MyTru Advantage

2024 Summary of Benefits

January 1, 2024 – December 31, 2024

This booklet summarizes the benefits for MyTruAdvantage HMO, and PPO plans effective January 1 to December 31, 2024. Inside you'll find information to help you make an informed decision on the plan that best meets your needs.

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Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium, and/or copayments/coinsurance may change on January 1 of each year. For a complete list of services covered, including any limitations or exclusions, review the Evidence of Coverage (EOC) document available online at www.MyTruAdvantage.com/Documents-and-Forms. This document is available in other formats such as Braille, large print or audio.

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General

MyTruAdvantage HMO Plans

MyTruAdvantage PPO Plans

Contact Us

Call us.
1-833-213-6731 (TTY: 711)

- October 1 – March 31:
  - 7 days a week, 8:00am – 8:00pm, Local Time
  - On Thanksgiving and Christmas Day, leave us a message and we'll return your call within 1 business day.
- April 1 – September 30:
  - Monday – Friday 8:00am – 8:00pm, Local Time
  - On weekends and holidays, leave us a message and we'll return your call within 1 business day.

Meet with us.
Meet with a licensed Medicare Advisor in person. For more information, call the phone number above. Visit us online. www.MyTruAdvantage.com

MyTruAdvantage offers two plan types, HMO and PPO.

What's the difference?

HMO stands for Health Maintenance Organization. With HMO plans, your coverage applies only to doctors, hospitals, and other providers in the network. No referrals are needed. Except for emergency and urgent care, any service provided by an out-of-network provider will not be covered.

PPO stands for Preferred Provider Organization. With PPO plans, you're covered for benefits received from in-network providers and out-of-network providers. In-network benefits and out-of-network benefits are included in your coverage. Cost shares, such as co-pays or co-insurance, may differ for in-network and out-of-network benefits. Out-of-network benefits may be accessed locally and when you're traveling. No referrals are needed.

The network is the same for the HMO and PPO. The HMO and PPO network includes Columbus Regional Health, Community Health, Deaconess, Schneck Medical Center, and Union Health. The network includes more than 2,200 unique Primary Care Providers, 4,100 specialists, and more than 300 facilities.

Prescription drug benefits have no out-of-network coverage for the HMO or the PPO. If you purchase from an out-of-network pharmacy, you will be responsible for the payment. The pharmacy network includes many options nationally. For information regarding our pharmacy network please visit our website at www.MyTruAdvantage.com/Documents-and-Forms.

Easy Ways to Learn More and Enroll

Call Us at 1-833-213-6731 (TTY: 711)
Review your plan options with a Medicare Advisor over the phone. Our hours change throughout the year.
We are available:

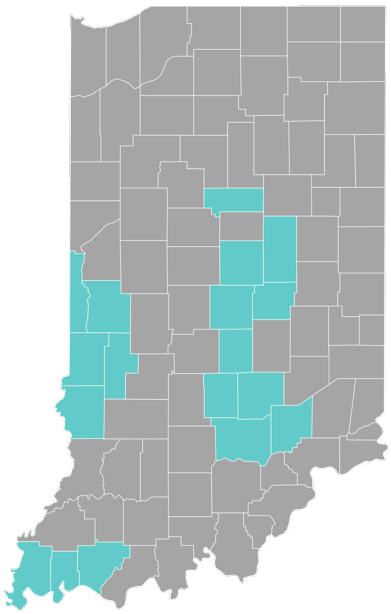
- October 1 – March 31:
  - 7 days a week, 8:00am – 8:00pm, Local Time
  - On Thanksgiving and Christmas Day, leave us a message and we'll return your call within 1 business day.
- April 1 – September 30:
  - Monday – Friday 8:00am – 8:00pm, Local Time
  - On weekends and holidays, leave us a message and we'll return your call within 1 business day.

Visit Our Website at www.MyTruAdvantage.com
Shop our plans, search for your doctors, learn about extra benefits, or chat with us live.

- Find your doctors: www.MyTruAdvantage.com/Documents-and-Forms
  Find your drug list: www.MyTruAdvantage.com/Documents-and-Forms
- Find your pharmacy: www.MyTruAdvantage.com/Documents-and-Forms
- Find the Evidence of Coverage: www.MyTruAdvantage.com/Documents-and-Forms

MyTruAdvantage Service Area in 18 Indiana Counties Including:

Bartholomew	Jackson	Posey
Brown	Jennings	Sullivan
Clay	Johnson	Vanderburgh
Hamilton	Madison	Vermillion
Hancock	Marion	Vigo
Howard	Parke	Warrick



MyTruAdvantage Select (HMO)

MyTruAdvantage Select Plus (HMO)

MyTruAdvantage Choice Plus (PPO)

Red, White and Tru (PPO)
(Medicare Advantage Only Plan)

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand the MyTruAdvantage benefits and rules.

Determining Eligibility

- [ ] In order to join any of our Medicare Advantage plans, you need to be enrolled in Medicare Part A and Part B, and live in the MyTruAdvantage service area.

Understanding the Benefits

- [ ] **Evidence of coverage.** The information in this booklet is not a complete description of benefits. You can review the full list of benefits, including limitations and exclusions, in the Evidence of Coverage (EOC). This is especially important for doctors and services that you use regularly. Visit www.MyTruAdvantage.com/Documents-and-Forms to view the EOC or call 1-833-213-6731 (TTY: 711).
- [ ] **Provider directory.** View the provider directory at www.MyTruAdvantage.com/Documents-and-Forms to see if your doctors are in the network. You can also ask your doctor. If your doctor is not listed, it means services from these doctors are not covered in the HMO and may have a higher cost-share (as out-of-network) in the PPO.
- [ ] **Pharmacy directory.** Review the pharmacy directory at www.MyTruAdvantage.com/Documents-and-Forms to make sure the pharmacy you use for prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- [ ] **Drug coverage.** Review our formulary, or the list of drugs our plans cover, at www.MyTruAdvantage.com/Documents-and-Forms to be sure that the prescriptions you take are covered.

Understanding Important Rules

- [ ] **Part B premium.** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] **Benefits may change every year.** Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.
- [ ] **For the HMOs, we do not cover services by out-of-network providers.** Except in emergency or urgent situations, we do not cover services provided by doctors who are not listed in the provider directory.
- [ ] **For the PPOs, we cover services by out-of-network providers.** While we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

Our hours change throughout the year. You can call us:

- October 1 – March 31:
  - 7 days a week, 8:00am – 8:00pm, Local Time
  - On Thanksgiving and Christmas Day, leave us a message and we'll return your call within 1 business day.
- April 1 – September 30:
  - Monday – Friday 8:00am – 8:00pm, Local Time
  - On weekends and holidays, leave us a message and we'll return your call within 1 business day.

Medicare: You Have Choices

Medicare Benefits

You have choices about how you can get your Medicare benefits:

- Through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- **OR** by joining a Medicare Advantage plan, such as a MyTruAdvantage plan.

Medicare Plan Comparisons

- This Summary of Benefits booklet outlines the MyTruAdvantage plan benefits, cost-shares, and limits.
- To compare MyTruAdvantage plans with other Medicare Advantage plans, please check Medicare Plan Finder at Medicare.gov, or ask other plans for their Summary of Benefits booklets.
- To understand Original Medicare, look in your current "Medicare & You" handbook or view it online at www.medicare.gov, or call 1-800-MEDICARE (800) 633-4227, 24 hours a day, seven (7) days a week. (TTY call (877) 486-2048.)

Important Health Insurance Terms and Definitions

Terms	Definitions
Coinsurance	A percentage of the cost you pay when you receive covered services (for example, 20%).
Copay	A fixed amount you pay when you receive a covered service or supply. For example, you might pay a $35 copay for a specialist doctor visit. Generally, copays are paid at the time you receive services.
Covered services	Health care services and supplies that are paid for by your health plan.
Deductible	A preset dollar amount you pay for covered services before your plan begins to pay. Not all plans have a deductible, and not all services apply.
In-network	A doctor, hospital, facility, or other provider that participates in the MyTruAdvantage network.
Out-of-network	Any doctor, hospital, facility, or other provider that does not participate in the MyTruAdvantage network.
Maximum out-of-pocket	This is the most you will have to pay during the coverage year for covered medical services. Once you reach this limit, your plan will pay all costs for covered medical services. **This is not a deductible.** This limit does not include Part D prescription drug costs.

MyTru Advantage

HMO Summary of Benefits 2024

January 1, 2024 – December 31, 2024

MyTruAdvantage offers two HMOs. Select & Select Plus

HMO stands for Health Maintenance Organization. In the HMOs, your coverage applies only to doctors, hospitals, and other providers in the network. Except emergency and urgent care, any service provided by an out-of-network provider will not be covered. No referrals are needed.

The MyTruAdvantage HMO network includes more than 2,200 unique Primary Care Providers, 4,100 specialists, and more than 300 facilities. Columbus Regional Health, Community Health, Deaconess, Schneck Medical Center, and Union Health all participate in our network.

- Find your doctor or hospital at: www.MyTruAdvantage.com/Documents-and-Forms
- Contact us at 1-833-213-6731 (TTY: 711)
- The pharmacy network includes many options nationally. For information regarding our pharmacy network please visit our website at www.MyTruAdvantage.com/Documents-and-Forms
- Find your pharmacies at: www.MyTruAdvantage.com/Documents-and-Forms
- Find your covered drugs at: www.MyTruAdvantage.com/Documents-and-Forms

Both HMOs feature $0 monthly premium, $0 medical deductible, $0 prescription deductible, and $0 Primary Care Physician copays. You'll select a Primary Care Physician to help you get all the care you need, but no referrals are required for any in-network services or in-network provider, so you can see your specialist (in-network) without needing a referral from your PCP. The HMO also includes supplemental benefits such as preventive and comprehensive dental, vision, hearing, fitness benefits including fitness center memberships, in-home and online programs, and an over-the-counter allowance.

As long as you use in-network providers, you have coverage. If you choose to receive care from an out-of-network provider, then you'll be responsible for the full payment for that visit, except for emergency benefits, you will have coverage.

Premiums and Benefits

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Monthly plan premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.	$0 Per Month In addition, you must keep paying your Medicare Part B premium.
Deductible	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan does not have a deductible ($0).	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan does not have a deductible ($0).
Maximum out-of-pocket	**In-network:** $3,500 yearly	**In-network:** $2,900 yearly
Inpatient hospital coverage[1]	**In-network:** Days 1-6: $295 each day $0 each additional day	**In-network:** Days 1-6: $275 each day $0 each additional day
Outpatient hospital coverage[1]	**Ambulatory surgical center** **In-network:** $175 copay for each visit **Outpatient hospital** **In-network:** $40-$175 copay for each visit **Observation** **In-network:** $175 copay for each stay	**Ambulatory surgical center** **In-network:** $175 copay for each visit **Outpatient hospital** **In-network:** $40-$175 copay for each visit **Observation** **In-network:** $175 copay for each stay
Doctor visits[1]	**Primary care physician (PCP)** **In-network:** $0 copay for each office visit **Specialist visit** **In-network:** $25 copay for each office visit	**Primary care physician (PCP)** **In-network:** $0 copay for each office visit **Specialist visit** **In-network:** $25 copay for each office visit
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-network:** $0 copay for each service	**In-network:** $0 copay for each service
Emergency care This amount is waived if you are admitted to the hospital within 24 hours from your emergency care visit.	**In-network and out-of-network:** $90 copay for each visit	**In-network and out-of-network:** $90 copay for each visit

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Urgently needed services	**In-network and out-of-network:** $35 copay for each visit	**In-network and out-of-network:** $25 copay for each visit
Outpatient diagnostic services (labs, radiology/imaging and x-rays)[1] This includes what you pay for radiology/ imaging services such as a CT scan or MRI, tests/procedures, lab services, outpatient x-rays, and radiation therapy.	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Lab services** **In-network:** $10 copay for each service **Tests/procedures** **In-network:** $10 copay for each service **Outpatient x-rays** **In-network:** $30 copay for each service **Radiation therapy** **In-network:** $40 copay for each service **General radiology/imaging** **In-network:** $40 copay for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Lab services** **In-network:** $10 copay for each service **Tests/procedures** **In-network:** $10 copay for each service **Outpatient x-rays** **In-network:** $10 copay for each service **Radiation therapy** **In-network:** $40 copay for each service **General radiology/imaging** **In-network:** $40 copay for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service
Hearing services Medicare-covered exam performed by a primary care physisican or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be provided by a TruHearing™ provider. One hearing aid covered per ear per year.	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Routine hearing exam** **In-network:** $0 copay one per year **Fitting/evaluation exams for hearing aids** **In-network:** $0 copay **Hearing aids** **In-network:** $699 or $999 depending on the type	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Routine hearing exam** **In-network:** $0 copay one per year **Fitting/evaluation exams for hearing aids** **In-network:** $0 copay **Hearing aids** **In-network:** $699 or $999 depending on the type

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Dental services Preventive (routine) dental services provided by Delta Dental®. See the Delta Dental® Certificate of Coverage for details. Comprehensive dental services provided by Delta Dental®. Please refer to the website under *Delta Dental® Coverage Certificate* for your complete dental coverage: www.MyTruAdvantage.com/Documents-and-Forms.	**Applies to all covered dental services:** **$0 Copay for all covered dental services up to $2000 yearly max.** **Periodontal Maintenance Services:** Periodontal maintenance counts toward the frequency of cleanings (2 total cleanings and/or periodontal maintenance per year. **Dental X-Ray Services** Bitewing X-rays covered once per calendar year. Full mouth series (including bitewing X-rays) or panorex X-rays are covered once every five years. **Restorative Services** Fillings are payable once in any two-year per period for the same tooth and same surface. Crown Repair is covered as needed, per dental provider. **Extraction Services** Simple extractions only. **Prosthodontics Services** Relines and Rebase to existing Full and Partial Dentures covered once every 36 months. Relines and Repairs to existing Bridges and Partial Denture covered once every 36 months. **Brush biopsy covered annually.**	**Applies to all covered dental services:** **$0 Copay for all covered dental services up to $2000 yearly max.** **Periodontal Maintenance Services** Periodontal maintenance counts toward the frequency of cleanings (2 total cleanings and/or periodontal maintenance per year. **Dental X-Ray Services:** Bitewing X-rays covered once per calendar year. Full mouth series (including bitewing X-rays) or panorex X-rays are covered once every five years. **Restorative Services** Fillings are payable once in any two-year per period for the same tooth and same surface. Crown Repair is covered as needed, per dental provider. **Extraction Services** Simple extractions only. **Prosthodontics Services:** Relines and Rebase to existing Full and Partial Dentures covered once every 36 months. Relines and Repairs to existing Bridges and Partial Denture covered once every 36 months. **Brush biopsy covered annually.**
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye, and additional Medicare-covered services. Routine vision services include tests for corrective eyewear. NOTE: $200 allowance annually for eye exam, eyeglasses (frames / lenses), eyeglass lenses, eyeglass frames or contacts.	$0 copayment for Medicare-covered eye exam $0 copayment for glaucoma screening $0 copayment for diabetic retinopathy screening **Applies to routine exams and eyewear:** $0 copay for all eye services/eyewear to $200 yearly max. Will be administered through flex card - MyTruCard. MyTruCard Flex Card Vision Benefits; can be used wherever the card is accepted.	$0 copayment for Medicare-covered eye exam $0 copayment for glaucoma screening $0 copayment for diabetic retinopathy screening **Applies to routine exams and eyewear:** $0 copay for all eye services/eyewear to $200 yearly max. Will be administered through flex card - MyTruCard. MyTruCard Flex Card Vision Benefits; can be used wherever the card is accepted.

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Mental health care[1] We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit** **In-network:** Days 1-5: $295 copay each day Days 6-90: $0 copay each day **Outpatient group therapy** **In-network:** $25 copay for each visit **Outpatient individual therapy** **In-network:** $25 copay for each visit	**Inpatient visit** **In-network:** Days 1-5: $275 copay each day Days 6-90: $0 copay each day **Outpatient group therapy** **In-network:** $25 copay for each visit **Outpatient individual therapy** **In-network:** $25 copay for each visit
Skilled nursing facility (SNF)[1] Our plan covers up to 100 days each benefit period when provided in-network. A benefit period starts the day you go into an SNF and ends when you go for 60 days in a row without SNF care.	**In-network:** Days 1-20: $0 copay each day Days 21-100: $188 copay each day	**In-network:** Days 1-20: $0 copay each day Days 21-100: $188 copay each day
Physical therapy	**In-network:** $35 copay for each visit	**In-network:** $35 copay for each visit
Ambulance[1] Air ambulance transportation to a hospital may be provided if you need immediate and rapid ambulance transportation that ground transportation can't provide. This amount is waived if you are admitted to the hospital within 24 hours from your Ambulance Services.	**Ground:** $260 copay per trip **Air:** $325 copay per trip	**Ground:** $260 copay per trip **Air:** $325 copay per trip
Transportation	Not covered	Not covered
Medicare Part B Drugs[1] Step Therapy may be required for certain Part B drugs (see Chapter 4 section 2.1 "Medicare Part B Drugs" of the EOC at www.MyTruAdvantage.com/Documents-and-Forms for more details).	**Chemotherapy drugs:** **In network** 0 – 20% Coinsurance **Other Part B Drugs** 0 – 20% coinsurance **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a one-month supply of each covered insulin product.	**Chemotherapy drugs:** **In network** 0 – 20% Coinsurance **Other Part B Drugs** 0 – 20% coinsurance **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a one-month supply of each covered insulin product.

[1]Prior Authorizations: For HMO and PPO plans, certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

Prescription Drug

MyTruAdvantage Select (HMO) Prescription Drug Benefits - Part D

Yearly Deductible
$0 per year for all Tiers: Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), Tier 5 (Specialty Tier), Tier 6 (Select Care) and Covered Insulins. There is no deductible for MyTruAdvantage Select (HMO) for covered Insulins.

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non- preferred, mail order, and 30, 60, or 90-day supply). Please see the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms for more information.

Initial Coverage
The pharmacy network includes many options nationally. For information regarding our pharmacy network please visit our website at www.MyTruAdvantage.com/Documents-and-Forms.

Important Message About What You Pay for Vaccines
Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Preferred Retail Cost-Sharing
For a list of preferred pharmacies, go to the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$37 Copay	$74 Copay	$111 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$180 Copay	$270 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$6 Copay	$12 Copay	$18 Copay
Tier 2 (Generic)	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Mail Order Cost-Sharing

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$2 Copay	$4 Copay	$0 Copay
Tier 2 (Generic)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5..*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Coverage Gap
After your total yearly drug costs reach $5,030, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $8,000. MyTruAdvantage Select (HMO) offers additional gap coverage for Covered Insulins. During the Coverage Gap stage, your out-of-pocket costs for Covered Insulins will not exceed $35 for a one-month supply, no matter the cost sharing tier.

Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0 copay.

MyTruAdvantage Select Plus (HMO) Prescription Drug Benefits - Part D

Yearly Deductible
$0 per year for all Tiers: Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), Tier 5 (Specialty Tier), Tier 6 (Select Care Drugs) and Covered Insulins. There is no deductible for MyTruAdvantage Select Plus (HMO) for Covered Insulins.

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non-preferred, mail order, and 30, 60 or 90-day supply). Please see the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms for more information.

Initial Coverage
You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you reach that amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

Important Message About What You Pay for Vaccines
Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$37 Copay	$74 Copay	$111 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$180 Copay	$270 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$6 Copay	$12 Copay	$18 Copay
Tier 2 (Generic)	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Mail Order Cost-Sharing

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$2 Copay	$4 Copay	$0 Copay
Tier 2 (Generic)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Coverage Gap

After your total yearly drug costs reach $5,030, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $8,000. MyTruAdvantage Select Plus (HMO) offers additional gap coverage for Covered Insulins. During the Coverage Gap stage, your out-of-pocket costs for Covered Insulins will not exceed $35 for a one-month supply, no matter what cost sharing tier.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0 copay.

Additional Medical Benefits Covered Under Your Plan

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Annual preventive physical exam	**In-network:** $0 for each service	**In-network:** $0 for each service
Over-the-counter (OTC) card The OTC benefit offers you an easy way to get over-the-counter health and wellness products via a flexible benefit card that can be used at most pharmacies.	**In-network:** Up to $75 every 3 months OTC benefits will be administered through a flex card called MyTruCard. The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused amounts are rolled over to the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next. OTC will cover COVID tests. OTC will be handled using a debit card – MyTruCard. Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.	**In-network:** Up to $75 every 3 months OTC benefits will be administered through a flex card called MyTruCard. The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused amounts are rolled over to the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next. OTC will cover COVID tests. OTC will be handled using a debit card – MyTruCard. Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.
Worldwide emergency, urgently needed care and transportation coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$90 copay for each emergency covered occurrence $35 copay for each urgent covered occurrence $260 copay for ground transportation $325 copay for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $25,000	$90 copay for each emergency covered occurrence $25 copay for each urgent covered occurrence $260 copay for ground transportation $325 copay for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $50,000

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Fitness benefit No-cost, annual fitness center membership: You may go to a Silver&Fit fitness center, YMCA, or exercise center near you that takes part in the Silver&Fit program. To find a participating fitness center, please visit www.SilverandFit.com. • Home Fitness Kits, one per plan year (options include Fitbit® or Garmin® Wearable Fitness Tracker, Yoga Kit, Pilates Kit, Strength Kit, or Swim Kit. • On-demand fitness classes (options include cardio, yoga, strength training and more) • Healthy Aging Coaching by phone, video, or chat • Personal Workout Plan	**In-network and out-of-network:** There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program	**In-network and out-of-network:** There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program
Medicare-covered chiropractic services	**In-network:** $20 copay for each visit	**In-network:** $20 copay for each visit
Medical equipment & supplies[1]	**Durable medical equipment (wheelchairs, oxygen, diabetic testing supplies, etc.)** **In-network:** 20% coinsurance **Medical supplies** **In-network:** 20% coinsurance **Prosthetics (braces, artificial limbs, etc.)** **In-network:** 20% coinsurance	**Durable medical equipment (wheelchairs, oxygen, diabetic testing supplies, etc.)** **In-network:** 20% coinsurance **Medical supplies** **In-network:** 20% coinsurance **Prosthetics (braces, artificial limbs, etc.)** **In-network:** 20% coinsurance
Diabetes services	**Diabetes self-management training** **In-network:** $0 copay for the service **Diabetic supplies and services (e.g., syringes, alcohol swabs, gauze, insulin, inhalers, etc.)** **In-network:** $0 copay for the service **Diabetes monitoring supplies** **In-network:** 20% coinsurance for Medicare-covered **Diabetic shoes or inserts** **In-network:** 15% coinsurance	**Diabetes self-management training** **In-network:** $0 copay for the service **Diabetic supplies and services (e.g., syringes, alcohol swabs, gauze, insulin, inhalers, etc.)** **In-network:** $0 copay for the service **Diabetes monitoring supplies** **In-network:** 20% coinsurance for Medicare-covered **Diabetic shoes or inserts** **In-network:** 15% coinsurance

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Covered Insulin *Important message about what you pay for insulin*	**30-day supply** You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **60-day supply** You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier. **90-day supply** You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier. **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a one-month supply of each covered insulin product.	**30-day supply** You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **60-day supply** You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier. **90-day supply** You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier. **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a one-month supply of each covered insulin product.
Virtual care (Also known as telehealth, virtual visits, or e-visits) Virtual care gives you the option to receive health care services from PCPs, specialists and mental health providers from places like your home, rather than requiring you to go to a healthcare facility.	**Primary care physician (PCP)** $0 copay for each visit **Specialist & Psychiatric** $25 copay for each visit **Individual outpatient mental health & substance abuse** $25 copay for each visit Copayment amounts are the same for Additional Telehealth Services as for in-person services.	**Primary care physician (PCP)** $0 copay for each visit **Specialist & Psychiatric** $25 copay for each visit **Individual outpatient mental health & substance abuse** $25 copay for each visit Copayment amounts are the same for Additional Telehealth Services as for in-person services.

Prior Authorizations: For HMO and PPO plans, certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

MyTru Advantage

PPO Summary of Benefits 2024

January 1, 2024 – December 31, 2024

MyTruAdvantage offers two PPOs.

- One with prescription drug coverage
- One without prescription drug coverage

PPO stands for Preferred Provider Organization. With the PPO, you're covered for benefits received from in-network providers and out-of-network providers. No referrals are needed.

Our PPO network includes more than 2,200 unique Primary Care Providers, 4,100 specialists, and more than 300 facilities. Columbus Regional Health, Community Health, Deaconess, Schneck Medical Center, and Union Health all participate in our network. Out-of-network providers and services in the PPO may be accessed locally and when you're traveling.

- Find your doctor or hospital at: www.MyTruAdvantage.com/Documents-and-Forms Contact us at 1-833-213-6731 (TTY: 711)

In-network benefits and out-of-network benefits are included in your coverage. Cost shares, such as co-pays or co-insurance, may differ for in-network and out-of-network providers. For instance, Complex Radiology/ Imaging (such as CT Scans and MRIs) is $235 copay for in-network and is 40% coinsurance for out-of-network. In some cases, the in-network and out-of-network coverage is the same. For instance, specialist office co-pays are $35 for in-network doctors and also $35 for out-of-network doctors.

Unlike medical benefits, prescription drugs have no out-of-network coverage. If you purchase from an out-of-network pharmacy, you will be responsible for the payment. The pharmacy network includes many options nationally. For information regarding our pharmacy network please visit our website at www.MyTruAdvantage.com/Documents-and-Forms.

- Find your pharmacies at: www.MyTruAdvantage.com/Documents-and-Forms
- Find your covered drugs at: www.MyTruAdvantage.com/Documents-and-Forms
- Contact us at 1-833-213-6731 (TTY: 711)

Both PPOs feature $0 monthly premium, $0 medical deductible, and $0 PCP copay, in-network, and low prescription drug copays. The PPO also includes supplemental benefits such as preventive and comprehensive dental, vision, hearing, fitness benefits including fitness center memberships, in-home and online programs, and an over-the-counter allowance.

Premiums and Benefits

	Red, White and Tru (PPO) (Medicare Advantage Only Plan)	MyTruAdvantage Choice Plus (PPO)
Monthly plan premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.	$0 Per Month In addition, you must keep paying your Medicare Part B premium.
Deductible	**Medical services** This plan does not have a deductible ($0). This plan does not have prescription drug coverage.	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan does not have a deductible ($0).
Maximum out-of-pocket responsibility Does not include prescription drugs or premiums.	**In-network and out-of-network services (combined):** $4,000 yearly	**In-network and out-of-network services (combined):** $4,000 yearly
Inpatient hospital coverage[1]	**In-network:** Days 1-5: $350 copay each day $0 copay each additional day	**In-network and out-of-network:** Days 1-5: $350 copay each day $0 copay each additional day
Outpatient hospital coverage[1]	**Ambulatory surgical center** **In-network and Out-of-network:** $325 copay for each visit **Outpatient hospital** **In-network and Out-of-network:** $35 - $325 copay for each visit **Observation In-network and Out-of-network:** $325 copay for each stay	**Ambulatory surgical center** **In-network and Out-of-network:** $325 copay for each visit **Outpatient hospital** **In-network and Out-of-network:** $35 - $325 copay for each visit **Observation In-network and Out-of-network:** $325 copay for each stay
Doctor visits[1]	**Primary care physician (PCP)** **In-network and Out-of-network:** $0 copay for each office visit **Specialist visit** **In-network and Out-of-network:** $35 copay for each office visit	**Primary care physician (PCP)** **In-network and Out-of-network:** $0 copay for each office visit **Specialist visit** **In-network and Out-of-network:** $35 copay for each office visit

	Red, White and Tru (PPO)	MyTruAdvantage Choice Plus (PPO)
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-network and out-of-network:** $0 copay for each service	**In-network and out-of-network:** $0 copay for each service
Emergency care This amount is waived if you are admitted to the hospital within 24 hours from your emergency care visit.	**In-network and out-of-network:** $90 copay for each visit	**In-network and out-of-network:** $90 copay for each visit
Urgently needed services	**In-network and out-of-network:** $35 copay for each visit	**In-network and out-of-network:** $35 copay for each visit
Outpatient diagnostic services (labs, radiology/imaging and x-rays)[1] This includes what you pay for radiology/imaging services such as a CT scan or MRI, tests/procedures, lab services, outpatient x-rays, and radiation therapy.	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Out-of-network:** 40% coinsurance for each service **Lab services** **In-network and out-of-network:** $15 copay for each service **Tests/procedures** **In-network and out-of-network:** $15 copay for each service **Outpatient x-rays** **In-network and out-of-network:** $30 copay for each service **Radiation therapy** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **General radiology/imaging** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service **Out-of-network:** 40% coinsurance for each service	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Out-of-network:** 40% coinsurance for each service **Lab services** **In-network and out-of-network:** $15 copay for each service **Tests/procedures** **In-network and out-of-network:** $15 copay for each service **Outpatient x-rays** **In-network and out-of-network:** $30 copay for each service **Radiation therapy** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **General radiology/imaging** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service **Out-of-network:** 40% coinsurance for each service
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be provided by a TruHearing™ provider.	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Out-of-network:** $55 copay for each visit **Routine hearing exam** **In-network and out-of-network:** $0 copay up to one per year **Hearing aid** **In-network and out-of-network:** $699 or $999 depending on the type per ear	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Out-of-network:** $55 copay for each visit **Routine hearing exam** **In-network and out-of-network:** $0 copay up to one per year **Hearing aid** **In-network and out-of-network:** $699 or $999 depending on the type per ear

	Red, White and Tru (PPO)	MyTruAdvantage Choice Plus (PPO)
Dental services Preventive (routine) dental services provided by Delta Dental®. See the Delta Dental® Certificate of Coverage for details. Comprehensive dental services provided by Delta Dental®. Please refer to the website under Delta Dental® Coverage Certificate for your complete dental coverage: www.MyTruAdvantage.com/Documents-and-Forms.	**Applies to all covered dental services:** **$0 Copay for all covered dental services up to $1500 yearly max.** **Periodontal Maintenance Services:** Periodontal maintenance counts toward the frequency of cleanings (2 total cleanings and/or periodontal maintenance per year. **Dental X-Ray Services:** Bitewing X-rays covered once per calendar year. Full mouth series (including bitewing X-rays) or panorex X-rays are covered once every five years. **Restorative Services:** Fillings are payable once in any two-year per period for the same tooth and same surface. Crown Repair is covered as needed, per dental provider. **Extraction Services:** Simple extractions only. **Prosthodontics Services:** Relines and Rebase to existing Full and Partial Dentures covered once every 36 months. Relines and Repairs to existing Bridges and Partial Denture covered once every 36 months. **Brush biopsy covered annually.**	**Applies to all covered dental services:** **Copay for all covered dental services up to $2000 yearly max.** **Periodontal Maintenance Services:** Periodontal maintenance counts toward the frequency of cleanings (2 total cleanings and/or periodontal maintenance per year. **Dental X-Ray Services:** Bitewing X-rays covered once per calendar year. Full mouth series (including bitewing X-rays) or panorex X-rays are covered once every five years. **Restorative Services:** Fillings are payable once in any two-year per period for the same tooth and same surface. Crown Repair is covered as needed, per dental provider. **Extraction Services:** Simple extractions only. **Prosthodontics Services:** Relines and Rebase to existing Full and Partial Dentures covered once every 36 months. Relines and Repairs to existing Bridges and Partial Denture covered once every 36 months. **Brush biopsy covered annually.**
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye, and additional Medicare-covered services. Routine vision services include tests for corrective eyewear. NOTE: $200 allowance annually for eye exam, eyeglasses (frames / lenses), eyeglass lenses, eyeglass frames or contacts.	$0 copayment for Medicare-covered eye exam $0 copayment for glaucoma screening $0 copayment for diabetic retinopathy screening **Applies to routine exams and eyewear:** $0 copay for all eye services/eyewear to $200 yearly max. Will be administered through flex card - MyTruCard. MyTruCard Flex Card Vision Benefits; can be used wherever the card is accepted.	$0 copayment for Medicare-covered eye exam $0 copayment for glaucoma screening $0 copayment for diabetic retinopathy screening **Applies to routine exams and eyewear:** $0 copay for all eye services/eyewear to $200 yearly max. Will be administered through flex card - MyTruCard. MyTruCard Flex Card Vision Benefits; can be used wherever the card is accepted.

	Red, White and Tru (PPO)	MyTruAdvantage Choice Plus (PPO)
Mental health care[1] We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit** **In-network and out-of-network:** **Days 1-5:** $350 copay each day **Days 6-90:** $0 each day **Outpatient group therapy** **In-network and out of network:** $35 copay for each visit **Outpatient individual therapy** **In-network and out-of-network:** $35 copay for each visit	**Inpatient visit** **In-network and out-of-network:** **Days 1-5:** $350 copay each day **Days 6-90:** $0 each day **Outpatient group therapy** **In-network and out of network:** $35 copay for each visit **Outpatient individual therapy** **In-network and out-of-network:** $35 copay for each visit
Skilled nursing facility (SNF)[1] Our plan covers up to 100 days each benefit period when provided in-network. A benefit period starts the day you go into an SNF and ends when you go for 60 days in a row without SNF care.	**In-network:** Days 1-20: $0 copay each day Days 21-100: $188 copay each day **Out-of-network:** Days 1-58: $175 copay each day Days 59-100: $0 copay each day	**In-network:** Days 1-20: $0 copay each day Days 21-100: $188 copay each day **Out-of-network:** Days 1-58: $175 copay each day Days 59-100: $0 copay each day
Physical therapy	**In-network:** $35 copay for each visit **Out-of-network:** $55 copay for each visit	**In-network:** $35 copay for each visit **Out-of-network:** $55 copay for each visit
Ambulance[1] Air ambulance transportation to a hospital may be provided if you need immediate and rapid ambulance transportation that ground transportation can't provide. This amount is waived if you are admitted to the hospital within 24 hours from your Ambulance Services.	**In-network and out-of-network:** **Ground:** $260 copay per trip **Air:** $325 copay per trip	**In-network and out-of-network:** **Ground:** $260 copay per trip **Air:** $325 copay per trip
Transportation	Not covered	Not covered
Medicare Part B drugs Step Therapy may be required for certain Part B drugs (see Chapter 4 section 2.1 "Medicare Part B Drugs" of the EOC at www.MyTruAdvantage.com/ Documents-and-Forms for more details).	**Chemotherapy drugs:** **In network:** 0 – 20% Coinsurance **Out of network:** 40% Coinsurance **Other Part B Drugs:** **In network:** 0 – 20% Coinsurance **Out of network:** 40% Coinsurance **Part B Insulins:** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump): You won't pay more than $35 for a one-month supply of each covered insulin product.	**Chemotherapy drugs:** **In network:** 0 – 20% Coinsurance **Out of network:** 40% Coinsurance **Other Part B Drugs:** **In network:** 0 – 20% Coinsurance **Out of network:** 40% Coinsurance **Part B Insulins:** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump): You won't pay more than $35 for a one-month supply of each covered insulin product.

[1]Prior Authorizations: For HMO and PPO plans, certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

Prescription Drug

MyTruAdvantage Choice Plus (PPO) Prescription Drug Benefits - Part D

Yearly Deductible
$0 per year for all Tiers: Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), Tier 5 (Specialty Tier), Tier 6 (Select Care Drugs) and Covered Insulins. There is no deductible for MyTruAdvantage Choice Plus (PPO) for Covered Insulins.

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non- preferred, mail order, and 30, 60, or 90-day supply). Please see the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms for more information.

Initial Coverage
You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you reach that amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

Important Message About What You Pay for Vaccines
Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$37 Copay	$74 Copay	$111 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$180 Copay	$270 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory at www.MyTruAdvantage.com/Documents-and-Forms.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$6 Copay	$12 Copay	$18 Copay
Tier 2 (Generic)	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Mail Order Cost-Sharing

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic) *Includes Enhanced Benefit	$2 Copay	$4 Copay	$0 Copay
Tier 2 (Generic)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Covered Insulin *Important message about what you pay for insulin*	You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier.	You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier.	You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier.

Coverage Gap

After your total yearly drug costs reach $5,030, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $8,000. MyTruAdvantage Choice (PPO) offers additional gap coverage for Covered Insulins. During the Coverage Gap stage, your out-of-pocket costs for Covered Insulins will not exceed $35 for a one-month supply, no matter what cost sharing tier it's on, even if you haven't paid your deductible.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay $0 copay.

Additional Medical Benefits Covered Under Your Plan

	Red, White and Tru (PPO)	MyTruAdvantage Choice Plus (PPO)
Annual preventive physical exam	**In-network:** $0 for each service **Out-of-network:** $0 for each service	**In-network:** $0 for each service **Out-of-network:** $0 for each service
Over-the-counter (OTC) card The OTC benefit offers you an easy way to get over-the-counter health and wellness products via a flexible benefit card that can be used at most pharmacies.	**In-network:** Up to $75 every 3 months OTC will be handled using a flex card – MyTruCard. The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused amounts are rolled over to the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next. OTC will cover COVID tests. OTC will be handled using a debit card – MyTruCard. Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.	**In-network:** Up to $75 every 3 months OTC will be handled using a flex card – MyTruCard. The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused amounts are rolled over to the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next. OTC will cover COVID tests. OTC will be handled using a debit card – MyTruCard. Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.
Worldwide emergency, urgently needed care and transportation coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$90 copay for each emergency covered occurrence $35 copay for each urgent covered occurrence $260 copay per trip for ground transportation $325 copay per trip for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $100,000.	$90 copay for each emergency covered occurrence $35 copay for each urgent covered occurrence $260 copay per trip for ground transportation $325 copay per trip for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $100,000.

	Red, White and Tru (PPO)	MyTruAdvantage Choice Plus (PPO)
Fitness benefit No-cost, annual fitness center membership: You may go to a Silver&Fit fitness center, YMCA, or exercise center near you that takes part in the Silver&Fit program. To find a participating fitness center, please visit www.SilverandFit.com. • Home Fitness Kits, one per plan year (options include Fitbit® or Garmin® Wearable Fitness Tracker, Yoga Kit, Pilates Kit, Strength Kit, or Swim Kit. • On-demand fitness classes (options include cardio, yoga, strength training and more) • Healthy Aging Coaching by phone, video, or chat • Personal Workout Plan	**In-network and out-of-network:** There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program.	**In-network and out-of-network:** There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program.
Medicare-covered chiropractic services	**In-network:** $20 for each visit **Out-of-network:** $55 for each visit	**In-network:** $20 for each visit **Out-of-network:** $55 for each visit
Medical equipment & supplies[1]	**Durable medical equipment (wheelchairs, oxygen, diabetic testing supplies, etc.)** **In-network and out-of-network** 20% coinsurance **Medical supplies** **In-network:** 20% coinsurance **Out-of-network:** 40% coinsurance **Prosthetics (braces, artificial limbs, etc.)** **In-network:** 20% coinsurance **Out-of-network:** 40% coinsurance	**Durable medical equipment (wheelchairs, oxygen, diabetic testing supplies, etc.)** **In-network and out-of-network** 20% coinsurance **Medical supplies** **In-network:** 20% coinsurance **Out-of-network:** 40% coinsurance **Prosthetics (braces, artificial limbs, etc.)** **In-network:** 20% coinsurance **Out-of-network:** 40% coinsurance
Diabetes services	**Diabetes self-management training** **In-network and out-of-network:** $0 copay for the service **Diabetic supplies and services (e.g., syringes, alcohol swabs, gauze, insulin, inhalers, etc.)** **In-network:** $0 copay for the service **Out-of-network:** $0 copay for the service **Diabetic shoes or inserts** **In-network:** 15% coinsurance **Out-of-network:** 0% coinsurance **Diabetic monitoring supplies** **In-network:** 20% coinsurance for Medicare-covered **Out-of-network:** 20% coinsurance for Medicare-covered	**Diabetes self-management training** **In-network and out-of-network:** $0 copay for the service **Diabetic supplies and services (e.g., syringes, alcohol swabs, gauze, insulin, inhalers, etc.)** **In-network:** $0 copay for the service **Out-of-network:** $0 copay for the service **Diabetic shoes or inserts** **In-network:** 15% coinsurance **Out-of-network:** 0% coinsurance **Diabetic monitoring supplies** **In-network:** 20% coinsurance for Medicare-covered **Out-of-network:** 20% coinsurance for Medicare-covered

	Red, White and Tru (PPO)	MyTruAdvantage Choice Plus (PPO)
Covered Insulin *Important message about what you pay for insulin*	**Part D Insulins not covered** **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump): You won't pay more than $35 for a one-month supply of each covered insulin product.	**30-day supply** You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier. **60-day supply** You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier. **90-day supply** You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier. **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump): You won't pay more than $35 for a one-month supply of each covered insulin product.
Virtual care (Also known as telehealth, virtual visits, or e-visits) Virtual care gives you the option to receive health care services from PCPs, specialists and mental health providers from places like your home, rather than requiring you to go to a healthcare facility.	**Primary care physician (PCP)** In-network and out-of-network: $0 copay for each visit **Specialist & Psychiatric** **In-network and out-of-network:** $35 copay for each visit **Individual outpatient mental health & substance abuse** **In-network and out-of-network:** $35 copay for each visit Copayment amounts are the same for Additional Telehealth Services as for in-person services.	**Primary care physician (PCP)** In-network and out-of-network: $0 copay for each visit **Specialist & Psychiatric** **In-network and out-of-network:** $35 copay for each visit **Individual outpatient mental health & substance abuse** **In-network and out-of-network:** $35 copay for each visit Copayment amounts are the same for Additional Telehealth Services as for in-person services.

Prior Authorizations: For both HMO and PPO plans, certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

MyTruAdvantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.425.4280 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語 言援助服務。請致電 1.844.425.4280 (TTY: 711)

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

See the Evidence of Coverage for a complete description of plan benefits, exclusion, limitations, and conditions of coverage.

Other providers are available in our network.

MyTru Advantage

www.MyTruAdvantage.com