Things like how many primary care visits, specialist visits or surgeries you anticipate this year. Then, it takes the costs of the premiums, deductibles, copays and coinsurance for each plan and compares them to how you answered the questions. Your estimated costs are then organized and displayed for each plan.

Rx lookup

With this tool, you can look up any medicine and see if it's covered under each plan. You can even search for a pharmacy to get your prescriptions filled. And, if you prefer mail-order pharmacy instead, there's an option for that. Based on your medicines and selections, this tool gives you an estimate of what you can expect to pay for your prescriptions under each plan.

Provider search

Making sure your doctors are in your network is important. Use the provider search tool to find out if your doctor is in network for a plan. And it's not just your doctors you can search for. You can find in-network specialists, hospitals, pharmacies and other health care facilities.

Our goal is to equip you with the knowledge you need to choose the health plan that's right for you. Once you're ready to start shopping for your plan, follow the instructions on the next page.

How to shop for plans

Step 1: Once you're logged in, click "Start shopping now" and follow the prompts. You'll be asked some questions to determine the plans available to you.

Step 2: Next, you'll see the types of plans available to you. From here, you can explore your plan options by clicking on "Details" in each plan type section.

Step 3: Find plans available in your area, and identify which plans may be best for you based on your personal needs.

- See if your prescriptions are covered. See if your doctors and pharmacies are in network.
- Use our estimator tool to calculate your annual medical and prescription drug costs for each plan you're considering. The tool lets you do this based on your expected health care needs.
- Look at plans side by side to compare costs and coverage. You can see the value of health care services covered in addition to premiums, deductibles and coinsurance for each plan.

Step 4: Once you've reviewed your plan options, select the plan you want to enroll in by clicking the "Enroll" button next to that plan.

If you want to enroll in more than one plan (for example, a separate medical plan and prescription drug plan), then you will need to repeat this process for each plan.*

Step 5: Want to enroll, ask questions or get help with comparing plans by phone? Just call **1-888-787-8945 (TTY: 711)**, Monday through Friday, 9 a.m. – 6 p.m. ET.

*Important note: Some Medicare Advantage plans include prescription drug coverage. If you enroll in a Medicare Advantage plan that doesn't include prescription drug coverage, you can't enroll in a separate prescription drug plan. If you select a Medicare Advantage plan, you won't be able to select any more Medicare plans. However, if you enroll in a Medicare Supplement (Medigap) plan instead of a Medicare Advantage plan, you can enroll in a separate prescription drug plan.

Frequently asked questions

Q. Where do I go to shop for my new individual plan?

A. You can shop for your new plan by logging in to **myretireehealth.net/retiree**.

Q. How many plans can I choose from on the MyRetiree Health exchange?

A. It depends on a number of factors such as where you live and your age. We're confident that you'll find a plan that fits your personal health needs and budget.

Q. Can my dependents enroll in a plan on the MyRetiree Health exchange?

A. Yes, your Medicare-eligible dependents are able to shop for and enroll in a plan on the MyRetiree Health exchange. Each person will select and enroll in their own plan.

Q. When does my current retiree coverage end?

A. January 1, 2025

Q. Is the MyRetiree Health exchange the same as the public exchange?

A. No, the MyRetiree Health exchange isn't the same as the public exchange. The MyRetiree Health exchange is a private exchange only offered to retirees of companies that have chosen to be part of the MyRetiree Health exchange.

Q. Are the plans offered on the MyRetiree Health exchange the same as those offered on the public exchange?

A. Maybe. You may see some of the same plans on the MyRetiree Health exchange and the public exchange. But there may also be plans available to you on the MyRetiree Health exchange that are not offered on the public exchange.

Q. Who can I call if I have questions?

A. Help is just a call away. Call us at **1-888-787-8945 (TTY: 711)**, Monday through Friday, 9 a.m. – 6 p.m. ET.

Worksheet: Compare plans

When you go to **myretireehealth.net/retiree**, you can use this worksheet to help you compare the important details for each of the plans you're considering.

	Example	
Plan name/ type	ABC PPO	
Deductible	$3,000 individual/ $6,000 family	
Coinsurance	20%	
Out of pocket	$10,000	
Primary doctor office visit	$25 copay	
Specialist	$40 copay	
Emergency room	$500 copay	
Other notes		

Worksheet
Compare plans, continued

Plan name/ type		
Deductible		
Coinsurance		
Out of pocket		
Primary doctor office visit		
Specialist		
Emergency room		
Other notes		

Glossary of health plan terms

Benefits

The services and expenses covered by the plans offered.

Carrier

The insurance company.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20 percent) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost sharing

The share of costs covered by your insurance that you pay out of your own pocket. This generally includes deductibles, coinsurance and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers or the costs for non-covered services.

Deductible

This is what you pay for covered services before your plan starts to pay.

Dependent

A family member, as defined by the health plan, who is eligible for coverage (for example, a spouse or dependent child of the individual who is initially offered coverage).

Drug formulary

A restricted list of prescription medicines that are chosen for use in specific treatments and dispensed through pharmacies. Drugs that aren't included in the drug formulary may be covered by your plan under a special exception or at a higher cost.

Effective date

The date on which an insurance policy or bond goes into effect and from which protection is furnished.

End-stage renal disease (ESRD)

The stage of kidney impairment that's irreversible, is permanent and requires dialysis or a kidney transplant to maintain life. ESRD patients are eligible for Social Security payments if found to be disabled.

In network

Characteristic of medical care or benefits for medical care received from a health care provider who is a contracted participant in a specific carrier's health maintenance organization (HMO) or point-of-service (POS) program.

Lifetime maximum

The most a plan will pay in claims per covered person for his or her lifetime. Some plans have a lifetime maximum; others don't.

Medicare

The health insurance program for the aged, the disabled and individuals with ESRD under Title XVIII of the Social Security Act, as amended. Part A, hospital insurance, provides for inpatient hospital services. Part B, supplementary medical insurance, pays for medically necessary doctors' services, outpatient hospital services and a number of other medical services and supplies not covered by Part A.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out of network

Characteristic of medical care or medical benefits received from a health care provider who is not a contracted participant in the specific HMO or POS program to which the patient belongs.

Out-of-pocket costs

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges or health care that your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Out-of-pocket maximum

This is the limit to what you will pay in a plan year for covered medical expenses.

Preferred provider organization (PPO)

A managed care plan in which you use doctors, hospitals and providers that belong to the network. You can use doctors, hospitals and providers outside the network for an additional cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription drugs

Drugs and medicines that, by law, require a prescription.

Primary care

Routine medical care normally provided in a doctor's office. This professional care and related services are administered by an internist, a family practitioner or a pediatrician, or, in some cases, an obstetrician/gynecologist in an ambulatory setting with referral to secondary care specialists as necessary.

Primary care physician (PCP)

A physician (doctor of medicine [MD] or doctor of osteopathic medicine [DO]) who directly provides or coordinates a range of health care services for a patient.

Provider

A physician (MD or DO), health care professional or health care facility licensed, certified or accredited as required by state law.

Rx

A commonly used abbreviation for a prescription or pharmacy benefit.

Service areas

Because HMOs, POS plans and PPOs involve networks of physicians, they typically define specific service areas to ensure that covered individuals have a range of network doctors available to them. The service areas may be represented as specific counties, cities or ZIP code.

Specialist

A physician specialist focuses on a special area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A nonphysician specialist is a provider who has more training in a specific area of health care.

Star Ratings

Medicare uses a Star Rating System to measure how well Medicare Advantage plans and Prescription Drug Plans (Part D) perform. Medicare scores how well plans did in several categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with 5 being the highest and 1 being the lowest score. Medicare assigns plans one overall star rating to summarize the plan's performance as a whole.

Notes

Notes

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