# SOUTH DAKOTA EAST
# Medica Advantage® (PPO) Plans

## Summary of Benefits

January 1, 2027 – December 31, 2027

This is a summary of drug and health services covered by **Medica Advantage Essential (PPO)**, **Select (PPO), Preferred (PPO),** and **Salute (PPO)**.

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 **Medica Advantage Essential (PPO)**, **Select (PPO)**, **Preferred (PPO)**, or **Salute (PPO)**).

### Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Medica Advantage** plans 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 **Medica Advantage** Plans
- Monthly Premium, Deductible, and Maximums 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 at 1 (800) 918-2416 (toll-free) (TTY: 711).

H8889-027-001, 028-001, 029-001, 009-000
MCR61132-701026A Y0088_61132_M

Medica

**Things to Know About Medica Advantage Plans**

**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 1 (877) 407-8494 (toll-free) (TTY: 711).
- If you are not a member of this plan, call 1 (800) 918-2416 (toll-free) (TTY: 711).
- Our website: Medica.com/Medicare

**Who Can Join?**

To join **Medica Advantage** plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in **South Dakota:** Brookings, Butte, Campbell, Clark, Codington, Corson, Custer, Davison, Day, Deuel, Dewey, Fall River, Haakon, Hamlin, Harding, Jackson, Kingsbury, Lawrence, Marshall, Meade, Pennington, Perkins, Roberts, Sanborn, Spink, Walworth, and Ziebach.

**Which doctors, hospitals, and pharmacies can I use?**

**Medica Advantage** plans have a network of doctors, hospitals, pharmacies, and other providers. You pay your lowest cost sharing when you visit an in-network provider. You have coverage for services at out-of-network providers, but you may pay more. Coverage for emergency care is the same in network as it is out of network (within the U.S. and its territories) plus you have coverage worldwide. Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*).

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs. You may search for network providers and pharmacies on our website at Medica.com/MyPlanDocs. Or, call us and we will send you a copy of the provider and pharmacy directories.

**What do we cover?**

**Medica Advantage Essential (PPO)**, **Select (PPO)**, and **Preferred (PPO)** cover everything that Original Medicare covers – plus more. Our plans cover medical and hospital services, Part D outpatient prescription drugs, and protect you from unlimited out-of-pocket costs.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, Medica.com/MyPlanDocs. Or, call us and we will send you a copy of the formulary.

**Medica Advantage Salute (PPO)** covers everything that Original Medicare covers – plus more. Our plan covers medical and hospital services and protects you from unlimited out-of-pocket costs.

We cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary and any restrictions on our website, Medica.com/MyPlanDocs. Or, call us and we will send you a copy of the formulary.

**SUMMARY OF BENEFITS**

January 1, 2027 – December 31, 2027

| | **Essential PPO ($40)** | **Select PPO ($80)** | **Preferred PPO ($247)** | **Salute PPO ($0)** |
|---|---|---|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUMS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | | | | |
| Monthly Plan Premium | $40 | $80 | $247 | $0 |
| Part B Premium Buy-Down | Not Applicable | Not Applicable | Not Applicable | $160 per month |
| Medical Deductible | $150 per year | No deductible | No deductible | No deductible |
| Maximum Out-Of-Pocket Responsibility *(does not include prescription drugs)* | In-Network: $7,150<br>In-Network and Out-of-Network combined: $10,750 | In-Network: $7,150<br>In-Network and Out-of-Network combined: $10,750 | In-Network: $4,450<br>In-Network and Out-of-Network combined: $6,700 | In-Network: $4,450<br>In-Network and Out-of-Network combined: $6,700 |

| | **Essential PPO ($40)** | **Select PPO ($80)** | **Preferred PPO ($247)** | **Salute PPO ($0)** |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Inpatient Hospital Coverage | | | | |
| In-Network | $459 copay each day for days 1 through 6<br>$0 copay for days 7 through 90 | $350 copay each day for days 1 through 6<br>$0 copay for days 7 through 90 | $300 copay each day for days 1 through 6<br>$0 copay for days 7 through 90 | $405 copay each day for days 1 through 6<br>$0 copay for days 7 through 90 |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| | $0 copay for up to 60 Medicare-covered lifetime reserve days. * | $0 copay for additional Medicare-covered days. * | $0 copay for additional Medicare-covered days. * | $0 copay for additional Medicare-covered days. * |
| Out-of-Network | $575 copay each day for days 1 through 6 | $435 copay each day for days 1 through 6 | $375 copay each day for days 1 through 6 | $455 copay each day for days 1 through 6 |
| | $0 copay for days 7 through 90 | $0 copay for days 7 through 90 | $0 copay for days 7 through 90 | $0 copay for days 7 through 90 |
| | $0 copay for up to 60 Medicare-covered lifetime reserve days. | $0 copay for additional Medicare-covered days. | $0 copay for additional Medicare-covered days. | $0 copay for additional Medicare-covered days. |
| Outpatient Hospital Coverage | **Outpatient Hospital Services:** | **Outpatient Hospital Services:** | **Outpatient Hospital Services:** | **Outpatient Hospital Services:** |
| In-Network | $0 - $650 copay * | $0 - $450 copay * | $0 - $300 copay * | $0 - $300 copay * |
| Out-of-Network | $0 - $815 copay | $0 - $500 copay | $0 - $375 copay | $0 - $375 copay |
| | **Outpatient Hospital Observation Services:** | **Outpatient Hospital Observation Services:** | **Outpatient Hospital Observation Services:** | **Outpatient Hospital Observation Services:** |
| In-Network | $459 copay per stay | $350 copay per stay | $300 copay per stay | $405 copay per stay |
| Out-of-Network | $575 copay per stay | $435 copay per stay | $375 copay per stay | $455 copay per stay |
| Ambulatory Surgery Center | | | | |
| In-Network | $0 - $550 copay * | $0 - $350 copay * | $0 - $200 copay * | |
| Out-of-Network | $0 - $690 copay | $0 - $435 copay | $0 - $250 copay | |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Doctor Visits | **Primary Care Provider:** | **Primary Care Provider:** | **Primary Care Provider:** | **Primary Care Provider:** |
| In-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| Out-of-Network | $25 copay | $15 copay | $10 copay | $30 copay |
| | **Specialist:** | **Specialist:** | **Specialist:** | **Specialist:** |
| In-Network | $75 copay | $0 - $60 copay | $20 copay | $50 copay |
| Out-of-Network | $90 copay | $15 - $75 copay | $35 copay | $65 copay |
| Preventive Care (e.g., Flu Vaccine, Diabetic Screenings) | | | | |
| In-Network | $0 copay | | | |
| Out-of-Network | $0 copay | | | |
| Emergency Care | $130 copay<br>Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories. | | $150 copay<br>Copay is waived if you are admitted to a hospital within 1 day within the U.S. and its territories. | |
| Urgently Needed Services | $50 copay | $45 copay | $40 copay | |
| Diagnostic and Therapeutic Services/ Labs/Imaging | | | | |
| | **Diagnostic Tests and Procedures:** | **Diagnostic Tests and Procedures:** | **Diagnostic Tests and Procedures:** | **Diagnostic Tests and Procedures:** |
| In-Network | $60 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies.<br>* | $50 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies.<br>* | $50 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies.<br>* | $50 copay for tests other than diagnostic colonoscopies, home-based sleep studies, and facility-based sleep studies.<br>* |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Out-of-Network | $60 copay | $50 copay | $50 copay | $50 copay |
| In-Network | $0 copay for home-based sleep studies and diagnostic colonoscopies. | $0 copay for home-based sleep studies and diagnostic colonoscopies. | $0 copay for home-based sleep studies and diagnostic colonoscopies. | $0 copay for home-based sleep studies and diagnostic colonoscopies. |
| Out-of-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| In-Network | $500 copay for facility-based sleep studies. * | $250 copay for facility-based sleep studies. * | $95 copay for facility-based sleep studies. * | $90 copay for facility-based sleep studies. * |
| Out-of-Network | $500 copay | $250 copay | $95 copay | $90 copay |
| | **Lab Services:** | **Lab Services:** | **Lab Services:** | **Lab Services:** |
| In-Network | $0 copay * | $0 copay * | $0 copay * | $0 copay * |
| Out-of-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| | **Diagnostic Radiology Services (e.g., MRI, CAT Scan):** | **Diagnostic Radiology Services (e.g., MRI, CAT Scan):** | **Diagnostic Radiology Services (e.g., MRI, CAT Scan):** | **Diagnostic Radiology Services (e.g., MRI, CAT Scan):** |
| In-Network | $150 copay for basic imaging | $40 copay for basic imaging | $50 copay for basic imaging | $30 copay for basic imaging |
| Out-of-Network | $150 copay | $40 copay | $50 copay | $30 copay |
| In-Network | $0 copay for diagnostic mammogram | $0 copay for diagnostic mammogram | $0 copay for diagnostic mammogram | $0 copay for diagnostic mammogram |
| Out-of-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| In-Network | $500 copay for advanced imaging * | $100 copay for advanced imaging * | $95 copay for advanced imaging * | $90 copay for advanced imaging * |
| Out-of-Network | $500 copay | $100 copay | $95 copay | $90 copay |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| | **Therapeutic Radiology Services:** | **Therapeutic Radiology Services:** | **Therapeutic Radiology Services:** | **Therapeutic Radiology Services:** |
| In-Network | $85 copay * | $85 copay * | $65 copay * | $80 copay * |
| Out-of-Network | $85 copay | $85 copay | $65 copay | $80 copay |
| | **X-Rays:** | **X-Rays:** | **X-Rays:** | **X-Rays:** |
| In-Network | $75 copay | $25 copay | $0 copay | $25 copay |
| Out-of-Network | $75 copay | $25 copay | $0 copay | $25 copay |
| Hearing Services | **Exam to Diagnose and Treat Hearing and Balance Issues:** | **Exam to Diagnose and Treat Hearing and Balance Issues:** | **Exam to Diagnose and Treat Hearing and Balance Issues:** | **Exam to Diagnose and Treat Hearing and Balance Issues:** |
| In-Network | $0 - $75 copay | $0 - $60 copay | $0 - $20 copay | $0 - $50 copay |
| Out-of-Network | $0 - $90 copay | $0 - $75 copay | $20 - $35 copay | $0 - $65 copay |
| Hearing Services (Continued) | **Routine Hearing Exam – Services from EPIC® Hearing Providers:**<br>Limited to 1 visit per calendar year.<br>$0 copay<br>**Fitting Evaluation(s) for Prescription Hearing Aids – Services from EPIC® Hearing Providers:**<br>One hearing aid fitting-evaluation is available with the purchase of private label Silver, Gold, or Platinum level hearing aids. Additional fitting-evaluation(s) available based on hearing-aid level.<br>$0 copay per fitting-evaluation for hearing aid.<br>**Hearing Aids – All Types of Hearing Aids from EPIC® Hearing Providers:**<br>Unlimited hearing aids every year.<br>$549 copay per Silver level hearing aid, $799 copay per Gold level hearing aid, $1,299 copay per Platinum level hearing aid, and $999 copay per pair of non-prescription (OTC) hearing aids. | | | |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Dental Services – Medicare-Covered | | | | |
| In-Network | $0 - $75 copay | $0 - $60 copay | $0 - $20 copay | $0 - $50 copay |
| Out-of-Network | $0 - $75 copay | $0 - $60 copay | $0 - $20 copay | $0 - $50 copay |
| Dental Services – Preventive (e.g., exams, routine cleanings, and certain x-rays) | | | | |
| In-Network | $0 copay | | | |
| Out-of-Network | 50% of the total cost | | | |
| Dental Services – Comprehensive (e.g., crowns, bridges, root canals, and extractions) Orthodontic services are not covered. | | | | |
| In-Network | Not covered | 50% of the total cost | | |
| Out-of-Network | Not covered | 50% of the total cost | | |
| Dental Services – Maximum annual limit (You are responsible for costs beyond the plan limit.) | NA | $600 every calendar year | $700 every calendar year | $1,500 every calendar year |
| Vision Services | **Exam to Diagnose and Treat Diseases and Conditions of the Eye:** | **Exam to Diagnose and Treat Diseases and Conditions of the Eye:** | **Exam to Diagnose and Treat Diseases and Conditions of the Eye:** | **Exam to Diagnose and Treat Diseases and Conditions of the Eye:** |
| In-Network | $75 copay | $60 copay | $20 copay | $50 copay |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Out-of-Network | $90 copay | $75 copay | $35 copay | $65 copay |
| | **Refraction related to Medicare-covered eye service (1 each calendar year):** | **Refraction related to Medicare-covered eye service (1 each calendar year):** | **Refraction related to Medicare-covered eye service (1 each calendar year):** | **Refraction related to Medicare-covered eye service (1 each calendar year):** |
| In-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| Out-of-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| | **Routine eye exam (1 exam and 1 refraction each calendar year):** | **Routine eye exam (1 exam and 1 refraction each calendar year):** | **Routine eye exam (1 exam and 1 refraction each calendar year):** | **Routine eye exam (1 exam and 1 refraction each calendar year):** |
| In-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| Out-of-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| | **Eyewear After Cataract Surgery:** | **Eyewear After Cataract Surgery:** | **Eyewear After Cataract Surgery:** | **Eyewear After Cataract Surgery:** |
| | One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. | One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. | One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. | One pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. |
| In-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| Out-of-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| | **Contact Lenses, Eyeglasses (Lenses and/ or Frames), and Upgrades:** | **Contact Lenses, Eyeglasses (Lenses and/ or Frames), and Upgrades:** | **Contact Lenses, Eyeglasses (Lenses and/ or Frames), and Upgrades:** | **Contact Lenses, Eyeglasses (Lenses and/ or Frames), and Upgrades:** |
| | Not covered | Not covered | Up to a $200 allowance every calendar year for non-Medicare-covered eyewear from an eyewear | Up to a $200 allowance every calendar year for non-Medicare-covered eyewear from an eyewear |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| | | | location or freestanding vision center that accepts Visa® at point of sale using the Health+ by Medica card. | location or freestanding vision center that accepts Visa® at point of sale using the Health+ by Medica card. |
| Mental Health Services | **Outpatient Group Therapy Visit:** | **Outpatient Group Therapy Visit:** | **Outpatient Group Therapy Visit:** | **Outpatient Group Therapy Visit:** |
| In-Network | $55 copay | $40 copay | $10 copay | $30 copay |
| Out-of-Network | $70 copay | $55 copay | $25 copay | $55 copay |
| | **Outpatient Individual Therapy Visit:** | **Outpatient Individual Therapy Visit:** | **Outpatient Individual Therapy Visit:** | **Outpatient Individual Therapy Visit:** |
| In-Network | $65 copay | $50 copay | $20 copay | $40 copay |
| Out-of-Network | $80 copay | $65 copay | $35 copay | $55 copay |
| | **Inpatient Hospital:** | **Inpatient Hospital:** | **Inpatient Hospital:** | **Inpatient Hospital:** |
| In-Network | $392 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days.<br>* | $350 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days.<br>* | $125 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days.<br>* | $345 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days.<br>* |
| Out-of-Network | $490 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days. | $435 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days. | $155 copay each day for days 1 through 6 and $0 copay for days 7 through 90<br>$0 copay for up to an additional 60 lifetime reserve days. | $395 copay each day for days 1 through 5 and $0 copay for days 6 through 90<br>$0 copay for up to an additional 60 lifetime reserve days. |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Skilled Nursing Facility (SNF) | | | | |
| In-Network | $0 copay for days 1 through 20, a $221 copay each day for days 21 through 54, and $0 copay for days 55 through 100 * | | $0 copay for days 1 through 20, a $221 copay each day for days 21 through 42, and $0 copay for days 43 through 100 * | |
| Out-of-Network | $100 copay each day for days 1 through 20, a $221 copay each day for days 21 through 61, and $0 copay for days 62 through 100 | | $100 copay each day for days 1 through 20, a $221 copay each day for days 21 through 43, and $0 copay for days 44 through 100 | |
| Outpatient Rehabilitation Services | **Physical or Speech Therapy Visit:** | **Physical or Speech Therapy Visit:** | **Physical, Speech, or Occupational Therapy Visit:** | **Physical, Speech, or Occupational Therapy Visit:** |
| In-Network | $75 copay | $60 copay | $20 copay | $50 copay |
| Out-of-Network | $90 copay | $75 copay | $35 copay | $65 copay |
| | **Occupational Therapy Visit:** | **Occupational Therapy Visit:** | | |
| In-Network | $50 copay | $50 copay | | |
| Out-of-Network | $65 copay | $65 copay | | |
| Ambulance Services | **Ground Ambulance:** $370 copay<br>**Air Ambulance:** $475 copay | **Ground Ambulance:** $395 copay<br>**Air Ambulance:** $515 copay | **Ground Ambulance:** $250 copay<br>**Air Ambulance:** $325 copay | **Ground Ambulance:** $395 copay<br>**Air Ambulance:** $475 copay |
| Transportation | Not covered | | | |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **COVERED MEDICAL AND HOSPITAL BENEFITS** | | | | |
| Medicare Part B Drugs<br>Part B rebatable drugs may be subject to a lower coinsurance.<br>For Part B insulin furnished through an external insulin pump, you will pay up to a $35 copay per a one-month supply. Deductibles do not apply. | | | | |
| In-Network | 20% of the total cost * | 20% of the total cost * | | 20% of the total cost * |
| Out-of-Network | 30% of the total cost | 20% of the total cost | | 30% of the total cost |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **PART D PRESCRIPTION DRUG BENEFITS** | | | | |
| Deductible Stage<br>You pay the full cost of your drugs until you reach this amount.<br>The deductible does not apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You will start receiving coverage immediately. | Tiers 1, 2, & 6 = $0<br>Tiers 3, 4, & 5 = $700 | Tiers 1, 2, & 6 = $0<br>Tiers 3, 4, & 5 = $455 | Tiers 1, 2, & 6 = $0<br>Tiers 3, 4, & 5 = $280 | NA |
| Initial Coverage Stage | You will stay in this stage until your yearly out-of-pocket drug costs reach $2,400.<br>In this stage you will pay up to a $35 copay for a one-month (30-day) supply or up to a $105 copay for a three-month (90-day) supply for insulin. | | | NA |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **STANDARD RETAIL COST SHARING** | | | | |
| **Tiers** | **1-month (30-day) supply** | **1-month (30-day) supply** | **1-month (30-day) supply** | **1-month (30-day) supply** |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay | NA |
| Tier 2 (Generic) | $10 copay | $10 copay | $10 copay | NA |
| Tier 3 (Preferred Brand) | 15% coinsurance | 18% coinsurance | 20% coinsurance | NA |
| Tier 4 (Non-Preferred Drug) | 25% coinsurance | 25% coinsurance | 25% coinsurance | NA |
| Tier 5 (Specialty Tier) | 25% coinsurance | 28% coinsurance | 30% coinsurance | NA |
| Tier 6 (Select Care) | $0 copay | $0 copay | $0 copay | NA |
| Insulin | You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. | | | NA |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute (PPO) ($0) |
|---|---|---|---|---|
| **PREFERRED MAIL-ORDER COST SHARING** | | | | |
| **Tiers** | **3-month (90-day) supply** | **3-month (90-day) supply** | **3-month (90-day) supply** | **3-month (90-day) supply** |
| Tier 1 (Preferred Generic) | $0 copay | $0 copay | $0 copay | NA |
| Tier 2 (Generic) | $30 copay | $30 copay | $30 copay | NA |
| Tier 3 (Preferred Brand) | 15% coinsurance | 18% coinsurance | 20% coinsurance | NA |
| Tier 4 (Non-Preferred Drug) | 25% coinsurance | 25% coinsurance | 25% coinsurance | NA |
| Tier 5 (Specialty Tier) | NA | NA | NA | NA |
| Tier 6 (Select Care) | $0 copay | $0 copay | $0 copay | NA |
| Insulin | You won’t pay more than $90 for a three-month supply of each covered insulin product regardless of the cost-sharing tier. | | | NA |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **STANDARD MAIL-ORDER COST SHARING** | | | | |
| **Tiers** | **3-month (90-day) supply** | **3-month (90-day) supply** | **3-month (90-day) supply** | **3-month (90-day) supply** |
| Tier 1 (Preferred Generic) | $48 copay | $45 copay | $39 copay | NA |
| Tier 2 (Generic) | $96 copay | $90 copay | $78 copay | NA |
| Tier 3 (Preferred Brand) | 15% coinsurance | 18% coinsurance | 20% coinsurance | NA |
| Tier 4 (Non-Preferred Drug) | 25% coinsurance | 25% coinsurance | 25% coinsurance | NA |
| Tier 5 (Specialty Tier) | NA | NA | NA | NA |
| Tier 6 (Select Care) | $0 copay | $0 copay | $0 copay | NA |
| Insulin | You won’t pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier. | | | NA |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **PART D COVERAGE STAGES** | | | | |
| **Catastrophic Coverage Stage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, the plan pays the full cost for your covered Part D drugs. You pay nothing. | | | NA |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **ADDITIONAL BENEFITS AND SERVICES** | | | | |
| Annual Physical Exam | | | | |
| In-Network | $0 copay | | | |
| Out-of-Network | $0 copay | | | |
| Cardiac Rehabilitation Services | | | | |
| In-Network | $40 copay | $35 copay | $20 copay | $40 copay |
| Out-of-Network | $55 copay | $50 copay | $35 copay | $60 copay |
| Chiropractic Services | | | | |
| In-Network | $15 copay | $15 copay | | $15 copay |
| Out-of-Network | $35 copay | $30 copay | | $35 copay |
| Diabetic Testing Supplies | **Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, Optium EZ, Optium Neo, Precision Neo, or Precision Xtra) and Ascensia Contour® (Next or Plus) test strips, diabetic testing supplies, and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):** | | **Medicare-covered Abbott FreeStyle® (InsuLinx, Lite, Optium EZ, Optium Neo, Precision Neo, or Precision Xtra) and Ascensia Contour® (Next or Plus) test strips, diabetic testing supplies, and blood glucose monitors (BGMs) and Abbott FreeStyle Libre and Dexcom continuous glucose monitors (CGMs):** | |
| In-Network | $0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions.<br>*<br>$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. | | $0 copay for CGMs when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions.<br>*<br>$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. | |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **ADDITIONAL BENEFITS AND SERVICES** | | | | |
| Out-of-Network | $0 copay for CGMs when obtained at a retail pharmacy or 30% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions.<br>*<br>$0 copay for BGMs, test strips, and diabetic testing supplies when obtained at a retail pharmacy or 30% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. | | $0 copay for CGMs when obtained at a retail pharmacy or 30% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions.<br>*<br>$0 copay for BGMs when obtained at a retail pharmacy or 30% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions.<br>$0 copay for test strips and diabetic testing supplies when obtained at a retail pharmacy or 20% of the total cost when obtained from a medical supplier and for Medica-approved non-preferred manufacturer exceptions. | |
| Durable Medical Equipment (DME) and Related Supplies | | | | |
| In-Network | 19% of the total cost<br>* | 20% of the total cost<br>* | | |
| Out-of-Network | 30% of the total cost | 30% of the total cost | | |
| Health and Wellness Education Programs | **HealthAdvocate℠ 24-hour NurseLine:**<br>$0 copay<br>**One Pass™ Fitness Program:**<br>$0 annual fee | | | |
| Health+ by Medica card | This card can be used to purchase OTC health and wellness products at participating retailers, online, or over the phone | Use this card to pay for eyewear benefits at a licensed eyewear provider that accepts Visa®. This card can also be used to purchase OTC health and wellness products at participating retailers, online, or over the phone. Allowances are added the first month you are enrolled in the plan. All allowance amounts expire as stated in the benefit, at the end of the plan year, or when you leave the plan. | | |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **ADDITIONAL BENEFITS AND SERVICES** | | | | |
| | where Visa® is accepted. Allowances are added the first month you are enrolled in the plan. All allowance amounts expire as stated in the benefit, at the end of the plan year, or when you leave the plan. | | | |
| Home Health Agency Care | | | | |
| In-Network | $0 copay | $0 copay | $0 copay | $0 copay |
| Out-of-Network | 30% of the total cost | 20% of the total cost | 20% of the total cost | 30% of the total cost |
| Over-The-Counter (OTC) Drugs and Supplies | You are eligible for a $15 allowance semi-annually by using the Health+ by Medica card at participating retailers, online, or over the phone. | You are eligible for a $20 allowance semi-annually by using the Health+ by Medica card at participating retailers, online, or over the phone. | You are eligible for a $60 allowance semi-annually by using the Health+ by Medica card at participating retailers, online, or over the phone. | You are eligible for a $100 allowance semi-annually by using the Health+ by Medica card at participating retailers, online, or over the phone. |
| Podiatry Services | | | | |
| In-Network | $75 copay | $60 copay | $20 copay | $50 copay |
| Out-of-Network | $90 copay | $75 copay | $35 copay | $65 copay |
| Pulmonary Rehabilitation Services | | | | |
| In-Network | $35 copay | | $20 copay | $35 copay |
| Out-of-Network | $50 copay | | $35 copay | $70 copay |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **ADDITIONAL BENEFITS AND SERVICES** | | | | |
| Special Supplemental Benefits for the Chronically Ill<br>The benefits mentioned are part of a special supplemental program for the chronically ill. You may be eligible if:<br>• Medica has paid a claim that shows you have been diagnosed with one or more of these chronic conditions, including but not limited to: cancer, cardiovascular disorders, diabetes, chronic lung disorders, and/or dementia.<br>• You have a high risk of hospitalization or other adverse health outcomes.<br>• You require intensive care coordination.<br>Eligibility for this benefit cannot be guaranteed based solely on your condition. All applicable eligibility requirements must be met before the | | | | |

| | Essential PPO ($40) | Select PPO ($80) | Preferred PPO ($247) | Salute PPO ($0) |
|---|---|---|---|---|
| **ADDITIONAL BENEFITS AND SERVICES** | | | | |
| benefit is provided. For details, please contact us.<br>In-Network<br><br><br><br>Out-of-Network | $0 copay<br>Members with chronic conditions who meet certain criteria may be eligible for supplemental benefits for the chronically ill. Benefit includes:<br>• Bathroom and home safety devices<br>• Meal benefit<br>$0 copay | | | |
| Visitor/Traveler Benefit | Visitor/Traveler benefit allows you to stay enrolled in the plan while you're temporarily and continuously outside of the service area (and within the U.S. and its territories) for not more than 6 consecutive months. You may receive all plan covered services at in-network cost sharing when using the Visitor/Traveler benefit. | | | |
| Welcome to Medicare Preventive Visit<br>In-Network<br>Out-of-Network | $0 copay<br>$0 copay | | | |
| Worldwide Emergency Care | 20% of the total cost | | $0 copay | 20% of the total cost |
| Worldwide Emergency Transportation | 20% of the total cost | | $0 copay | 20% of the total cost |

# Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-952-3455 (TTY: 711) for Medica, call 1-877-317-2410 (TTY: 711) for Dean Health Plan/Prevea360 Health Plan, or speak to your provider.

**Spanish:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. También están disponibles de forma gratuita asistencia y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-952-3455 (TTY: 711) para Medica, llame al 1-877-317-2410 (TTY: 711) para Dean Health Plan/Prevea360 Health Plan o hable con su proveedor de atención médica.

**Vietnamese/Việt:** LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-952-3455 (TTY: 711) đối với Medica, gọi theo số 1-877-317-2410 (TTY: 711) đối với Dean Health Plan/Prevea360 Health Plan hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

**Chinese Traditional:** 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-952-3455 (TTY: 711) 聯絡 Medica，致電 1-877-317-2410 (TTY: 711) 聯絡 Dean Health Plan/Prevea360 Health Plan，或與您的提供者討論。

**Hmong/Lus Hmoob:** LUS CEEV: Yog hais tias koj hais Lus Hmoob ces muaj kev pab txhais lus pub dawb rau koj. Muaj khoom siv thiab muaj kev saib xyuas pab uas tsim nyog los npaj kom muaj cov ntaub ntawv uas siv tau dawb. Hu rau 1-800-952-3455 (TTY: 711) rau Medica, hu rau 1-877-317-2410 (TTY: 711) rau Dean Health Plan/Prevea360 Health Plan, los sis tham rau koj tus kws kuaj mob.

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-952-3455 (TTY: 711) für Medica bzw. 1-877-317-2410 (TTY: 711) für Dean Health Plan/Prevea360 Health Plan oder sprechen Sie mit Ihrem Gesundheitsdienstleister.

**Cushitic-Oromo:** XIYYEEFFANNOO: Ingiliffaa dubbattu taanaan, tajaajilli deggersa afaan bilisaa ni jira. Tajaajilli deggersa bu'ura dhiheessii odeeffannoo kaffaltii tokko malee ni jira. Lakkoofsa bilbilaa 1-800-952-3455 (TTY: 711) Tajaajila Fayyaaf, lakkoofsa Medica 1-877-317-2410 (TTY: 711), Dean Health Plan/Prevea360 Health Plan, ykn dhiheessaa keessan dubbisaa.

**العربية/Arabic**

كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تنبيه: (الهاتف النصي: 711) للتواصل مع 1-800-952-3455اتصل على الرقم المعلومات بتنسيقات يمكن الوصول إليها مجانًا. Dean Health Plan، اتصل على الرقم 1-877-317-2410 (الهاتف النصي: 711) بشأن خطة الرعاية الصحية Medica Plan/Prevea360 Health Plan

**Korean/한국어:** 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. Medica 의 경우 1-800-952-3455(TTY: 711)번으로, Dean Health Plan/Prevea360 Health Plan 의 경우 1-877-317-2410(TTY: 711)번으로 전화하시거나, 서비스 제공업체에 문의하십시오.

**Russian/Русский:** Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-952-3455 (TTY: 711) относительно Medica, позвоните по телефону 1-877-317-2410 (TTY: 711) относительно Dean Health Plan/Prevea360 Health Plan или обратитесь к своему поставщику услуг.

**Laos/ ລາວ:** ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ນອກຈາກນີ້ ຈະມີເຄື່ອງຊ່ວຍເສີມ ແລະ
ບໍລິການແບບທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີ 1-800-952-3455 (TTY: 711) ສຳລັບ Medica, ໂທ 1-877-317-2410 (TTY: 711) ສຳລັບ Dean Health Plan/Prevea360 Health Plan ຫຼື ຕິດຕໍ່ຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

**French/ Français:** ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-952-3455 (TTY : 711) pour Medica, appelez le 1-877-317-2410 (TTY : 711) pour le régime de santé Dean Health Plan/Prevea360, ou parlez à votre prestataire de santé.

**Serbo-Croatian:** PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge tumača. Odgovarajuća dodatna pomagala i usluge za pružanje informacija u pristupačnim formatima su takođe dostupne besplatno. Za Medica zdravstveno osiguranje pozovite 1-800-952-3455 (TTY: 711), za Dean/Prevea360 zdravstveno osiguranje pozovite 1-877-317-2410 (TTY: 711) ili razgovarajte sa svojim pružaocem usluga.

**Tagalog:** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-952-3455 (TTY: 711) para sa Medica, tumawag sa 1-877-317-2410 (TTY: 711) para sa Dean Health Plan/Prevea360 Health Plan, o makipag-usap sa iyong tagapagbigay ng serbisyo.

**Karen/ထၢနှာ်လီၤဖဲအံၤ:** ဟ်သူဉ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်နၫ် တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး ပှၤနီၢ်ခိက့ၢ်ဂီၤတဆူဉ်တကျၢၤအဂီၢ် ပီးလီဒီးတၢ်တိစၢၤမၤစၢၤလၢအကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-952-3455 (TTY: 711) လၢ Medica အဂီၢ်, ကိး 1-877-317-2410 (TTY: 711) လၢ Dean Health Plan/Prevea360 Health Plan အဂီၢ်, မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ်နၤတၢ်ကွၢ်ထွဲတက့ၢ်.

**Amharic/ አማርኛ:-** ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። ለMedica በ1-800-952-3455 (TTY: 711) ይደውሉ፣ ለDean የጤና እቅድ/Prevea360 የጤና እቅድ በ1-877-317-2410 (TTY: 711) ይደውሉ ወይም ለእርስዎን አቅራቢ የሆነውን ያነጋግሩ።

Medica.

Medica is a PPO plan with a Medicare contract. Enrollment in Medica depends on contract renewal.

Health+ by Medica card: Card can only be used for Qualified Purchases indicated by your plan provider everywhere Visa® debit cards are accepted. Card is issued by Sutton Bank, pursuant to a license from Visa U.S.A. Inc. Please contact your Program Sponsor directly for a full list of Qualified Purchases. Visa is a registered trademark of Visa, U.S.A. Inc. All other trademarks and service marks belong to their respective owners. No Cash or ATM Access. Terms and conditions apply, contact your Plan Provider for details.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Member Services number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

© 2026 Medica