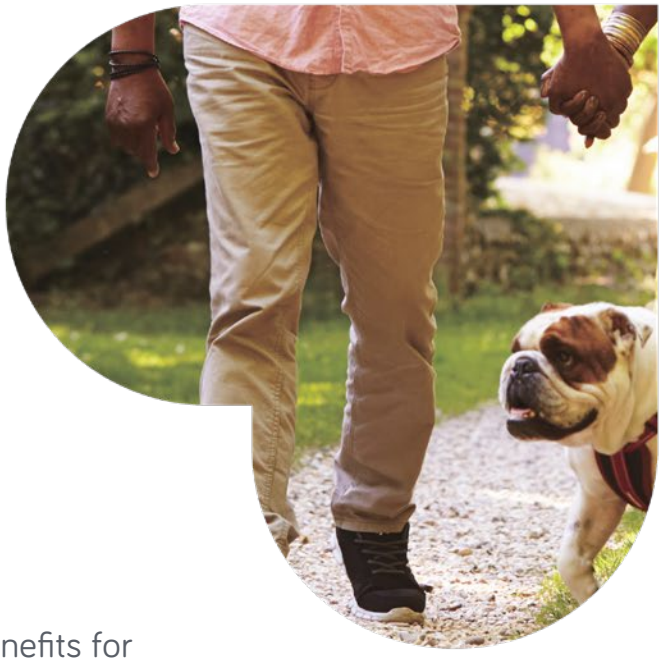
MyTru Advantage



2023 Summary of Benefits

January 1, 2023 – December 31, 2023

This booklet summarizes the benefits for MyTruAdvantage HMO and PPO plans effective January 1 to December 31, 2023. Inside you'll find information to help you make an informed decision on the plan that best meets your needs.

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

Table of Contents

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. Except for emergency and urgent care, any service provided by an out-of-network provider will not be covered.

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

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

Prescription drug benefits have no out-of-network coverage for the HMO or the PPO. If you purchase from an out-of-network pharmacy, you will be responsible for the payment. The pharmacy network includes 24,000 preferred pharmacies nationally, including many national and regional chains like CVS, Costco, Kroger, Walmart, and independent pharmacies.

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: www.MyTruAdvantage.com/Provider-Search
- Find your drug list: www.MyTruAdvantage.com/2023-Formulary
- Find your pharmacy: www.MyTruAdvantage.com/Pharmacy-Directory-2023
- Find the Evidence of Coverage: www.MyTruAdvantage.com/Documents-and-Forms

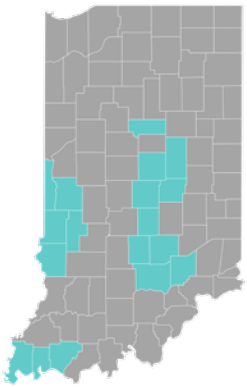
MyTruAdvantage Service Area in 18 Indiana Counties Including:

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

Offered in Posey, Warrick and Vanderburgh Counties

MyTruAdvantage Select Plus HMO

Offered in all MyTruAdvantage Counties



MyTruAdvantage Select HMO

MyTruAdvantage Choice Plus PPO

MyTruAdvantage Choice PPO

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 limitation and exclusions, in the Evidence of Coverage (EOC). This is especially important for doctors and services that you use regularly. Visit www.MyTruAdvantage.com/Documents-and-Forms to view the EOC or call 1-833-213-6731 (TTY: 711).
- [ ] **Provider directory.** View the provider directory at www.MyTruAdvantage.com/Provider-Search 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/Pharmacy-Directory-2023 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/2023-Formulary 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, 2024.
- [ ] **For the HMOs, we do not cover services by out-of-network providers.** Except in emergency or urgent situations, we do not cover services provided by doctors who are not listed in the provider directory.
- [ ] **For the PPOs, we cover services by out-of-network providers.** While we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

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

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

Medicare: You Have Choices

Medicare Benefits

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

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

Medicare Plan Comparisons

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

Important Health Insurance Terms and Definitions

Terms	Definitions
Coinsurance	A percentage of the cost you pay when you receive a 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 2023

January 1, 2023 – December 31, 2023

MyTruAdvantage offers two HMOs.

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

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

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

The pharmacy network includes 24,000 preferred pharmacies nationally, including many national and regional chains like CVS, Costco, Kroger, Walmart, and independent pharmacies.

- Find your pharmacies at: www.MyTruAdvantage.com/Pharmacy-Directory-2023
- Find your covered drugs at: www.MyTruAdvantage.com/2023-Formulary
- Contact us at 1-833-213-6731 (TTY: 711)

Both HMOs feature $0 monthly premium, $0 medical deductible, $0 prescription deductible, and $0 Primary Care Physician copays. You'll select a Primary Care Physician to help you get all the care you need, but no referrals are required for any in-network services or in-network provider, so you can see your specialist (in-network) without needing a referral from your PCP. The HMO also includes supplemental benefits such as preventive and comprehensive dental, vision, hearing, fitness benefits including fitness center memberships, in-home and online programs, and an over-the-counter allowance. You can pay an additional monthly premium of $25 for an optional supplemental dental benefit that includes coverage for initial crowns and dentures.

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

Premiums and Benefits

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

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

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Dental services Preventive (routine) dental services provided by Delta Dental®. See the Delta Dental® Certificate of Coverage for details. Comprehensive dental services provided by Delta Dental®. Please refer to the website under *Delta Dental® Coverage Certificate* for your complete dental coverage: www.MyTruAdvantage.com/Documents-and-Forms.	**Medicare-covered dental** **In-network:** 20% of all Medicare-covered dental services **Preventive (routine) dental** $0 for two cleanings per year $0 for two exams per year $0 for two fluoride treatments 0% to 50% coinsurance for one set of dental x-rays per year 40% coinsurance for minor fillings, crown repair and simple extractions, comprehensive dental services, provided through Delta Dental®. 50% coinsurance for non-routine, diagnostic, relines and rebase to existing full and partial dentures, relines and repairs to existing bridges. Partial dentures, root canal, and brush biopsy covered annually. Comprehensive dental services provided through Delta Dental®. $1,000 maximum benefit coverage per year There is a buy-up option with additional coverage for an additional premium. Please see Optional Benefits section for more information.	**Medicare-covered dental** **In-network:** 20% of all Medicare-covered dental services **Preventive (routine) dental** $0 for two cleanings per year $0 for two exams per year $0 for two fluoride treatments 0% to 50% coinsurance for one set of dental x-rays per year 40% coinsurance for minor fillings, crown repair and simple extractions, comprehensive dental services, provided through Delta Dental®. 50% coinsurance for non-routine, diagnostic, relines and rebase to existing full and partial dentures, relines and repairs to existing bridges. Partial dentures, root canal, and brush biopsy covered annually. Comprehensive dental services provided through Delta Dental®. $1,500 maximum benefit coverage per year There is a buy-up option with additional coverage for an additional premium. Please see Optional Benefits section for more information.
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 EyeMed® "Select" provider. NOTE: Glasses/contacts allowance is for: eyeglasses (frames/lenses), eyeglass lenses, eyeglass frames or contacts.	**Medicare-covered vision exam** In-network: $0 for each exam **Routine vision exam (one per year)** In-network: $0 for each exam **Glasses/contacts** In-network: $150 annual benefit amount	**Medicare-covered vision exam** In-network: $0 for each exam **Routine vision exam (one per year)** In-network: $0 for each exam **Glasses/contacts** In-network: $200 annual benefit amount

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Mental health care[1] We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit** **In-network:** Days 1-5: $295 each day Days 6-90: $0 each day **Outpatient group therapy** **In-network:** $25 for each visit **Outpatient individual therapy** **In-network:** $25 for each visit	**Inpatient visit** **In-network:** Days 1-5: $275 each day Days 6-90: $0 each day **Outpatient group therapy** **In-network:** $25 for each visit **Outpatient individual therapy** **In-network:** $25 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 each day Days 21-100: $188 each day	**In-network:** Days 1-20: $0 each day Days 21-100: $188 each day
Physical therapy	**In-network:** $35 for each visit	**In-network:** $35 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.	**Ground:** $260 per trip **Air:** $325 per trip	**Ground:** $260 per trip **Air:** $325 per trip
Transportation	Not covered	Not covered
Medicare Part B Drugs[1] Step Therapy may be required for certain Part B drugs (see Chapter 4 section 2.1 "Medicare Part B Drugs" of the EOC at www.MyTruAdvantage.com/Documents-and-Forms for more details).	**Chemotherapy drugs** **In-network:** 20% **Other Part B drugs** **In-network:** 20%	**Chemotherapy drugs** **In-network:** 20% **Other Part B drugs** **In-network:** 20%

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

Prescription Drug

MyTruAdvantage Select (HMO) Prescription Drug Benefits - Part D

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

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non- preferred, mail order, and 30, 60, or 90-day supply). Please see the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023 for more information.

Initial Coverage
You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you reach that amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

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

Preferred Retail Cost-Sharing
For a list of preferred pharmacies, go to the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$7 Copay	$14 Copay	$21 Copay
Tier 3 (Preferred Brand)	$42 Copay	$84 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$190 Copay	$285 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 2 (Generic)	$12 Copay	$24 Copay	$36 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier 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)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5..*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Coverage Gap
After your total yearly drug costs reach $4,660, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $7,400. MyTruAdvantage Select (HMO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a one-month supply.

Catastrophic Coverage
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic), and a $10.35 copay for all other drugs.

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

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

Please note, costs may differ based on pharmacy type or status (e.g., preferred/non-preferred, mail order, and 30, 60 or 90-day supply). Please see the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023 for more information.

Initial Coverage
After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you reach that amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

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

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$37 Copay	$74 Copay	$111 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$180 Copay	$270 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 2 (Generic)	$15 Copay	$30 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier 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)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5..*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Coverage Gap

After your total yearly drug costs reach $4,660, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $7,400. MyTruAdvantage Select Plus (HMO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a one-month supply.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic), and a $10.35 copay for all other drugs.

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 by phone at (888) 628-2770 (TTY: 711), in store at CVS Caremark select locations or online at www.cvs.com/otchs/MyTruAdvantage If you order online from a list of approved OTC items, and OTC Health Solutions will mail them directly to your home address.	**In-network:** Up to $75 every 3 months Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.	**In-network:** Up to $75 every 3 months Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.
Worldwide emergency, urgently needed care and transportation coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$90 for each emergency covered occurrence $50 for each urgent covered occurrence $260 ground transportation $325 air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $25,000	$90 for each emergency covered occurrence $50 for each urgent covered occurrence $260 ground transportation $325 air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $50,000

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

	MyTruAdvantage Select (HMO)	MyTruAdvantage Select Plus (HMO)
Select Insulins Senior Savings program Participate in Senior Savings in CY 2023. Copay for Select Insulin from participating manufacturers will be capped. **Important message about what you pay for insulin** You won't pay more than the cost-sharing for a 30-day, 60-day or 90-day supply listed for each insulin product covered by our plan, no matter what cost-sharing tier it's on.	**30-day supply** $35 copay **60-day supply** $70 copay **90-day supply** $105 copay	**30-day supply** $35 copay **60-day supply** $70 copay **90-day supply** $105 copay
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 & Phsychiatric** $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 & Phsychiatric** $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.

Optional Dental Package for MyTruAdvantage Select (HMO) and Select Plus (HMO)

Customize your HMO coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

Optional Dental	Benefit
$25 monthly premium	**50%** Coinsurance. Full/partial dentures covered at 1 per 5 years. Crowns are covered as needed, per dental provider. Maximum benefit is **$1,500.** Benefits offered through Delta Dental®. See Certificate of Coverage at www.MyTruAdvantage.com/Documents-and-Forms

MyTruAdvantage Select (HMO) and Select Plus (HMO) Optional supplemental benefits (OSB) are only available to members of MyTruAdvantage Select (HMO) and Select Plus (HMO).

Members of MyTruAdvantage plans that offer OSBs may enroll in OSBs at the time of MAPD enrollment or within two months of the MAPD plan's effective date. Benefits may change on January 1 each year.

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 2023

January 1, 2023 – December 31, 2023

MyTruAdvantage offers two PPOs.

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/Provider-Search
- Contact us at 1-833-213-6731 (TTY: 711)

In-network benefits and out-of-network benefits are included in your coverage. Cost shares, such as co-pays or co-insurance, may differ for in-network and out-of-network providers. For instance, specialist office co-pays may be $35 for in-network doctors and $55 for out-of-network doctors. In some cases, the in-network and out-of-network coverage is the same. For instance, specialist office co-pays are $35 for in-network doctors and also $35 for out-of-network doctors.

Unlike medical benefits, prescription drugs have no out-of-network coverage. If you purchase from an out-of-network pharmacy, you will be responsible for the payment. The pharmacy network includes 24,000 preferred pharmacies nationally, including many national and regional chains like CVS, Costco, Kroger, Walmart, and independent pharmacies.

- Find your pharmacies at: www.MyTruAdvantage.com/Pharmacy-Directory-2023
- Find your covered drugs at: www.MyTruAdvantage.com/2023-Formulary
- 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. You can pay an additional monthly premium of $25 for an optional supplemental dental benefit that includes coverage for initial crowns and dentures.

Premiums and Benefits

	MyTruAdvantage Choice (PPO)	MyTruAdvantage Choice Plus (PPO)
Monthly plan premium	$0 Per Month In addition, you must keep paying your Medicare Part B premium.	$0 Per Month In addition, you must keep paying your Medicare Part B premium.
Deductible	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan has a $100 deductible for Part D prescription drugs that applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier). This plan does not have a deductible for prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 6 (Select Care), or Select Insulins.	**Medical services** This plan does not have a deductible ($0). **Prescription drugs (Part D)** This plan does not have a deductible ($0).
Maximum out-of-pocket responsibility Does not include prescription drugs or premiums.	**In-network:** $3,650 **In-network and out-of-network services (combined):** $8,950	**In-network:** $4,225 **In-network and out-of-network services (combined):** $4,225
Inpatient hospital coverage[1]	**In-network:** Days 1-5: $350 each day $0 each additional day **Out-of-network:** 40% for each stay	**In-network and out-of-network:** Days 1-5: $350 each day $0 each additional day
Outpatient hospital coverage[1]	**Ambulatory surgical center** **In-network:** $225 for each visit **Out-of-network:** $375 for each visit **Outpatient hospital** **In-network:** $225 for each visit **Out-of-network:** $375 for each visit **Observation** **In-network:** $225 for each stay **Out-of-network:** $375 for each stay	**Ambulatory surgical center** **In-network:** $325 for each visit **Out-of-network:** $325 for each visit **Outpatient hospital** **In-network:** $325 for each visit **Out-of-network:** $325 for each visit **Observation** **In-network:** $325 for each stay **Out-of-network:** $325 for each stay
Doctor visits[1]	**Primary care physician (PCP)** **In-network:** $0 for each office visit **Out-of-network:** $35 for each office visit **Specialist visit** **In-network:** $35 for each office visit **Out-of-network:** $55 for each office visit	**Primary care physician (PCP)** **In-network:** $0 for each office visit **Out-of-network:** $0 for each office visit **Specialist visit** **In-network:** $35 for each office visit **Out-of-network:** $35 for each office visit

	MyTruAdvantage Choice (PPO)	MyTruAdvantage Choice Plus (PPO)
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-network and out-of-network:** $0 for each service	**In-network and out-of-network:** $0 for each service
Emergency care This amount is waived if you are admitted to the hopsital within 24 hours from your emergency care visit.	**In-network and out-of-network:** $90 for each visit	**In-network and out-of-network:** $90 for each visit
Urgently needed services	**In-network and out-of-network:** $35 for each visit	**In-network and out-of-network:** $35 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 for each service **Out-of-network:** 40% for each service **Lab services** **In-network:** $10 for each service **Out-of-network:** $15 for each service **Tests/procedures** **In-network** $10 for each service **Out-of-network:** $15 for each service **Outpatient x-rays** **In-network:** $15 for each service **Out-of-network:** $30 for each service **Radiation therapy** **In-network:** $60 for each service **Out-of-network:** 40% for each service **General radiology/imaging** **In-network:** $60 for each service **Out-of-network:** 40% for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $225 for each service Out-of-network: 40% for each service	**Dexa Scan and Diagnostic Mammography** **In-network:** $0 for each service **Out-of-network:** 40% for each service **Lab services** **In-network and out-of-network:** $15 for each service **Tests/procedures** **In-network and out-of-network:** $15 for each service **Outpatient x-rays** **In-network and out-of-network:** $30 for each service **Radiation therapy** **In-network:** $60 for each service **Out-of-network:** 40% for each service **General radiology/imaging** **In-network:** $60 for each service **Out-of-network:** 40% for each service **Complex radiology/imaging (such as MRI and CT scan)** **In-network:** $235 for each service Out-of-network: 40% 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 for each visit **Out-of-network:** $55 for each visit **Routine hearing exam** **In-network and out-of-network:** $0, up to one per year **Hearing aid** **In-network and out-of-network:** $699 or $999 depending on the type	**Medicare-covered hearing exam** **In-network:** $0 for each visit **Out-of-network:** $55 for each visit **Routine hearing exam** **In-network and out-of-network:** $0, up to one per year **Hearing aid** **In-network and out-of-network:** $699 or $999 depending on the type

	MyTruAdvantage Choice (PPO)	MyTruAdvantage Choice Plus (PPO)
Dental services Preventive (routine) dental services provided by Delta Dental®. See the Delta Dental® Certificate of Coverage for details. Comprehensive dental services provided by Delta Dental®. Please refer to the website under *Delta Dental® Coverage Certificate* for your complete dental coverage: www.MyTruAdvantage.com/Documents-and-Forms.	**Medicare-covered dental** **In-network:** 20% of all Medicare-covered dental services **Preventive (routine) dental** $0 for two cleanings per year $0 for two exams per year $0 for two fluoride treatments 0% to 50% coinsurance for one set of dental x-rays per year 40% coinsurance for minor fillings, crown repair and simple extractions, comprehensive dental services, provided through Delta Dental®. 50% coinsurance for non-routine, diagnostic, relines and rebase to existing full and partial dentures, relines and repairs to existing bridges and partial dentures, root canal, and brush biopsy covered annually. Comprehensive dental services provided through Delta Dental®. $1,000 maximum benefit coverage per year There is a buy-up option with additional coverage for an additional premium; see Optional Dental Package for MyTruAdvantage section of this document. **Out-of-network:** 40% of all Medicare-covered dental services 50% of all preventive dental services 50% of all comprehensive dental services	**Medicare-covered dental** **In-network:** 20% of all Medicare-covered dental services **Preventive (routine) dental** $0 for two cleanings per year $0 for two exams per year $0 for two fluoride treatments 0% to 50% coinsurance for one set of dental x-rays per year 40% coinsurance for minor fillings, crown repair and simple extractions, comprehensive dental services, provided through Delta Dental®. 50% coinsurance for non-routine, diagnostic, relines and rebase to existing full and partial dentures, relines and repairs to existing bridges and partial dentures, root canal, and brush biopsy covered annually. Comprehensive dental services provided through Delta Dental®. $1,500 maximum benefit coverage per year There is a buy-up option with additional coverage for an additional premium; see Optional Dental Package for MyTruAdvantage section of this document. **Out-of-network:** 40% of all Medicare-covered dental services 50% of all preventive dental services 50% of all comprehensive dental 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 EyeMed® "Select" provider. NOTE: Glasses/contacts allowance is for: eyeglasses (frames/lenses), eyeglass lenses, eyeglass frames or contacts.	**Medicare-covered vision exam** **In-network:** $0 for each exam **Out-of-network:** $40 for each exam **Routine vision exam (one per year)** **In-network:** $0 for each exam **Out-of-network:** $40 for each exam **Glasses/contacts** **In-network:** $150 annual benefit amount **Out-of-network:** 50%, up to $150 annual benefit amount	**Medicare-covered vision exam** **In-network:** $0 for each exam **Out-of-network:** $40 for each exam **Routine vision exam (one per year)** **In-network:** $0 for each exam **Out-of-network:** $40 for each exam **Glasses/contacts** **In-network:** $200 annual benefit amount **Out-of-network:** 50%, up to $200 annual benefit amount

	MyTruAdvantage Choice (PPO)	MyTruAdvantage Choice Plus (PPO)
Mental health care[1] We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	**Inpatient visit** **In-network:** Days 1-5: $350 each day Days 6-90: $0 each day **Out-of-network:** 40% for each stay **Outpatient group therapy** **In-network:** $30 for each visit **Out-of-network:** $40 for each visit **Outpatient individual therapy** **In-network:** $30 for each visit **Out-of-network:** $40 for each visit	**Inpatient visit** **In-network and out-of-network:** Days 1-5: $350 each day Days 6-90: $0 each day **Outpatient group therapy** **In-network and out of network:** $35 for each visit **Outpatient individual therapy** **In-network and out-of-network:** $35 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 each day Days 21-100: $188 each day **Out-of-network:** Days 1-58: $175 each day Days 59-100: $0 each day	**In-network:** Days 1-20: $0 each day Days 21-100: $188 each day **Out-of-network:** Days 1-58: $175 each day Days 59-100: $0 each day
Physical therapy	**In-network:** $35 for each visit **Out-of-network:** $55 for each visit	**In-network:** $35 for each visit **Out-of-network:** $55 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.	**In-network and out-of-network:** **Ground:** $260 per trip **Air:** $325 per trip	**In-network and out-of-network:** **Ground:** $260 per trip **Air:** $325 per trip
Transportation	Not covered	Not covered
Medicare Part B drugs 1 Step Therapy may be required for certain Part B drugs (see Chapter 4 section 2.1 "Medicare Part B Drugs" of the EOC at www.MyTruAdvantage.com/Documents-and-Forms for more details).	**Chemotherapy drugs** **In-network:** 20% **Out-of-network:** 40% **Other Part B drugs** **In-network:** 20% **Out-of-network:** 40%	**Chemotherapy drugs** **In-network:** 20% **Out-of-network:** 40% **Other Part B drugs** **In-network:** 20% **Out-of-network:** 40%

[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 (PPO) Prescription Drug Benefits - Part D

Yearly Deductible
$100 per year for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), Tier 5 (Specialty Tier).

There is no deductible for MyTruAdvantage Choice (PPO) for Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 6 (Select Care Drugs) and Select Insulins.

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

Initial Coverage
You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you reach that amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

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

Preferred Retail Cost-Sharing

For a list of preferred pharmacies, go to the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$2 Copay	$4 Copay	$6 Copay
Tier 2 (Generic)	$8 Copay	$16 Copay	$24 Copay
Tier 3 (Preferred Brand)	$42 Copay	$84 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$95 Copay	$190 Copay	$285 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	31% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$7 Copay	$14 Copay	$21 Copay
Tier 2 (Generic)	$14 Copay	$28 Copay	$42 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	31% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

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)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Coverage Gap

After your total yearly drug costs reach $4,660, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $7,400. MyTruAdvantage Choice (PPO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a one-month supply, no matter what cost sharing tier it's on, even if you haven't paid your deductible.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic), and a $10.35 copay for all other drugs.

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

Yearly Deductible
There is no deductible for MyTruAdvantage Choice Plus (PPO): (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), Tier 5 (Specialty Tier), Tier 6 (Select Care Drugs) and Select Insulin. 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/Pharmacy-Directory-2023.

Initial Coverage
You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. Once you reach that amount, you will enter the Coverage Gap. You may get your drugs at network retail pharmacies and mail order pharmacies.

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

Preferred Retail Cost-Sharing
For a list of preferred pharmacies, go to the Pharmacy Directory on www.MyTruAdvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay	$0 Copay
Tier 2 (Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 3 (Preferred Brand)	$37 Copay	$74 Copay	$111 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$180 Copay	$270 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Standard Retail Cost-Sharing

All other network retail pharmacies. Find a list in the Pharmacy Directory on mytruadvantage.com/Pharmacy-Directory-2023.

Tier	30-Day Supply	60-Day Supply	90-Day Supply
Tier 1 (Preferred Generic)	$5 Copay	$10 Copay	$15 Copay
Tier 2 (Generic)	$10 Copay	$20 Copay	$30 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *The Specialty Tier is limited to a 30-day supply.*	33% of the cost	Not covered	Not covered
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier 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)	$8 Copay	$16 Copay	$0 Copay
Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$200 Copay	$300 Copay
Tier 5 (Specialty Tier) *Mail-order is not available for drugs in Tier 5.*	Not available	Not available	Not available
Tier 6 (Select Care Drugs)	$0 Copay	$0 Copay	$0 Copay
Select Insulin *Important message about what you pay for insulin*	$35 Copay You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$70 Copay You won't pay more than $70 for a two-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	$105 Copay You won't pay more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Coverage Gap

After your total yearly drug costs reach $4,660, you pay 25% of the price for brand name drugs (plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $7,400. MyTruAdvantage Choice Plus (PPO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $35 for a one-month supply.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay the greater of: 5% of the cost, or $4.15 copay for generic (including brand drugs treated as generic), and a $10.35 copay for all other drugs.

Additional Medical Benefits Covered Under Your Plan

	MyTruAdvantage Choice (PPO)	MyTruAdvantage Choice Plus (PPO)
Annual preventive physical exam	**In-network:** $0 for each service **Out-of-network:** $0 for each service	**In-network:** $0 for each service **Out-of-network:** $0 for each service
Over-the-counter (OTC) card The OTC benefit offers you an easy way to get over-the-counter health and wellness products by phone at (888) 628-2770 (TTY: 711), in store at CVS Caremark select locations or online at www.cvs.com/otchs/MyTruAdvantage If you order online from a list of approved OTC items, and OTC Health Solutions will mail them directly to your home address.	**In-network:** Up to $75 every 3 months Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.	**In-network:** Up to $75 every 3 months Unused balances at the end of each quarter can be rolled over into the next quarter, up to a maximum of $150. Any amount greater than $150 will not roll over from one quarter to the next.
Worldwide emergency, urgently needed care and transportation coverage Emergency and Urgent care and emergency transportation coverage when traveling outside of the United States.	$90 for each emergency covered occurrence $35 for each urgent covered occurrence $260 per trip for ground transportation $325 per trip for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $50,000	$90 for each emergency covered occurrence $35 for each urgent covered occurrence $260 per trip for ground transportation $325 per trip for air transportation Maximum plan benefit including Emergency, Urgent and Transportation benefits combined is $100,000

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

	MyTruAdvantage Choice (PPO)	MyTruAdvantage Choice Plus (PPO)
Senior Savings program Participate in Senior Savings in CY 2023. Copay for Select Insulin from participating manufacturers will be capped. **Important message about what you pay for insulin** You won't pay more than the cost-sharing for a 30 day, 60 day or 90 day supply listed for each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.	**30-day supply** $35 copay **60-day supply** $70 copay **90-day supply** $105 copay	**30-day supply** $35 copay **60-day supply** $70 copay **90-day supply** $105 copay
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: $0 copay for each visit Out-of-network: $35 copay for each visit **Specialist & Phsychiatric** In-network: $35 copay for each visit Out-of-nework: $55 copay for each visit **Individual outpatient mental health & substance abuse** In-network: $30 copay for each visit Out-of-network: $40 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 & Phsychiatric** In-network and out-of-network: $35 copay for each visit **Individual outpatient mental health & substance abuse** In-network and out-of-network: $35 copay for each visit Copayment amounts are the same for Additional Telehealth Services as for in-person services.

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

Optional Dental Package for MyTruAdvantage Choice (PPO) and Choice Plus (PPO)

Customize your PPO coverage for an extra monthly premium when you enroll. You can choose from the following to help create your Medicare plan.

Optional Dental	Benefit
$25 monthly premium	**50%** Coinsurance, as determined by dental provider. Full/partial dentures covered at 1 per 5 years. Crowns are covered as needed, per dental provider.

MyTruAdvantage Choice (PPO) and Choice Plus (PPO) Optional supplemental benefits (OSB) are only available to members of MyTruAdvantage Choice (PPO) and Choice Plus (PPO).

Members of MyTruAdvantage plans that offer OSBs may enroll in OSBs at the time of MAPD enrollment or within two months of the MAPD plan's effective date. Benefits may change on January 1 each year.

Enrollees must use network providers for specific OSBs when stated in the Evidence of Coverage (EOC); otherwise, covered services may be received from non-network providers at a higher cost. Enrollees must continue to pay the Medicare Part B premium, their MyTruAdvantage plan premium, and the OSB premium.

This information is not a complete description of benefits. Call Member Services for more information.

The MyTruAdvantage pharmacy network includes limited lower-cost, preferred pharmacies in Indiana. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call Member Services or consult the online pharmacy directory at www.MyTruAdvantage.com/Members.

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

www.MyTruAdvantage.com