MyTruAdvantage Choice Complete (PPO) offered by Southeastern Indiana Health Organization, Inc.

Annual Notice of Change for 2027

You're enrolled as a member of MyTruAdvantage Choice Complete (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in MyTruAdvantage Choice Complete (PPO).
- To change to a **different plan,** visit Medicare.gov or review the list in the back of your *Medicare & You 2027* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at https://www.mytruadvantage.com/information-2027 or call Member Services at 1-844-425-4280 (TTY users call 711) to get a copy by mail.

More Resources

- Call Member Services at 1-844-425-4280 (TTY users call 711). This call is free.

  Hours are:

  - October 1 – March 31:
    - 7 Days a week, 8:00 a.m. – 8:00 p.m., Local Time
    - On Thanksgiving and Christmas Day, leave a message and it will be returned within 1 business day.
  - April 1 – September 30:
    - Monday – Friday, 8:00 a.m. – 8:00 p.m., Local Time
    - On weekends and holidays, leave a message and it will be returned within 1 business day.
- Please call Member Services if you would like to receive materials in alternate formats (e.g., braille, large print, audio CD, or data CD).

About MyTruAdvantage Choice Complete (PPO)

- MyTruAdvantage Choice Complete is a PPO plan with a Medicare contract. Enrollment in MyTruAdvantage Choice Complete (PPO) depends on contract renewal.
- When this material says “we,” “us,” or “our,” it means Southeastern Indiana Health Organization, Inc. When it says “plan” or “our plan,” it means MyTruAdvantage Choice Complete (PPO).
- **If you do nothing by December 7, 2026, you’ll automatically be enrolled in MyTruAdvantage Choice Complete (PPO).** Starting January 1, 2027, you’ll get your medical and prescription drug coverage through MyTruAdvantage Choice Complete (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* *Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	$34.80 per month	**$17 per month**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $3,800 From network and out-of-network providers combined: $3,800	**From network providers: $4,460 From network and out-of-network providers combined: $8,500**
Primary care office visits	**In-Network** $0 copayment per visit. **Out-of-Network** $0 copayment per visit.	**In-Network** **$0 copayment per visit.** **Out-of-Network** **$0 copayment per visit.**
Specialist office visits	**In-Network** $30 copayment per visit. **Out-of-Network** $30 copayment per visit.	**In-Network** **$25 copayment per visit.** **Out-of-Network** **$25 copayment per visit.**

	2026 (this year)	2027 (next year)
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network** Days 1-6: $355 copayment per day Beyond Day 6: $0 copayment per day **Out-of-Network** Days 1-6: $355 copayment per day Beyond Day 6: $0 copayment per day	**In-Network** **Days 1-7: $355 copayment per day** **Beyond Day 7: $0 copayment per day** **Out-of-Network** **Days 1-7: 20% coinsurance per day** **Beyond Day 7: 20% coinsurance per day**
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible The deductible is $200 for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) for MyTruAdvantage Choice Complete (PPO) except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: Standard retail cost sharing (in-network) for up to a 30-day supply: Drug Tier 1: $0 Drug Tier 2: $0 Drug Tier 3: $47	**Part D drug coverage deductible** **The deductible is $500 for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) for MyTruAdvantage Choice Complete (PPO) except for covered insulin products and most adult Part D vaccines.** **Copayment/Coinsurance during the Initial Coverage Stage:** **Standard retail cost sharing (in network) for up to a 30-day supply:** **Drug Tier 1: $0** **Drug Tier 2: $0**

	2026 (this year)	2027 (next year)
	You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 4: 28% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 5: 30% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 6: $0 Preferred retail cost sharing (in-network) for up to a 30-day supply: Drug Tier 1: $0 Drug Tier 2: $0 Drug Tier 3: $41 You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 4: 28% You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 5: 30% You pay no more than $35 per month supply of	**Drug Tier 3: 20%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 4: 25%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 5: 28%** **You pay no more than $35 per month supply of each covered insulin product on this tier.** **Drug Tier 6: $0** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.** **You can have cost sharing for drugs that are covered under our enhanced benefit.**

	2026 (this year)	2027 (next year)
	each covered insulin product on this tier. Drug Tier 6: $0 Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs. You can have cost sharing for drugs that are covered under our enhanced benefit.	

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$34.80	**$17**

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get "Extra Help" with your prescription drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$3,800	**$4,460** **Once you've paid $4,460 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.**
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$3,800	**$8,500** **Once you've paid $8,500 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.**

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2027 *Provider Directory* https://secure.healthx.com/s/directorymytruadvantage to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider Directory*:

- Visit our website at https://www.mytruadvantage.com/information-2027.
- Call Member Services at 1-844-425-4280 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Member Services at 1-844-425-4280 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

Beginning January 1, 2027, our plan will no longer have preferred cost-sharing pharmacies. All network pharmacies will charge the same cost-sharing amount for covered Part D drugs. If you use a preferred cost-sharing pharmacy today, your costs may be different next year. Review the Pharmacy Directory to see your network pharmacy options and check your 2027 drug costs.

Our network of pharmacies has changed for next year. Review the 2027 *Pharmacy Directory* https://openenrollment.medimpact.com/#/web/sih/chooseplan to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at https://www.mytruadvantage.com/information-2027.
- Call Member Services at 1-844-425-4280 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Member Services at 1-844-425-4280 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Ambulance services	**In-Network & Out-of-Network:** You pay a $260 copayment for Medicare-covered ground ambulance services. You pay a $325 copayment for Medicare-covered air ambulance services.	**In-Network:** **You pay a $260 copayment for Medicare-covered ground ambulance services.** **You pay a $325 copayment for Medicare-covered air ambulance services.** **Out-of-Network:** **You pay 50% coinsurance for Medicare-covered ground ambulance services and air ambulance services.**
Cardiac rehabilitation services	**In-Network:** You pay a $35 copayment per Medicare-covered cardiac rehabilitative visit and intensive cardiac rehabilitative visit. **Out-of-Network:** You pay 40% coinsurance of the total cost for Medicare-covered cardiac rehabilitative visit and intensive cardiac rehabilitative visit.	**In-Network:** **You pay a $35 copayment per Medicare-covered cardiac rehabilitative visit and intensive cardiac rehabilitative visit.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered cardiac rehabilitative visit and intensive cardiac rehabilitative visit.**

	2026 (this year)	2027 (next year)
Chiropractic services	**In-Network:** You pay a $20 copayment for Medicare-covered chiropractic services. **Out-of-Network:** You pay a $55 copayment for Medicare-covered chiropractic services.	**In-Network:** **You pay a $15 copayment for Medicare-covered chiropractic services.** **Out-of-Network:** **You pay a $55 copayment for Medicare-covered chiropractic services.**
Dental services	**In Network & Out-of-Network:** You pay a $0 copayment for Medicare-covered dental services. You receive a $2,500 annual allowance for preventive and comprehensive dental services. **Preventive Dental** You pay a $0 copayment for this benefit. **Comprehensive Dental** You pay a $0 copayment for this benefit.	**In Network & Out-of-Network:** **You pay a $0 copayment for Medicare-covered dental services.** **You receive a $2,500 annual allowance for preventive and comprehensive dental services.** **Preventive Dental** **You pay 0% coinsurance of the total cost for this benefit.** **Comprehensive Dental** **You pay 50% coinsurance of the total cost for this benefit.** **Periodontics –** **You pay 0% coinsurance of the total cost for periodontic maintenance.**

	2026 (this year)	2027 (next year)
		You pay 50% coinsurance of the total cost for all other services for this benefit. **Adjunctive General Services –** **You pay 0% coinsurance of the total cost for brush biopsy.** **You pay 50% coinsurance of the total cost for all other services for this benefit.** **Out-of-network exclusions and limitations may apply.**
Diabetic Therapeutic Shoes or Inserts	**In-Network:** You pay 15% coinsurance of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts. **Out-of-Network:** You pay 40% coinsurance of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts.	**In-Network:** **You pay 15% coinsurance of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered Diabetic Therapeutic Shoes or Inserts.**
Dialysis services	**In-Network:** You pay 20% coinsurance of the total cost for Medicare-covered renal dialysis	**In-Network:** **You pay 20% coinsurance of the total cost for Medicare-covered renal**

	2026 (this year)	2027 (next year)
	services. **Out-of-Network:** You pay 20% coinsurance of the total cost for Medicare-covered renal dialysis services.	**dialysis services.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered renal dialysis services.**
Durable Medical Equipment (DME) and related supplies	**In-Network:** You pay 20% coinsurance of the total cost for Medicare-covered DME. You pay 20% coinsurance of the total cost for Continuous Glucose Monitors (CGMs). **Out-of-Network:** You pay 20% coinsurance of the total cost for Medicare-covered DME. You pay 20% coinsurance of the total cost for Continuous Glucose Monitors (CGMs).	**In-Network:** **You pay 20% coinsurance of the total cost for Medicare-covered DME.** **You pay 20% coinsurance of the total cost for Continuous Glucose Monitors (CGMs).** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered DME.** **You pay 50% coinsurance of the total cost for Continuous Glucose Monitors (CGMs).**
Emergency care	**In-Network & Out-of-Network:** You pay a $150 copayment for Medicare-covered emergency room visits.	**In-Network & Out-of-Network:** **You pay a $130 copayment for Medicare-covered emergency room visits.**

	2026 (this year)	2027 (next year)
Fitness Benefit	**In-Network & Out-of-Network:** Members have access to the Silver&Fit® Healthy Aging and Exercise program at no cost. In addition, members can choose 1 (one) home fitness kit per benefit year at no cost. Home kit options include* (1) exercise band, (2) Pilates ball, (3) yoga mat, (4) foam roller, or (5) pedometer, or (6) wearable tracking device.	**In-Network:** **Members have access to the Silver&Fit® Healthy Aging and Exercise program at (no/low) cost. In addition, members can choose 1 (one) wearable tracking device (Fitbit) per benefit year.** **Out-of-Network:** **You pay 80% coinsurance of the total cost for the fitness benefit comparable to the in-network fitness benefit.** **Out-of-network exclusions and limitations may apply.**
Hearing services	**In-Network & Out-of-Network:** You pay a $0 copayment for Medicare-covered Hearing services. You pay a $0 copayment for routine hearing exam. You pay a $0 copayment for hearing aid Fitting/Evaluation Exam. Hearing Aids: Copayments for hearing aids- Standard: $399;	**In-Network:** **You pay a $0 copayment for Medicare-covered Hearing services.** **You pay a $0 copayment for one routine hearing exam.** **You pay a $0 copayment for hearing aid Fitting/Evaluation Exam.** **Hearing Aids:** **Copayments for hearing aids- Standard: $399; Advanced: $599; Premium: $899**

	2026 (this year)	2027 (next year)
	Advanced: $599; Premium: $899	**Out-of-Network:** **You pay a $55 copayment for Medicare-covered Hearing services.** **You pay 80% coinsurance of the total cost for one routine hearing exam.** **You pay 80% coinsurance of the total cost for hearing aid Fitting/Evaluation Exam.** **Hearing Aids:** **You pay 80% coinsurance of the total cost for hearing aids.** **Out-of-network exclusions and limitations may apply.**
Home infusion therapy	**In-Network:** You pay 0%- 20% coinsurance of the total cost for Medicare-covered home infusion therapy. **Out-of-Network:** You pay 40% coinsurance of the cost for Medicare-covered home infusion therapy. Step therapy is required for certain Medicare Part B drugs.	**In-Network:** **You pay 0%- 20% coinsurance of the total cost for Medicare-covered home infusion therapy.** **Out-of-Network:** **You pay 50% coinsurance of the cost for Medicare-covered home infusion therapy.** **Step therapy is not required for Medicare Part B drugs.**

	2026 (this year)	2027 (next year)
Inpatient hospital care	**In-Network & Out-of-Network:** For Medicare-covered hospital stay: Days 1-6: You pay a $355 copayment per day. Beyond Day 6: You pay a $0 copayment per day.	**In-Network:** **For Medicare-covered hospital stay:** **Days 1-7: You pay a $355 copayment per day.** **Beyond Day 7: You pay a $0 copayment per day.** **Out-of-Network:** **For Medicare-covered hospital stay:** **Days 1-7: You pay a 20% coinsurance of the total cost per day.** **Beyond Day 7: You pay a 20% coinsurance of the total cost per day.**
Inpatient services in a psychiatric hospital	**In-Network & Out-of-Network:** For Medicare-covered hospital stay: Days 1-6: You pay a $355 copayment per day. Days 7-90: You pay a $0 copayment per day.	**In-Network:** **For Medicare-covered hospital stay:** **Days 1-6: You pay a $355 copayment per day.** **Days 7-90: You pay a $0 copayment per day.** **Out-of-Network:** **For Medicare-covered hospital stay:** **Days 1-6: You pay 20% coinsurance of the total cost per day.** **Days 7-90: You pay 20% coinsurance of the total cost per day.**

	2026 (this year)	2027 (next year)
Meal Benefit	**In-Network & Out-of-Network:** You pay a $0 copayment for the Meal Benefit.	**In-Network:** **You pay a $0 copayment for the Meal Benefit.** **Out-of-Network:** **You pay a $0 copayment for the Meal Benefit. Medically tailored meals from approved meal providers (not general food establishments) to members following discharge from an inpatient hospital, skilled nursing facility, or rehabilitation facility during the benefit year. To qualify, the plan will provide a referral. The benefit includes 2 meals per day for up to 14 days per discharge occurrence. Benefit not permitted without a 30-day window between discharges. Out-of-network exclusions and limitations may apply.**
Medicare Part B Drugs	**In-Network:** Medicare Part B Insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan. You pay 0-20% coinsurance	**In-Network:** **Medicare Part B Insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan.**

	2026 (this year)	2027 (next year)
	of the total cost for Medicare Part B prescription drugs. **Out-of-Network:** Medicare Part B Insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan. You pay 40% coinsurance of the total cost for Medicare Part B prescription drugs. Step therapy is required for certain Medicare Part B drugs.	**You pay 0-20% coinsurance of the total cost for Medicare Part B prescription drugs.** **Out-of-Network:** **Medicare Part B Insulins: You won't pay more than $35 for a one-month supply of each insulin product covered by our plan.** **You pay 50% coinsurance of the total cost for Medicare Part B prescription drugs.** **Step therapy is not required for Medicare Part B drugs.**
Opioid treatment program services	**In-Network:** You pay a $0 copayment for Medicare-covered opioid treatment program services. **Out-of-Network:** You pay 20% coinsurance of the total cost for Medicare-covered opioid treatment program services.	**In-Network:** **$0 copayment for Medicare-covered opioid treatment program services.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered opioid treatment program services.**

	2026 (this year)	2027 (next year)
Outpatient diagnostic tests and therapeutic services	**In-Network:** You pay a $25 copayment for Medicare-covered Diagnostic Procedures/Tests. You pay a $10 copayment for Medicare-covered Lab Services. You pay a $0 copayment for Medicare-covered DEXA scan. You pay a $0 copayment for Medicare-covered Diagnostic Mammography. You pay a $0 copayment for Medicare-covered blood services. You pay a $60 copayment for Medicare-covered therapeutic radiology. You pay a $25 copayment for Medicare-covered Outpatient X-Ray services. You pay 20% coinsurance of the total cost for Medicare-covered surgical supplies, splints, casts, and other devices. You pay a $235 copayment for Medicare-covered complex diagnostic radiology (CT, MRI, etc.) **Out-of-Network:** You pay a $25 copayment for Medicare-covered Diagnostic	**In-Network:** **You pay a $25 copayment for Medicare-covered Diagnostic Procedures/Tests.** **You pay a $10 copayment for Medicare-covered Lab Services.** **You pay a $0 copayment for Medicare-covered DEXA scan.** **You pay a $0 copayment for Medicare-covered Diagnostic Mammography.** **You pay a $0 copayment for Medicare-covered blood services.** **You pay a $60 copayment for Medicare-covered therapeutic radiology.** **You pay a $25 copayment for Medicare-covered Outpatient X-Ray services.** **You pay 20% coinsurance of the total cost for Medicare-covered surgical supplies, splints, casts, and other devices.** **You pay a $235 copayment for Medicare-covered complex diagnostic radiology (CT, MRI, etc.)** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered**

	2026 (this year)	2027 (next year)
	Procedures/Tests. You pay a $10 copayment for Medicare-covered Lab Services. You pay 0% coinsurance of the total cost for Medicare-covered DEXA Scan. You pay 0% coinsurance of the total cost for Medicare-covered Diagnostic Mammography. You pay 40% coinsurance of the total cost for Medicare-covered blood services. You pay 40% coinsurance of the total cost for Medicare-covered therapeutic radiology. You pay a $25 copayment for Medicare-covered Outpatient X-Ray services. You pay 40% coinsurance of the total cost for Medicare-covered surgical supplies, splints, casts, and other devices. You pay 40% coinsurance of the total cost for Medicare-covered complex diagnostic radiology (CT, MRI, etc.)	**Diagnostic Procedures/Tests.** **You pay 50% coinsurance of the total cost for Medicare-covered Lab Services.** **You pay 0% coinsurance of the total cost for Medicare-covered DEXA Scan.** **You pay 0% coinsurance of the total cost for Medicare-covered Diagnostic Mammography.** **You pay 50% coinsurance of the total cost for Medicare-covered blood services.** **You pay 50% coinsurance of the total cost for Medicare-covered therapeutic radiology.** **You pay 50% coinsurance of the total cost for Medicare-covered Outpatient X-Ray services.** **You pay 50% coinsurance of the total cost for Medicare-covered surgical supplies, splints, casts, and other devices.** **You pay 50% coinsurance of the total cost for Medicare-covered complex diagnostic radiology (CT, MRI, etc.)**

	2026 (this year)	2027 (next year)
Outpatient hospital observation	**In-Network:** You pay a $275 copayment per Medicare-covered outpatient hospital observation service. **Out-of-Network:** You pay a $275 copayment per Medicare-covered outpatient hospital observation service.	**In-Network:** **You pay a $275 copayment per Medicare-covered outpatient hospital observation service.** **Out-of-network:** **You pay 50% coinsurance of the total cost for Medicare-covered outpatient hospital observation services.**
Outpatient hospital services	**In-Network & Out-of-network:** You pay a $35 minimum copayment for Medicare-covered outpatient hospital services. You pay a $350 maximum copayment for Medicare-covered outpatient hospital services. You pay a $275 copayment for each Medicare-covered observation service. You pay a $275 copayment for each Medicare-covered ambulatory surgical center (ASC) service.	**In-Network:** **You pay a $325 copayment for Medicare-covered outpatient hospital services.** **You pay a $275 copayment for each Medicare-covered observation service and ambulatory surgical center (ASC) service.** **Out-of-network:** **You pay 50% coinsurance of the total cost for each Medicare-covered outpatient hospital services, observation service, and ambulatory surgical center (ASC) service.**

	2026 (this year)	2027 (next year)
Over-The-Counter (OTC) Benefit	Over-the-Counter (OTC): $100 quarterly allowance. Unused benefits will be carried forward to the next quarter.	**Over-the-Counter (OTC): $100 quarterly allowance. Unused benefits will not be carried forward to the next quarter.** **In-Network:** **OTC benefit card administered by CVS can be used in store, online, and for catalogue purchases.** **Out-of-Network:** **Over-the-Counter (OTC) benefit is available for reimbursement up to the member's quarterly allowance.** **Out-of-Network exclusions and limitations may apply.**
Partial hospitalization services and Intensive outpatient services	**In-Network:** You pay a $55 copayment for Medicare-covered Partial hospitalization services and Intensive outpatient services. **Out-of-Network:** You pay a $75 copayment for Medicare-covered Partial hospitalization services and Intensive outpatient services.	**In-Network:** **You pay a $55 copayment for Medicare-covered Partial hospitalization services and Intensive outpatient services.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered Partial hospitalization services and Intensive outpatient services.**

	2026 (this year)	2027 (next year)
Personal Emergency Response System (PERS)	**In-Network & Out-of-Network:** You pay a $0 copayment for one Personal Emergency Response System (PERS) device.	**In-Network:** **You pay a $0 copayment for one Personal Emergency Response System (PERS).** **Out-of-Network:** **You pay 80% coinsurance of the total cost for one Personal Emergency Response System (PERS). Out-of-network exclusions and limitations may apply.**
Physician/Practitioner services	**In-Network & Out-of-Network:** You pay a $30 copayment for Medicare-covered specialists visit.	**In-Network & Out-of-Network:** **You pay a $25 copayment for Medicare-covered specialists visit.**
Prosthetic and orthotic devices and related supplies	**In-Network:** You pay 20% coinsurance of the total cost for Medicare-covered prosthetic devices and related supplies. **Out-of-Network:** You pay 40% coinsurance of the total cost for Medicare-covered prosthetic devices and related supplies.	**In-Network:** **You pay 20% coinsurance of the total cost for Medicare-covered prosthetic devices and related supplies.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered**

	2026 (this year)	2027 (next year)
		prosthetic devices and related supplies.
Pulmonary rehabilitation services	**In-Network:** You pay a $35 copayment per Medicare-covered pulmonary rehabilitation service. **Out-of-Network:** You pay 40% coinsurance of the total cost per Medicare-covered pulmonary rehabilitation service.	**In-Network:** **You pay a $35 copayment per Medicare-covered pulmonary rehabilitation service.** **Out-of-Network:** **You pay 50% coinsurance of the total cost per Medicare-covered pulmonary rehabilitation service.**
Skilled nursing facility (SNF)	**In-Network:** For Medicare-covered stays: Days 1-20: You pay a $0 copayment per day. Days 21-100: You pay a $218 copayment per day. **Out-of-Network:** For Medicare-covered stays: Days 1-58: You pay a $175 copayment per day. Days 59-100: You pay a $0 copayment per day.	**In-Network:** **For Medicare-covered stays:** **Days 1-20: You pay a $0 copayment per day.** **Days 21-100: You pay a $221 copayment per day.** **Out-of-Network:** **For Medicare-covered stays:** **Days 1-58: You pay a $175 copayment per day.** **Days 59-100: You pay a $0 copayment per day.**

	2026 (this year)	2027 (next year)
Supervised Exercise Therapy (SET)	**In-Network:** You pay a $30 copayment for Medicare-covered Supervised Exercise Therapy (SET) services. **Out-of-Network:** You pay 40% coinsurance of the total cost for Medicare-covered Supervised Exercise Therapy (SET) services.	**In-Network:** **You pay a $25 copayment for Medicare-covered Supervised Exercise Therapy (SET) services.** **Out-of-Network:** **You pay 50% coinsurance of the total cost for Medicare-covered Supervised Exercise Therapy (SET) services.**
Vision care	**In-Network:** You pay a $0 copayment for Medicare-covered eye exams. You pay a $0 copayment for routine eye exam provided by EyeMed “Insight” provider. $300 annual allowance through EyeMed for qualified eyewear. **Out-of-Network:** You pay a $0 copayment for Medicare-covered eye exams. You receive up to a $40 reimbursement for routine eye exam. You receive up to a $300	**In-Network:** **You pay a $0 copayment for Medicare-covered eye exams.** **You pay a $0 copayment for one routine eye exam provided by EyeMed “Insight” provider.** **$300 annual allowance through EyeMed for qualified eyewear purchased in a single transaction.** **Out-of-Network:** **You pay a $0 copayment for Medicare-covered eye exams.** **You receive up to a $50 reimbursement for one routine eye exam.**

	2026 (this year)	2027 (next year)
	reimbursement for qualified eyewear.	**You receive up to a $300 reimbursement for qualified eyewear purchased in a single transaction. Out-of-network exclusions and limitations may apply.**
Worldwide emergency coverage	**In-Network & Out-of-Network:** You pay a $150 copayment for Worldwide Emergency room services outside the United States.	**In-Network & Out-of-Network:** **You pay a $130 copayment for Worldwide Emergency room services outside the United States.**
Prior Authorization Updates:	**Prior Authorization for the following benefits:** Prior authorization is required for Observation Admissions exceeding 23 hours. Prior authorization is required for Home Health Care visits exceeding 10 visits annually for PT, OT, or Skilled Nursing when extending beyond a consecutive 60-day period. Prior authorization is required for ABA Therapy. Prior authorization is required for PET Scans. Prior authorization is not required for procedures that	**Prior Authorization changes for the following benefits:** **Prior authorization is required for Observation Admissions of 2 or more midnights.** **Prior authorization is required for Home Health Care when extending beyond a consecutive 60-day period.** **Prior authorization is not required for ABA Therapy.** **Prior authorization is required only when the PET Scan is not billed with a cancer diagnosis.**

	2026 (this year)	2027 (next year)
	could be considered cosmetic. Prior authorization is required for dialysis treatment.	**Prior authorization is required for procedures that could be considered cosmetic.** **Prior authorization is not required for dialysis treatment.**

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically and posted online at https://www.mytruadvantage.com/information-2027.

You can get the *complete* Drug List by calling Member Services at 1-844-425-4280 (TTY users call 711) or visiting our website at https://www.mytruadvantage.com/information-2027.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Member Services at 1-844-425-4280 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, call Member Services at 1-844-425-4280 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you reach the yearly deductible.

- ***Stage 2: Initial Coverage***

  In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach $2,400.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage

	2026 (this year)	**2027 (next year)**
Yearly Deductible	The deductible is $200 for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) During this stage, you pay: **Tier 1 (Preferred Generic):** Standard Cost Sharing: You pay $0 per prescription. Preferred Cost Sharing: You pay $0 per prescription.	**The deductible is $500 for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier)** **During this stage, you pay:** **Tier 1 (Preferred Generic):** **Standard Cost Sharing: You pay $0 per prescription.**

	2026 (this year)	2027 (next year)
	Tier 2 (Generic): Standard Cost Sharing: You pay $0 per prescription. Preferred Cost Sharing: You pay $0 per prescription.	**Tier 2 (Generic): Standard Cost Sharing: You pay $0 per prescription.**
	Tier 6 (Select Care Drugs): Standard Cost Sharing: You pay $0 per prescription. Preferred Cost Sharing: You pay $0 per prescription.	**Tier 6 (Select Care Drugs): Standard Cost Sharing: You pay $0 per prescription.**
	During this stage you pay the cost sharing on the drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.	**During this stage you pay the cost sharing on the drugs on Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty Tier) until you have reached the yearly deductible.**

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3 (Preferred Brand Drug), your cost sharing in the Initial Coverage Stage is changing from a copayment to a coinsurance. Go to the following table for the changes from 2026 to 2027.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (next year)
Tier 1 (Preferred Generic):	*Standard Cost Sharing:* You pay $0 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* *Preferred Cost Sharing:* You pay $0 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)* *Mail-Order Prescription:* You pay $2 per prescription. *Enhanced Benefit (Erectile Dysfunction Generic Drug)*	***Standard Cost Sharing:*** **You pay $0 per prescription.** ***Enhanced Benefit (Erectile Dysfunction Generic Drug)*** ***Mail-Order Prescription:*** **You pay $2 per prescription.** ***Enhanced Benefit (Erectile Dysfunction Generic Drug)***
Tier 2 (Generic):	*Standard Cost Sharing:* You pay $0 per prescription. *Preferred Cost Sharing:* You pay $0 per prescription. *Mail-Order Prescription:* You pay $8 per prescription.	***Standard Cost Sharing:*** **You pay $0 per prescription.** ***Mail-Order Prescription:*** **You pay $8 per prescription.**

	2026 (this year)	2027 (next year)
Tier 3 (Preferred Brand):	*Standard Cost Sharing:* You pay $47 per prescription. *Preferred Cost Sharing:* You pay $41 per prescription. *Mail-Order Prescription:* You pay $47 per prescription. You pay no more than $35 per month supply of each covered insulin product on this tier.	***Standard Cost Sharing:*** **You pay 20% of the total cost.** ***Mail-Order Prescription:*** **You pay 20% of the total cost.** **You pay no more than $35 per month supply of each covered insulin product on this tier.**
Tier 4 (Non-Preferred Drug):	*Standard Cost Sharing:* You pay 28% of the total cost. *Preferred Cost Sharing:* You pay 28% of the total cost. *Mail-Order Prescription:* You pay 28% of the total cost per prescription. You pay no more than $35 per month supply of each covered insulin product on this tier.	***Standard Cost Sharing:*** **You pay 25% of the total cost.** ***Mail-Order Prescription:*** **You pay 25% of the total cost.** **You pay no more than $35 per month supply of each covered insulin product on this tier.**

	2026 (this year)	2027 (next year)
Tier 5 (Specialty Tier):	*Standard Cost Sharing:* You pay 30% of the total cost. *Preferred Cost Sharing:* You pay 30% of the total cost. You pay no more than $35 per month supply of each covered insulin product on this tier.	***Standard Cost Sharing:*** **You pay 28% of the total cost.** **You pay no more than $35 per month supply of each covered insulin product on this tier.**
Tier 6 (Select Care Drugs):	*Standard Cost Sharing:* You pay $0 per prescription. *Preferred Cost Sharing*: You pay $0 per prescription. *Mail-Order Prescription:* You pay $0 per prescription.	***Standard Cost Sharing:*** **You pay $0 per prescription.** ***Mail-Order Prescription:*** **You pay $0 per prescription.**

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Updated Plan Service Area	Our service area includes these counties in Indiana: Bartholomew, Brown, Clay, Decatur, Dubois, Gibson, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Jackson, Jennings, Johnson, Madison, Marion, Parke, Perry, Pike, Posey, Shelby, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, and Warrick	**Our service area includes these counties in Indiana: Bartholomew, Boone, Brown, Clay, Daviess, Decatur, Dubois, Gibson, Greene, Hamilton, Hancock, Hendricks, Henry, Howard, Jackson, Jennings, Johnson, Knox, Madison, Marion, Parke, Perry, Pike, Posey, Rush, Scott, Shelby, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick, Washington**

SECTION 3 How to Change Plans

To stay in MyTruAdvantage Choice Complete (PPO), you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, you'll automatically be enrolled in our MyTruAdvantage Choice Complete (PPO).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from MyTruAdvantage Choice Complete (PPO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from MyTruAdvantage Choice Complete (PPO).

- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Member Services at 1-844-425-4280 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit Medicare.gov, check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Southeastern Indiana Health Organization, Inc. offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
    - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday -Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
    - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** Indiana has a program called HoosierRx that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Indiana State Department of Health, HIV/STD Viral Hepatitis Division. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-866-588-4948. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be

automatically renewed for 2027. You do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-844-425-4280 (TTY users call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from MyTruAdvantage Choice Complete (PPO)

- **Call Member Services at 1-844-425-4280. (TTY users call 711)**

  We're available for phone calls. Calls to these numbers are free.

  Hours are:

  - October 1 – March 31:
    - 7 Days a week, 8:00 a.m. – 8:00 p.m., Local Time
    - On Thanksgiving and Christmas Day, leave a message and it will be returned within 1 business day.
  - April 1 – September 30:
    - Monday – Friday, 8:00 a.m. – 8:00 p.m., Local Time
    - On weekends and holidays, leave a message and it will be returned within 1 business day.

  Member Services also has free language interpreter services available for non-English speakers.

- **Read your 2027 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for MyTruAdvantage Choice Complete (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at https://www.MyTruAdvantage.com/information-2027 or call Member Services at 1-844-425-4280 (TTY users call 711) to ask us to mail you a copy.

- **Visit https://www.MyTruAdvantage.com/information-2027**

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Indiana, the SHIP is called Indiana State Health Insurance Assistance Program.

Call Indiana State Health Insurance Assistance to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Indiana State Health Insurance Assistance at 1-800-452-4800. Learn more about Indiana State Health Insurance Assistance by visiting https://www.in.gov/ship.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with** Medicare.gov

  You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You* 2027**

  The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Notice of Nondiscrimination and Language Assistance Services

MyTruAdvantage complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. MyTruAdvantage does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Federal law requires that we provide you with this Notice of Nondiscrimination and Language assistance services.

Free aids and services

MyTruAdvantage provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

MyTruAdvantage provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact MyTruAdvantage Member Services by calling 1.844.425.4280 (TTY users call x711). Hours are 8:00 a.m. - 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within one (1) business day.

To file a civil rights grievance

If you believe that MyTruAdvantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

MyTruAdvantage
Attention: Compliance Officer
P.O. Box 428
Columbus, IN 47202
Toll free: 1.844.372.8392
(TTY users call x711) Fax: 855.633.7673
compliance@mytruadvantage.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MyTruAdvantage Member Services and the Compliance Officer are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

Phone: 1.800.368.1019, 1.800.537.7697 (TDD)
Complaint forms are available at *hhs.gov/ocr/office/file/index.html*.

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 1-844-425-4280 (TTY: 711) for or speak to your provider.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-425-4280 (TTY: 711) o hable con su proveedor.

Việt (Vietnamese)
LƯU Ý: Nếu bạn 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 1-844-425-4280 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

中文 **(Chinese-Simplified)**
注意：如果您说 中文， 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-844-425-4280 （文本电话：711）或咨询您的服务提供商。

РУССКИЙ (Russian)
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-425-4280 (TTY: 711) или обратитесь к своему поставщику услуг.

한국어 (Korean)
주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용

가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-425-4280 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

日本語 (Japanese)
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-425-4280 （TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

العربية (Arabic)
انية .كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات
بتنسيقات يمكن الوصول إليها مجانًا .اتصل على الرقم 1-844-425-4280- (711) أو تحدث إلى مقدم الخدمة.

Deutsch (German)
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 1-844-425-4280 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Pennsylvanisch Deitsch (Pennsylvania Dutch)
Uffgepasst: Wann Sie Pennsylvaanisch Deitsch schwetze, sinn freie Schprooch Helfe-Services fer Sie do. B passende Hilfsmiddel un Services fer Information in leicht grickliche Wege gewwe sinn aa frei. Ruf 1-844-425-4280 (TTY: 711) fer oder schwetz zu deim Dokter.

Nederlands (Dutch)
Aandacht: Als u Nederlands spreekt, zijn er gratis taalassistentiediensten voor u beschikbaar. Passende hulpmiddelen en diensten voor informatie in toegankelijke formaten zijn ook gratis. Bel 1-844-425-4280 (TTY: 711) of spreek met uw zorgaanbieder.

ဂရုစိုက်ပါ (Burmese)
သင်သည် အင်္ဂလိပ်စကား ပြောနိုင်ပါက အခမဲ့ဘာသာစကားကူညီမှု ဝန်ဆောင်မှုများ ရရှိနိုင်ပါသည်။ အသေးစိတ်အချက်အလက်များကို စီစဉ်ရင်း ဝင်ရောက်သုံးစွဲနိုင်သော ဖော်မတ်များအား ပေးစွပ်စနစ်များနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ရရှိနိုင်ပါသည်။ ၁-၈၀၀-၃၃၀-၂၇၃၂ ကို ဖုန်းခေါ်ပါ (TTY: 711) သို့မဟုတ် သင်၏ ပေးသူနှင့် ပြောပါ

Français (French)
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 1-844-425-4280 (TTY : 711) ou parlez à votre fournisseur.

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 1-844-425-4280 (TTY: 711) o makipag-usap sa iyong provider.

िहंदी (Hindi)
ान दें: यिद आप िहंदी बोलते हैं, तो आपके िलए िनः शु भाषा सहायता सेवाएं उपल होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के िलए उपयु4 सहायक साधन और सेवाएँ भी िनः शु उपल हैं। 1-844-425-4280 (TTY: 711) पर कॉल करें याअपने प्रदाता से बात करें।

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੀਆਂ ਸਹਾਇਕ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1-844-425-4280 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal.

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.