South Koochiching Rainy River School

Group Medicare Employer Plan and Rate Information

Coverage Effective Start Date: 01/01/2027

Coverage Effective End Date: 12/31/2027

The following pages of this 2027 Group Medicare Employer Plan and Rate Information document must be completed for benefits renewal and includes the following sections:

Current Plans

This section reflects the current plan offerings and premium rates for comparison to the rates listed in the Renewal Plans section.

Renewal Plans

This section lists your current plans with any applicable rate changes effective January 1st of the upcoming plan year.

You may also see a section titled **Alternate Plans** which lists alternative plan options. If included, you may consider this/these plan(s) as a replacement for a plan currently offered.
If you would like to discuss alternate plan options before making final selection(s), talk with your Blue Cross Account Manager or agent.

STEPS TO COMPLETE YOUR RENEWAL

1. Place a check mark in the **"Yes" or "No"** box next to each plan design listed in the ***Group Medicare Employer Plan and Rate Information*** document to validate the selection (example below).

If alternate plans have been included:

   a. To **renew** the current plan(s) with no changes for the upcoming plan year, you must select "Yes" for the current plan(s) and "No" for the alternate plan(s)
   b. To **replace** a plan (or plans) for the upcoming plan year, you must select "No" for the current plan(s) and "Yes" for the alternate plan(s).

2. Complete, sign and date the authorization page.
3. Scan the complete signed copy and return it to your Blue Cross Account Manager or agent
4. **If you are renewing your current plan offering(s) only, notify retirees of rate changes for the upcoming plan year by December 1.**

If you have selected an alternate plan (or plans) for the upcoming year, we will be in contact to assist with next steps.

EXAMPLE:

Renewal Plans — **2027 Premium Rate Per Member Per Month** — **Renewing Plan**

			Medical	Drug	Commission	Other Fees	Pre-MACRA Total	Post-MACRA Total	☑ Yes/No for All Quoted Plan Designs: Yes	No
1)	Group Medicare Supplement	*Pre-MACRA*	*$XXX.XX*	*N/A*	*$XXX.XX*	*$XXX.XX*			✓	
	Group Senior Gold	*Post-MACRA*	*$XXX.XX*							
	Group Medicare PDP $5/$15/$35/$60			*$XXX.XX*	*$XXX.XX*	*N/A*	*$XXX.XX*	*$XXX.XX*	✓	

BlueCross BlueShield Minnesota

South Koochiching Rainy River School

Group Medicare Employer Plan and Rate Information

Coverage Effective Start Date: 01/01/2027
Coverage Effective End Date: 12/31/2027

Underwriter: Loftus, Julie
Account Manager: Baskett, Becky

Total Members:
Renewal

Current Plans

			2026 Premium Rate Per Member Per Month			
			Medical	Drug	Pre-MACRA Total	Post-MACRA Total
1)	Group Medicare Supplement	*Pre-MACRA*	*$335.00*	*N/A*		
	Group Senior Gold	*Post-MACRA*	*$311.00*			
	Group Medicare PDP			*$194.50*	*$529.50*	*$505.50*
	$0/$20/$40/$60					

Renewal Plans

			2027 Premium Rate Per Member Per Month				Renewing Plan Design? ☑ Yes/No for All Quoted Plan Designs	
			Medical	Drug	Pre-MACRA Total	Post-MACRA Total	Yes	No
1)	Group Medicare Supplement	*Pre-MACRA*	*$360.50*	*N/A*				
	Group Senior Gold	*Post-MACRA*	*$336.20*					
	Group Medicare PDP			*$180.50*	*$541.00*	*$516.70*		
	$0/$20/$40/$60							

BlueCross BlueShield Minnesota

Group Medicare Renewal Acceptance Form

Client Number: 207212
Servicing Year: January 1, 2027 - December 31, 2027

Underwriter: Loftus, Julie
Account Manager: Baskett, Becky

Thank you for choosing Blue Cross Blue Shield of Minnesota (BCBSMN) for your employees' health care benefits. We appreciate the opportunity to service you and your employees.

I am authorized to certify that the information provided is complete and accurate to the best of my knowledge. I understand that the information provided will be relied upon by BCBSMN. BCBSMN may have the right to not renew coverage if my company does not meet participation requirements as stated in my contract.

Contact Name: _____

Email Address: _____ Phone: _____

Printed Name: _____

Signature: _____ Date: _____

Please select your plan option(s) and complete this form. Return all information to your BCBSMN Account Manager.