OSF with Medica Advantage (HMO and HMO-POS) and Medical-Only (HMO-POS)

Summary of Benefits

January 1 – December 31, 2024

This is a summary of drug and health services covered by **OSF with Medica Advantage Value (HMO), OSF with Medica Advantage Select (HMO-POS), OSF with Medica Advantage Preferred (HMO-POS)** and **Medica Advantage Salute (HMO-POS).**

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "***Evidence of Coverage***."

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare Advantage plan (such as **OSF with Medica Advantage Value (HMO)**, **OSF with Medica Advantage Select (HMO-POS)**, **OSF with Medica Advantage Preferred (HMO-POS)** or **Medica Advantage Salute (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Advantage® OSF with Medica Advantage Value (HMO)**, **OSF with Medica Advantage Select (HMO-POS)**, **OSF with Medica Advantage Preferred (HMO-POS)** and **Medica Advantage Salute (HMO-POS)** cover and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Medicare Advantage℠ plans**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Part D Prescription Drug Benefits
- Additional Benefits and Services

This document is available in other formats such as braille and large print. This document may be available in a non-English language. For additional information, call us toll-free at 1-877-301-3326 (TTY: 711).

Things to Know About Medica Advantage®

Hours of Operation

- From Oct. 1 – March 31, you can call us from 8 a.m. – 8 p.m. CT, 7 days a week.
- From April 1 – Sept. 30, you can call us from 8 a.m. – 8 p.m. CT, Monday – Friday.

Medica Advantage℠ Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-877-301-3326 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-877-234-0126 (TTY: 711).
- Our website: https://central.medica.com/medicare

Who Can Join?

To join **OSF with Medica Advantage Value (HMO)**, **OSF with Medica Advantage Select (HMO-POS)**, **OSF with Medica Advantage Value (HMO)** or **OSF with Medica Advantage Select (HMO-POS)**,you must be enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B), and live in our service area.

Our service area includes the following counties in **Illinois**: DeWitt, Marshall, McLean, Peoria, Stark, Tazewell, and Woodford.

Which doctors, hospitals, and pharmacies can I use?

Medica Advantage℠ has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

- You can see our plan's provider directory at our website, https://central.medica.com/medicare.
- You can see our plan's pharmacy directory at our website https://central.medica.com/medicare.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You may search for network providers and pharmacies on our website at https://central.medica.com/medicare. Or, call us and we will send you a copy of the provider and pharmacy directories.

SUMMARY OF BENEFITS

January 1, 2024 – December 31, 2024

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Monthly Premium You must continue to pay your Medicare Part B premium	$0	$0	$160	$0
Part B Buy Back OSF Healthcare Plan provides a monthly credit that will automatically be applied towards your Medicare Part B premium	$10	Not Applicable	Not Applicable	$65
Medical Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Maximum Out-Of-Pocket Responsibility If you reach the limit on out-of-pocket costs, you will keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. (Does not include prescription drugs)	$3,500 for in-network services	$3,900 for in-network and $8,800 for in-network and out-of-network services combined	$0 for in-network and $5,000 for in-network and out-of-network services combined	$5,500 for in-network and $10,000 for in-network and out-of-network services combined

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Inpatient Hospital Coverage* For Medicare-covered stays				
In-Network	$325 copay each day for days 1 through 7 $0 each day for days 8 to discharge	$325 copay each day for days 1 through 7 $0 each day for days 8 to discharge	$0 copay each day for days 1 through 90	$325 copay each day for days 1 through 7 $0 each day for days 8 to discharge
Out-of-Network	Not Covered	40% coinsurance each day for days 1 through 7 $0 each day for days 8 to discharge	40% coinsurance each day for days 1 through 7 $0 each day for days 8 to discharge	40% coinsurance each day for days 1 through 7 $0 each day for days 8 to discharge
Outpatient Hospital Coverage*				
In-Network	$320 copay	$320 copay	$0 copay	$325 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
Ambulatory Surgery Center*				
In-Network	$320 copay	$320 copay	$0 copay	$295 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Doctor Visits	**Primary Care Providers:**	**Primary Care Providers:**	**Primary Care Providers:**	**Primary Care Providers:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Specialists:	**Specialists:**	**Specialists:**	**Specialists:**
In-Network	$40 copay	$40 copay	$0 copay	$40 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Palliative Care:	**Palliative Care:**	**Palliative Care:**	**Palliative Care:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
Preventive Care (e.g., Flu Vaccine, Diabetic Screenings)				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
Emergency Care In the U.S. (Waived if admitted)				
In-Network	$110 copay	$110 copay	$0 copay	$120 copay
Out-of-Network	$110 copay	$110 copay	$0 copay	$120 copay

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Urgently Needed Services In the U.S.				
In-Network	$40 copay	$40 copay	$0 copay	$40 copay
	Your cost may be reduced based on level of treating provider	Your cost may be reduced based on level of treating provider	Your cost may be reduced based on level of treating provider	Your cost may be reduced based on level of treating provider
Out-of-Network	$40 copay	$40 copay	$0 copay	$40 copay
Diagnostic Services / Labs / Imaging*	**Outpatient X-ray:**	**Outpatient X-ray:**	**Outpatient X-ray:**	**Outpatient X-ray:**
In-Network	$20 - $35 copay	$20 - $35 copay	$0 copay	$10 - $20 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Laboratory Tests:	**Laboratory Tests:**	**Laboratory Tests:**	**Laboratory Tests:**
In-Network	$0 - $25 copay	$0 - $25 copay	$0 copay	$0 - $20 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Radiation Therapy:	**Radiation Therapy:**	**Radiation Therapy:**	**Radiation Therapy:**
In-Network	$20 - $65 copay	$20 - $65 copay	$0 copay	$20 - $65 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
	Diagnostic Procedures/ Tests:	**Diagnostic Procedures/ Tests:**	**Diagnostic Procedures/ Tests:**	**Diagnostic Procedures/ Tests:**
In-Network	$10 - $40 copay	$10 - $40 copay	$0 copay	$15 - $20 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Diagnostic Mammograms:	**Diagnostic Mammograms:**	**Diagnostic Mammograms:**	**Diagnostic Mammograms:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Diagnostic Radiology:	**Diagnostic Radiology:**	**Diagnostic Radiology:**	**Diagnostic Radiology:**
In-Network	$0 - $150 copay	$0 - $150 copay	$0 copay	$0 - $200 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
Hearing Services	**Medicare-covered-exam to diagnose and treat hearing and balance issues:**	**Medicare-covered-exam to diagnose and treat hearing and balance issues:**	**Medicare-covered-exam to diagnose and treat hearing and balance issues:**	**Medicare-covered-exam to diagnose and treat hearing and balance issues:**
In-Network	$40 copay	$40 copay	$0 copay	$40 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Routine hearing exam:	**Routine hearing exam:**	**Routine hearing exam:**	**Routine hearing exam:**
In-Network	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
	Hearing aid fitting / evaluation:	**Hearing aid fitting / evaluation:**	**Hearing aid fitting / evaluation:**	**Hearing aid fitting / evaluation:**
In-Network	$0 copay per fitting for 1 fitting every calendar year	$0 copay per fitting for 1 fitting every calendar year	Not Covered	$0 copay per fitting for 1 fitting every calendar year
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
	Hearing aid allowance:	**Hearing aid allowance:**	**Hearing aid allowance:**	**Hearing aid allowance:**
In-Network	$0 copay	$0 copay	Not Covered	$0 copay
	Our plan pays up to $750 both ears combined every calendar year for hearing aids	Our plan pays up to $750 both ears combined every calendar year for hearing aids		Our plan pays up to $750 both ears combined every calendar year for hearing aids
	You are responsible for costs beyond the plan limit	You are responsible for costs beyond the plan limit		Additional allowance included in FlexSpend benefit
				You are responsible for costs beyond the plan limit
Out-of-Network	Not Covered	Not Covered	Not Covered	Included in FlexSpend benefit

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Preventive Dental	**Preventive exams:**	**Preventive exams:**	**Preventive exams:**	**Preventive exams:**
In-Network	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year	$0 copay per visit for 2 visits every calendar year
Out-of-Network	Not Covered	Not Covered	Not Covered	$0 copay per visit for 2 visits every calendar year
	Cleanings:	**Cleanings:**	**Cleanings:**	**Cleanings:**
In-Network	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year
Out-of-Network	Not Covered	Not Covered	Not Covered	$0 copay per visit for 1 visit every calendar year
	X-Ray:	**X-Ray:**	**X-Ray:**	**X-Ray:**
In-Network	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year	$0 copay per visit for 1 visit every calendar year
Out-of-Network	Not Covered	Not Covered	Not Covered	$0 copay per visit for 1 visit every calendar year
Comprehensive Dental	**Diagnostic services:**	**Diagnostic services:**	**Diagnostic services:**	**Diagnostic services:**
In-Network	$0 copay	$0 copay	$0 copay	50% coinsurance
Out-of-Network	Not Covered	Not Covered	Not Covered	50% coinsurance
	Gum disease maintenance and bridge/implants/ dentures repairs:	**Gum disease maintenance and bridge/implants/ dentures repairs:**	**Gum disease maintenance and bridge/implants/ dentures repairs:**	**Gum disease maintenance and bridge/implants/ dentures repairs:**

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
In-Network	$0 copay	$0 copay	$0 copay	50% coinsurance
Out-of-Network	Not Covered	Not Covered	Not Covered	50% coinsurance
	Fillings, gum disease treatment, and extractions:	**Fillings, gum disease treatment, and extractions:**	**Fillings, gum disease treatment, and extractions:**	**Fillings, gum disease treatment, and extractions:**
In-Network	$0 copay	$0 copay	$0 copay	50% coinsurance
Out-of-Network	Not Covered	Not Covered	Not Covered	50% coinsurance
	Root canals, bridges, implants, dentures, and crowns:	**Root canals, bridges, implants, dentures, and crowns:**	**Root canals, bridges, implants, dentures, and crowns:**	**Root canals, bridges, implants, dentures, and crowns:**
In-Network	$0 copay	$0 copay	$0 copay	50% coinsurance
Out-of-Network	Not Covered	Not Covered	Not Covered	50% coinsurance
Dental Maximum Annual limit that OSF Health Plan will pay for preventive and comprehensive dental services	**You are responsible for costs beyond the plan limit:**	**You are responsible for costs beyond the plan limit:**	**You are responsible for costs beyond the plan limit:**	**You are responsible for costs beyond the plan limit:**
In-Network	$1,000 every calendar year for dental services	$1,000 every calendar year for dental services	$300 every calendar year for dental services	$300 every calendar year for dental services
Out-of-Network	Not Covered	Not Covered	Not Covered	Additional allowance included in FlexSpend benefit.

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Vision Services	**Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:**	**Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:**	**Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:**	**Medicare-covered exam to treat to diagnose and treat diseases and conditions of the eye:**
In-Network	$40 copay	$40 copay	$0 copay	$40 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Medicare-covered eyewear after cataract surgery:	**Medicare-covered eyewear after cataract surgery:**	**Medicare-covered eyewear after cataract surgery:**	**Medicare-covered eyewear after cataract surgery:**
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	Not Covered	Not Covered	Not covered
	Routine eye exam:	**Routine eye exam:**	**Routine eye exam:**	**Routine eye exam:**
In-Network	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year	$0 copay per exam for 1 exam every calendar year
Out-of-Network	Not Covered	Not Covered	Not Covered	Not covered
	Eyewear (eyeglasses, frames, lenses or contact lenses):	**Eyewear (eyeglasses, frames, lenses or contact lenses):**	**Eyewear (eyeglasses, frames, lenses or contact lenses):**	**Eyewear (eyeglasses, frames, lenses or contact lenses):**
In-Network	Our plan pays up to a total of $250 every two years	Our plan pays up to a total of $250 every two years	Our plan pays up to a total of $100 every two years	Included in FlexSpend benefit

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
	You are responsible for costs beyond the plan limit	You are responsible for costs beyond the plan limit	You are responsible for costs beyond the plan limit	
Out-of-Network	Not Covered	Not Covered	Not Covered	Included in FlexSpend benefit
Mental Health Services:				
Hospital Care* For Medicare-covered stays				
In-Network	$325 copay each day for days 1 - 7	$310 copay each day for days 1 - 7	$0 copay each day for days 1 - 90	$310 copay each day for days 1 - 7
	$0 each day for days 8 - 90	$0 each day for days 8 - 90		$0 each day for days 8 - 90
Out-of-Network	Not Covered	40% coinsurance each day for days 1 - 7	40% coinsurance each day for days 1 - 7	40% coinsurance each day for days 1 - 7
		$0 each day for days 8 - 90	$0 each day for days 8 - 90	$0 each day for days 8 - 90
Outpatient Care	**Outpatient Individual Therapy:**	**Outpatient Individual Therapy:**	**Outpatient Individual Therapy:**	**Outpatient Individual Therapy:**
In-Network	$0 copay	$0 copay	$0 copay	$40 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
	Outpatient Group Therapy:	**Outpatient Group Therapy:**	**Outpatient Group Therapy:**	**Outpatient Group Therapy:**
In-Network	$0 copay	$0 copay	$0 copay	$30 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
Skilled Nursing Facility* Our plan covers up to 100 day per benefit period in a SNF				
In-Network	$0 each day for days 1 - 20 $203 each day for days 21 - 100	$0 each day for days 1 - 20 $203 each day for days 21 - 100	$0 each day for days 1 - 100	$0 each day for days 1 - 20 $203 each day for days 21 - 100
Out-of-Network	Not Covered	40% coinsurance each day for days 1 - 100	40% coinsurance each day for days 1 - 100	40% coinsurance each day for days 1 - 100
A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row				

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
Therapy Outpatient physical therapy, speech language pathology, and occupational therapy				
In-Network	$40 copay per visit	$40 copay per visit	$0 copay per visit	$40 copay per visit
Out-of-Network	Not Covered	40% coinsurance per visit	40% coinsurance per visit	40% coinsurance per visit
Ambulance Services – Ground For each one-way Medicare-covered trip				
In-Network	$300 copay	$300 copay	$0 copay	$300 copay
Out-of-Network	$300 copay	$300 copay	$0 copay	$300 copay
Ambulance Services – Air				
In-Network	$300 copay	$300 copay	$0 copay	$300 copay
Out-of-Network	$300 copay	$300 copay	$0 copay	$300 copay
Transportation For rides to medical appointments				

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
In-Network	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year	$0 copay per ride for 24 one-way rides every calendar year
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Medicare Part B Prescription Drugs*	**Part B Chemotherapy Drugs:**	**Part B Chemotherapy Drugs:**	**Part B Chemotherapy Drugs:**	**Part B Chemotherapy Drugs:**
In-Network	0% - 20% coinsurance	0% - 20% coinsurance	$0 copay	0% - 20% coinsurance
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
	Other Part B Drugs:	**Other Part B Drugs:**	**Other Part B Drugs:**	**Other Part B Drugs:**
In-Network	0% - 20% coinsurance	0% - 20% coinsurance	$0 copay	0% - 20% coinsurance
Out-of-Network	40% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance
	Part B prescription drugs received in the pharmacy:	**Part B prescription drugs received in the pharmacy:**	**Part B prescription drugs received in the pharmacy:**	**Part B prescription drugs received in the pharmacy:**
In-Network	$0 copay - $47 copay	$0 copay - $47 copay	$0 copay	$0 copay - $47 copay
Out-of-Network	Not Covered	40% coinsurance	40% coinsurance	40% coinsurance
Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance.				

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
COVERED MEDICAL AND HOSPITAL BENEFITS *Benefit may require prior authorization				
For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one-month supply.				

"NA" means "Not Applicable".

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
PART D PRESCRIPTION DRUG BENEFITS				
Deductible	$0 There is no deductible. You begin in the initial coverage stage.	$0 There is no deductible. You begin in the initial coverage stage.	$200 Applies to Tier 3, Tier 4 and Tier 5	NA

	Value HMO ($0.00)		Select HMO-POS ($0.00)		Preferred HMO-POS ($160.00)		Salute HMO-POS ($0.00)	
PREFERRED RETAIL COST SHARING								
Tiers	**1-Month (30-day) supply**	**3-Month (100-day) supply**	**1-Month (30-day) supply**	**3-Month (100-day) supply**	**1-Month (30-day) supply**	**3-Month (100-day) supply**	**1-Month (30-day) supply**	**3-Month (100-day) supply**
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	NA	NA
Tier 2 (Generic)	$8 copay	$16 copay	$8 copay	$16 copay	$8 copay	$16 copay	NA	NA
Tier 3 (Preferred Brand)	$42 copay	$117.50 copay	$42 copay	$117.50 copay	$42 copay	$117.50 copay	NA	NA
Tier 4 (Non-Preferred Drug)	$95 copay	$285 copay	$95 copay	$285 copay	$95 copay	$285 copay	NA	NA
Tier 5 (Specialty Tier)	33% of the cost	NA	33% of the cost	NA	30% of the cost	NA	NA	NA
Tier 6 (Vaccines)	$0 copay	NA	$0 copay	NA	$0 copay	NA	NA	NA

	Value HMO ($0.00)		Select HMO-POS ($0.00)		Preferred HMO-POS ($160.00)		Salute HMO-POS ($0.00)	
STANDARD RETAIL COST SHARING								
Tiers	**1-Month (30-day) supply**	**3-Month (100-day) supply**	**1-Month (30-day) supply**	**3-Month (100-day) supply**	**1-Month (30-day) supply**	**3-Month (100-day) supply**	**1-Month (30-day) supply**	**3-Month (100-day) supply**
Tier 1 (Preferred Generic)	$7 copay	$7 copay	$7 copay	$7 copay	$7 copay	$7 copay	NA	NA
Tier 2 (Generic)	$13 copay	$26 copay	$13 copay	$26 copay	$13 copay	$26 copay	NA	NA
Tier 3 (Preferred Brand)	$47 copay	$130 copay	$47 copay	$130 copay	$47 copay	$130 copay	NA	NA
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay	$100 copay	$300 copay	$100 copay	$300 copay	NA	NA
Tier 5 (Specialty Tier)	33% of the cost	NA	33% of the cost	NA	30% of the cost	NA	NA	NA
Tier 6 (Vaccines)	$0 copay	NA	$0 copay	NA	$0 copay	NA	NA	NA

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
PART D COVERAGE STAGES				
Stage 1 Deductible	There is no deductible. You begin in the initial coverage stage.	There is no deductible. You begin in the initial coverage stage.	You pay in full until you reach your deductible. (Applies to Tier 3, Tier 4 and Tier 5 only)	Not Covered

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
PART D COVERAGE STAGES				
Stage 2 Initial Coverage	You pay copays or coinsurance, and we pay the remainder until together our spending reaches $5,030	You pay copays or coinsurance, and we pay the remainder until together our spending reaches $5,030	You pay copays or coinsurance, and we pay the remainder until together our spending reaches $5,030	Not Covered
Stage 3 Coverage Gap You will continue to pay initial coverage stage cost-sharing for Tier 1 drugs until you reach the Catastrophic Stage.	Above $5,030, you pay 25% of the cost for generics and brand drugs until your expenses reach $8,000	Above $5,030, you pay 25% of the cost for generics and brand drugs until your expenses reach $8,000	Above $5,030, you pay 25% of the cost for generics and brand drugs until your expenses reach $8,000	Not Covered
Stage 4 Catastrophic	Above $8,000 the plan pays the full cost for your covered Part D drugs. You pay nothing.	Above $8,000 the plan pays the full cost for your covered Part D drugs. You pay nothing.	Above $8,000 the plan pays the full cost for your covered Part D drugs. You pay nothing.	Not Covered
100 day fills at mail order pharmacies	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	$0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy	Not Covered

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
ADDITIONAL BENEFITS AND SERVICES				
FlexSpend Benefit Allowance on a prepaid debit card to spend on dental services, vision services, eyewear, hearing services and hearing aids You can use your FlexSpend allowance at: • In-network and out-of-network dental offices • In-network eyeglass locations and freestanding vision centers • In-network hearing aid locations and freestanding hearing centers	Not Covered	Not Covered	Not Covered	$500 yearly
Over-the-Counter Allowance for Health and Wellness Products Shop online, in-store, or by catalog.				
In-Network	$65 quarterly allowance	$60 quarterly allowance	$30 quarterly allowance	$40 quarterly allowance
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
ADDITIONAL BENEFITS AND SERVICES				
Post Discharge Meals Mom's Meals delivered to your door after you are discharged from the hospital or a skilled nursing facility.				
In-Network	Two meals per day for 7 days after an inpatient stay at no cost to you	Two meals per day for 7 days after an inpatient stay at no cost to you	Two meals per day for 7 days after an inpatient stay at no cost to you	Two meals per day for 7 days after an inpatient stay at no cost to you
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Fitness Benefit One Pass™ Fitness Program				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Routine Chiropractic				
In-Network	$20 copay for an additional 12 routine chiropractic visits every calendar year	$20 copay for an additional 12 routine chiropractic visits every calendar year	$0 copay for an additional 12 routine chiropractic visits every calendar year	$20 copay for an additional 12 routine chiropractic visits every calendar year
Out-of-Network	Not Covered	40% coinsurance for an additional combined 12 routine chiropractic visits every calendar year	40% coinsurance for an additional combined 12 routine chiropractic visits every calendar year	40% coinsurance for an additional combined 12 routine chiropractic visits every calendar year

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
ADDITIONAL BENEFITS AND SERVICES				
Living Healthy Rewards for completing healthy activities like receiving a flu shot, going to the dentist and getting an annual physical				
In-Network	$150 every calendar year	$150 every calendar year	$150 every calendar year	$150 every calendar year
Out-of-Network	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Worldwide Emergency and Urgent Care Outside the US				
In-Network	$110 copay	$110 copay	$0 copay	$120 copay
	No Limit	No Limit	No Limit	No Limit
Out-of-Network	$110 copay	$110 copay	$0 copay	$120 copay
	No Limit	No Limit	No Limit	No Limit
Nurse Line Nurses are available 24 hours a day, 365 days a year.				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered

	Value HMO ($0.00)	Select HMO-POS ($0.00)	Preferred HMO-POS ($160.00)	Salute HMO-POS ($0.00)
ADDITIONAL BENEFITS AND SERVICES				
Virtual Visits See conditions treated and complete an online health interview at https://www.osfhealthcare.org/c/oncall-virtual-visit/.				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Smoking and tobacco use cessation – Quit for Life Program				
In-Network	$0 copay	$0 copay	$0 copay	$0 copay
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
This supplemental program is designed to help you overcome physical, psychological, and behavioral addictions using a seamlessly integrated mix of medication, one-on-one coaching, group video sessions and digital tools for support.				

Form Approved
OMB# 0938-1421

MULTI-LANGUAGE INSERT

Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-317-2410 (TTY: 711).** Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-317-2410.** Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-877-317-2410**。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-877-317-2410**。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-877-317-2410.** Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-877-317-2410.** Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-877-317-2410** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-317-2410.** Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-317-2410**번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-877-317-2410.** Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة مجانية فوري، ليس عليك سوى الاتصال بنا على **1 877 317-2410**. سيقوم شخص ما يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-317-2410**पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-877-317-2410.** Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-877-317-2410.** Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-877-317-2410.** Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-877-317-2410.** Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-877-317-2410**にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Medica.

Medica Advantage®

Medica Central Health Plan is an HMO/HMO-POS with a Medicare Contract. Enrollment in Medica Central Health Plan depends on contract renewal. Medica Central Health Plan markets under the name Medica. This information is not a complete description of benefits. Call 833-942-2153 (TTY: 711)for more information. You must continue to pay your Medicare Part B premium.