HEALTH PLAN OPTIONS FOR NON-MEDICARE ELIGIBLE RETIREES

Kathleen D. Rowe
Doyle Rowe LTD
November 22, 2016

DRL
Doyle Rowe LTD

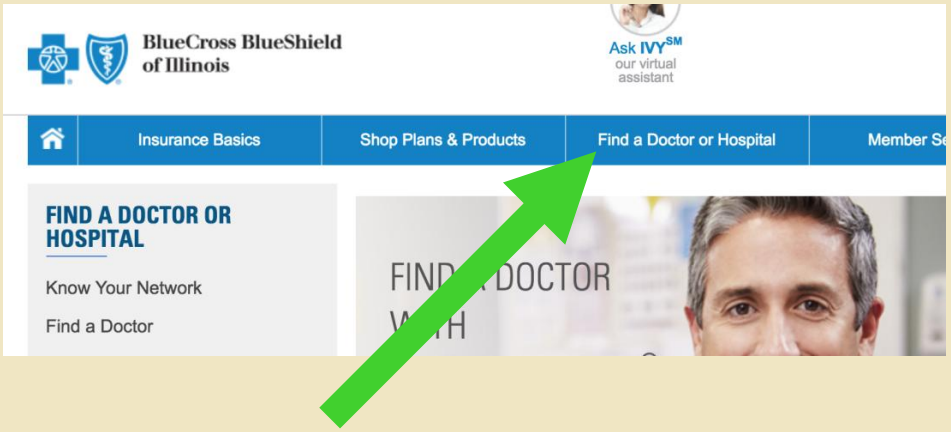
NON-MEDICARE RETIREES

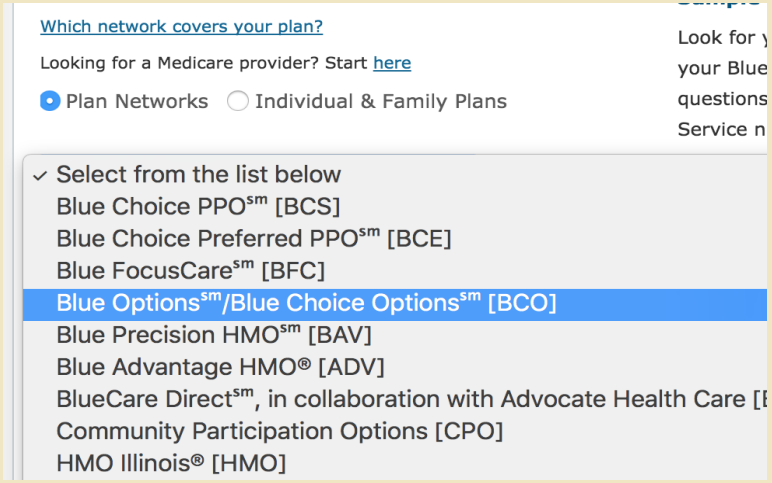
- Blue Cross and Blue Shield of Illinois is offering two group plan options for your consideration.
  - Annuitants must enroll by December 15, 2016.
    - Member authorization must be submitted to Fund office if monthly premium is to be deducted from annuity payment.

DRL
Doyle Rowe LTD

NON-MEDICARE RETIREES GROUP PLANS

- **Group Option A providers mirror the provider network you have today.**
- **Group Option B also includes these providers; some are considered Tier One providers, others are Tier Two**
- **To determine whether your providers are Tier One or Tier 2 visit www.bcbsil.com and click on Find a Doctor or Hospital**

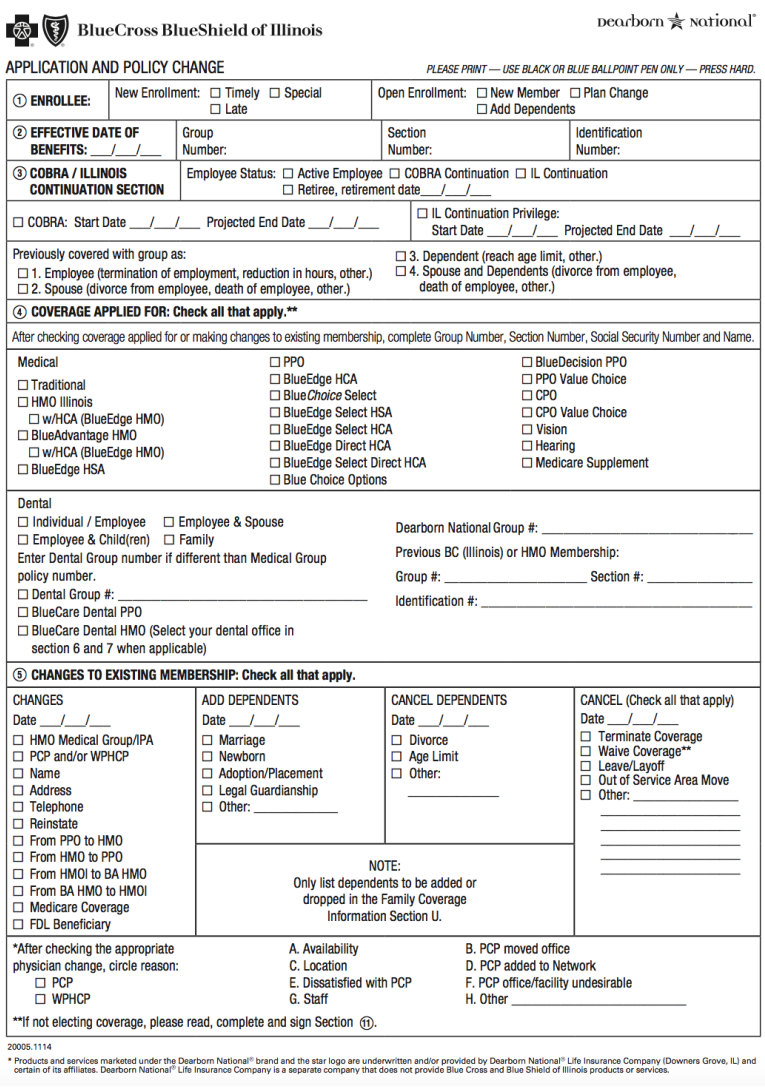




Schedule of Benefits	PPO Plan		Blue Choice Options℠		
Provider Network	PPO		Blue Choice OPT℠ (Tier 1); PPO (Tier 2); Out of Network (Tier 3)		
Single Premium	$1,466		$1,295		
Couple Premium	$2,610		$2,305		
Family Premium	$3,622		$3,198		
Lifetime Maximum Amount	Unlimited		Unlimited		
	In Network	Out of Network	Tier 1	Tier 2	Tier 3
Individual Deductible	$427	$998	$1,545	$2,545	$3,545
Family Deductible	$1,285	$2,995	$4,120	$5,120	$6,120
Individual Out-of-Pocket Limit	$2,497	$4,989	$6,180	$7,180	$8,180
Family Out-of-Pocket Limit	$4,992	$9,979	$12,360	$13,360	$14,360
In-Network Coinsurance	90% after deductible is met	70% after deductible is met	90% after deductible is met	75% after deductible is met	50% after deductible is met
Preventive Services	$0	Not covered	$0	$0	Not covered
Primary Care Office Visit Copay	Subject to deductible and coinsurance		$20	$30	Subject to deductible and coinsurance
Specialist Services Office Visit Copay	Subject to deductible and coinsurance		$45	$55	Subject to deductible and coinsurance
Emergency Room Copay	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$258 then deductible and coinsurance	$258 then deductible and coinsurance	$258 then deductible and coinsurance
Emergency Room Coinsurance	90% after deductible is met		90% after deductible is met		
Inpatient Hospitalization	90%; subject to deductible and coinsurance	70%; subject to deductible and coinsurance	$250 then deductible and coinsurance	$250 then deductible and coinsurance	$350 then deductible and coinsurance
Outpatient Surgery	90%; subject to deductible and coinsurance	70%; subject to deductible and coinsurance	$200 then deductible and coinsurance	$200 then deductible and coinsurance	$300 then deductible and coinsurance
Prescription Drug Copays (generic drugs and formulary brand drugs)	$100 deductible applies and then applicable copayments		$100 deductible applies and then applicable copayments		
	Retail: 20% of the contracted cost for Generic 20% of the contracted cost for Formulary Brand Name 20% of the contracted cost plus $15 for non-formulary brand name drugs **Mail Order:** $27 Generic $71 Formulary Brand Name N/A Non-Formulary Brand Name	If you do not go to a network retail pharmacy, you pay the full amount when you pick up your prescription. You must then submit a receipt for reimbursement. The Plan will pay 60% of the Plan's cost, after you've met the deductible (if applicable). The formulary list does not apply to out-of-network pharmacies.	**Retail:** 20% of the contracted cost for Generic 20% of the contracted cost for Formulary Brand Name 20% of the contracted cost plus $15 for non-formulary brand name drugs **Mail Order:** $27 Generic $71 Formulary Brand Name N/A Non-Formulary Brand Name	If you do not go to a network retail pharmacy, you pay the full amount when you pick up your prescription. You must then submit a receipt for reimbursement. The Plan will pay 60% of the Plan's cost, after you've met the deductible (if applicable). The formulary list does not apply to out-of-network pharmacies.	

* **For retirees who are not eligible for Medicare and Retired on or after August 23, 1989.** Effective 1/1/17 to 12/31/17.
** Tier 1 providers are located in Cook, DuPage, Will, Kane, McHenry, Lake, and Kankakee counties.

HOW TO COMPLETE THE GROUP APPLICATION



BlueCross BlueShield of Illinois

Dearborn National

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① **ENROLLEE:**	New Enrollment: ☐ Timely ☐ Special ☐ Late	Open Enrollment: ☐ New Member ☐ Plan Change ☐ Add Dependents	
② **EFFECTIVE DATE OF BENEFITS:** ___/___/___	Group Number:	Section Number:	Identification Number:
③ **COBRA / ILLINOIS CONTINUATION SECTION**	Employee Status: ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___		
☐ COBRA: Start Date ___/___/___ Projected End Date ___/___/___		☐ IL Continuation Privilege: Start Date ___/___/___ Projected End Date ___/___/___	

Previously covered with group as:
☐ 1. Employee (termination of employment, reduction in hours, other.)
☐ 2. Spouse (divorce from employee, death of employee, other.)
☐ 3. Dependent (reach age limit, other.)
☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ **COVERAGE APPLIED FOR: Check all that apply.****

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

Medical
☐ Traditional
☐ HMO Illinois
☐ w/HCA (BlueEdge HMO)
☐ BlueAdvantage HMO
☐ w/HCA (BlueEdge HMO)
☐ BlueEdge HSA
☐ PPO
☐ BlueEdge HCA
☐ BlueChoice Select
☐ BlueEdge Select HSA
☐ BlueEdge Select HCA
☐ BlueEdge Direct HCA
☐ BlueEdge Select Direct HCA
☐ Blue Choice Options
☐ BlueDecision PPO
☐ PPO Value Choice
☐ CPO
☐ CPO Value Choice
☐ Vision
☐ Hearing
☐ Medicare Supplement

Dental
☐ Individual / Employee ☐ Employee & Spouse
☐ Employee & Child(ren) ☐ Family
Enter Dental Group number if different than Medical Group policy number.
☐ Dental Group #: _____
☐ BlueCare Dental PPO
☐ BlueCare Dental HMO (Select your dental office in section 6 and 7 when applicable)

Dearborn National Group #: _____
Previous BC (Illinois) or HMO Membership:
Group #: _____ Section #: _____
Identification #: _____

⑤ **CHANGES TO EXISTING MEMBERSHIP: Check all that apply.**

CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
Date ___/___/___	Date ___/___/___	Date ___/___/___	Date ___/___/___
☐ HMO Medical Group/IPA	☐ Marriage	☐ Divorce	☐ Terminate Coverage
☐ PCP and/or WPHCP	☐ Newborn	☐ Age Limit	☐ Waive Coverage**
☐ Name	☐ Adoption/Placement	☐ Other:	☐ Leave/Layoff
☐ Address	☐ Legal Guardianship	_____	☐ Out of Service Area Move
☐ Telephone	☐ Other: _____		☐ Other: _____
☐ Reinstate			_____
☐ From PPO to HMO			_____
☐ From HMO to PPO			_____
☐ From HMOI to BA HMO			_____
☐ From BA HMO to HMOI			_____
☐ Medicare Coverage			
☐ FDL Beneficiary			

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section U.

*After checking the appropriate physician change, circle reason:
☐ PCP
☐ WPHCP
A. Availability
C. Location
E. Dissatisfied with PCP
G. Staff
B. PCP moved office
D. PCP added to Network
F. PCP office/facility undesirable
H. Other _____

**If not electing coverage, please read, complete and sign Section ⑪.

20005.1114

⑥ **EMPLOYEE INFORMATION:**	Company Name:	
Last Name:	First Name:	Mid. Initial
E-Mail Address:	Cell Phone Number:	
Street Address:	Apt. No.:	
City:	State:	Zip:

Date of Birth: ___/___/___ Are You Eligible for Family Coverage: ☐ No ☐ Yes
Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
Gender: ☐ Male ☐ Female
Employee Social Security Number: _____ — _____ — _____
Employee Identification Number (if known): _____
Telephone No.: Bus.: (_____) _____ Home: (_____) _____ Date of Hire: ___/___/___
Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____
If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____
PCP #: _____ PCP Name: _____
WPHCP Medical Group/IPA#: _____ WPHCP Medical Group Name: _____
WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____
If CPO/CPO Value Choice: Network # CO: _____ If BlueCare Dental HMO: Office ID#: _____
Employment Status: ☐ Actively at Work ☐ Retired If retired, retirement date:_____ ☐ COBRA/IL Continuation

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Are you covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes
If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑦ **FAMILY COVERAGE INFORMATION:** List All Eligible Dependents.

⑦Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union ☐ Male ☐ Female Date of Birth: ___/___/___
Last Name (Only If Different): _____
First Name: _____ Social Security Number: _____ — _____ — _____
If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____
WPHCP Medical Group/IPA#: _____
PCP #: _____ PCP Name: _____
WPHCP Medical Group Name: _____
WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____
If BlueCare Dental HMO: Office ID#:_____

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes
If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

20005.1114

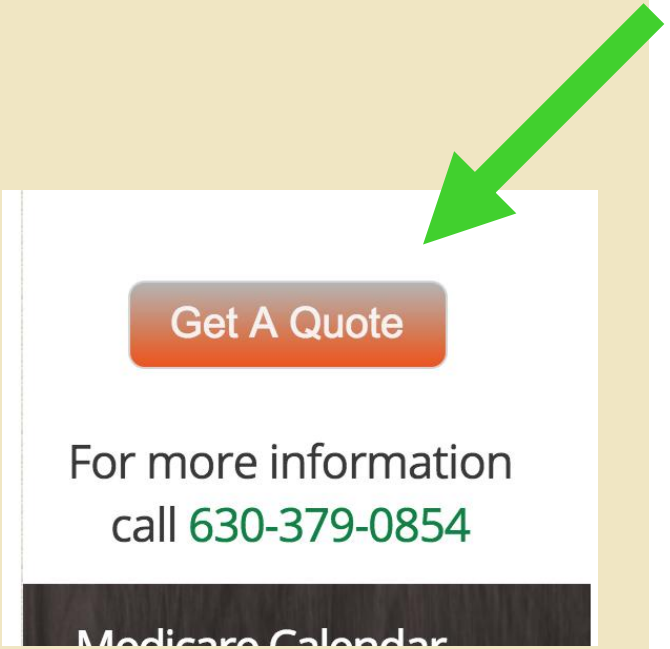
INDIVIDUAL PLANS

- There are a variety of Blue Cross and Blue Shield individual plan PPO and HMO options which you may want to consider
- There are approximately 20 plans to choose from falling into four categories:
  - Platinum, Gold, Silver or Bronze
- HMO plans are available under each “metallic” category and PPO options are available under the Gold, Silver and Bronze categories.

DRL
Doyle Rowe LTD

INDIVIDUAL PLANS CONTINUED

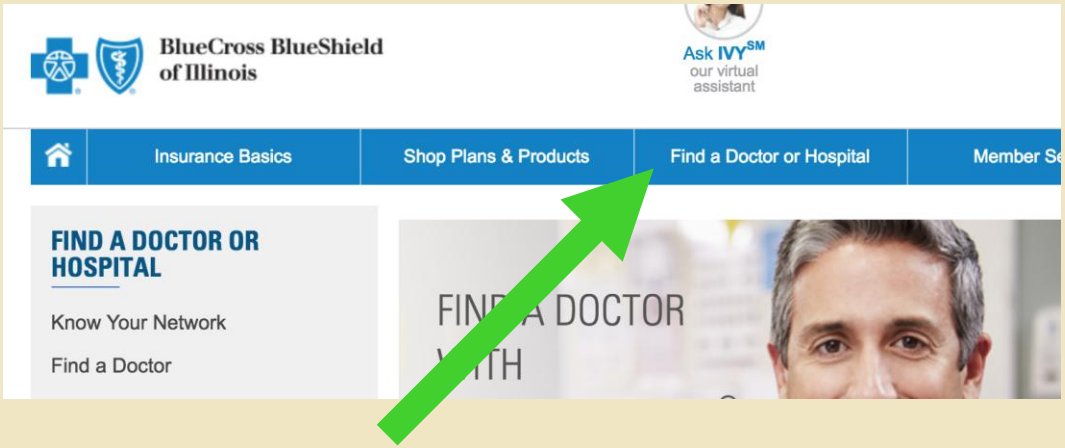
- To view your plan options visit www.doylerowe.com and click on *Learn More* under City of Chicago Annuitants then click on "Get A Quote."
- Next enter the requested information, zip code, county, date of birth, etc. and click on *Next.*
- Your plan options and pricing will be displayed. You will have the opportunity to check providers and determine if you are subsidy eligible.



DRL
Doyle Rowe LTD

INDIVIDUAL PLANS (CONTINUED)

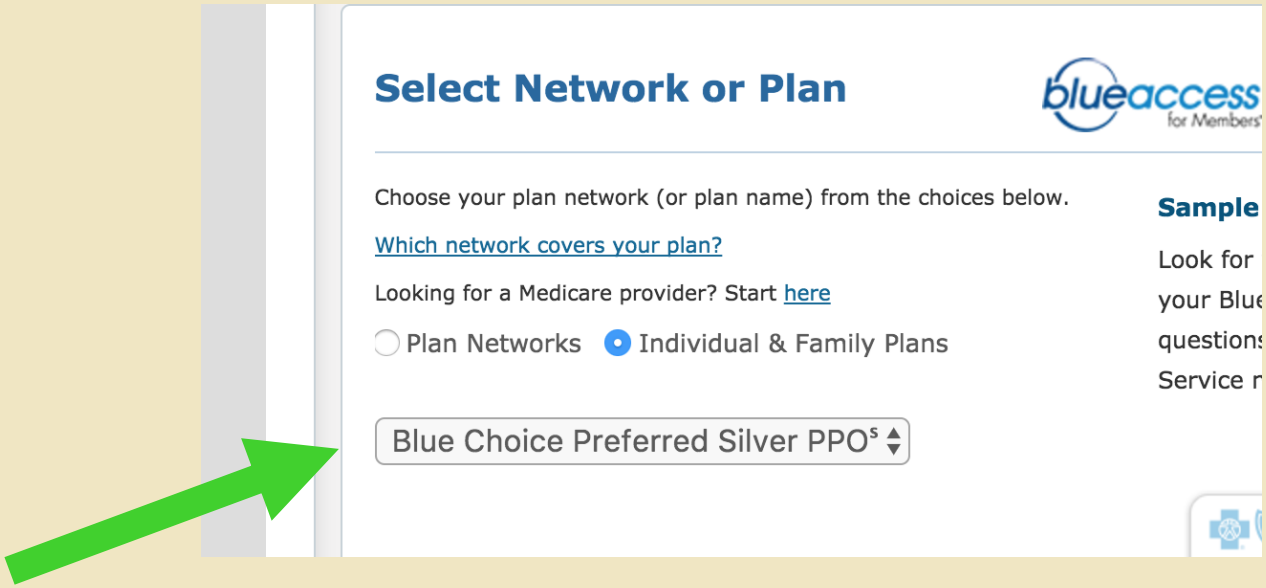
- **When considering the best choice for you and your family there are several things to consider:**
  - **Are my providers in the network?**
  - **<u>A PROVIDER MAY BE IN ONE BLUE CROSS AND BLUE SHIELD NETWORK AND NOT IN ANOTHER. IT IS VERY IMPORTANT THAT YOU DETERMINE IF YOUR PROVIDERS ARE IN THE NETWORK APPLICABLE TO THE PLAN YOU HAVE SELECTED.</u>**



DRL
Doyle Rowe LTD

INDIVIDUAL PLANS (CONTINUED)

- **To determine if your providers are in the plan you are interested in click on “check if my provider is in this network”, choose Individual and Family plans and select the applicable network.**



DRL
Doyle Rowe LTD

DO I QUALIFY FOR A SUBSIDY?

- Some individuals may qualify for an Affordable Care Act subsidy to assist with premium costs. Generally the guidelines are as follows:

Household Size	2017 Projected Modified Adjusted Gross Income
1	Less than $47,080.00
2	Less than $63,720.00
3	Less than $80,360.00
4	Less than $97,000.00

- You will have the opportunity to determine if you qualify for a subsidy by following the individual plan link

SAMPLE RATES

	Type/Ded/OOP/Coins/Copay/Rx?	Type/Ded/OOP/Coins/Copay/Rx?	Type/Ded/OOP/Coins/Copay/Rx?
Gender/Age/Smoker/Zip/Subsidy	AD/Gold HMO/$1750/$3500/20%/Y/Ded	Silver PPO/$3250/$6850/20%/Y/$0/$50	AD/Bronze HMO/$7000/$7150/50%/N/Ded
Female/58/Y/60126/No	$1,183.81	$1,078.29	611.02
Female/58/Y/60126/Yes	$950.81	$1,311.29	844.02
Male/60/N/60601/No	$991.57	$1,105.02	$797.39
Male/60/Y/60601/No	$1,252.31	$1,409.09	$882.93
Male/57/Y/60609/No	$1,237.07	$1,376.95	$862.24
Male/57/Y/60609/Yes	$963.37	$1,093.60	$616.24
Female/79/N/60060/No	$1,019.85	$1,159.35	$865.56
Female/79/N/60060/Yes	$531.85	$671.35	$239.11
Male/24/N/60657/No	$355.15	$421.09	$253.21
All rates are for illustrative purposes			

DRL
Doyle Rowe LTD

GROUP VS. INDIVIDUAL: HOW DO I DECIDE?

- Do you want the broadest network or are you comfortable with a narrower network? For example, Northwestern, Rush and University of Chicago providers are not part of any individual plan network.
- If your primary concern is being covered should a catastrophic illness or injury occur you may want to select an individual plan with lower premiums and higher deductible and out of pocket maximums. These plans often require you pay for your doctor's office visits and prescriptions until you meet your deductible.
- If, however, you prefer lower cost sharing in the form of deductibles, co-pays and co-insurance amounts, you will pay a higher premium and may prefer a group plan.
- To learn more contact Doyle Rowe LTD at 1-866-201-2524, email info@doylerowe.com or visit www.doylerowe.com

DRL
Doyle Rowe LTD

NEXT STEPS

- Doyle Rowe LTD (DRL) staff are on hand to collect your completed group plan application and member authorization (Laborers).
- If you are interested in a personal consultation supply your contact information on the sheets provided for this purpose and a DRL representative will contact you.
- Those interested in obtaining an individual plan quote should follow the steps outlined in this presentation. A handout with these instructions is available.
- Questions? Contact DRL at 1-866-201-2524 or email your questions to info@doylerowe.com

DRL
Doyle Rowe LTD

HEALTH PLAN OPTIONS FOR MEDICARE ELIGIBLE RETIREES

Kathleen D. Rowe
Doyle Rowe LTD
November 22, 2016

DRL
Doyle Rowe LTD

MEDICARE ELIGIBLE RETIREES - MEDICARE PART A & B REQUIRED

- Blue Cross and Blue Shield of Illinois has developed three group Medicare Advantage Prescription Drug Plans (MAPD) for your consideration.
- These are PPO plans that have the same benefit levels whether you utilize an in network provider or an out of network provider. Providers must agree to treat the member, accept Medicare assignment and bill BCBS directly.
- Monthly premium ranges from $339.00 for Option 1 to $59.00 for Option 3.
- Applications must be received by December 15, 2016.
- Premium must be deducted from your annuity payment each month. The completed Member Authorization must be submitted to your Fund office.

DRL
Doyle Rowe LTD

	Blue Cross Medicare Advantage (PPO)SM		
	Option 1	**Option 2**	**Option 3**
Annual Deductible The Annual Deductible applies to all coverages that require coinsurance. It does not apply to coverages that require a copay.	In-Network: This plan does not have a deductible. Out-of-Network: This plan does not have a deductible.	In-Network: $250 Out-of-Network: $250	In-Network: $750 Out-of-Network: $750
Out-of-Pocket Maximum Includes the Annual Deductible	In-Network: $0 Out-of-Network: $0	In-Network: $1,500 Out-of-Network: $1,500	In-Network: $6,700 Out-of-Network: $6,700
Primary Care Office Visit	In-Network: $0 copay Out-of-Network: $0 copay	In-Network: $25 copay Out-of-Network: $25 copay	In-Network: $25 copay Out-of-Network: $25 copay
Specialist Office Visit	In-Network: $0 copay Out-of-Network: $0 copay	In-Network: $25 copay Out-of-Network: $25 copay	In-Network: $50 copay Out-of-Network: $50 copay
Inpatient Hospital Care	In-Network: $0/stay Out-of-Network: $0/stay	In-Network: $0/stay Out-of-Network: $0/stay	In-Network: $250/Day (1-7) Out-of-Network: $250/Day (1-7)
Outpatient Hospital Services	In-Network: $0 copay Out-of-Network: $0 copay	In-Network: $0 copay Out-of-Network: $0 copay	In-Network: 20% of the total cost Out-of-Network: 20% of the total cost
Emergency Care	$0 copay	$50 copay	20% of the total cost
Emergency Ambulance	$0 copay	20% of the total cost	20% of the total cost
Prescription Drug Deductible	$100	$200	$400
Prescription Drug Retail Coinsurance	One-month supply: 20% of the total cost	One-month supply: 20% of the total cost	One-month supply: 25% of the total cost
Formulary	Formulary includes additional Brand and some generic products than the standard formulary.	Standard Formulary	Standard Formulary
Supplemental Drug Benefit	Included. In addition to the drugs listed on the Formulary select drugs in the following categories are covered as a supplemental benefit; Cough and Cold, Sexual Dysfunction, Prescription Vitamins/Combos, OTC Drugs and Non-FDA Approved Drugs.	Not Included	Not Included
Coverage Gap - Retail Cost-Sharing	One-month supply: 20% of the total cost	One-month supply: 20% of the total cost	One-month supply: After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap.

DRL
Doyle Rowe LTD

GROUP PLAN APPLICATION

Blue Cross Medicare Advantage (PPO)℠

Blue Cross Medicare Advantage℠ Plan Group Employee Enrollment Form

To enroll in Blue Cross Medicare Advantage, please provide the following information:

Please check the plan you want to enroll in:
- ☐ PPO Option #1: $339 Per Member Per Month
- ☐ PPO Option #2: $236 Per Member Per Month
- ☐ PPO Option #3: $59 Per Member Per Month

Please check the name of your pension fund:
- ☐ Laborers & Retirement Board Employees (LABF)
- ☐ Municipal Employees (MEABF)
- ☐ Policemen (PABF)
- ☐ Firemen (FABF)

Employer: **City of Chicago** Group #: **PIL00006**

LAST name: FIRST name: Middle Initial: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: ☐☐/☐☐/☐☐☐☐ (M M / D D / Y Y Y Y) Sex: ☐ M ☐ F

Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Alternate Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Permanent Residence Street Address (P.O. Box is not allowed):

City: County: State: ZIP Code: ☐☐☐☐☐

Mailing Address (only if different from your Permanent Residence Address):
Street Address: City: State: ZIP Code: ☐☐☐☐☐

Emergency Contact Name:

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Relationship to You:

Member Email Address:

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.
- Please fill in these blanks so they match your red, white and blue Medicare card.

– OR –
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number ☐☐☐-☐☐-☐☐☐☐ Sex ☐

is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Applicant LAST name: FIRST name:

Please read and answer these important questions:

1. Are you the retiree? ☐ Yes ☐ No If yes, retirement date: ☐☐/☐☐/☐☐☐☐ (M M / D D / Y Y Y Y)

If no, name of retiree: _____

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If yes, name of spouse: _____

Name(s) of dependent(s): _____

3. Do you or your spouse work? ☐ Yes ☐ No

4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis. Otherwise, we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Blue Cross Medicare Advantage? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street): _____

7. Are you enrolled in your state Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

Please choose the name of a Primary Care Physician (PCP), clinic or health center:

PCP First Name:	PCP Last Name:	PCP ID#:	Current Patient: ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:
- ☐ Spanish
- ☐ Braille/Large Print

Please contact Blue Cross Medicare Advantage at 1-866-390-4276 if you need information in another format or language than what is listed above. We are open 8:00 a.m. – 8:00 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. TTY/TDD 711

Applicant LAST name: FIRST name:

INDIVIDUAL MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

- You also have the option of selecting individual Medicare Advantage or Medicare Supplement plans along with a Medicare Part D prescription drug plan. These options may be more cost effective than the group option.
- These plans offer comprehensive medical and prescription drug benefits.

DRL
Doyle Rowe LTD

MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS (MAPD)

- Managed care plans which combine medical benefits with a prescription drug plan.
- Administered by private insurance companies on behalf of Centers for Medicare and Medicaid (CMS) Services the government entity that oversees Medicare.

DRL
Doyle Rowe LTD

MAPD PLANS (CONTINUED)

- **IMPORTANT: Individual Medicare Advantage plans differ from the Group Medicare Advantage plans being offered by Blue Cross and Blue Shield.**
  - **Network based, you must use network providers to get the full benefit offered by the plan (non-emergency)**
    - **In the case of HMO plans there are often no benefits for out of network providers**
    - **In the case of POS or PPO plans reduced benefits are available for out of network providers.**
    - **Always check to be certain your providers are in network.**

DRL
Doyle Rowe LTD

INDIVIDUAL MEDICARE SUPPLEMENT and MEDICARE PART D PRESCRIPTION DRUG PLAN MEDICARE PART A & B REQUIRED

- Traditional Medicare Supplement plans pay after Medicare has made payment.
- There is no network. There are a variety of options, the most popular are Plan F and more recently Plan G.

DRL
Doyle Rowe LTD

Blue Cross and Blue Shield of Illinois Medicare Supplement Choices

A	B	C	F/F*	G	K	L	N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*	Basic, including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	Part A Deductible
		Part B Deductible	Part B Deductible				
			Part B Excess (100%)	Part B Excess (100%)			
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency
					Out-of-pocket limit $4,960; paid at 100% after limit reacehed	Out-of-pocket limit $2,480; paid at 100% after limit reacehed	

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exeed $2,180. Out-of-pocket expenses for this ductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare dudctibles for Part A and Part B, but do not include the paln's separate foreign travel emergency deductible.

Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency the $1,288 deductible is covered at any hospital fromm which you receive care.

DRL
Doyle Rowe LTD

SUPPLEMENT PLANS (CONTINUED)

- **Blue Cross and Blue Shield also offers most Medicare supplement plans as either Standard or Med-Select.**
- **Benefits under each plan are the same, however…**
  - ***The Med-Select option requires that the member utilize a Med-Select hospital for planned, inpatient stays and lives within 30 miles of a Med-Select hospital. There are over 60 Med-Select hospitals in Chicago and suburbs. Premiums are less under the Med-Select option.***

DRL
Doyle Rowe LTD

MEDICARE SUPPLEMENT RATES

Sample Rates

AGE	OPTION	A	B	C	F	High Deductible Plan F*	G	K	L	N
U65	Standard	170.00	295.00	334.00	345.00	109.00	309.00	170.00	245.00	237.00
	Medicare Select	N/A	225.00	249.00	273.00	N/A	240.00	150.00	204.00	188.00
Age 65	Standard	73.00	124.00	154.00	155.00	49.00	139.00	77.00	110.00	107.00
	Medicare Select	N/A	103.00	132.00	140.00	N/A	125.00	72.00	105.00	97.00
Age 70	Standard	97.00	159.00	195.00	207.00	64.00	185.00	103.00	146.00	142.00
	Medicare Select	N/A	132.00	169.00	187.00	N/A	164.00	100.00	140.00	126.00
Age 75	Standard	119.00	204.00	246.00	261.00	82.00	234.00	130.00	184.00	179.00
	Medicare Select	N/A	161.00	198.00	220.00	N/A	192.00	119.00	163.00	150.00
Age 80	Standard	140.00	240.00	276.00	288.00	91.00	260.00	144.00	204.00	199.00
	Medicare Select	N/A	185.00	211.00	231.00	N/A	202.00	126.00	171.00	157.00
Age 85	Standard	156.00	269.00	303.00	314.00	100.00	283.00	156.00	223.00	216.00
	Medicare Select	N/A	206.00	227.00	248.00	N/A	218.00	136.00	185.00	171.00
Age 90	Standard	165.00	285.00	321.00	332.00	106.00	298.00	165.00	237.00	227.00
	Medicare Select	N/A	218.00	241.00	263.00	N/A	232.00	146.00	196.00	182.00
Age 95	Standard	168.00	290.00	327.00	340.00	108.00	305.00	168.00	242.00	233.00
	Medicare Select	N/A	222.00	246.00	268.00	N/A	237.00	148.00	201.00	185.00
Age 100+	Standard	170.00	295.00	334.00	345.00	109.00	309.00	170.00	245.00	237.00
	Medicare Select	N/A	225.00	249.00	273.00	N/A	240.00	150.00	204.00	188.00

DRL
Doyle Rowe LTD

MEDICARE PART D PLANS

- These are prescription drug plans that must meet criteria established by the Centers for Medicare and Medicaid Services (CMS) which are offered by private companies.
- Some have a deductible, some are co-pay only. Each has their own formulary, which is a list of prescription drugs the plan covers and at what level.
  - *For example, Plan A may cover Advair as a Tier 2 drug, while another covers the same drug as a Tier 3 drug.*
- Many also have a preferred network of pharmacies where co-pays may be less.
- You do not need a Medicare Part D plan if you are enrolling in a MAPD plan. You will be disenrolled from a MAPD plan if you enroll in a Medicare Part D plan separately.

DRL
Doyle Rowe LTD

NEXT STEPS

- Doyle Rowe LTD (DRL) staff are on hand to collect your completed group plan application and member authorization (Laborers).
- If you are interested in a personal consultation supply your contact information on the sheets provided for this purpose and a DRL representative will contact you.
- Questions? Contact DRL at 1-866-201-2524 or email your questions to info@doylerowe.com

DRL
Doyle Rowe LTD