Employer Group
Medicare Advantage Plan

City of Racine

Quote Proposal

1/1/2026 - 12/31/2026

PRESENTED BY:

John Whittemore, MBA
Vice President Government Business

Kimberly Gehrke
Director of Individual Medicare Sales

Kristy Van Beek
Client Implementation Executive

Employer Group Medicare Advantage Plan

Renewal Proposal

Group Name: City of Racine

Effective Date: 1/1/2026

	2025 Plans - 2026 Change of Rx OOP	
Plan Name	PPO	
Plan Type	**Network Health Cornerstone 1002 (PPO)**	
Provider Network	INN	OON
Member Monthly Premium	**$163**	
Part B Giveback	**$0**	
Deductible (Part A & B)	$1,000	$1,000
Max Out-of-Pocket	$2,500	$2,500
Professional		
Primary Care (PCP)	20%	20%
Specialty Care	20%	20%
Preventive	$0	$0
Prof X-ray	20%	20%
Prof Diagnostic Test (not Rad)	20%	20%
Prof Diagnostic Radiology	20%	20%
Prof Therapeutic Radiology	20%	20%
Hearing Exam	20%	20%
Vision Service	20%	20%
Mental Health/SA	20%	20%
Chiropractic	20%	20%
Outpatient Hospital		
Emergency Room	20%	20%
Urgent Care	20%	20%
Outpatient Hosp- Surgery	20%	20%
Ambulatory Surg Center	20%	20%
Observation	20%	20%
Low Cost Laboratory	20%	20%
Laboratory	20%	20%
X-Ray	20%	20%
Diagnostic Test (not Rad)	20%	20%
Diagnostic Radiology	20%	20%
Therapeutic Radiology	20%	20%
PT/OT/ST	20%	20%
Psych / SA	20%	20%
Cardiac Rehab	20%	20%
Home Health	20%	20%

Inpatient (Acute)		
IP Acute - Copay / Day	20%	20%
Start Day	1	1
End Day	Unlimited	Unlimited
Cover Unlimited (Y/N)	Y	Y
Inpatient (Mental Health)		
IP MH - Copay / Day	20%	20%
Start Day	1	1
End Day	Unlimited	Unlimited
Cover Unlimited (Y/N)	Y	Y
Skilled Nursing Facility		
IP Acute - Copay / Day	20%	20%
Start Day	1	1
End Day	100	100
Other		
Ambulance	20%	20%
DME, Supplies & Prosthetics	20%	20%
Part B Drugs	20%	20%
Non-Medicare Covered		
Worldwide Emergency	$125	$125
Vision Exams (EyeMed)	$0	$0
Vision Hardware (EyeMed)	Not Covered	Not Covered
Hearing & Speech Exams	Covered	Covered
Hearing Aids (Allowance)	$500	$500
Dental Benefit	Not Covered	Not Covered
Fitness (Optumn)	$0	Not Covered
Routine Physicals	$0	$0
Meals Post-Discharge	28 meals	28 meals
In-home Support Post-Discharge	6 Hours	6 Hours

EMBEDDED DRUG PLAN	
Annual Rx Deductible	$0
Deductible Applies To	NA
Drug Maximum Out of Pocket	**$2,100**
Preferred Retail Rx Copay	**(Per 30-day Supply)**
Tier 1 - Preferred Generic*	$2
Tier 2 - Non-Preferred Generic	$8
Tier 3 - Preferred Brand	20%
Tier 4 - Non-Preferred Brand	25%
Tier 5 - Specialty	25%
Non-Preferred Retail Rx Copay	
Tier 1 - Preferred Generic*	$7
Tier 2 - Non-Preferred Generic	$15
Tier 3 - Preferred Brand	20%
Tier 4 - Non-Preferred Brand	25%
Tier 5 - Specialty	25%
Preferred Mail Rx Copay	**100-Day Supply Tier 1** **90-Day Supply Tier 2-4**
Tier 1 - Preferred Generic	$0
Tier 2 - Non-Preferred Generic	$0
Tier 3 - Preferred Brand	20%
Tier 4 - Non-Preferred Brand	25%
Tier 5 - Specialty	Not Covered
Retail Coverage in Gap	N/A
Total Monthly Premium	$163
Employer Contribution	$163
We accept the following Plan(s):	☐

Group Signature: **Agent Signature:**