

2017 GROUP MEDICARE PLAN COMPARISON

Public Employees Insurance Program (PEIP)



Contact Innovo Benefits Administration at 1-800-829-5601 with questions or to request an enrollment kit.

2017	Group Platinum Blue SM (Cost) Plan A with Group MedicareBlue SM Rx(PDP)	Group Platinum Blue SM (Cost) Plan C with Group MedicareBlue SM Rx(PDP)
	High Option: Total is \$249.50	Low Option: Total is \$190.50
Monthly premium You must continue to pay your Medicare Part B premium Blue Cross bills you directly for the medical and Rx premiums	Group Platinum Blue Plan A Medical \$106.00 Group MedicareBlue Rx Prescription drug \$143.50	Group Platinum Blue Plan C Medical \$74.00 Group MedicareBlue Rx Prescription drug \$116.50
Plan descriptions	A Medicare-approved Cost plan and a stand-alone prescription drug plan with a Medicare contract	A Medicare-approved Cost plan and a stand-alone prescription drug plan with a Medicare contract
Residency requirements	Group Platinum Blue: Must be a permanent resident of Minnesota Group MedicareBlue Rx: Must be a permanent resident of the United States	Group Platinum Blue: Must be a permanent resident of Minnesota Group MedicareBlue Rx: Must be a permanent resident of the United States
Provider networks	Group Platinum Blue: Platinum Blue network in Minnesota; may travel up to 9 months and receive In-Network plan benefits from any Medicare contracted provider Group MedicareBlue Rx: Over 67,000 pharmacies nationwide	Group Platinum Blue: Platinum Blue network in Minnesota; may travel up to 9 months and receive In-Network plan benefits from any Medicare contracted provider Group MedicareBlue Rx: Over 67,000 pharmacies nationwide
Individual lifetime maximum	None	None
Deductible Medical or Prescription Drug	None	None
Out of pocket maximum Medical only	\$3,000 (medical)	\$3,000 (medical)
Medical coverage	Group Platinum Blue Plan A	Group Platinum Blue Plan C
Office visits		
Primary care/specialist visits	100% coverage	\$20 copay
Chiropractic care (manual manipulation of the spine)	100% coverage	\$20 copay
Inpatient care		
Hospital care	100% coverage	\$200 copay for each Medicare-covered stay
Skilled nursing facility	100% coverage	100% coverage

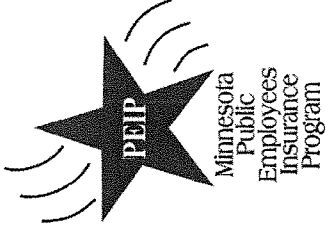
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Medical coverage	Group Platinum Blue Plan A	Group Platinum Blue Plan C
Outpatient care		
Ambulatory surgery center	100% coverage	\$75 copay
Diagnostic tests, X-rays, and lab services	100% coverage	100% coverage
Physical, speech, and occupational therapy	100% coverage	\$20 copay
Home health care	100% coverage	100% coverage
Emergency/Urgent care		
Emergency care	100% coverage	\$50 copay
Urgent care	100% coverage	\$20 copay
Ambulance service	100% coverage	\$75 copay
Other outpatient services		
Certain outpatient prescription drugs covered under Medicare Part B	100% coverage	20% coinsurance
Durable medical equipment	100% coverage	20% coinsurance
Diabetic supplies (includes glucose monitors, test strips, lancets)	100% coverage	20% coinsurance
Preventive care		
Annual routine physical, eye exam, and hearing screening	100% coverage	100% coverage
Additional services and support	24-hour Nurse Line, Silver&Fit® Exercise and Healthy Aging Program, \$125 annual eyewear benefit, \$450 annual hearing aid benefit	24-hour Nurse Line, Silver&Fit® Exercise and Healthy Aging Program, \$125 annual eyewear benefit, \$450 annual hearing aid benefit
Prescription Drug Coverage	Group MedicareBlue Rx (prescription drug) \$5/\$15/\$35/\$60	Group MedicareBlue Rx (prescription drug) \$10/\$25/\$60/25%
No deductible and no coverage gap Amounts shown are for a 30-day supply Two copays for a 90-day supply by mail order or at a preferred extended supply retail pharmacy	Tier 1: Generic drugs \$5 copay Tier 2: Preferred Brand drugs \$15 copay Tier 3: Non-Preferred Brand drugs \$35 copay Tier 4: Specialty Tier drugs \$60 copay Supplemental Drug Coverage: 25% coinsurance for certain sexual dysfunction and cough and cold kits	Tier 1: Generic drugs \$10 copay Tier 2: Preferred Brand drugs \$25 copay Tier 3: Non-Preferred Brand drugs \$60 copay Tier 4: Specialty Tier drugs 25% coinsurance Supplemental Drug Coverage: 25% coinsurance for certain sexual dysfunction and cough and cold kits
Catastrophic coverage (the amount spent on supplemental drugs does not apply toward catastrophic coverage)	If your yearly out-of-pocket costs reach \$4,950, you pay the greater of: \$3.30 copay for generic or multi-source preferred brand drugs, \$8.25 copay for all other drugs, or 5% of the drug cost	If your yearly out-of-pocket costs reach \$4,950, you pay the greater of: \$3.30 copay for generic or multi-source preferred brand drugs, \$8.25 copay for all other drugs, or 5% of the drug cost

Blue Cross offers Cost and PDP plans with Medicare contracts. Enrollment in these plans depends on renewal of the plan sponsor's Medicare contract. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance for Group Platinum Blue and Group MedicareBlue Rx may change on January 1 of each year. The premium for Group Senior Gold may also change on January 1 of each year. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. You may also refer to the *Summary of Benefits* and/or *Summary of Coverage and Disclosure of Information* documents provided in your enrollment kit.



**PEIP Retiree Health
HealthPartners Freedom Plan Options
January 1, 2017 through December 31, 2017**

	HealthPartners Freedom Plan High Option \$265.70	HealthPartners Freedom Plan Low Option \$147.50
Prescription Drugs	<p>\$15 copay for generic drugs \$25 copay for brand drugs \$50 copay brand non-formulary 25% coinsurance for specialty Mail order is 2 copays for 90-day supply Same copays through the Donut Hole</p>	<p>\$15 copay for tier 1 drugs (preferred generic) \$20 copay for tier 2 drugs (generic) \$45 copay for tier 3 drugs (preferred brand) \$80 copay for tier 4 drugs (non-preferred brand) 33% coinsurance for Tier 5 drugs (specialty) Mail order is 2 copays for 90-day supply In the Donut Hole, members receive some coverage. Please refer to the Evidence of Coverage for specific details.</p>
Travel Benefits	May be out of the service area for up to 9 consecutive months annually	May be out of the service area for up to 9 consecutive months annually
Medicare	Must have Parts A & B	Must have Parts A & B
Preventive Care (including annual physicals, cancer screenings, eye exams, and immunizations)	100% coverage	100% coverage
Office Visits	\$15 copay	\$15 copay primary care \$30 copay specialty care including acupuncture/chiropractic, mental and chemical health, physical therapy, speech therapy, occupational therapy, podiatry
In-patient Hospital	100% coverage after \$100 copay	100% coverage after \$300 copay
Emergency Care	\$75 copay, waived if admitted in U.S. 80% coverage outside U.S.	\$75 copay, waived if admitted in U.S. 80% coverage outside U.S.
Out-of-Pocket Maximum	\$3,000 (Medical Only)	\$3,400 (Medical Only)

**HealthPartners Freedom Plan Options
January 1, 2017 through December 31, 2017**

	HealthPartners Freedom Plan High Option \$265.70	HealthPartners Freedom Plan Low Option \$147.50
Ambulance	90% coverage in the U.S., 80% outside U.S.	90% coverage in the U.S., 80% outside U.S.
Outpatient Surgery	\$200 copay	\$250 copay
Urgent Care	\$15 copay, 80% coverage outside the U.S.	\$30 copay, 80% coverage outside the U.S.
Additional Benefits	<ul style="list-style-type: none"> • \$1,000 toward any hearing aid every 2 years • Up to 35% discount off of eyewear • Unlimited E-visits @ 100% • Fitness Club memberships at most major clubs at no cost 	<ul style="list-style-type: none"> • \$1,000 toward any hearing aid every 2 years • Up to 35% discount off of eyewear • Unlimited E-visits @ 100% • Fitness Club memberships at most major clubs at no cost
Catastrophic Prescription Coverage	Once the amount both you and Medicare pay (as the extra help) reaches \$4,950 in a year, your copay amount(s) will go down to \$3.30 generic, \$8.35 brand and 5% specialty but not higher than the initial Coverage Level benefit.	Once the amount both you and Medicare pay (as the extra help) reaches \$4,950 in a year, your copay amount(s) will go down to \$3.30 generic, \$8.35 brand and 5% specialty but not higher than the initial Coverage Level benefit.

You must be a Minnesota resident or a resident residing within specific counties of western Wisconsin to enroll in this plan. Please call 952-883-7979 or 1-800-233-9645 for specific information.

This is a brief summary of benefits. Not all covered services, exclusions, and limitations are shown here. Please contact HealthPartners for more information at 952-883-5601 or 1-800-247-7015.

PEIP Retiree Health
Group UCare for Seniors
January 1, 2017 through December 31, 2017



	Group UCare for Seniors High Option \$332.00 monthly	Group UCare for Senior Core Option \$155.00 monthly	Group UCare for Seniors Basic Option \$65.00 monthly
Prescription Drugs (30-day supply, formulary)	<p>\$50 annual deductible \$10 co-pay generic drugs \$40 co-pay preferred brand drugs \$80 co-pay brand 32% coinsurance speciality</p> <p>Mail order only. 2-copays for 90-day supply. No Coverage Gap (no Donut Hole) Medicare Catastrophic begins once the out of pocket of \$4,950 is met.</p>	<p>\$100 annual deductible \$15 co-pay generic drugs \$45 co-pay preferred brand drugs \$90 co-pay brand 31% coinsurance speciality</p> <p>Mail order only. 2-copays for 90-day supply. Once total yearly Rx costs reach \$3,700, you pay \$15 generic copay & 40% of Brand Name drugs until the out of pocket of \$4,950 is met. Catastrophic Rx begins at that time.</p>	<p>\$200 annual deductible \$15 co-pay generic drugs \$45 co-pay preferred brand drugs \$90 co-pay brand 29% coinsurance speciality</p> <p>Mail order only. 2-copays for 90-day supply. Once total yearly Rx costs reach \$3,700 you pay 51% of generic & 40% of Brand Name drugs until the out of pocket of \$4,950 is met. Catastrophic Rx begins at that time.</p>
Medicare	Must have Parts A & B of Medicare		
Residency Requirements	Must reside within the service area which consists of the entire State of Minnesota and Western Wisconsin.		
Preventive Care routine physicals, cancer screenings, eye and hearing exams, immunizations)	100% coverage		
Office Visits	Primary \$15 co-pay Specialist \$15 co-pay	Primary \$15 co-pay Specialist \$30 co-pay	Primary \$15 co-pay Specialist \$40 co-pay
Lab	100%	100%	10% coinsurance
In-Patient Hospital	100% after \$100 co-pay per admission	100% after \$200 co-pay per admission	\$300/day co-pay for days 1-5, then 100%
Outpatient Surgery	\$200 co-pay	\$250 co-pay	\$250 co-pay
Emergency Care	\$50 co-pay per hospital emergency	\$75 co-pay per hospital emergency	\$75 co-pay per hospital emergency
Travel Benefit Option	Can live outside of the service area up to 6 months a year. Coverage for non-emergencies outside the UCare for Seniors network is at 80%.		
Additional Benefits	<ul style="list-style-type: none"> Preventive Dental – 100% coverage; 3 cleanings per year at participating providers. Add comprehensive dental for additional \$22/mo. Hearing Aid Benefits - \$500 every 36 months • Eyewear - \$75 annual allowance – High and Core Options only Silver Sneakers® Fitness Program –and Health Club Savings Program 		
Out-of-Pocket Maximum	\$3,400 per calendar year for Part A & B Services		
Service Area	Service area includes: All of Minnesota and the following 26 counties in western Wisconsin: Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Crawford, Douglas, Dunn, Eau Claire, Grant, Iowa, Jackson, Juneau, La Crosse, Monroe, Pepin, Pierce, Polk, Richland, St. Croix, Sauk, Sawyer, Trempealeau, Vernon and Washburn		

This is a brief summary of benefits. Not all covered services, exclusions, and limitations are shown here. Please call UCare benefit team at 612-676-6900 or 1-877-598-6574 for specific information or visit www.ucare.org.