myBenefitsMentor®
Frequently Asked Questions

1. **How can I access myBenefitsMentor®?**

   myBenefitsMentor® is available in Employee Self-Service through my.delaware.gov for active State of Delaware employees. Delaware Transit Corporation employees can assess the tool through my.delaware.gov. State of Delaware non-Medicare pensioners retired and enrolled as a pensioner in a non-Medicare health plan as of December 31, 2023, can access the tool at delawarepensions.com or the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits (*Navigation*: Select your Group > Enrollment > myBenefitsMentor).

2. **When is myBenefitsMentor® available for me to use?**

   myBenefitsMentor® is available to active State of Delaware employees, Delaware Transit Corporation employees and non-Medicare pensioners beginning April 15, 2024. Access to the tool is limited to State of Delaware non-Medicare pensioners retired and enrolled as a pensioner in a non-Medicare State of Delaware health plan as of December 31, 2023.

3. **I have accessed myBenefitsMentor®, added dependents in Step 2 – Choose a Health Plan and saved the changes; however, when I go back into the tool, the dependents I added previously are gone. Is there a way to retain dependents that I add so that I do not need to re-enter them each time I access the tool?**

   The myBenefitsMentor® online tool will always reset to the information provided from your health plan and prescription plan which includes enrollment and claims paid as of December 31, 2023. If you are a State of Delaware employee who was not enrolled in a health plan through the State Group Health Insurance Plan (GHIP) as of December 31, 2023, you will have to reenter information for your family members each time you access the tool.

4. **I am a State of Delaware school district employee and I receive Flex credits to offset my health premiums. I have accessed myBenefitsMentor® and my 2023 Year to Date and 2022 – 2023 premiums do not appear to be reduced by the amount of my Flex credit offset. Why not?**

   Flex credits received by a school district or charter school employee to reduce their employee premiums for healthcare are not reflected in the Premiums Paid By You portion of the Total Healthcare Costs for 2023 Year to Date or 2022 – 2023 Total Costs or the Yearly Premiums in the plan choices and enrollment guides.

5. **I have accessed myBenefitsMentor® and my most recent claims costs don't seem to be included in my summary. Why not?**

   Your information displayed in myBenefitsMentor® is updated based on paid medical and prescription claims data received from your health plan and prescription plan, through December 31, 2023. In order to help you understand your historic healthcare costs, we have included medical and prescription claims history from January 1, 2023 through December 31, 2023.

6. **I have accessed myBenefitsMentor® and the summary cost and services information is inaccurate or unfamiliar. What should I do?**

   Your myBenefitsMentor® information is populated based on the information sent by your health plan and prescription plan, through December 31, 2023. If you have access to more recent information through your health plan portal or explanation of benefits statements you've received, it might be

useful to review those sources to supplement your myBenefitsMentor® experience. If you know your approximate out-of-pocket expenses over the most recent 12 months, you can still use that information as a starting point for estimating your expenses for next year.

7. **I have accessed myBenefitsMentor® and the summary cost and services information and it is displaying zero totals for either costs, services, or both. Why is there no information showing for me and my family?**

   Your myBenefitsMentor® information is populated based on the information sent by your health plan and prescription plan, through December 31, 2023. There are, however, a number of situations that can result in showing zero dollars or services for the period of time on the report:

   - You had no health or prescription drug claims paid
   - You had paid claims, but no out-of-pocket expenses
   - You had claims, but they were not paid in time for us to receive information about them
   - We did not have access to your paid claims information
   - You are a benefit-eligible State of Delaware employee but you are enrolled in a health plan through the State Group Health Plan as a spouse or dependent of a benefit-eligible State of Delaware employee or non-Medicare pensioner. If that is the case, your summary costs and services will be displayed on the information for the person who carries you on their plan.

8. **On my Healthcare History page, myBenefitsMentor® lists a Preventive Visits category that shows $75 in out-of-pocket costs. Why do I have preventive costs when preventive care is covered at 100% under my health plan?**

   This situation can occur when an individual receives preventive services that fall outside of the preventive guidelines for your age, health and family history. It is important to review the preventive guidelines for your health plan to know what services are covered at 100% by the plan with no out-of-pocket costs to the member. The Highmark Delaware and Aetna covered preventive services can be found at https://dhr.delaware.gov/benefits/preventive-care/index.shtml.

9. **On my Healthcare History page, myBenefitsMentor® lists a Hospital Admissions category that shows $125 in out-of-pocket costs. Why do I have hospital costs when I was never admitted to the hospital?**

   This situation can occur when an individual has services that fall into the inpatient category. For example, being held for observation but the individual was not admitted. Depending on the types of claims submitted during this type of experience, myBenefitsMentor® may not consider these services as hospital “admissions.” So the “Services Used” column may display 0 while the “Cost” column may be populated with costs associated with the hospital services.

10. **Why doesn’t myBenefitsMentor® include more detailed information on my family members? I would like to see more detailed information on my dependents’ healthcare information.**

    Due to HIPAA regulations and the strict privacy policies of Merative, dependent information can only be included at a family summary level. If you want to see more detailed information on your dependents’ healthcare claims you can check on your health plan’s website or call them directly to see what information they can provide.

11. How does myBenefitsMentor® make adjustments in my estimated healthcare spending if I or my family members add new or planned surgeries?

We take the services and/or conditions that you add in the online solution and using your mailing address information, apply an estimated allowed amount for your area for each service or condition and adjust your healthcare spending from the last year. A similar adjustment can also be made by changing the level of care in the drop down for you and each family member. There are three different levels of care – preventive care, basic care, and additional care – and a user with historical experience will be assigned to one of these levels based on their healthcare spending from last year. If you are undecided, there is a helpful video that explains levels of care in more detail.

12. Does myBenefitsMentor® allow me to add any service and/or condition in my estimated healthcare spending?

The services and/or conditions which can be added to your estimated healthcare spending are limited to ones which the online solution can accurately estimate using available market data and based upon your mailing address information. Services and/or conditions which are not easy to estimate because the costs can range widely based upon diagnosis or severity, will not be available.

13. Does myBenefitsMentor® allow me to add prescription medications in my estimated healthcare spending?

Prescription medications cannot be added as a service or condition. If you add a service and/or condition, prescription costs will be included in the condition based estimate. If an added service and/or condition is one which requires a patient to take certain medications on a long term basis (e.g., cholesterol maintenance medication after a cardiac catheterization) the long-term costs are not added to your estimated healthcare spending until evident in your historical claims activity.

14. The cost of prescription medications available to me and my family through the State of Delaware's CVS Caremark prescription plan are always based upon a fixed copay and only vary based upon the medication's quantity (30 days or less or 90 days) and if the medication is a generic or brand. The myBenefitsMentor® tool includes high and low prescriptions in the list of healthcare services I might expect next year. What is the difference between high and low prescriptions?

The reference to high and low prescriptions is intended to help you understand that some prescription medications are very expensive as they are treating complex and serious conditions while other medications, like generic medications may be inexpensive. The cost to you when enrolled in a State of Delaware non-Medicare health plan and obtaining prescription coverage under your CVS Caremark prescription benefit is always a fixed copay because the State of Delaware is paying the remaining cost of the prescription medications obtained by you or your family members.

15. Why are my Total Estimated Costs in the portion of the tool where I can estimate my healthcare expenses for next year different from my estimated Out-of-Pocket Expenses and Total Cost in other portions of the online tool?

Total estimated costs are intended to show you the total cost that both you and the State of Delaware are paying for estimated healthcare you and your family may receive next year. The total estimated costs include your out-of-pocket expenses (copays and/or co-insurance) as well as the amount that is paid for claims submitted under your healthcare and prescription plans by your doctors, other providers and for prescription medications received by you and your family members. Total healthcare costs in other areas of the online tool represent what is paid by you and your employer (State) in premiums plus your out-of-pocket costs.

16. How does myBenefitsMentor® determine what is listed under "WHAT YOU MIGHT EXPECT" and "TOTAL ESTIMATED COSTS" in the portion of the tool where I can estimate my healthcare expenses for next year?

Total Estimated Costs represent both your estimated out-of-pocket expenses and what your healthcare and prescription plans will pay (claims). Services, conditions and prescription medications listed are intended to represent an average example for each level.

17. How are you calculating my Estimated Out-of-Pocket Expenses for comparing my plan options?

We take your medical and prescription drug claims paid from January 1, 2023 through December 31, 2023 as a starting point. If we don't have enough claims history for a person, we use national average cost data. For users of our online solution we can adjust these amounts based on information you have provided during your use of the tool (changes in dependents, other major medical services, and your assessment of healthcare need levels).

We then model what your estimated total costs would be for each plan to help you understand how the plans compare. We start with the annual premium amounts (payroll or pension deductions) for each plan, and add your estimated out-of-pocket costs for next year. To estimate the out-of-pocket expenses, we use your expected healthcare costs and apply detailed information we know about each plan (copayments, deductibles, coinsurance, and out-of-pocket maximum limits).

18. I am enrolled in the CDH Gold Plan and my Health Reimbursement Account (HRA) pays most of my out-of-pocket expenses. Why do my historical healthcare expenses show that I had out-of-pocket expenses?

The myBenefitsMentor® tool does not reduce your out-of-pocket expenses by any HRA funds you may have available to you during the plan year.

19. I have twin children but cannot see claims for both of them. Why not?

All of the claims for your same sex multiples are in myBenefitsMentor® but associated with one dependent in the online tool. The plan modeling is not affected because all available claims for the

family are still included – just attributed to a single child's name. Be sure to add the other member who is missing to properly reflect your family Coverage Tier.

20. Is my personal information shared with my employer or the State Group Health Insurance Plan (GHIP)?

No. myBenefitsMentor® is made available to you by Merative, a recognized and trusted healthcare information steward. In providing the myBenefitsMentor® solution, your personal health information is not shared with your employer or the State Group Health Insurance Plan (GHIP).

21. How is my data used?

Your healthcare claims information is used to provide you with a useful summary of your historic healthcare costs and services. The Statewide Benefits Office may receive summary reports that are used to determine the value of myBenefitsMentor® to your enrollment decision-making process, but we do not share your personal information with your employer, the State Group Health Insurance Plan (GHIP) or the Statewide Benefits Office as part of the myBenefitsMentor® process.

22. Who is Merative and why do they have access to my healthcare spending information?

Merative is the State Group Health Insurance Plan's (GHIP) current vendor for healthcare database and analytic services. Merative stores medical and prescription claims and cost data on the 129,000 members of the GHIP. In addition, Merative provides analytical support to assist the State of Delaware and the State Employee Benefits Committee (SEBC) in 1) reducing and managing costs, 2) providing clinical decision support (for example, the myBenefitsMentor® tool), 3) cutting down on fraud and abuse, 4) improving care coordination and 5) improving member wellness. The State of Delaware and the SEBC do not have access to personal healthcare information through Merative and Merative is required to conform to all privacy and confidentiality standards. Data analytics are a necessary service to manage large self-insured health plans and have been utilized by the SEBC since 2005.

23. I am interested in learning more about the health plans that are available to me and my family during this Open Enrollment period. Where can I go to obtain information?

Go to de.gov/statewidebenefits (*Navigation*: Select your group > Enrollment).

24. I am experiencing issues accessing the myBenefitsMentor® online tool. Who do I contact for assistance?

If you meet the criteria defined in Question #1 and are receiving an error message and cannot access the online tool, please contact the SBO Customer Service Team anytime Monday through Friday, 8 am to 4:30 pm at 1-800-489-8933 or benefits@delaware.gov for further assistance.