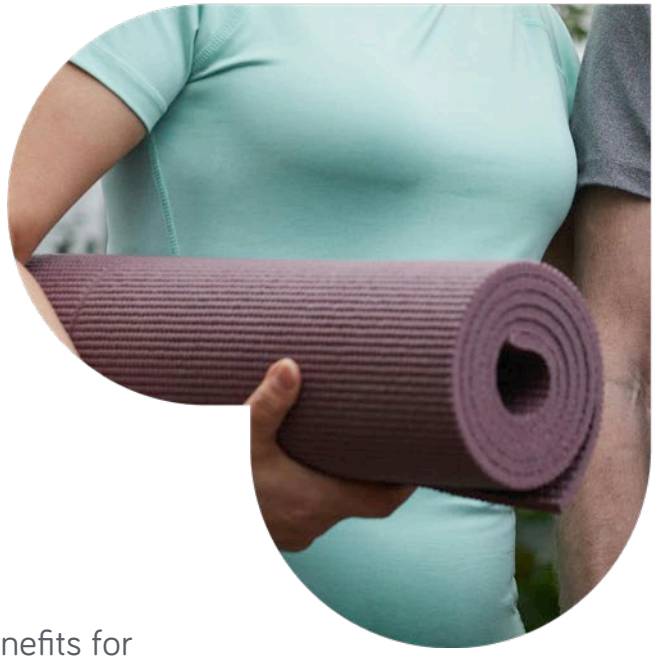
MyTru Advantage

2025 Summary of Benefits



January 1, 2025 – December 31, 2025

This booklet summarizes the benefits for MyTruAdvantage HMO and PPO plans effective January 1 to December 31, 2025. 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-2025. This document is available in other formats such as Braille, large print or audio.

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General

MyTruAdvantage HMO Plans

MyTruAdvantage PPO Plans

MyTruAdvantage offers two plan types, HMO and PPO.

What's the difference?

HMO stands for Health Maintenance Organization.
With HMO plans, your coverage applies only to doctors, hospitals, and other providers in the network. No referrals are needed. 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 co-pays or co-insurance, may differ for in-network and out-of-network benefits. Out-of-network benefits may be accessed locally and when you're traveling. No referrals are needed.

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

Prescription drug benefits have 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 preferred pharmacies nationwide as well as independent pharmacies. For information regarding our pharmacy network please visit our website at www.mytruadvantage.com/information-2025.

Contact Us

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

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

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

Easy Ways to Learn More and Enroll

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

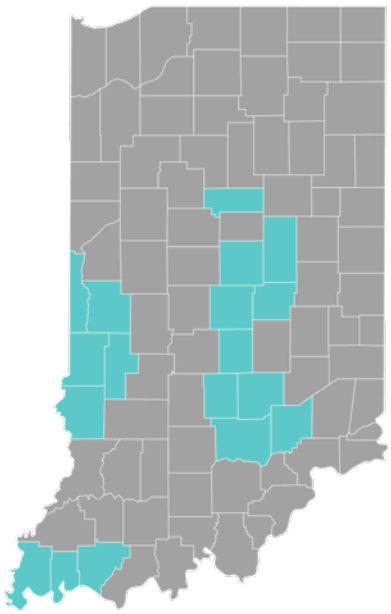
- October 1 – March 31:
  - 7 days a week, 8:00am – 8:00pm, Local Time
  - On Thanksgiving and Christmas Day, leave us a message and we'll return your call within 1 business day.
- April 1 – September 30:
  - Monday – Friday 8:00am – 8:00pm, Local Time
  - On weekends and holidays, leave us a message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

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

- Find your doctors, your drug list, your pharmacy, and your Evidence of Coverage at: www.mytruadvantage.com/information-2025

MyTruAdvantage Service Area in 18 Indiana Counties Including:

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



MyTruAdvantage Select (HMO)

MyTruAdvantage Select Plus (HMO)

MyTruAdvantage Choice Plus (PPO)

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

Pre-Enrollment Checklist

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

Determining Eligibility

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

Understanding the Benefits

- [ ] **Evidence of coverage.** The information in this booklet is not a complete description of benefits. You can review the full list of benefits, including limitations and exclusions, in the Evidence of Coverage (EOC). This is especially important for doctors and services that you use regularly. Visit www.mytruadvantage.com/information-2025 to view the EOC or call 1-833-213-6731 (TTY: 711).
- [ ] **Provider directory.** View the provider directory at www.mytruadvantage.com/information-2025 to see if your doctors are in the network. You can also ask your doctor. If your doctor is not listed, it means services from these doctors are not covered in the HMO and may have a higher cost-share (as out-of-network) in the PPO.
- [ ] **Pharmacy directory.** Review the pharmacy directory at www.mytruadvantage.com/information-2025 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-2025 to be sure that the prescriptions you take are covered.

Understanding Important Rules

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

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

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

Medicare: You Have Choices

Medicare Benefits

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

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

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option on the prescription drug law 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).

Starting in 2025, anyone with a Medicare drug plan or Medicare health plan with drug coverage (like Medicare Advantage Plan with drug coverage) can use this payment option. All plans offer 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 your prescription drugs (instead of paying at the pharmacy). There is no 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 Medicare Plan Finder at Medicare.gov, or ask other plans for their Summary of Benefits booklets.
- To understand Original Medicare, look in your current "Medicare & You" handbook or view it online at www.medicare.gov, or call 1-800-MEDICARE (800) 633-4227, 24 hours a day, seven (7) days a week. (TTY call (877) 486-2048.)

Important Health Insurance Terms and Definitions

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

MyTru Advantage

HMO Summary of Benefits 2025

January 1, 2025 – December 31, 2025

MyTruAdvantage offers two HMOs. Select & Select Plus

HMO stands for Health Maintenance Organization. In the HMOs, your coverage applies only to doctors, hospitals, and other providers in the network. Out-of-network providers are not covered under the HMO plans. However, emergency and urgent care services are covered out-of-network.

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

- Find your doctor or hospital at: www.mytruadvantage.com/information-2025 Contact us at 1-833-213-6731 (TTY: 711)

The pharmacy network includes thousands of preferred pharmacies nationwide as well as independent pharmacies. To find your pharmacies, and covered drugs please visit our website at www.mytruadvantage.com/information-2025. Contact us at 1-833-213-6731 (TTY: 711)

Both HMOs feature $0 monthly premium, $0 medical deductible, and $0 PCP copay, and low prescription drug copays. You'll select a Primary Care Physician to help you get all the care you need, but no referrals are required for any in-network services or in-network provider, so you can see your specialist (in-network) without needing a referral from your PCP.

The HMO also includes supplemental benefits such as preventive and comprehensive dental, vision, hearing, fitness benefits including fitness center memberships, in-home and online programs, and an over-the-counter allowance.

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

Premiums and Benefits

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Monthly plan premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.	$0 Per Month In addition, you must keep paying your Medicare Part B premium.
Deductible	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan does not have a deductible ($0).	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan has a deductible ($200). Deductible applies to Tier 3, Tier 4, and Tier 5.
Maximum out-of-pocket	**In-network:** $3,500 yearly	**In-network:** $3,700 yearly
Inpatient hospital coverage[1]	**In-network:** Days 1-6: $335 each day $0 each additional day	**In-network:** Days 1-6: $335 each day $0 each additional day
Outpatient hospital coverage[1]	**Ambulatory surgical center** **In-network:** $250 copay for each visit **Outpatient hospital** **In-network:** $250 copay for each visit **Observation** **In-network:** $250 copay for each stay	**Ambulatory surgical center** **In-network:** $250 copay for each visit **Outpatient hospital** **In-network:** $300 copay for each visit **Observation** **In-network:** $250 copay for each stay
Doctor visits[1]	**Primary care physician (PCP)** **In-network:** $0 copay for each office visit **Specialist visit** **In-network:** $25 copay for each office visit	**Primary care physician (PCP)** **In-network:** $0 copay for each office visit **Specialist visit** **In-network:** $30 copay for each office visit
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-network:** $0 copay for each service	**In-network:** $0 copay for each service
Emergency care This amount is waived if you are admitted to the hospital within 24 hours from your emergency care visit.	**In-network and out-of-network:** $90 copay for each visit	**In-network and out-of-network:** $140 copay for each visit

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Urgently needed services	**In-network and out-of-network:** $30 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 for each service **Lab services** **In-network:** $0 copay for each service **Tests/procedures** **In-network:** $50 copay for each service **Outpatient x-rays** **In-network:** $25 copay for each service **Radiation therapy** **In-network:** $40 copay for each service **General radiology/imaging** **In-network:** $40 copay for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $205 copay for each service	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Lab services** **In-network:** $10 copay for each service **Tests/procedures** **In-network:** $50 copay for each service **Outpatient x-rays** **In-network:** $25 copay for each service **Radiation therapy** **In-network:** $40 copay for each service **General radiology/imaging** **In-network:** $40 copay for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service
Hearing services Medicare-covered exam performed by a primary care 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 one per 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	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Routine hearing exam** **In-network:** $0 copay one per year **Fitting/evaluation exams for hearing aids** **In-network:** $0 copay **Hearing aids** **In-network:** Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Dental services Preventive (routine) dental services provided by Delta Dental®. See the Delta Dental® Certificate of Coverage for details. Comprehensive dental services provided by Delta Dental®. Please refer to the website under *Delta Dental® Coverage Certificate* for your complete dental coverage: www.mytruadvantage.com/information-2025.	**Applies to all covered dental services:** **$0 Copay for all covered dental services up to $2,560 yearly max.** **In-network:** You pay 0% of the total cost for Medicare-covered dental services. All Delta Dental covered services for Preventive and Comprehensive have a $0 copayment up to the annual allowance of $2,560 for all services.	**Applies to all covered dental services:** **$0 Copay for all covered dental services up to $2,560 yearly max.** **In-network:** You pay 0% of the total cost for Medicare-covered dental services. All Delta Dental covered services for Preventive and Comprehensive have a $0 copayment up to the annual allowance of $2,560 for all 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 vision services include tests for corrective eyewear. Routine eye exam and eyewear must be provided by an approved provider. NOTE: Eyewear allowance is for: eyeglasses (frames/lenses), eyeglass lenses, eyeglass frames or contacts.	**Applies to routine exams and eyewear:** $0 copay for all eye services/eyewear to $250 yearly max. Will be administered through Debit Card - MyTruCard.	**Applies to routine exams and eyewear:** $0 copay for all eye services/eyewear to $250 yearly max. Will be administered through Debit Card - MyTruCard.

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Mental health care[1] We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit** **In-network:** Days 1-6: $335 copay each day Days 7-90: $0 copay each day **Outpatient group therapy** **In-network:** $25 copay for each visit **Outpatient individual therapy** **In-network:** $25 copay for each visit	**Inpatient visit** **In-network:** Days 1-6: $335 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 an SNF and ends when you go for 60 days in a row without SNF care.	**In-network:** Days 1-20: $0 copay each day Days 21-100: $214 copay each day	**In-network:** Days 1-20: $0 copay each day Days 21-100: $214 copay each day
Physical therapy	**In-network:** $35 copay for each visit	**In-network:** $35 copay for each visit
Ambulance[1] Air ambulance transportation to a hospital may be provided if you need immediate and rapid ambulance transportation that ground transportation can't provide. This amount is waived if you are admitted to the hospital within 24 hours from your Ambulance Services.	**Ground:** $260 copay per trip **Air:** $325 copay per trip	**Ground:** $265 copay per trip **Air:** $325 copay per trip
Transportation	Not covered	Not covered
Medicare Part B Drugs[1] Step Therapy may be required for certain Part B drugs (see Chapter 4 section 2.1 "Medicare Part B Drugs" of the EOC at www.mytruadvantage.com/information-2025 for more details).	**Chemotherapy drugs:** **In-network:** 0–20% Coinsurance **Other Part B Drugs** 0–20% coinsurance **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a one-month supply of each covered insulin product.	**Chemotherapy drugs:** **In-network:** 0–20% Coinsurance **Other Part B Drugs** 0–20% coinsurance **Part B Insulins** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a one-month supply of each covered insulin product.

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

Prescription Drug

MyTruAdvantage Select (HMO) Prescription Drug Benefits - Part D

Beginning in 2025
There are three drug payment stages: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage will no longer exist in the Part D benefit.

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non- preferred, mail order, and 30, 60, or 90-day supply). Please see the Pharmacy Directory at www.mytruadvantage.com/information-2025 for more information.

Yearly Deductible
There is no deductible for MyTruAdvantage Select (HMO) for all Tiers. There is also no deductible for MyTruAdvantage Select (HMO) for covered insulins.

Initial Coverage
Your Medicare Drug Coverage (Part D) will have an annual out-of-pocket maximum of $2,000. This annual out of pocket (also referred to as your TrOOP) does not apply to out-of-pocket spending on Part B 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 $2,000, 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.

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory at www.mytruadvantage.com/information-2025.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$0 Copay	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$41 Copay	$82 Copay	$123 Copay
Tier 4 (Non-Preferred Drug)	33% coinsurance	33% coinsurance	33% coinsurance
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% coinsurance	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay 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.	Up to $70 Copay 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.	Up to $105 Copay 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.

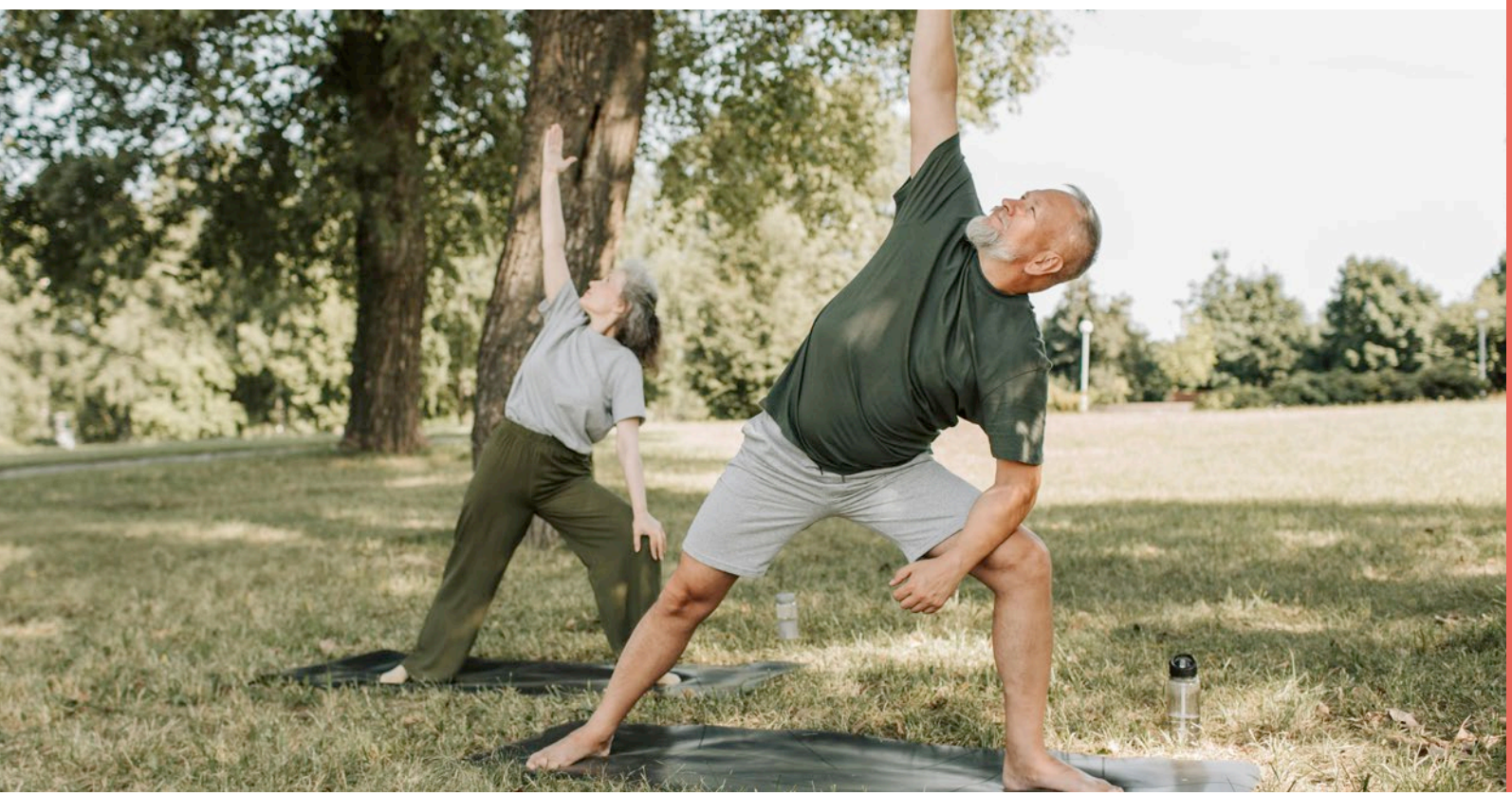
Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory at www.mytruadvantage.com/information-2025.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$6 Copay	$12 Copay	$18 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	33% coinsurance	33% coinsurance	33% coinsurance
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% coinsurance	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay 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.	Up to $70 Copay 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.	Up to $105 Copay 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.

Mail Order Cost-Sharing

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$2 Copay	$4 Copay	$0 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	33% coinsurance	33% coinsurance	33% coinsurance
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not Available	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay 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.	Up to $70 Copay 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.	Up to $105 Copay 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.



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

Beginning in 2025
There are three drug payment stages: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage will no longer exist in the Part D benefit.

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non- preferred, mail order, and 30, 60, or 90-day supply). Please see the Pharmacy Directory at www.mytruadvantage.com/information-2025 for more information.

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.

Yearly Deductible
This plan has a $200 deductible for Part D prescription drugs that applies to the following tiers: Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty). There is no deductible for MyTruAdvantage Select Plus (HMO) for covered insulins.

This plan does 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
Your Medicare Drug Coverage (Part D) will have an annual out-of-pocket maximum of $2,000. This annual out of pocket (also referred to as your TrOOP) does not apply to out-of-pocket spending on Part B 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 $2,000, you pay $0 copay for the remainder of the year.

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory at www.mytruadvantage.com/information-2025.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$41 Copay	$82 Copay	$123 Copay
Tier 4 (Non-Preferred Drug)	29% coinsurance	29% coinsurance	29% coinsurance
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	30% coinsurance	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay You won't pay more than $35 for a one-month supply of each covered insulin product regardless of its cost-sharing tier.	Up to $70 Copay You won't pay more than $70 for a two-month supply of each covered insulin product regardless of its cost-sharing tier.	Up to $105 Copay You won't pay more than $105 for a three-month supply of each covered insulin product regardless of its cost-sharing tier.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory at www.mytruadvantage.com/information-2025.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$6 Copay	$12 Copay	$18 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	29% coinsurance	29% coinsurance	29% coinsurance
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	30% coinsurance	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay You won't pay more than $35 for a one-month supply of each covered insulin product regardless of its cost-sharing tier.	Up to $70 Copay You won't pay more than $70 for a two-month supply of each covered insulin product regardless of its cost-sharing tier.	Up to $105 Copay You won't pay more than $105 for a three-month supply of each covered insulin product regardless of its cost-sharing tier.

Mail Order Cost-Sharing

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$2 Copay	$4 Copay	$0 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	29% coinsurance	29% coinsurance	29% coinsurance
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not Available	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay You won't pay more than $35 for a one-month supply of each covered insulin product regardless of its cost-sharing tier.	Up to $70 Copay You won't pay more than $70 for a two-month supply of each covered insulin product regardless of its cost-sharing tier.	Up to $105 Copay You won't pay more than $105 for a three-month supply of each covered insulin product regardless of its cost-sharing tier.

Additional Medical Benefits Covered Under Your Plan

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Annual preventive physical exam	**In-network:** $0 for each service	**In-network:** $0 for each service
Over-the-counter (OTC) card The OTC benefit offers you an easy way to get over-the-counter health and wellness products which is administered by CVS Caremark. These options include; in store (CVS), on-line, or by phone.	**In-network:** Up to $100 every 3 months The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused benefit can be carried forward to the next quarter, please refer to your Evidence of Coverage for benefit details and plan maximums. Any unused benefit as of 12/31/2025 will be forfeited.	**In-network:** Up to $100 every 3 months The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused benefit can be carried forward to the next quarter, please refer to your Evidence of Coverage for benefit details and plan maximums. Any unused benefit as of 12/31/2025 will be forfeited.
Worldwide emergency, urgently needed care and transportation coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$90 copay for each emergency covered occurrence $35 copay for each urgent covered occurrence $260 copay for ground transportation $325 copay for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $25,000	$90 copay for each emergency covered occurrence $25 copay for each urgent covered occurrence $260 copay for ground transportation $325 copay for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $50,000

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

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

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

MyTru Advantage

PPO Summary of Benefits 2025

January 1, 2025 – December 31, 2025

MyTruAdvantage offers two PPOs.

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

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

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

- Find your doctor or hospital at: www.mytruadvantage.com/information-2025
- Contact us at 1-833-213-6731 (TTY: 711)

In-network benefits and out-of-network benefits are included in your coverage. Cost shares, such as co-pays or co-insurance, may differ for in-network and out-of-network providers. In some cases, the in-network and out- of-network coverage is the same.

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

Unlike medical benefits, prescription drugs have 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 preferred pharmacies nationwide as well as independent pharmacies.

- Find your pharmacies and covered drugs at: www.mytruadvantage.com/information-2025
- Contact us at 1-833-213-6731 (TTY: 711)

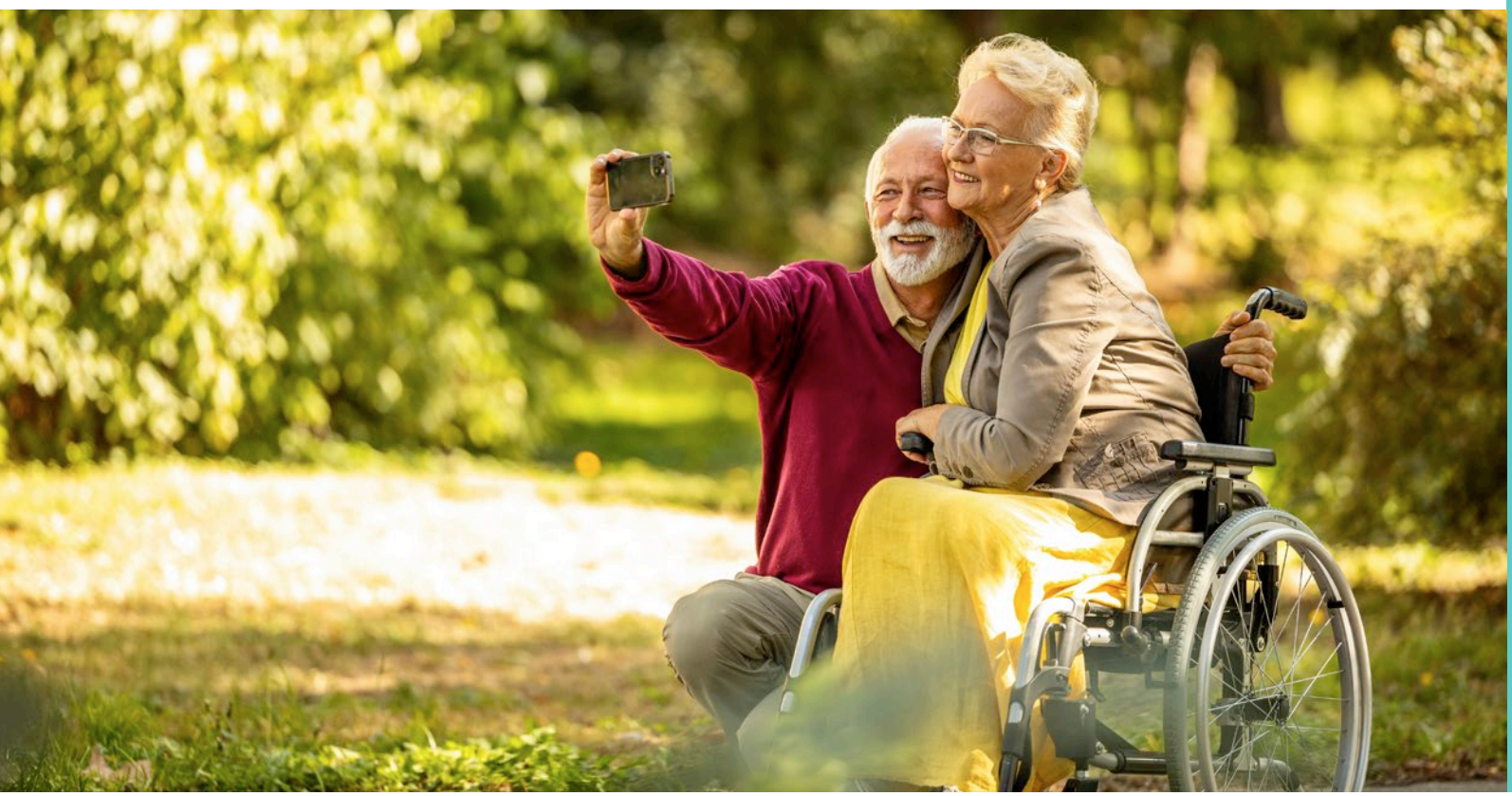
Both PPOs feature $0 monthly premium, $0 medical deductible, and $0 PCP copay, in-network, and low prescription drug copays. The PPO also includes supplemental benefits such as preventive and comprehensive dental, vision, hearing, fitness benefits including fitness center memberships, in-home and online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

Premiums and Benefits

	Red, White and Tru (PPO) (Medicare Advantage Only Plan)	MyTruAdvantage Choice Plus (PPO)
Monthly plan premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.	$0 Per Month In addition, you must keep paying your Medicare Part B premium.
Part B premium reduction	A $75 reduction will be applied to your Social Security check or your Medicare Part B premium bill.	Not Available
Deductible	**Medical services** This plan does not have a deductible ($0).	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan has a deductible ($200). **Deductible applies to Tier 3, Tier 4, and Tier 5**
Maximum out-of-pocket responsibility Does not include prescription drugs or premiums.	**In-network and out-of-network services (combined):** $4,000 yearly	**In-network and out-of-network services (combined):** $4,000 yearly
Inpatient hospital coverage	**In-network:** Days 1-5: $390 copay each day $0 copay each additional day	**In-network and out-of-network:** Days 1-5: $390 copay each day $0 copay each additional day
Outpatient hospital coverage	**Ambulatory surgical center** **In-network and Out-of-network:** $325 copay for each visit **Outpatient hospital** **In-network and Out-of-network:** $350 copay for each visit **Observation In-network and Out-of-network:** $325 copay for each stay	**Ambulatory surgical center** **In-network and Out-of-network:** $325 copay for each visit **Outpatient hospital** **In-network and Out-of-network:** $350 copay for each visit **Observation In-network and Out-of-network:** $325 copay for each stay
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	**Primary care physician (PCP)** **In-network and Out-of-network:** $0 copay for each office visit **Specialist visit** **In-network and Out-of-network:** $35 copay for each office visit

	Red, White and Tru (PPO) (Medicare Advantage Only Plan)	MyTruAdvantage Choice Plus (PPO)
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-network and out-of-network:** $0 copay for each service	**In-network and out-of-network:** $0 copay for each service
Emergency care This amount is waived if you are admitted to the hospital within 24 hours from your emergency care visit.	**In-network and out-of-network:** $140 copay for each visit	**In-network and out-of-network:** $140 copay for each visit
Urgently needed services	**In-network and out-of-network:** $35 copay for each visit	**In-network and out-of-network:** $35 copay for each visit
Outpatient diagnostic services (labs, radiology/imaging and x-rays)[1] This includes what you pay for radiology/imaging services such as a CT scan or MRI, tests/procedures, lab services, outpatient x-rays, and radiation therapy.	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Out-of-network:** 40% coinsurance for each service **Lab services** **In-network and out-of-network:** $15 copay for each service **Tests/procedures** **In-network and out-of-network:** $25 copay for each service **Outpatient x-rays** **In-network and out-of-network:** $30 copay for each service **Radiation therapy** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **General radiology/imaging** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service **Out-of-network:** 40% coinsurance for each service	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 copay for each service **Out-of-network:** 40% coinsurance for each service **Lab services** **In-network and out-of-network:** $15 copay for each service **Tests/procedures** **In-network and out-of-network:** $25 copay for each service **Outpatient x-rays** **In-network and out-of-network:** $30 copay for each service **Radiation therapy** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **General radiology/imaging** **In-network:** $60 copay for each service **Out-of-network:** 40% coinsurance for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 copay for each service **Out-of-network:** 40% coinsurance for each service
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be provided by a TruHearing™ provider.	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Out-of-network:** $55 copay for each visit **Routine hearing exam** **In-network and out-of-network:** $0 copay up to one per year **Hearing aid** **In-network and out-of-network:** Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00	**Medicare-covered hearing exam** **In-network:** $0 copay for each visit **Out-of-network:** $55 copay for each visit **Routine hearing exam** **In-network and out-of-network:** $0 copay up to one per year **Hearing aid** **In-network and out-of-network:** Standard Copay $399.00 Advanced Copay $599.00 Premium Copay $899.00

	Red, White and Tru (PPO) (Medicare Advantage Only Plan)	MyTruAdvantage Choice Plus (PPO)
Dental services Preventive (routine) dental services provided by Delta Dental®. See the Delta Dental® Certificate of Coverage for details. Comprehensive dental services provided by Delta Dental®. Please refer to the website under Delta Dental® Coverage Certificate for your complete dental coverage: www.mytruadvantage.com/information-2025.	**Applies to all covered dental services:** **$0 Copay for all covered dental services up to $1,750 yearly max.** **In-network:** You pay 0% of the total cost for Medicare-covered dental services. All Delta Dental covered services for Preventive and Comprehensive have a $0 copayment up to the annual allowance of $1,750 for all services.	**Applies to all covered dental services:** **Copay for all covered dental services up to $2,340 yearly max.** **In-network:** You pay 0% of the total cost for Medicare-covered dental services. All Delta Dental covered services for Preventive and Comprehensive have a $0 copayment up to the annual allowance of $2,340 for all 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 vision services include tests for corrective eyewear. NOTE: Glasses/contacts allowance is for: eyeglasses (frames/lenses), eyeglass lenses, eyeglass frames or contacts.	$0 copay for all eye services/eyewear to $250 yearly max. Will be administered through Debit Card - MyTruCard.	$0 copay for all eye services/eyewear to $250 yearly max. Will be administered through Debit Card - MyTruCard.



	Red, White and Tru (PPO) (Medicare Advantage Only Plan)	MyTruAdvantage Choice Plus (PPO)
Mental health care[1] We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit** **In-network and out-of-network:** **Days 1-5:** $390 copay each day **Days 6-90:** $0 each day **Outpatient group therapy** **In-network and out of network:** $35 copay for each visit **Outpatient individual therapy** **In-network and out-of-network:** $35 copay for each visit	**Inpatient visit** **In-network and out-of-network:** **Days 1-5:** $390 copay each day **Days 6-90:** $0 each day **Outpatient group therapy** **In-network and out of network:** $35 copay for each visit **Outpatient individual therapy** **In-network and out-of-network:** $35 copay for each visit
Skilled nursing facility (SNF)[1] Our plan covers up to 100 days each benefit period when provided in-network. A benefit period starts the day you go into an SNF and ends when you go for 60 days in a row without SNF care.	**In-network:** Days 1-20: $0 copay each day Days 21-100: $214 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: $214 copay each day **Out-of-network:** Days 1-58: $175 copay each day Days 59-100: $0 copay each day
Physical therapy	**In-network:** $35 copay for each visit **Out-of-network:** $55 copay for each visit	**In-network:** $35 copay for each visit **Out-of-network:** $55 copay for each visit
Ambulance[1] Air ambulance transportation to a hospital may be provided if you need immediate and rapid ambulance transportation that ground transportation can't provide. This amount is waived if you are admitted to the hospital within 24 hours from your Ambulance Services.	**In-network and out-of-network:** **Ground:** $260 copay per trip **Air:** $325 copay per trip	**In-network and out-of-network:** **Ground:** $260 copay per trip **Air:** $325 copay per trip
Transportation	Not covered	Not covered
Medicare Part B drugs[1] Step Therapy may be required for certain Part B drugs[1] (see Chapter 4 section 2.1 "Medicare Part B Drugs" of the EOC at www.mytruadvantage.com/information-2025 for more details).	**Chemotherapy drugs:** **In-network:** 0–20% Coinsurance **Out-of-network:** 40% Coinsurance **Other Part B Drugs:** **In-network:** 0–20% Coinsurance **Out-of-network:** 40% Coinsurance **Part B Insulins:** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump): You won't pay more than $35 for a one-month supply of each covered insulin product.	**Chemotherapy drugs:** **In-network:** 0–20% Coinsurance **Out-of-network:** 40% Coinsurance **Other Part B Drugs:** **In-network:** 0–20% Coinsurance **Out-of-network:** 40% Coinsurance **Part B Insulins:** Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump): You won't pay more than $35 for a one-month supply of each covered insulin product.

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

Prescription Drug

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

Beginning in 2025
There are three drug payment stages: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage will no longer exist in the Part D benefit.

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non- preferred, mail order, and 30, 60, or 90-day supply). Please see the Pharmacy Directory on www.mytruadvantage.com/information-2025 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
This plan has a $200 deductible for Part D prescription drugs that applies to the following tiers: Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty). There is no deductible for MyTruAdvantage Choice Plus (PPO) for covered insulins.

This plan does 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
Your Medicare Drug Coverage (Part D) will have an annual out-of-pocket maximum of $2,000. 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 $2,000, you pay $0 copay for the remainder of the year.

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory at www.mytruadvantage.com/information-2025.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$41 Copay	$82 Copay	$123 Copay
Tier 4 (Non-Preferred Drug)	28% coinsurance	28% coinsurance	28% coinsurance
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	30% coinsurance	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	Up to $70 Copay You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	Up to $105 Copay You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory at www.mytruadvantage.com/information-2025.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$6 Copay	$12 Copay	$18 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	28% coinsurance	28% coinsurance	28% coinsurance
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	30% coinsurance	Not Available	Not Available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	Up to $70 Copay You won't pay more than $70 for a two-month supply of each covered insulin product regardless of the cost-sharing tier.	Up to $105 Copay You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Mail Order Cost-Sharing

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$2 Copay	$4 Copay	$0 Copay
Tier 2 (Generic) *Includes Enhanced Benefit	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	28% coinsurance	28% coinsurance	28% coinsurance
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Insulin *Important message about what you pay for insulin*	Up to $35 Copay. 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.	Up to $70 Copay. 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.	Up to $105 Copay. 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.

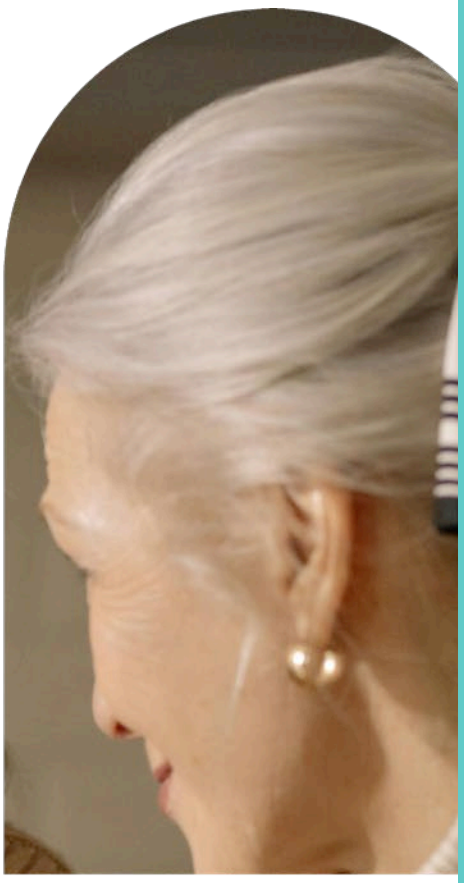
Additional Medical Benefits Covered Under Your Plan

	Red, White and Tru (PPO) (Medicare Advantage Only Plan)	MyTruAdvantage Choice Plus (PPO)
Annual preventive physical exam	**In-network:** $0 for each service **Out-of-network:** $0 for each service	**In-network:** $0 for each service **Out-of-network:** $0 for each service
Over-the-counter (OTC) card The OTC benefit offers you an easy way to get over-the-counter health and wellness products which is administered by CVS CareMark. These options include; In Store (CVS), Online, or by phone.	**In-network:** Up to $75 every 3 months The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused benefit can be carried forward to the next quarter, please refer to your Evidence of Coverage for benefit details and plan maximums. Any unused benefit as of 12/31/2025 will be forfeited. OTC will be administered by CVS CareMark.	**In-network:** Up to $100 every 3 months The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs. Weight loss items excluded from coverage. Unused benefit can be carried forward to the next quarter, please refer to your Evidence of Coverage for benefit details and plan maximums. Any unused benefit as of 12/31/2025 will be forfeited. OTC will be administered by CVS CareMark.
Worldwide emergency, urgently needed care and transportation coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$90 copay for each emergency covered occurrence $35 copay for each urgent covered occurrence $260 copay per trip for ground transportation $325 copay per trip for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $100,000.	$90 copay for each emergency covered occurrence $35 copay for each urgent covered occurrence $260 copay per trip for ground transportation $325 copay per trip for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $100,000.

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

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

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



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

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services

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

Other providers are available in our network.

MyTru Advantage

www.MyTruAdvantage.com