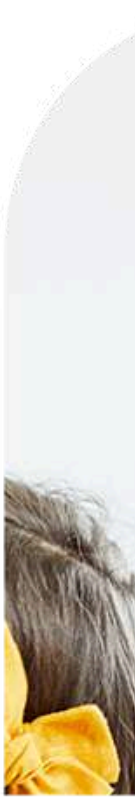
MyTru Advantage



2027 Summary of Benefits

January 1, 2027 – December 31, 2027

This booklet summarizes the benefits for MyTruAdvantage HMO and PPO plans effective January 1 to December 31, 2027. 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/Information-2027.
This document is available in other formats such as Braille, Large Print, Audio CD and Data CD.

Table of Contents

General

MyTruAdvantage HMO Plan

MyTruAdvantage PPO Plans

MyTruAdvantage MA-Only PPO Plan

MyTruAdvantage offers HMO and PPO plans.

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. Out-of-network providers are not covered under the HMO plans. However, emergency and urgent care services are covered out-of-network.

PPO stands for Preferred Provider Organization.
With PPO plans, you're covered for benefits received from in-network providers and out-of-network providers. Cost shares, such as copays or coinsurance, 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 MyTruAdvantage network is the same for the HMO and PPO.
The network includes more than 5,000 unique primary care providers, 11,900 specialists, and 800 facilities.

Prescription drug benefits have limited out-of-network coverage for the HMO and PPO plans.
Due to coverage limitations, purchasing your prescriptions from an out-of-network pharmacy may lead to higher out of pocket costs. The pharmacy network includes thousands of retail pharmacies nationwide, including independent pharmacies. For information regarding our pharmacy network please visit our website at www.MyTruAdvantage.com/Information-2027.

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 or visit us online at www.MyTruAdvantage.com.

2027 Service Area Map and Plans

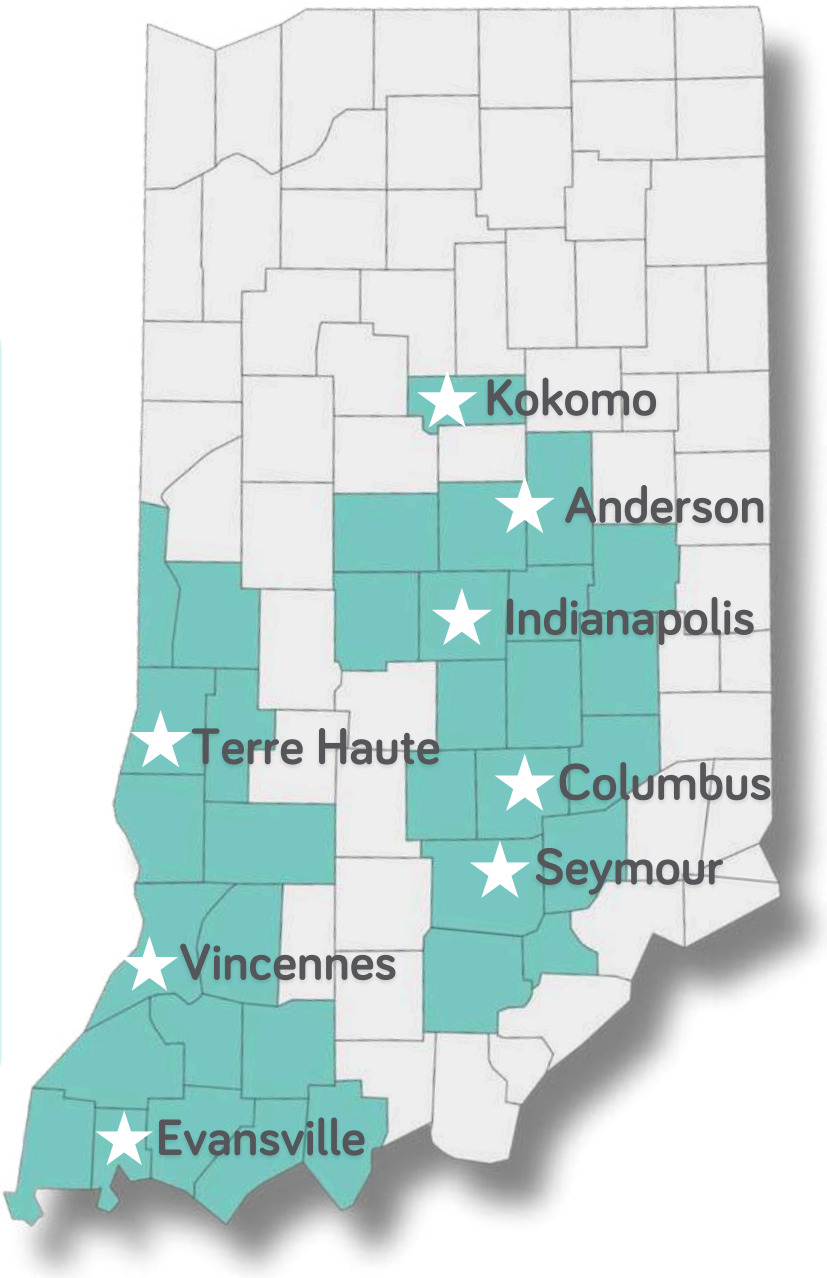
2027 Plans

MyTruAdvantage Select (HMO)

MyTruAdvantage Choice Plus (PPO)

MyTruAdvantage Choice Complete (PPO)

MyTruAdvantage Red, White and Tru (MA-Only PPO)



MyTruAdvantage Service Area

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

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. Information in this Summary of Benefits 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/Information-2027 to view the EOC or call 1-833-213-6731 (TTY: 711).

- [ ] Provider directory. View the provider directory at www.MyTruAdvantage.com/Information-2027 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. View the pharmacy directory at www.MyTruAdvantage.com/Information-2027 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/information-2027 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, 2028.

- [ ] For the HMO, 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 contracted with the plan.

- [ ] 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 at 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.

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 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 Medicare Part D drug costs by spreading them across the calendar year (January- December).

In 2027, 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 and participation is voluntary.

If you select this payment option, each month you'll continue to pay your plan premium (if you have one), and you'll get a bill from your health or drug plan to pay for your prescription drugs (instead of paying at the pharmacy). There is no extra cost to participate in the Medicare Prescription Payment Plan.

Medicare Plan Comparisons

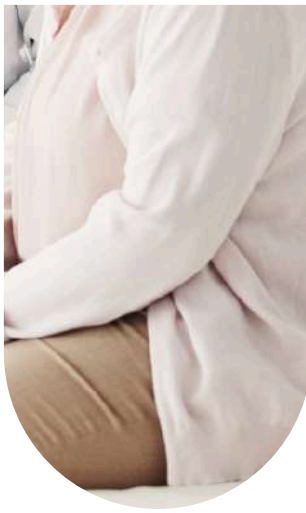
- This Summary of Benefits booklet outlines the MyTruAdvantage plan benefits, cost-shares, and limits.
- To compare MyTruAdvantage plans with other Medicare Advantage plans, please check the Medicare Plan Finder at Medicare.gov, or ask other plans for their Summary of Benefits booklets.
- To understand Original Medicare, look in your current "Medicare & You" handbook, 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.)

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.
Premium	A regular payment (usually monthly) that you pay to keep your health insurance policy active, regardless of whether you use any medical services.

MyTru Advantage

MyTruAdvantage Select (HMO)



HMO stands for Health Maintenance Organization.

In the HMO plan, your coverage applies only to doctors, hospitals, and other providers in the network.

Out-of-network providers are not covered under the HMO plan. However, emergency and urgent care services are covered out-of-network.

The network includes more than 5,000 unique primary care providers, 11,900 specialists, and 800 facilities.

- Find your doctor or hospital at: www.MyTruAdvantage.com/Information-2027.
- Contact us at 1-833-213-6731 (TTY: 711)

The pharmacy network includes thousands of pharmacies nationwide, including independent pharmacies.

- To find your pharmacies and covered drugs please visit our website at: www.MyTruAdvantage.com/Information-2027.
- Contact us at 1-833-213-6731 (TTY: 711)

MyTruAdvantage Select HMO features a $0 monthly premium, $0 PCP copay, and low prescription drug copays and coinsurance.

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 visits. 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 care, vision, hearing, fitness programs, meal support, a Personal Emergency Response System (PERS), 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 urgent care or emergency benefits where you will have coverage.

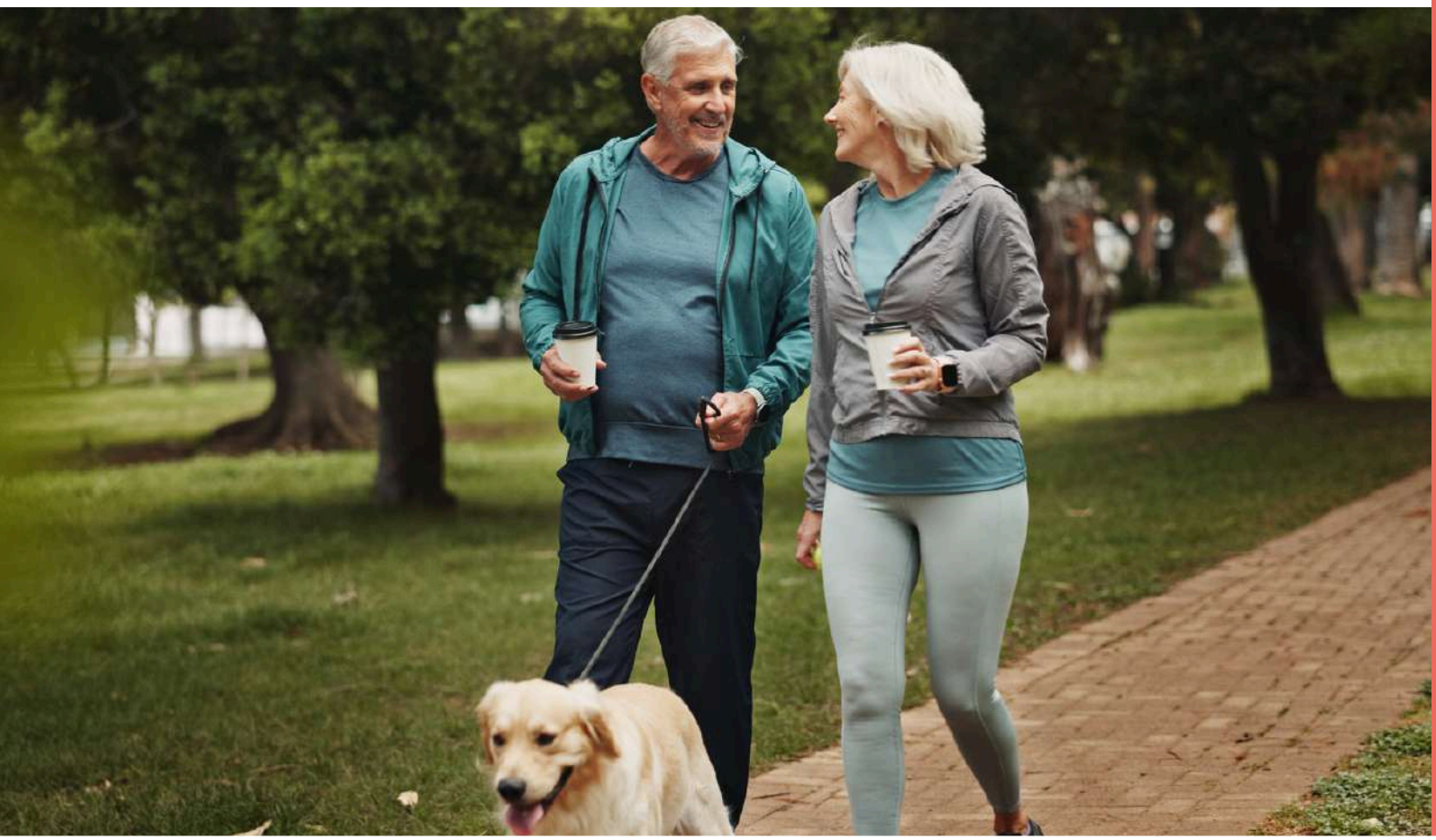
Premiums and Benefits

January 1, 2027 – December 31, 2027

	MyTruAdvantage Select (HMO)
Monthly Plan 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 has a deductible ($300). **Deductible applies to Tier 3, Tier 4, and Tier 5**
Maximum Out-of-Pocket Responsibility Does not include prescription drugs or premiums.	In-network services: $3,900 yearly
Inpatient Hospital Coverage[1]	In-network: Days 1-6: $385 copay each day Beyond Day 6: $0 copay each day
Outpatient Hospital Coverage[1]	**Outpatient Hospital** In-network: $325 copay for each visit **Outpatient Observation** In-network: $250 copay for each stay
Ambulatory Surgical Center (ASC) Services[1]	In-network: $300 copay for each visit
Doctor Visits	**Primary Care Physician (PCP)** In-network: $0 copay for each office visit **Specialist Visit** In-network: $30 copay for each office visit

	MyTruAdvantage Select (HMO)
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	In-network: $0 copay
Emergency Care This amount is waived if you are admitted to the hospital within 24 hours from your emergency care visit.	In-network: $150 copay for each visit
Urgently Needed Services	In-network: $30 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 **Lab Services** In-network: $10 copay **Tests/Procedures** In-network: $25 copay **Outpatient X-Rays** In-network: $25 copay **Radiation Therapy** In-network: $40 copay **General Radiology/Imaging** In-network: $40 copay **Complex Radiology/Imaging (such as MRI and CT scan)** In-network: $205 copay
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. 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 once a year **Fitting/Evaluation Exams for Hearing Aids** In-network: $0 copay **Hearing Aids** In-network: Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00

	MyTruAdvantage Select (HMO)
Dental Services In-network preventive (routine) and comprehensive dental services are provided through the Delta Dental® Medicare Advantage "PPO + Premier" Network, with dentists located in IN, MI & OH. For complete details about your covered dental benefits, review your Delta Dental Member Handbook at: www.MyTruAdvantage.com/information- 2027.	**Applies to all covered dental services:** **Up to $2,000 yearly max for covered services.** In-network: You pay 0% coinsurance of the total cost for Medicare-covered dental services. Preventive Dental: You pay 0% coinsurance for covered services Comprehensive Dental: You pay 50% coinsurance for most covered services
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 exam and eyewear must be provided by an EyeMed® "Insight" Network provider.	In-network: **Medicare-Covered Eye Exam:** $0 copay for each exam **Routine Eye Exam:** $0 copay once a year **Eyewear:** Up to $300 annual allowance for one qualified eyewear purchase. Note: Qualified eyewear purchase includes single transaction of either glasses (frames & lenses), frames, lenses or contacts.



	MyTruAdvantage Select (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 1-6: $385 copay each day Days 7-90: $0 copay each day **Outpatient Group Therapy** In-network: $30 copay for each visit **Outpatient Individual Therapy** In-network: $30 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 a 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: $221 copay each day
Physical Therapy and Other Rehabilitation Services[1]	**Physical and Speech-Language Therapy** In-network: $20 copay for each visit **Occupational Therapy** 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.	In-network: Ground: $260 copay per trip Air: $325 copay per trip
Transportation	Not covered
Medicare Part B Drugs[1]	**Chemotherapy Drugs** In-network: 0–20% coinsurance **Other Part B Drugs** In-network: 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. Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

MyTruAdvantage Select (HMO) Prescription Drug Benefits - Part D

Continuing in 2027
There are three drug payment stages: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

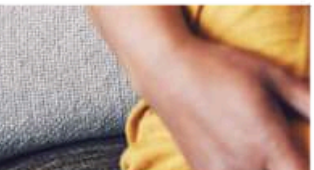
Please note, costs may differ based on pharmacy type or day supply (e.g., retail, mail order, and 30, 60, 90 or 100-day supply).
Please see the Pharmacy Directory at www.MyTruAdvantage.com/information-2027 for more information.

Yearly Deductible
MyTruAdvantage Select (HMO) has a $300 deductible for Part D prescription drugs that applies to the following tiers: Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty). There is no deductible for MyTruAdvantage Select (HMO) covered insulins.

Initial Coverage
The Medicare Drug Coverage (Part D) will have an annual out-of-pocket maximum of $2,400 for MyTruAdvantage Select (HMO). This annual out-of-pocket (also referred to as your TrOOP) does not apply to out-of-pocket spending on Part B drugs or excluded drugs. Medicare Part B covers drugs that are administered by a doctor, nurse, or other healthcare provider in an outpatient setting, such as a doctor's office. For example, some cancer drugs and injectable drugs are covered under Part B. You may get your drugs at network retail pharmacies and mail-order pharmacies.

Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, you pay $0 copay for the remainder of the year.

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.



30-Day Supply - MyTruAdvantage Select (HMO)

Tier	Retail	Mail Order
Tier 1: Preferred Generic **Includes Enhanced Benefit*	$0 Copay	$2 Copay
Tier 2: Generic	$0 Copay	$8 Copay
Tier 3: Preferred Brand	20% Coinsurance	20% Coinsurance
Tier 4: Non-Preferred Brand	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier **Specialty Tier is not available for mail order*	30% Coinsurance	Not Available
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	You pay no more than a $35 copay for a one-month supply of each covered insulin product regardless of its cost sharing tier.	You pay no more than a $35 copay for a one-month supply of each covered insulin product regardless of its cost sharing tier.

100-Day Supply - MyTruAdvantage Select (HMO)

Tier	Retail	Mail Order
Tier 1: Preferred Generic **Includes Enhanced Benefit*	$0 Copay	$0 Copay
Tier 2: Generic	$0 Copay	$0 Copay
Tier 3: Preferred Brand **Tier 3 is limited to a 90-day supply*	20% Coinsurance	20% Coinsurance
Tier 4: Non-Preferred Brand **Tier 4 is limited to a 90-day supply*	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier **Specialty Tier is limited to a 30-day supply*	Not Available	Not Available
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	You pay no more than a $105 copay for a three-month supply of each covered insulin product regardless of its cost sharing tier.	You pay no more than a $105 copay for a three-month supply of each covered insulin product regardless of its cost sharing tier.

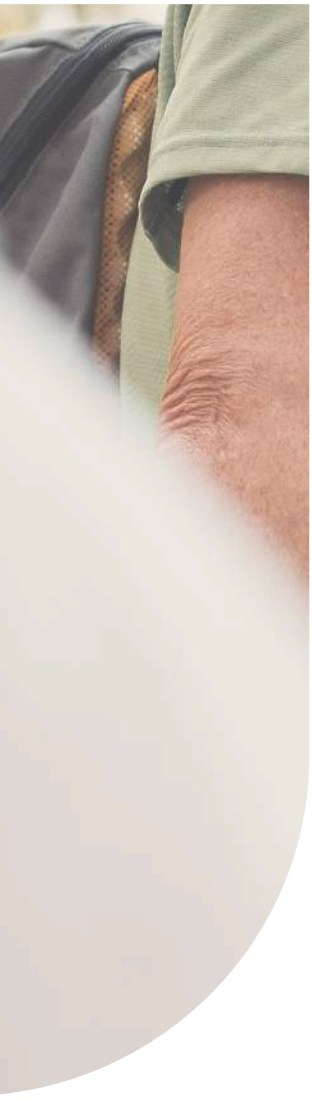
For a list of pharmacies, go to the Pharmacy Directory at www.MyTruAdvantage.com/Information-2027.

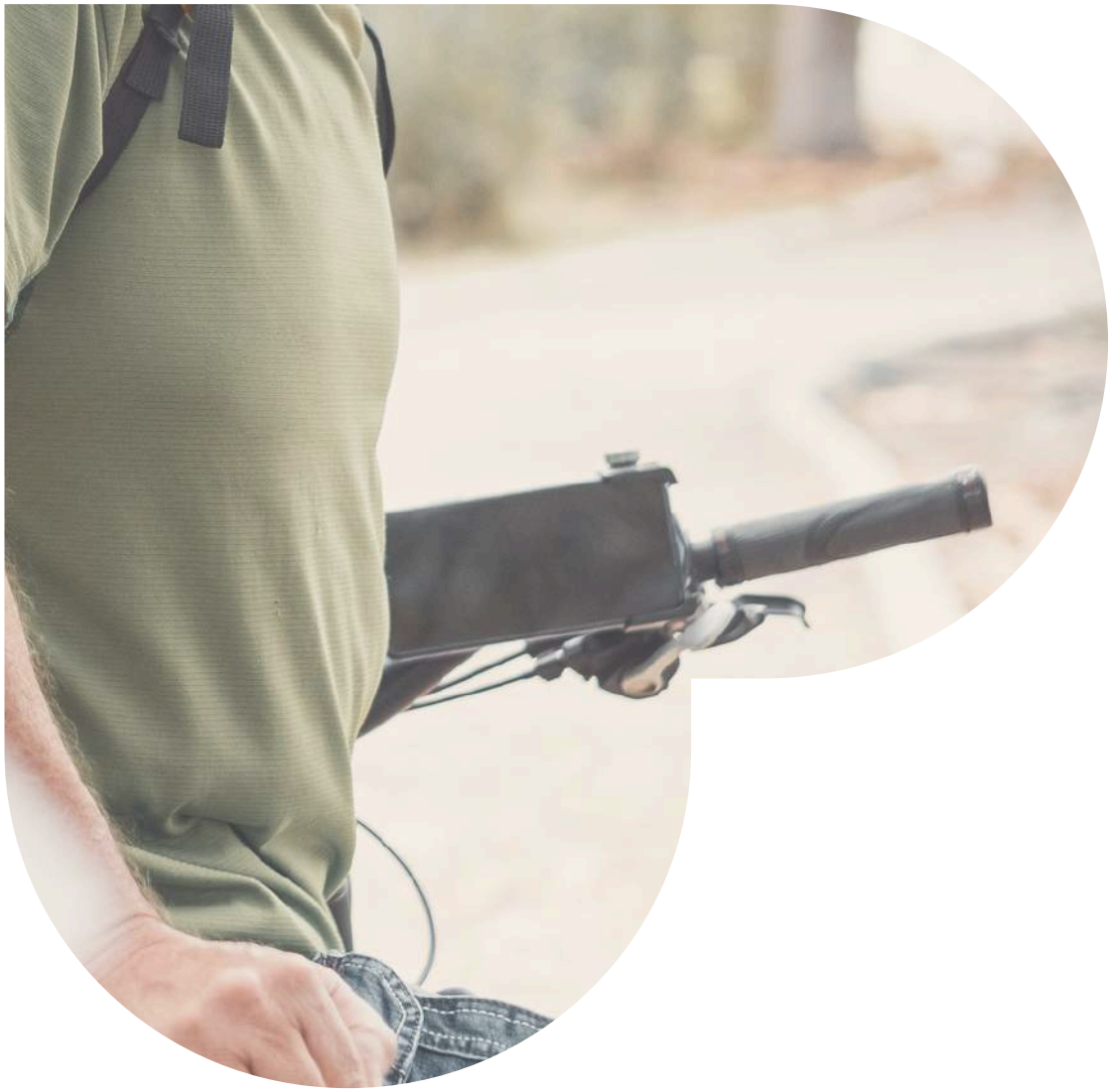
Additional Medical Benefits Covered Under Your Plan

	MyTruAdvantage Select (HMO)
Annual Preventive Physical Exam	In-network: $0 copay
Over-The-Counter (OTC) Benefit The OTC benefit offers you an easy way to get over-the-counter health and wellness products by using a benefit card that can be used at most CVS stores, online, or by phone.	You will receive $75 each quarter to spend on OTC products. OTC allowance will be administered through a CVS benefit card. Unused quarterly allowance amounts do not roll over and will be forfeited at the end of each quarter.
Worldwide Emergency, Urgently Needed Care and Transportation Coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$150 copay for each emergency covered occurrence $30 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 $100,000
Fitness Benefit Benefit offers low to no-cost annual fitness center membership at a Silver&Fit participating fitness center. Members can also receive 1 (one) wearable tracking device (Fitbit) per benefit year. To find a participating fitness center, please visit www.SilverandFit.com.	In-network: There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program

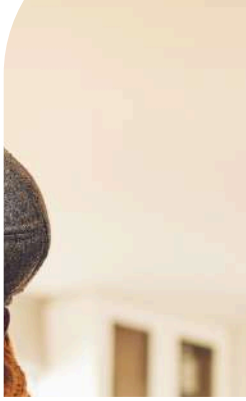
	MyTruAdvantage Select (HMO)
Medicare-Covered Chiropractic Services	In-network: $20 copay for each visit
Medical Equipment & Supplies[1]	**Durable Medical Equipment (wheelchairs, oxygen, etc.)** In-network: 20% coinsurance **Medical Supplies** In-network: 20% coinsurance **Prosthetics (braces, artificial 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, etc.)** In-network: $0 copay **Diabetic Shoes or Inserts** In-network: 15% coinsurance **Diabetes Monitoring Supplies (e.g., continuous glucose monitors, test strips)** In-network: 20% coinsurance for Medicare-covered
Meal Benefit Following an inpatient hospital, inpatient rehabilitation facility, and/or skilled nursing facility discharge, the meal benefit includes delivery of 2 meals a day for 14 days. Benefit provided by Mom's Meals. Please call Member Services for more information.	In-network: $0 copay for post-discharge meals
Personal Emergency Response System (PERS) Coverage of one personal emergency response system that offers continuous monitoring when arranged by the plan. PERS is provided by Valued Relationships, Inc. (VRI). Please call Member Services for more information.	In-network: $0 copay for one personal emergency response system while enrolled in the plan.

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





MyTru Advantage



MyTruAdvantage Choice Plus (PPO)

MyTruAdvantage Choice Complete (PPO)

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.

The network includes more than 5,000 unique primary care providers, 11,900 specialists, and 800 facilities.

Out-of-network providers and services in the PPO network may be accessed locally and when you're traveling.

- Find your doctor or hospital at: www.MyTruAdvantage.com/Information-2027
- 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 copays or coinsurance, may differ for in-network and out-of-network providers. In some cases, the in-network and out-of-network coverage is the same.

Unlike medical benefits, prescription drugs have limited out-of-network coverage. Due to coverage limitations, purchasing your prescriptions from an out-of-network pharmacy may lead to higher out-of-pocket costs. The pharmacy network includes thousands of retail pharmacies nationwide, including independent pharmacies.

- Find your pharmacies and covered drugs at: www.MyTruAdvantage.com/Information-2027
- Contact us at 1-833-213-6731 (TTY: 711)

MyTruAdvantage Choice Plus PPO offers a $0 monthly premium, $0 medical deductible, $0 in-network copay for primary care visits, and low prescription drug costs. It also includes valuable supplemental benefits like preventive and comprehensive dental care, vision, hearing, fitness programs, meal support, a Personal Emergency Response System (PERS), and an over-the-counter allowance.

MyTruAdvantage Choice Complete PPO has a $17 monthly premium, $0 medical deductible, $0 copay for primary care visits, and low prescription drug costs. It also includes valuable supplemental benefits like preventive and comprehensive dental care, vision, hearing, fitness programs, meal support, a Personal Emergency Response System (PERS), and an over-the-counter allowance.

Premiums and Benefits

January 1, 2027 – December 31, 2027

	MyTruAdvantage Choice Plus (PPO)	MyTruAdvantage Choice Complete (PPO)
Monthly Plan Premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.	$17 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 has a deductible ($500). **Deductible applies to Tier 3, Tier 4, and Tier 5**	**Medical Services** This plan does not have a deductible ($0). **Prescription Drugs (Part D)** This plan has a deductible ($500). **Deductible applies to Tier 3, Tier 4, and Tier 5**
Maximum Out-of-Pocket Responsibility Does not include prescription drugs or premiums.	In-network services: $4,700 yearly In-network and out-of-network services (combined): $9,200 yearly	In-network services: $4,460 yearly In-network and out-of-network services (combined): $8,500 yearly
Inpatient Hospital Coverage[1]	In-network: Days 1-7: $390 copay each day Beyond Day 7: $0 copay each day Out-of-network: 17% coinsurance	In-network: Days 1-7: $355 copay each day Beyond Day 7: $0 copay each day Out-of-network: 20% coinsurance
Outpatient Hospital Coverage[1]	**Outpatient Hospital** In-network: $350 copay for each visit Out-of-network: 50% coinsurance **Outpatient Observation** In-network: $390 copay for each visit Out-of-network: 50% coinsurance	**Outpatient Hospital** In-network: $325 copay for each visit Out-of-network: 50% coinsurance **Outpatient Observation** In-network: $275 copay for each visit Out-of-network: 50% coinsurance
Ambulatory Surgical Center (ASC) Services[1]	In-network: $325 copay for each visit Out-of-network: 50% coinsurance	In-network: $275 copay for each visit Out-of-network: 50% coinsurance
Doctor Visits	**Primary Care Physician (PCP)** In-network: $0 copay for each visit Out-of-network: 50% coinsurance **Specialist Visit** In-network: $35 copay for each visit Out-of-network: 50% coinsurance	**Primary Care Physician (PCP)** In-network and out-of-network: $0 copay for each visit **Specialist Visit** In-network and out-of-network: $25 copay for each visit

	MyTruAdvantage Choice Plus (PPO)	MyTruAdvantage Choice Complete (PPO)
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	In-network: $0 copay for each visit Out-of-network: 50% coinsurance	In-network and out-of-network: $0 copay for each visit
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: $130 copay for each visit	In-network and out-of-network: $130 copay for each visit
Urgently Needed Services	In-network and out-of-network: $35 copay for each visit	In-network and out-of-network: $30 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 Out-of-network: 0% coinsurance **Lab Services** In-network: $15 copay Out-of-network: 50% coinsurance **Tests/Procedures** In-network: $25 copay Out-of-network: 50% coinsurance **Outpatient X-Rays** In-network: $30 copay Out-of-network: 50% coinsurance **General Radiology/Imaging & Radiation Therapy** In-network: $60 copay Out-of-network: 50% coinsurance **Complex Radiology/Imaging (such as MRI and CT scan)** In-network: $300 copay Out-of-network: 50% coinsurance	**Dexa Scan and Diagnostic Mammography** In-network: $0 copay Out-of-network: 0% coinsurance **Lab Services** In-network: $10 copay Out-of-network: 50% coinsurance **Tests/Procedures** In-network: $25 copay Out-of-network: 50% coinsurance **Outpatient X-Rays** In-network: $25 copay Out-of-network: 50% coinsurance **General Radiology/Imaging & Radiation Therapy** In-network: $60 copay Out-of-network: 50% coinsurance **Complex Radiology/Imaging (such as MRI and CT scan)** In-network: $235 copay Out-of-network: 50% coinsurance
Hearing Services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. In-network routine hearing services must be provided by a TruHearing™ provider. One hearing aid covered per ear, per year. Out-of-network exclusions and limitations may apply.	**Medicare-Covered Hearing Exam** In-network: $0 copay for each visit Out-of-network: 50% coinsurance **Routine Hearing Exam** In-network: $0 copay once a year Out-of-network: 80% coinsurance **Fitting/Evaluation for Hearing Aids** In-network: $0 copay Out-of-network: 80% coinsurance **Hearing Aid** In-network: Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00 Out-of-network: 80% coinsurance	**Medicare-Covered Hearing Exam** In-network: $0 copay for each visit Out-of-network: $55 copay **Routine Hearing Exam** In-network: $0 copay once a year Out-of-network: 80% coinsurance **Fitting/Evaluation for Hearing Aids** In-network: $0 copay Out-of-network: 80% coinsurance **Hearing Aid** In-network: Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00 Out-of-network: 80% coinsurance

	MyTruAdvantage Choice Plus (PPO)	MyTruAdvantage Choice Complete (PPO)
Dental Services In-network preventive (routine) and comprehensive dental services are provided through the Delta Dental® Medicare Advantage "PPO + Premier" Network, with dentists located in IN, MI & OH. For complete details about your covered dental benefits, review your Delta Dental Member Handbook at: www.MyTruAdvantage.com/information - 2027. Out-of-network exclusions and limitations may apply.	**Applies to all covered dental services:** Up to $2,000 yearly max for covered services. In-network: You pay 0% coinsurance of the total cost for Medicare-covered dental services. Preventive Dental: You pay 0% coinsurance for covered services Comprehensive Dental: You pay 50% coinsurance for most covered services	**Applies to all covered dental services:** Up to $2,500 yearly max for covered services. In-network: You pay 0% coinsurance of the total cost for Medicare-covered dental services. Preventive Dental: You pay 0% coinsurance for covered services Comprehensive Dental: You pay 50% coinsurance for most covered services
Vision Services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye, and additional Medicare-covered services. In-network routine exam and eyewear must be provided by an EyeMed® "Insight" Network provider. Out-of-network exclusions and limitations may apply.	**Medicare-Covered Eye Exam:** In-network: $0 copay for each exam Out-of-network: 50% Coinsurance for each exam **Routine Eye Exam:** In-network: $0 copay once a year Out-of-network: Up to $50 reimbursement for one exam **Eyewear** In-network: Up to $250 annual allowance for one qualified eyewear purchase Out-of-network: Up to $250 reimbursement for one qualified eyewear purchase Note: Qualified eyewear purchase includes single transaction of either glasses (frames & lenses), frames, lenses or contacts.	**Medicare-Covered Eye Exam:** In-network: $0 copay for each exam Out-of-network: $0 copay for each exam **Routine Eye Exam:** In-network: $0 copay once a year Out-of-network: Up to $50 reimbursement for one exam **Eyewear** In-network: Up to $300 annual allowance for one qualified eyewear purchase Out-of-network: Up to $300 reimbursement for one qualified eyewear purchase Note: Qualified eyewear purchase includes single transaction of either glasses (frames & lenses), frames, lenses or contacts.

	MyTruAdvantage Choice Plus (PPO)	MyTruAdvantage Choice Complete (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: Days 1-6: $390 copay each day Days 7-90: $0 copay each day Out-of-network: 17% coinsurance **Outpatient Group Therapy** In-network: $35 copay for each visit Out-of-network: 50% coinsurance **Outpatient Individual Therapy** In-network: $35 copay for each visit Out-of-network: 50% coinsurance	**Inpatient Visit** In-network: Days 1-6: $355 copay each day Days 7-90: $0 copay each day Out-of-network: 20% coinsurance **Outpatient Group Therapy** In-network and out-of-network: $30 copay for each visit **Outpatient Individual Therapy** In-network and out-of-network: $30 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 a 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: $221 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: $221 copay each day Out-of-network: Days 1-58: $175 copay each day Days 59-100: $0 copay each day
Physical Therapy and Other Rehabilitation Services[1]	**Physical and Speech-Language Therapy** In-network: $30 copay for each visit Out-of-network: 50% coinsurance **Occupational Therapy** In-network: $35 copay for each visit Out-of-network: 50% coinsurance	**Physical and Speech-Language Therapy** In-network: $20 copay for each visit Out-of-network: $50 copay for each visit **Occupational Therapy** In-network: $30 copay for each visit Out-of-network: $50 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: Ground: $260 copay per trip Air: $325 copay per trip Out-of-network: Ground and Air: 50% coinsurance	In-network: Ground: $260 copay per trip Air: $325 copay per trip Out-of-network: Ground and Air: 50% coinsurance
Transportation	Not covered	Not covered
Medicare Part B Drugs[1]	**Chemotherapy Drugs** In-network: 0–20% coinsurance Out-of-network: 50% coinsurance **Other Part B Drugs** In-network: 0–20% coinsurance Out-of-network: 50% 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: 50% coinsurance **Other Part B Drugs** In-network: 0–20% coinsurance Out-of-network: 50% 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. Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

MyTruAdvantage Choice Plus and Choice Complete (PPO)

Prescription Drug Benefits - Part D

Continuing in 2027
There are three drug payment stages: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

Please note, costs may differ based on pharmacy type or day supply (e.g., retail, mail order, and 30, 60, 90 or 100-day supply). Please see the Pharmacy Directory at www.MyTruAdvantage.com/information-2027 for more information.

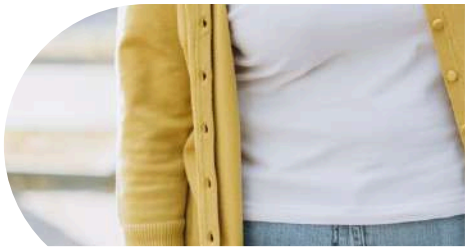
Important Message About What You Pay for Vaccines
Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

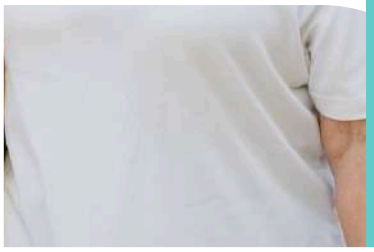
Yearly Deductible
MyTruAdvantage Choice Plus (PPO) has a $500 deductible and MyTruAdvantage Choice Complete (PPO) has a $500 deductible for Part D prescription drugs that apply to the following tiers: Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Brand), and Tier 5 (Specialty).

These plans do not have a deductible for Part D prescription drugs for the following tiers; Tier 1 (Preferred Generic), Tier 2 (Generic) and Tier 6 (Select Care Drugs).

Initial Coverage
The Medicare Drug Coverage (Part D) will have an annual out-of-pocket maximum of $2,400 for MyTruAdvantage Choice Plus (PPO) and MyTruAdvantage Choice Complete (PPO). This annual out of pocket (also referred to as your TrOOP) does not apply to out-of-pocket spending on Part B drugs or excluded drugs. Medicare Part B covers drugs that are administered by a doctor, nurse, or other healthcare provider in an outpatient setting such as a doctor's office. For example, some cancer drugs and injectable drugs are covered under Part B. You may get your drugs at network retail pharmacies and mail order pharmacies

Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,400, you pay $0 copay for the remainder of the year.





30-Day Supply - MyTruAdvantage Choice Plus (PPO)

Tier	Retail	Mail Order
Tier 1: Preferred Generic **Includes Enhanced Benefit*	$0 Copay	$2 Copay
Tier 2: Generic	$0 Copay	$8 Copay
Tier 3: Preferred Brand	20% Coinsurance	20% Coinsurance
Tier 4: Non-Preferred Brand	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier **Specialty Tier is not available for mail order*	28% Coinsurance	Not Available
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	You pay no more than a $35 copay for a one-month supply of each covered insulin product regardless of its cost sharing tier.	You pay no more than a $35 copay for a one-month supply of each covered insulin product regardless of its cost sharing tier.

100-Day Supply - MyTruAdvantage Choice Plus (PPO)

Tier	Retail	Mail Order
Tier 1: Preferred Generic **Includes Enhanced Benefit*	$0 Copay	$0 Copay
Tier 2: Generic	$0 Copay	$0 Copay
Tier 3: Preferred Brand **Tier 3 is limited to a 90-day supply*	20% Coinsurance	20% Coinsurance
Tier 4: Non-Preferred Brand **Tier 4 is limited to a 90-day supply*	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier **Specialty Tier is limited to a 30-day supply*	Not Available	Not Available
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	You pay no more than a $105 copay for a three-month supply of each covered insulin product regardless of its cost sharing tier.	You pay no more than a $105 copay for a three-month supply of each covered insulin product regardless of its cost sharing tier.

For a list of pharmacies, go to the Pharmacy Directory at www.MyTruAdvantage.com/Information-2027.

30-Day Supply - MyTruAdvantage Choice Complete (PPO)

Tier	Retail	Mail Order
Tier 1: Preferred Generic **Includes Enhanced Benefit*	$0 Copay	$2 Copay
Tier 2: Generic	$0 Copay	$8 Copay
Tier 3: Preferred Brand	20% Coinsurance	20% Coinsurance
Tier 4: Non-Preferred Brand	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier **Specialty Tier is not available for mail order*	28% Coinsurance	Not Available
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	You pay no more than a $35 copay for a one-month supply of each covered insulin product regardless of its cost sharing tier.	You pay no more than a $35 copay for a one-month supply of each covered insulin product regardless of its cost sharing tier.

100-Day Supply - MyTruAdvantage Choice Complete (PPO)

Tier	Retail	Mail Order
Tier 1: Preferred Generic **Includes Enhanced Benefit*	$0 Copay	$0 Copay
Tier 2: Generic	$0 Copay	$0 Copay
Tier 3: Preferred Brand **Tier 3 is limited to a 90-day supply*	20% Coinsurance	20% Coinsurance
Tier 4: Non-Preferred Brand **Tier 4 is limited to a 90-day supply*	25% Coinsurance	25% Coinsurance
Tier 5: Specialty Tier **Specialty Tier is limited to a 30-day supply*	Not Available	Not Available
Tier 6: Select Care Drugs	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	You pay no more than a $105 copay for a three-month supply of each covered insulin product regardless of its cost sharing tier.	You pay no more than a $105 copay for a three-month supply of each covered insulin product regardless of its cost sharing tier.

For a list of pharmacies, go to the Pharmacy Directory at www.MyTruAdvantage.com/Information-2027.

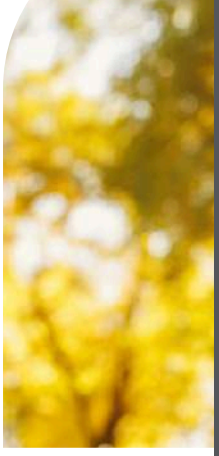
Additional Medical Benefits Covered Under Your Plan

	MyTruAdvantage Choice Plus (PPO)	MyTruAdvantage Choice Complete (PPO)
Annual Preventive Physical Exam	In-network and out-of-network: $0 copay	In-network and out-of-network: $0 copay
Over-The-Counter (OTC) Benefit Get over-the-counter health and wellness products by using your quarterly allowance. In-network allowance is administered through a benefit card that can be used at most CVS stores, online, or by phone. Out-of-network exclusions and limitations may apply.	In-network and out-of-network: You receive $50 each quarter to spend on OTC products. Unused quarterly allowance amounts do not roll over and will be forfeited at the end of each quarter.	In-network and out-of-network: You receive $100 each quarter to spend on OTC products. Unused quarterly allowance amounts do not roll over and will be forfeited at the end of each quarter.
Worldwide Emergency, Urgently Needed Care and Transportation Coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$130 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 $100,000	$130 copay for each emergency covered occurrence $30 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 $100,000
Fitness Benefit In-network benefit offers low to no-cost annual fitness center membership at a Silver&Fit participating fitness center. Members can also receive 1 (one) wearable tracking device (Fitbit) per benefit year. To find a participating fitness center, please visit www.SilverandFit.com.	In-network: There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program Out-of-Network: 80% coinsurance (Certain restrictions apply. Refer to your Evidence of Coverage for more details.)	In-network: There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program Out-of-Network: 80% coinsurance (Certain restrictions apply. Refer to your Evidence of Coverage for more details.)

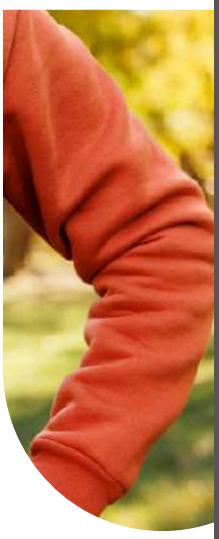
	MyTruAdvantage Choice Plus (PPO)	MyTruAdvantage Choice Complete (PPO)
Medicare-Covered Chiropractic Services	In-network: $15 copay for each visit Out-of-network: 50% coinsurance	In-network: $15 copay for each visit Out-of-network: $55 copay for each visit
Medical Equipment & Supplies[1]	**Durable Medical Equipment (wheel-chairs, oxygen, etc.)** In-network: 20% coinsurance Out-of-network: 40% coinsurance **Medical Supplies** In-network: 20% coinsurance Out-of-network: 50% coinsurance **Prosthetics (braces, artificial limbs, etc.)** In-network: 20% coinsurance Out-of-network: 50% coinsurance	**Durable Medical Equipment (wheel-chairs, oxygen, etc.)** In-network: 20% coinsurance Out-of-network: 50% coinsurance **Medical Supplies** In-network: 20% coinsurance Out-of-network: 50% coinsurance **Prosthetics (braces, artificial limbs, etc.)** In-network: 20% coinsurance Out-of-network: 50% coinsurance
Diabetes Services	**Diabetes Self-Management Training** In-network: $0 copay for the service Out-of-network: 50% coinsurance **Diabetic Supplies and Services (e.g., syringes, alcohol swabs, gauze, etc.)** In-network and out-of-network: $0 copay **Diabetic Shoes or Inserts** In-network: 15% coinsurance Out-of-network: 50% coinsurance **Diabetic Monitoring Supplies (e.g., continuous glucose monitors, test strips)** In-network: 20% coinsurance for Medicare-covered Out-of-network: 50% 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, etc.)** In-network and out-of-network: $0 copay **Diabetic Shoes or Inserts** In-network: 15% coinsurance Out-of-network: 50% coinsurance **Diabetic Monitoring Supplies (e.g., continuous glucose monitors, test strips)** In-network: 20% coinsurance for Medicare-covered Out-of-network: 50% coinsurance for Medicare-covered
Meal Benefit Following an inpatient hospital, inpatient rehabilitation facility, and/or skilled nursing facility discharge, the meal benefit includes delivery of 2 meals a day for 14 days. In-network benefit provided by Mom's Meals. Please call Member Services for more information.	In-network and out-of-network: $0 copay for post-discharge meals Out-of-network benefit meals must be medically tailored meals from approved meal providers (not general food establishments). To qualify, the plan will provide a referral.	In-network and out-of-network: $0 copay for post-discharge meals Out-of-network benefit meals must be medically tailored meals from approved meal providers (not general food establishments). To qualify, the plan will provide a referral.
Personal Emergency Response System (PERS) Coverage of one personal emergency response system that offers continuous monitoring when arranged by the plan. In-network PERS is provided by Valued Relationships, Inc. (VRI). Please call Member Services for more information.	In-network: $0 copay for one personal emergency response system while enrolled in the plan. Out-of-network: 80% coinsurance (Certain restrictions apply. Refer to the Evidence of Coverage for more details.)	In-network: $0 copay for one personal emergency response system while enrolled in the plan. Out-of-network: 80% coinsurance (Certain restrictions apply. Refer to the Evidence of Coverage for more details.)

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

MyTru Advantage



MyTruAdvantage Red, White and Tru (MA-Only PPO)



An MA-Only plan covers all your Medicare Part A and Part B benefits with no Part D prescription drug coverage included.
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.

The network includes more than 5,000 unique primary care providers, 11,900 specialists, and 800 facilities.

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/Information-2027
- 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 copays or coinsurance, may differ for in-network and out-of-network providers.

In some cases, the in-network and out-of-network coverage is the same.

For instance, specialist office copays are $35 for in-network and out-of-network doctors.

MyTruAdvantage Red, White and Tru (MA-Only PPO) features a $0 monthly premium, $0 medical deductible, $125 Part B Giveback, and $0 PCP copay.

MyTruAdvantage Red, White and Tru (MA-Only PPO) also includes valuable supplemental benefits like preventive and comprehensive dental care, vision, hearing, fitness programs, meal support, a Personal Emergency Response System (PERS), and an over-the-counter allowance.

Premiums and Benefits

January 1, 2027 – December 31, 2027

	MyTruAdvantage Red, White and Tru (MA-Only PPO)
Monthly Plan Premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.
Part B Premium Reduction	$125 Part B premium reduction
Deductible	**Medical Services** This plan does not have a deductible ($0).
Maximum Out-Of-Pocket Responsibility Does not include prescription drugs or premiums.	In-network services: $5,500 yearly In-network and out-of-network services (combined): $7,500 yearly
Inpatient Hospital Coverage[1]	In-network: Days 1-6: $390 copay each day Beyond Day 6: $0 copay each day Out-of-network: 14% coinsurance
Outpatient Hospital Coverage[1]	**Outpatient Hospital** In-network: $350 copay for each visit Out-of-network: 50% coinsurance **Outpatient Observation** In-network and out-of-network: $325 copay for each stay
Ambulatory Surgical Center (ASC) Services[1]	In-network and out-of-network: $325 copay for each visit
Doctor Visits	**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

	MyTruAdvantage Red, White and Tru (MA-Only 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
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: $130 copay for each visit
Urgently Needed Services	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 Out-of-network: 0% coinsurance **Lab Services** In-network and out-of-network: $15 copay **Tests/Procedures** In-network and out-of-network: $25 copay **Outpatient X-Rays** In-network and out-of-network: $30 copay **General Radiology/Imaging & Radiation Therapy** In-network: $60 copay Out-of-network: 50% coinsurance **Complex Radiology/Imaging (such as MRI and CT scan)** In-network: $235 copay Out-of-network: 50% coinsurance
Hearing Services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. In-network routine hearing services must be provided by a TruHearing™ provider. One hearing aid covered per ear, per year. Out-of-network exclusions and limitations may apply.	**Medicare-Covered Hearing Exam** In-network: $0 copay for each visit Out-of-network: $55 copay **Routine Hearing Exam** In-network: $0 copay once a year Out-of-network: 80% coinsurance **Fitting/Evaluation for Hearing Aids** In-network: $0 copay Out-of-network: 80% coinsurance **Hearing Aid** In-network: Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00 Out-of-network: 80% coinsurance

	MyTruAdvantage Red, White and Tru (MA-Only PPO)
Dental Services In-network preventive (routine) and comprehensive dental services are provided through the Delta Dental® Medicare Advantage "PPO + Premier" Network, with dentists located in IN, MI & OH. For complete details about your covered dental benefits, review your Delta Dental Member Handbook at: www.MyTruAdvantage.com/information- 2027. Out-of-network exclusions and limitations may apply.	**Applies to all covered dental services:** **$0 copay for all covered dental services up to $2,500 yearly max.** In-network and out-of-network: You pay 0% coinsurance for Medicare-covered dental services. Preventive Dental: You pay 0% coinsurance for covered services Comprehensive Dental: You pay 0% coinsurance for covered services
Vision Services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye, and additional Medicare-covered services. In-network routine exam and eyewear must be provided by an EyeMed® "Insight" Network provider. Out-of-network exclusions and limitations may apply.	**Medicare-Covered Eye Exam:** In-network: $0 copay for each exam Out-of-network: $0 copay for each exam **Routine Eye Exam:** In-network: $0 copay once a year Out-of-network: Up to $50 reimbursement for one exam **Eyewear:** In-network: $250 annual allowance for qualified eyewear Out-of-network: Up to $250 reimbursement on qualified eyewear Note: Qualified eyewear purchase includes single transaction of either glasses (frames & lenses), frames, lenses or contacts.

	MyTruAdvantage Red, White and Tru (MA-Only 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: Days 1-6: $390 copay each day Days 7-90: $0 copay each day Out-of-network: 14% coinsurance **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 a 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: $221 copay each day Out-of-network: Days 1-58: $175 copay each day Days 59-100: $0 copay each day
Physical Therapy and Other Rehabilitation Services[1]	**Physical and Speech-Language Therapy** In-network: $20 copay for each visit Out-of-network: $50 copay for each visit **Occupational Therapy** 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
Transportation	Not covered
Medicare Part B Drugs[1]	**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:** In-network: 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. Out-of-network: 40% coinsurance

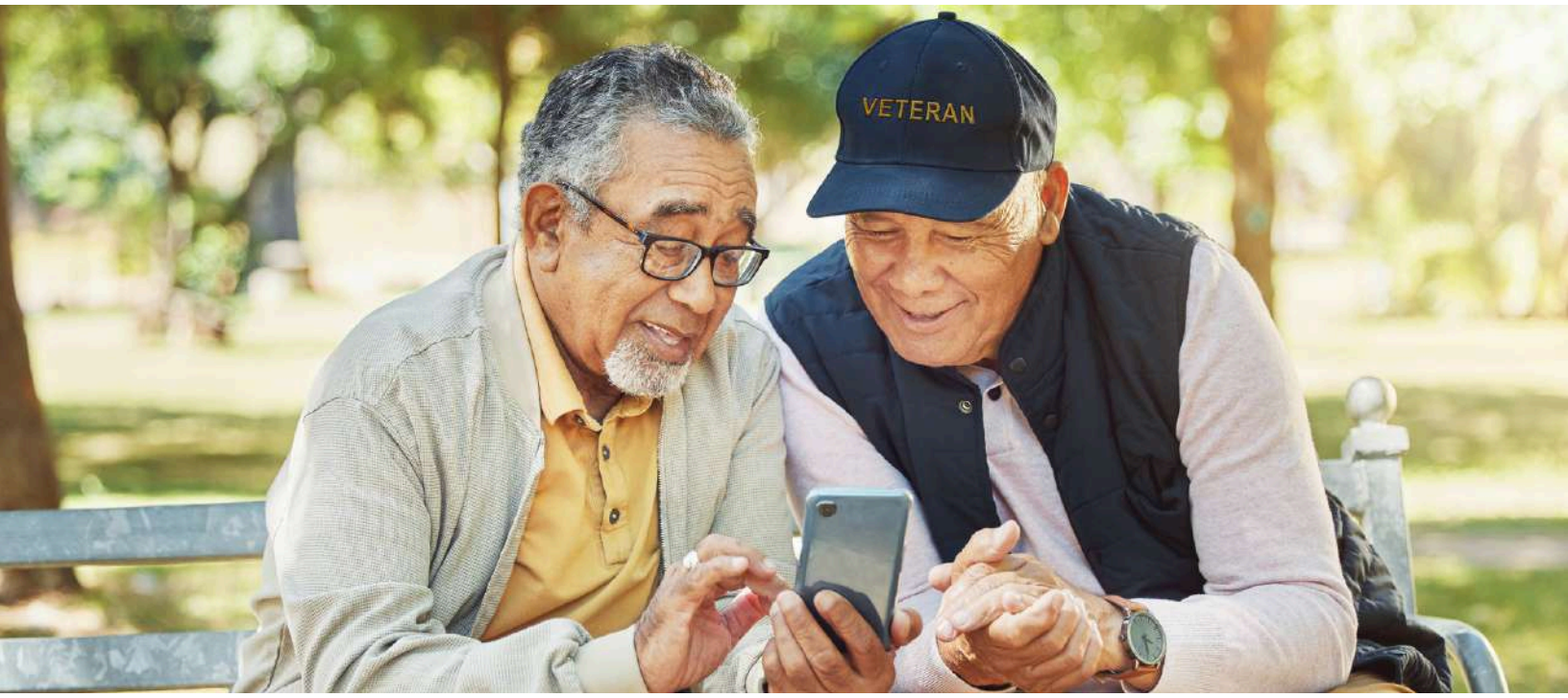
[1]Prior Authorizations: For HMO and PPO plans, certain procedures, services and drugs may need advance approval from your plan. Please refer to the Evidence of Coverage (EOC) for services that require prior authorization from the plan.

Additional Medical Benefits Covered Under Your Plan

	MyTruAdvantage Red, White and Tru (MA-Only PPO)
Annual Preventive Physical Exam	In-network and out-of-network: $0 copay
Over-The-Counter (OTC) Benefit Get over-the-counter health and wellness products by using your quarterly allowance. In-network allowance is administered through a benefit card that can be used at most CVS stores, online, or by phone. Out-of-network exclusions and limitations may apply.	In-network and out-of-network: You receive $50 each quarter to spend on OTC products. Unused quarterly allowance amounts do not roll over and will be forfeited at the end of each quarter.
Worldwide Emergency, Urgently Needed Care and Transportation Coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$130 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 $100,000

	MyTruAdvantage Red, White and Tru (MA-Only PPO)
Fitness Benefit In-network benefit offers low to no-cost annual fitness center membership at a Silver&Fit participating fitness center. Members can also receive 1 (one) wearable tracking device (Fitbit) per benefit year. To find a participating fitness center, please visit www.SilverandFit.com.	In-network: There is no cost to you for participating in the Fitness Benefit: The Silver&Fit® Healthy Aging and Exercise Program Out-of-Network: 80% coinsurance (Certain restrictions apply. Refer to your Evidence of Coverage for more details.)
Medicare-Covered Chiropractic Services	In-network: $15 copay for each visit Out-of-network: $55 copay for each visit
Medical Equipment & Supplies[1]	**Durable medical equipment (wheelchairs, oxygen, etc.)** In-network: 20% coinsurance Out-of-network: 40% coinsurance **Medical supplies** In-network: 20% coinsurance Out-of-network: 50% coinsurance **Prosthetics (braces, artificial limbs, etc.)** In-network: 20% coinsurance Out-of-network: 50% 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, etc.)** In-network and out-of-network: $0 copay **Diabetic Shoes or Inserts** In-network: 15% coinsurance Out-of-network: 50% coinsurance **Diabetic Monitoring Supplies (e.g., continuous glucose monitors, test strips)** In-network: 20% coinsurance for Medicare-covered Out-of-network: 50% coinsurance for Medicare-covered

	MyTruAdvantage Red, White and Tru (MA-Only PPO)
Insulin Important message about what you pay for insulin	**Part B Insulins Only:** **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 it's on. **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 it's on. **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 it's on.
Meal Benefit Following an inpatient hospital, inpatient rehabilitation facility, and/or skilled nursing facility discharge, the meal benefit includes delivery of 2 meals a day for 14 days. In-network benefit provided by Mom's Meals. Please call Member Services for more information.	In-network and out-of-network: $0 copay for post-discharge meals Out-of-network benefit meals must be medically tailored meals from approved meal providers (not general food establishments). To qualify, the plan will provide a referral.
Personal Emergency Response System (PERS) Coverage of one personal emergency response system that offers continuous monitoring when arranged by the plan. In-network PERS is provided by Valued Relationships, Inc. (VRI). Please call Member Services for more information.	In-network: $0 copay for one personal emergency response system while enrolled in the plan. Out-of-network: 80% coinsurance (Certain restrictions apply. Refer to the Evidence of Coverage for more details.)



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

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product you want the agent to discuss.

_____ Medicare Advantage Prescription Drug Plans (Part C) (MA/MAPD)

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
[Plan use only]	
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

Medicare Advantage Prescription Drug Plans (Part C) (MA/MAPD)
Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost.

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