

2027 Summary of Benefits

True West No Rx 3 (PPO)

H8267-003-000

January 1, 2027 – December 31, 2027

Range Health, Inc. is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in Range Health, Inc. depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call 1-833-574-6031 (TTY: 711) and request the "Evidence of Coverage" or access it online at ***rangehealth.com/MemberResources***.

To join True West No Rx 3 (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following counties-

- Idaho: Bonner, Kootenai, Latah, and Nez Perce
- Montana: Broadwater, Cascade, Flathead, Jefferson, Lewis and Clark, Sanders, Stillwater, Teton, and Yellowstone

You can use out-of-network providers in emergency situations for the same copay as in-network providers. For all other care, services from out-of-network providers may lead to higher copays and/or coinsurance on the full cost of services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at ***medicare.gov*** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print or audio.

Free language interpreter services are available for non-English speakers.

For more information, please call customer service at: 1-833-574-6031 (TTY: 711)

8 a.m. – 8 p.m.

Oct. – Mar.: seven days a week

Apr. – Sept.: Mon. – Fri.

Or please visit us at ***rangehealth.com***.

	IN-NETWORK	OUT-OF-NETWORK
Monthly Plan Premium You must continue to pay your Medicare Part B premium	\$149	
Medical Deductible This plan does not have a medical deductible	\$0: you pay nothing	
Maximum Out-of-Pocket Responsibility The most you pay for covered Part A and Part B medical services. Doesn't include monthly premium.	\$6,750 in-network	\$10,100 combined in- and out-of-network
Inpatient Hospital Coverage⁰	\$400 daily: days 1 - 5; \$0 daily: days 6 - 90	50% of cost
Outpatient Hospital⁰	\$450 copay; 20% orthopedic surgery; \$0 diagnostic colonoscopy	50% of cost
Observation Coverage⁰	\$450 copay	20% of cost
Ambulatory Surgery Center⁰	\$250 copay; 20% orthopedic surgery; \$0 diagnostic colonoscopy	50% of cost
Doctor Visits Primary care	\$0: you pay nothing	50% of cost
Specialists	\$35 copay	50% of cost
Preventive Care	\$0: you pay nothing	
Emergency Care Copay waived if admitted to the hospital within 24 hours	\$130 copay	
Urgent Care	\$45 copay	
Worldwide Emergency and Urgent Coverage	\$130 emergency room care copay; \$45 urgent care copay; \$325 ground ambulance; \$1,250 air ambulance	
Diagnostic Tests and Procedures	\$30 copay	50% of cost
Lab Services⁰	\$0: you pay nothing	50% of cost
Diagnostic Radiology (MRI, CT, PET)⁰	\$250 copay in hospital; \$150 copay non-hospital; \$0 diagnostic mammogram	50% of cost
X-rays⁰	\$0 copay	50% of cost
Medicare-Covered Hearing Services	\$30 copay	50% of cost
TruHearing[®] Hearing Exam Benefit is one exam per year	\$0: you pay nothing	90% of cost

⁰Your provider may need to obtain prior authorization.

	IN-NETWORK	OUT-OF-NETWORK
TruHearing® Hearing Aids Benefit is two per year (one per ear per year)	\$499 copay per Standard aid; \$699 copay per Advanced aid; \$999 copay per Premium aid Benefit is limited to the TruHearing Standard, Advanced, and Premium hearing aids Optional \$50 additional cost per rechargeable aid on select models. First year of follow-up provider visits for fitting/evaluation of hearing aid and adjustments are covered.	90% of cost from providers whose primary business is hearing care services after \$1,000 out-of-network hearing aid deductible
Medicare-Covered Dental Services	\$35 copay	50% of cost
Preventive Dental	\$0 copay per visit • Two routine preventive exams per year • Two cleanings per year • One emergency exam per year • One bitewing and fluoride application per year • One full mouth X-ray every three years	50% of cost after \$100 out-of-network dental deductible
	\$500 combined in- and out-of-network preventive dental coverage limit	
Medicare-Covered Eye Exam⁰ Diagnosis and treatment of medical eye diseases and conditions	\$35 copay	50% of cost
VSP® Vision Exam Benefit is for one per year	\$0: you pay nothing	50% of cost

⁰Your provider may need to obtain prior authorization.

	IN-NETWORK	OUT-OF-NETWORK
VSP® Eyewear Benefit is for every two years	\$35 copay for one pair of glasses (frames in the VSP Genesis Collection); \$50 allowance for non-Genesis frames \$35 copay for medically necessary contacts \$100 allowance towards contacts in lieu of glasses	\$50 frame allowance 50% of cost for single vision lenses 50% of cost for Standard Progressive lenses, UV Coating, and Scratch Resistance Coating \$100 allowance towards contacts in lieu of glasses \$35 copay for medically necessary contacts
Inpatient Mental Health Care[◊]	\$400 daily: days 1 - 5; \$0 daily: days 6 - 90	50% of cost
Outpatient Mental Health Care Individual and Group therapy	\$20 copay	50% of cost
Skilled Nursing Facility (SNF)[◊]	\$0 daily: days 1 - 20; \$221 daily: days 21 - 70; \$0 daily: days 71 - 100	50% of cost: days 1 - 100
Occupational Therapy	\$35 copay	50% of cost
Physical and Speech Therapy	\$35 copay	50% of cost
Ground Ambulance[◊]	\$325 copay	\$325 copay
Air Ambulance[◊]	\$1,250 copay	\$1,250 copay
Transportation	Not covered	Not covered
Medicare Part B Prescription Drugs^{◊**} (i.e., chemotherapy, hospital-administered infusions) Part B drugs may be rebatable and subject to a lower coinsurance	20% of cost	50% of cost
Part B Insulin Part B drugs may be rebatable and subject to a lower coinsurance	20% of cost; \$35 maximum per month	50% of cost; \$35 maximum per month

[◊]Your provider may need to obtain prior authorization.

^{**}Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Annual Physical Exam	\$0: you pay nothing	25% of cost
Additional Telehealth Services	Follows your in-network copay for participating providers	Not covered
Durable Medical Equipment[∘]	20% of cost	50% of cost
Prosthetic Medical Devices[∘]	20% of cost	50% of cost
Diabetic Shoes and Inserts	20% of cost	50% of cost
Diabetic Supplies Glucose monitors, test strips, and lancets	\$0: you pay nothing	50% of cost
Silver&Fit[®] Membership	\$0: you pay nothing for gym memberships at participating Silver&Fit [®] locations	90% of cost at a gym whose primary function is fitness services after \$600 out-of-network fitness deductible

[∘]Your provider may need to obtain prior authorization.

DISCRIMINATION IS AGAINST THE LAW

Range Health complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Range Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Range Health Civil Rights Coordinator at 1-833-574-6031 (TTY: 711).

ATTENTION: If you speak Arabic, Bosnian, Chinese, French, German, Italian, Japanese, Korean, Nepali, Portuguese, Russian, Spanish, Swahili, Tagalog, or Vietnamese, appropriate auxiliary aids and language assistance services are available free of charge. Call 1-833-574-6031 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً اتصل على 1-833-574-6031 (للصم والبكم: 711).

Bosnian: PAŽNJA: Ako govorite bosanski, dostupne su vam besplatne jezičke usluge. Pozovite 1-833-574-6031 (TTY: 711).

Chinese: 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 1-833-574-6031 (TTY: 711)。

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-574-6031 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-574-6031 (TTY: 711).

Italian: ATTENZIONE: Se parli italiano, hai a disposizione servizi gratuiti di assistenza linguistica. Chiama 1-833-574-6031 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-833-574-6031 (TTY: 711) まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-574-6031 (TTY: 711) 번으로 전화해 주십시오.

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

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-833-865-3453
Fax: 208-387-6690
Email: CivilRightsCoordinator@rangehealth.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

Nepali: ध्यान दनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नम्रित् भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-833-574-6031 (टटिविड: 711)।

Portuguese: ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Ligue para 1-833-574-6031 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-574-6031 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-574-6031 (TTY: 711).

Swahili: TAZAMA: Ikiwa unazungumza Kiswahili, huduma za usaidizi za lugha bila malipo zinapatikana kwa ajili yako. Piga simu kwa 1-833-574-6031 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-574-6031 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-574-6031 (TTY: 711).

For more information, call **1-844-419-2760 (TTY: 711)**.

8 a.m. to 8 p.m

October 1 to March 31: seven days a week

April 1 to September 30: Monday through Friday

Range Health, Inc. is a PPO Medicare Advantage plan with a Medicare contract. Enrollment in Range Health, Inc. depends on contract renewal.

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On behalf of Range Health, Inc., TruHearing, VSP Vision Care, and American Specialty Health, independent companies, administer supplemental benefit programs. VSP Vision Care administers the vision program, TruHearing administers the hearing aid coverage program, and American Specialty Health administers the fitness program to Medicare Advantage plan members.

Out-of-network/non-contracted providers are under no obligation to treat Range Health, Inc. Medicare Advantage members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.