

2027 Summary of Benefits

True West Rx 4 (PPO)

H8267-004-000

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 Rx 4 (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 in Idaho: Kootenai.

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	\$139	
Medical Deductible Medical deductible only applies to some services; you pay 100% of the cost up to the deductible, then your plan begins to help pay. Other services are covered before you meet your deductible; however, you may still be responsible for a copayment or coinsurance. The Summary of Benefits only lists some common services. For a complete list of services and if they apply to the deductible, refer to the plan's Evidence of Coverage (EOC).	\$700 combined in- and out-of-network deductible	
	See below for services where medical deductible applies	Deductible applies to most out-of-network benefits See below for services where medical deductible applies
Maximum Out-of-Pocket Responsibility The most you pay for covered Part A and Part B medical services. Doesn't include monthly premium.	\$8,000 in-network	\$10,500 combined in- and out-of-network
Inpatient Hospital Coverage [◇]	\$415 daily: days 1 - 5; \$0 daily: days 6 - 90	\$450 daily: days 1 - 10; \$0 daily: days 11 - 90 after medical deductible
Outpatient Hospital [◇]	\$495 copay; 20% for orthopedic surgery; \$0 diagnostic colonoscopy; all after medical deductible	50% of cost after medical deductible
Observation Coverage [◇]	\$425 copay after medical deductible	50% of cost after medical deductible
Ambulatory Surgery Center [◇]	\$300 copay; 20% for orthopedic surgery; \$0 diagnostic colonoscopy; all after medical deductible	50% of cost after medical deductible
Doctor Visits Primary care	\$0: you pay nothing	50% of cost after medical deductible
Specialists	\$50 copay	50% of cost after medical deductible
Preventive Care	\$0: you pay nothing	
Emergency Care Copay waived if admitted to the hospital within 24 hours	\$115 copay	
Urgent Care	\$40 copay	

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

	IN-NETWORK	OUT-OF-NETWORK
Worldwide Emergency and Urgent Coverage	\$115 emergency room care copay; \$40 urgent care copay; \$325 ground ambulance copay; 20% of cost for air ambulance; \$10,000 maximum; all after medical deductible	
Diagnostic Tests and Procedures	\$30 copay after medical deductible	50% of cost after medical deductible
Lab Services[◇]	\$0: you pay nothing	50% of cost after medical deductible
Diagnostic Radiology (MRI, CT, PET)[◇]	\$250 copay in hospital; \$150 copay non-hospital; \$0 diagnostic mammogram; all after medical deductible	50% of cost after medical deductible
X-rays[◇]	\$0 copay	50% of cost after medical deductible
Medicare-Covered Hearing Services	\$30 copay	50% of cost after medical deductible
TruHearing® Routine Hearing Exam Benefit is one per year	\$0: you pay nothing	90% of cost
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.	\$1,000 out-of-network hearing aid deductible 90% of cost from providers whose primary business is hearing care services

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

	IN-NETWORK	OUT-OF-NETWORK
Medicare-Covered Dental Services	\$30 copay	50% of cost after medical deductible
Preventive Dental	\$0: you pay nothing • 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 Exam[◊]	\$30 copay	50% of cost after medical deductible
VSP® Vision Exam Benefit is for one per year	\$0 copay	50% of cost
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[◊]	\$415 daily: days 1 - 5; \$0 daily: days 6 - 90	\$450 daily: days 1 - 10; \$0 daily: days 11 - 90 after medical deductible
Outpatient Mental Health Care Individual and Group therapy	\$20 copay	50% of cost after medical deductible
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 after medical deductible
Occupational Therapy	\$30 copay	50% of cost after medical deductible
Physical and Speech Therapy	\$30 copay	50% of cost after medical deductible

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

	IN-NETWORK	OUT-OF-NETWORK
Ground Ambulance [◇]	\$325 copay	\$325 copay after medical deductible
Air Ambulance [◇]	20% of cost	20% of cost after medical deductible
Transportation	Not covered	Not covered
Medicare Part B Prescription Drugs ^{◇**} Part B drugs may be rebatable and subject to a lower coinsurance	20% of cost after medical deductible	50% of cost after medical deductible
Part B Insulin Part B Insulin 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 the Evidence of Coverage for details.

Medicare Part D: Prescription Drugs

Costs may vary based on pharmacy type (standard, preferred, mail-order). Your provider may need to get prior authorization.

ANNUAL DEDUCTIBLE

You are responsible for the full cost of your prescription drugs until you meet the deductible first.

Drug tiers group your prescription drugs into levels that determine your share of the cost

Tier 1 Part D	\$0: you pay nothing
Tier 2 Part D	
Tier 3 Part D	\$205 per year for prescriptions
Tier 4 Part D	
Tier 5 Part D	

INITIAL COVERAGE PERIOD

After you meet the deductible, you are then responsible for a limited copay or coinsurance. You pay a small amount until you reach \$2,400 in total out-of-pocket drug costs. You can save by visiting a preferred retail pharmacy or using mail order. See chart below for the cost share amounts per month.

	Preferred retail cost: 30-day supply	Standard retail cost: 30-day supply	Standard mail-order**cost: 30-day supply
Tier 1: Preferred Generic Up to 100-day supply	\$0 copay		
Tier 2: Generic Up to 100-day supply	\$4 copay	\$15 copay	\$4 copay
Tier 3: Preferred Brand	22% of cost; \$35 copay for insulin		
Tier 4: Non-Preferred Drug	26% of cost; \$35 copay for insulin		
Tier 5: Specialty Tier Up to 30-day supply	31% of cost		

CATASTROPHIC

After you reach \$2,400 in out-of-pocket costs, you pay nothing for Part D drugs.



Wondering what your prescriptions will cost? Scan this code with your phone's camera to visit rangehealth.com/FindAPharmacy. Enter your prescriptions to check coverage and tiers, or see if your local pharmacy is covered or considered preferred in order to save money.

Part D drugs may be subject to Step Therapy. See the Evidence of Coverage for more details.

**See next page for mail-order options

WHAT IF MY DRUG ISN'T COVERED

If your medication is not covered, you still have options. Your provider may:

- Request a coverage determination
- Prescribe a lower-cost alternative

Visit rangehealth.com/pharmacy or call 1-844-870-0613 (TTY: 711) for help with next steps.

MEDICARE PRESCRIPTION PAYMENT PLAN

You may be eligible for this voluntary payment option to help you manage your drug costs by spreading them across the calendar year. This program may help you manage your expenses, but it doesn't save you money or lower your drug costs. Visit rangehealth.com/pharmacy or call 1-844-870-0613 to help you determine if this program is right for you.

MAIL ORDER

******You have choices when it comes to getting your medicines from a mail-order pharmacy.

CarelonRx Pharmacy; Have your provider send your prescription to CarelonRx Pharmacy, or you can set up mail order by logging in to your member account at rangehealth.com/members. Contact CarelonRx Pharmacy at 1-833-396-0309 (TTY: 711) if you need help or have questions.

Amazon Pharmacy; Your provider can send your prescription directly to Amazon Pharmacy, or you can transfer existing prescriptions online. To sign up for an Amazon Pharmacy account visit pharmacy.amazon.com. You will need an Amazon account but do not need an Amazon Prime account. For questions about setting up an account, call 1-855-745-5725 or visit amazon.com.

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
Annual Physical Exam	\$0: you pay nothing	50% of cost
Additional Telehealth Services	Follows your in-network copay for participating provider	Not covered
Durable Medical Equipment[∅]	18% of cost	50% of cost after medical deductible
Prosthetic Medical Devices[∅]	18% of cost	50% of cost after medical deductible
Diabetic Shoes and Inserts	20% of cost	50% of cost after medical deductible
Diabetic Supplies Glucose monitors, test strips, and lancets	\$0: you pay nothing	50% of cost after medical deductible
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: तपार्इले नेपाली बोल्नुहुन्छ भने तपार्इको नमित् 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.

©2026 Range Health, Inc.

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.

Amazon Pharmacy is an independent company that contracts with Range Health Inc.'s pharmacy benefits manager to offer online pharmacy services. Amazon Pharmacy is solely responsible for its services. Range Health is not responsible for the provision of, or failure to provide, any services offered by Amazon Pharmacy.

Range Health, Inc.'s pharmacy network includes limited lower-cost, preferred pharmacies in rural areas of Montana. 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 1-833-574-6031 (TTY: 711) or consult the online pharmacy directory at rangehealth.com/FindAPharmacy.

Out-of-network/non-contracted providers are under no obligation to treat Range Health, Inc. 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.