2025 HealthPartners® Retiree National Choice (PDP) Change Form

If you want to switch your HealthPartners® Retiree National Choice plan, please complete and return this form to HealthPartners by the last day of the month **before** the month you want your coverage to change. **Your change will be effective the first of the month following receipt of this form by HealthPartners.** If you don't want to change from your current coverage, you don't need to complete this form.

Choose ONE option:

- ❒ HealthPartners® Retiree National Choice Emeriti Plan 1 ($340.70 per month)
- ❒ HealthPartners® Retiree National Choice Emeriti Plan 2 ($262.10 per month)
- ❒ HealthPartners® Retiree National Choice Emeriti Plan 3 ($215.20 per month)

See the back of this form for details of the differences between the plans or refer to your Summary of Benefits.

Send the completed, signed and dated form to HealthPartners in the enclosed self-addressed stamped envelope.

I agree to this change and understand the effective date will be the first of the month following receipt of the form.

Release of Information: By joining this Prescription Drug Plan, I acknowledge that the Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that HealthPartners will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I've read and understand the contents of this application. If signed by an authorized individual (as described above) this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

(SIGN here) ____ Date ____________________
(Enrollee or authorized representative)

Name **(print)** ______________________________ Member ID Number ________________________

If you are the authorized representative, you must sign above and provide the following information:

Name ________________________________ Relationship to Enrollee ________________________

Address ____

City______________________ State____ ZIP code_______ Phone Number (____)______________________

If you have any questions or concerns, please contact Emeriti at **866- EMERITI** (**866-363-7484**).

HealthPartners Use Only:		
Entered By:	Effective Date:	IC#

Flip the page for a partial list of benefit differences for your plan options. See your Summary of Benefits for more detail.

Benefit/Service	Plan 1	Plan 2	Plan 3
Lifetime maximum	Unlimited	Unlimited	Unlimited
Annual deductible	$100	$150	$200
Monthly premium	$340.70	$262.10	$215.20
Annual out-of-pocket maximum	$1,750 (Medical only)	$3,000 (Medical only)	$5,000 (Medical only)
Office Visits	**You pay**	**You pay**	**You pay**
Routine physical, eye and hearing exams	$0	$0	$0
Immunizations	$0	$0	$0
For illness or injury	$15 Primary/$30 Specialty	$20 Primary/$40 Specialty	$25 Primary/$45 Specialty
Chiropractic care	$30 copay	$40 copay	$45 copay
Mental health care	$15 copay	$20 copay	$25 copay
Podiatry	$30 copay	$40 copay	$45 copay
E-visits	$0	$0	$0
Inpatient Hospital Care	**You pay**	**You pay**	**You pay**
For illness or injury (in U.S.)	$100 copay	$200 copay	$500 copay
Mental health care	$100 copay	$200 copay	$500 copay
Chemical health care	$100 copay	$200 copay	$500 copay
Skilled nursing facility	$0	$0	$0
Emergency Care (in U.S.)	**You pay**	**You pay**	**You pay**
Emergency room	$50 copay	$50 copay	$100 copay
Urgently needed care	$30 copay	$40 copay	$50 copay
Ambulance	$0	10% of the cost	20% of the cost
Outpatient Medical Services and Supplies	**You pay**	**You pay**	**You pay**
Physical/occupational therapy	$0	$15 copay	$50 copay
Speech/language therapy	$30 copay	$40 copay	$50 copay
Durable medical equipment	10% of the cost	10% of the cost	20% of the cost
Prosthetics	10% of the cost	10% of the cost	20% of the cost
Diabetes supplies	10% of the cost	10% of the cost	20% of the cost
Diagnostic test, radiology, lab services	$0	$0	20% of the cost
Drug Benefit (30-day supply)	**You pay**	**You pay**	**You pay**
Deductible (applies to preferred brand, non-preferred brand and specialty drugs)	$150	$150	$150
Preferred generic drugs	$10 copay	$10 copay	$15 copay
Generic drugs	$10 copay	$15 copay	$20 copay
Preferred brand drugs	$20 copay	$45 copay	$50 copay
Non-preferred brand drugs	$40 copay	$65 copay	$90 copay
Specialty drugs	25% of the cost	25% of the cost	33% of the cost

This information is not a complete description of benefits. Call **952-883-7428** or **866-993-7428** (TTY: **711**) for more information.