

Group Medicare–Yakima	SignalAdvantage HMO Option 1 (available for groups only)	SignalAdvantage HMO Option 2 (available for groups only)
Monthly Premium	\$249	\$238
Member Benefits	In-Network Only	In-Network Only
Plan Year Deductible	\$0	\$0
Plan Year Out-of-Pocket Maximum	\$4,000	\$6,700
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$0 copayment
Primary Care Office Visit	\$10 copayment	\$15 copayment
Specialist Office Visit	\$45 copayment	\$50 copayment
Outpatient Diagnostic Procedures/Tests/Lab	\$10 copayment	\$15 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	\$300 copayment	\$300 copayment
Outpatient Radiological Services- X-rays	\$30 copayment	\$30 copayment
Outpatient Hospital Services- Surgery	\$300 copayment	\$350 copayment
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$450 each day for days 1–4, \$0 each day for days 5 and beyond	\$450 each day for days 1–4, \$0 each day for days 5 and beyond
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$160 each day for days 21–100	\$0 each day for days 1–20, \$164 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment
Urgently Needed Care	\$40 copayment	\$55 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance
Preferred brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	0% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	\$0 deductible	\$0 deductible
Tier 1 Preferred Generic at Walgreens and other preferred pharmacies	\$0 copayment	\$0 copayment
Tier 1 Preferred Generic Elsewhere	\$10 copayment	\$10 copayment
Tier 2 Generic	\$20 copayment	\$20 copayment
Tier 3 Preferred Brand	\$20 copayment	\$20 copayment
Tier 4 Non-Preferred Drug	\$100 copayment	\$100 copayment
Tier 5 Specialty Tier	25% coinsurance	25% coinsurance
Coverage Gap Stage One-month (30-day) supply	Prescription Drug Coverage continues through Medicare’s Coverage Gap Stage.	
Catastrophic Coverage One-month (30-day) supply	After member’s yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.	

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies).

Group Medicare– Yakima	SignalAdvantage HMO (available for groups and individuals)	SignalAdvantage HMO Rx (available for groups and individuals)	SignalAdvantage HMO Rx Plus (available for groups and individuals)
Monthly Premium	\$45	\$73	\$106
Member Benefits	In-Network Only	In-Network Only	In-Network Only
Plan Year Deductible	\$0	\$0	\$0
Plan Year Out-of-Pocket Maximum	\$5,900	\$5,900	\$3,900
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$0 copayment	\$0 copayment
Primary Care Office Visit	\$10 copayment	\$10 copayment	\$5 copayment
Specialist Office Visit	\$50 copayment	\$50 copayment	\$35 copayment
Outpatient Diagnostic Procedures/Tests/ Lab	\$5 copayment	\$5 copayment	\$0 copayment
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	\$275 copayment	\$275 copayment	\$150 copayment
Outpatient Radiological Services- X-rays	\$30 copayment	\$30 copayment	\$15 copayment
Outpatient Hospital Services- Surgery	\$350 copayment	\$350 copayment	\$150 copayment
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$360 each day for days 1–5, \$0 each day for days 6 and beyond	\$360 each day for days 1–5, \$0 each day for days 6 and beyond	\$302 each day for days 1–6, \$0 each day for days 7 and beyond
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$167.50 each day for days 21–100	\$0 each day for days 1–20, \$160 each day for days 21–100
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$40 copayment	\$40 copayment	\$30 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	20% coinsurance	20% coinsurance
Preferred brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	0% coinsurance	0% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	20% coinsurance	20% coinsurance
Prescription Drugs (30-day supply)**	N/A	\$0 deductible	\$0 deductible
Tier 1 Preferred Generic at Walgreens and other preferred pharmacies	N/A	\$0 copayment	\$0 copayment
Tier 1 Preferred Generic Elsewhere	N/A	\$9 copayment	\$9 copayment
Tier 2 Generic	N/A	\$20 copayment	\$20 copayment
Tier 3 Preferred Brand	N/A	\$47 copayment	\$47 copayment
Tier 4 Non-Preferred Drug	N/A	50% coinsurance	50% coinsurance
Tier 5 Specialty Tier	N/A	33% coinsurance	33% coinsurance
Coverage Gap Stage One-month (30-day) supply	N/A	From \$3,750 until member's yearly out-of-pocket drug costs reach \$5,000, member pays 44% of generic drugs and 35% for brand-name drugs after the 50% manufacturer discount and 10% brand name coverage.	
Catastrophic Coverage One-month (30-day) supply	N/A	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.	

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All Rx plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies), and 44%/35% generic/brand coverage for non-low income members in the coverage gap.

Group Medicare–Yakima	POS Option 1 (available for groups only)		POS Option 2 (available for groups only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium	\$242		\$282	
Member Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	\$0		\$0	
Plan Year Out-of-Pocket Maximum	\$5,900	\$10,000 (in- and out-of-network combined)	\$3,900	\$6,000 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Primary Care Office Visit	\$10 copayment	30% coinsurance	\$5 copayment	30% coinsurance
Specialist Office Visit	\$50 copayment	30% coinsurance	\$35 copayment	30% coinsurance
Outpatient Diagnostic Procedures/Tests/Lab	\$5 copayment	30% coinsurance	\$0 copayment	30% coinsurance
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	\$275 copayment	30% coinsurance	\$150 copayment	30% coinsurance
Outpatient Radiological Services- X-rays	\$30 copayment	30% coinsurance	\$15 copayment	30% copayment
Outpatient Hospital Services- Surgery	\$350 copayment	30% coinsurance	\$150 copayment	30% coinsurance
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$360 each day for days 1–5, \$0 each day for days 6 and beyond	30% coinsurance	\$302 each day for days 1–6, \$0 each day for days 7 and beyond	30% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$167.50 each day for days 21–100	30% coinsurance	\$0 each day for days 1–20, \$160 each day for days 21–100	30% coinsurance
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$40 copayment	\$40 copayment	\$30 copayment	\$30 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Preferred brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Prescription Drugs (30-day supply)**	\$0 deductible		\$0 deductible	
Tier 1 Preferred Generic at Walgreens and other preferred pharmacies	\$0 copayment		\$0 copayment	
Tier 1 Preferred Generic Elsewhere	\$10 copayment		\$10 copayment	
Tier 2 Generic	\$20 copayment		\$20 copayment	
Tier 3 Preferred Brand	\$20 copayment		\$20 copayment	
Tier 4 Non-Preferred Drug	\$100 copayment		\$100 copayment	
Tier 5 Specialty Tier	25% coinsurance		25% coinsurance	
Coverage Gap Stage One-month (30-day) supply	Prescription Drug Coverage continues through Medicare's Coverage Gap Stage.			
Catastrophic Coverage One-month (30-day) supply	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.			

*Immunizations, annual physical exam, mammograms, pap smears, cancer screenings, and more. Age/frequency schedules apply.

**All plans include 2 x 30-day copay for 90-day scripts filled at Walgreens & preferred pharmacies (2.5 x 30-day copays for 90-day scripts at all other contracted pharmacies).

Group Medicare– Yakima	SignalAdvantage POS (available for groups and individuals)		SignalAdvantage POS Rx (available for groups and individuals)		SignalAdvantage POS Rx Plus (available for groups and individuals)	
Monthly Premium	\$70		\$98		\$131	
Member Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible	\$0		\$0		\$0	
Plan Year Out-of-Pocket Maximum	\$5,900	\$10,000 (in- and out-of-network combined)	\$5,900	\$10,000 (in- and out-of-network combined)	\$3,900	\$6,000 (in- and out-of-network combined)
Be Healthy Annual Physical and Preventive Services*	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment	\$0 copayment
Primary Care Office Visit	\$10 copayment	30% coinsurance	\$10 copayment	30% coinsurance	\$5 copayment	30% coinsurance
Specialist Office Visit	\$50 copayment	30% coinsurance	\$50 copayment	30% coinsurance	\$35 copayment	30% coinsurance
Outpatient Diagnostic Procedures/Tests/ Lab	\$5 copayment	30% coinsurance	\$5 copayment	30% coinsurance	\$0 copayment	30% coinsurance
Outpatient Radiological Services- Complex Diagnostic (e.g. MRI/CT Scans)	\$275 copayment	30% coinsurance	\$275 copayment	30% coinsurance	\$150 copayment	30% coinsurance
Outpatient Radiological Services- X-rays	\$30 copayment	30% coinsurance	\$30 copayment	30% coinsurance	\$15 copayment	30% coinsurance
Outpatient Hospital Services- Surgery	\$350 copayment	30% coinsurance	\$350 copayment	30% coinsurance	\$150 copayment	30% coinsurance
Inpatient Hospital Care <i>Unlimited days each benefit period</i>	\$360 each day for days 1–5, \$0 each day for days 6 and beyond	30% coinsurance	\$360 each day for days 1–5, \$0 each day for days 6 and beyond	30% coinsurance	\$302 each day for days 1–6, \$0 each day for days 7 and beyond	30% coinsurance
Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	\$0 each day for days 1–20, \$167.50 each day for days 21–100	30% coinsurance	\$0 each day for days 1–20, \$167.50 each day for days 21–100	30% coinsurance	\$0 each day for days 1–20, \$160 each day for days 21–100	30% coinsurance
Emergency Care/Post Stabilization Care	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment	\$80 copayment
Urgently Needed Care	\$40 copayment	\$40 copayment	\$40 copayment	\$40 copayment	\$30 copayment	\$30 copayment
Durable Medical Equipment and Prosthetic Devices	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Preferred brand (Abbott) Diabetic Test Strips and Blood Glucose Monitors	0% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance
Non-Preferred Diabetic Test Strips and Blood Glucose Monitors	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Prescription Drugs (30-day supply)**	N/A	N/A	\$0 deductible		\$0 deductible	
Tier 1 Preferred Generic at Walgreens and other preferred pharmacies	N/A	N/A	\$0 copayment		\$0 copayment	
Tier 1 Preferred Generic Elsewhere	N/A	N/A	\$9 copayment		\$9 copayment	
Tier 2 Generic	N/A	N/A	\$20 copayment		\$20 copayment	
Tier 3 Preferred Brand	N/A	N/A	\$47 copayment		\$47 copayment	
Tier 4 Non-Preferred Drug	N/A	N/A	50% coinsurance		50% coinsurance	
Tier 5 Specialty Tier	N/A	N/A	33% coinsurance		33% coinsurance	
Coverage Gap Stage One-month (30-day) supply	N/A	N/A	From \$3,750 until member's yearly out-of-pocket drug costs reach \$5,000, member pays 44% of generic drugs and 35% for brand-name drugs after the 50% manufacturer discount and 10% brand name coverage.			
Catastrophic Coverage One-month (30-day) supply	N/A	N/A	After member's yearly out-of-pocket drug costs reach \$5,000, member pays the greater of: \$3.35 copay for generic drugs and \$8.35 copay for brand-name drugs, OR 5% coinsurance.			

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