



MyAdvocate Medicare Advantage GOLD (HMO-POS)

H0816-001

SUMMARY OF BENEFITS

January 1, 2026 - December 31, 2026

This booklet is a summary of health and prescription drug services covered by MyAdvocate Medicare Advantage GOLD (HMO-POS).

It is an overview of what we cover and what you pay. The benefit information provided does not list every service that we cover or list every limitation or exclusion. The complete list of services we cover is found in the *Evidence of Coverage*. You can access it online at www.MyAdvocateMA.com. If you would like a printed copy mailed to you, please call Member Services.

To join MyAdvocate Medicare Advantage GOLD (HMO-POS) you must:

- be entitled to Medicare Part A,
- *and* be enrolled in Medicare Part B,
- *and* live in our service area.

The MyAdvocate Medicare Advantage service area includes these Nebraska counties:

Buffalo	Gage	Jefferson	Nemaha	Saline
Butler	Hall	Johnson	Otoe	Saunders
Cass	Hamilton	Lancaster	Pawnee	Seward
Fillmore	Howard	Merrick	Polk	York

Providers & Pharmacies

MyAdvocate Medicare Advantage has a network of doctors, hospitals, pharmacies, and other providers.

For your medical care you can use both in-network and out-of-network providers, however, you may pay less for your covered services if you use an in-network provider. With the exception of emergency situations, out-of-network providers are not required to accept you as a patient. You can see our plan's provider directory at our website www.MyAdvocateMA.com.

You must generally use an in-network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website www.MyAdvocateMA.com/pharmacy-and-drug-coverage.com.

You can see our complete formulary (list of Part D prescription drugs) and any restrictions on our website at www.MyAdvocateMA.com/pharmacy-and-drug-coverage.com.

If you would like a paper copy of the provider directory, pharmacy directory, or formulary, contact our Member Services Department. The pharmacy network, and/or provider network may change at any time. You will receive notice of changes when necessary.

Contact Information

For more information, contact our Member Services Department:

- Call us: 1-888-298-4650 (TTY users call 711).

We are open 7 days a week, 8 a.m. to 8 p.m., Oct. 1-March 31; and Monday through Friday, 8 a.m. to 8 p.m., April 1-Sept. 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.

- Medicare Part D drug coverage information, call 1-888-298-4560. (TTY users call 711).
- Email us: MemberServices@MyAdvocateMA.com
- Visit us: www.MyAdvocateMA.com

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.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 languages other than English and other formats such as Braille and large print. For additional information, call Member Services.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
+ Your provider must obtain prior authorization from our plan. If you use an out-of-network provider, you are responsible for prior authorization.		
Monthly Plan Premium	\$69 You must continue to pay the Medicare Part B premium.	
Deductible		
Medical	\$0	\$0
Part D Prescription Drugs	\$0 per year for Tier 1, Tier 2, Tier 6	In general, Part D drug coverage is not available out of network. See Chapter 5, Section 2.4 in the Evidence of Coverage
Part D Deductible	\$250 per year for Tier 3, Tier 4, Tier 5	
Maximum Out-of-Pocket Amount <i>Does not include amounts you pay for Part D prescription drugs and/or non-Medicare covered benefits.</i> If you reach the maximum out-of-pocket, you keep getting Medicare-covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your Medicare Part B premium, your plan premium and any cost sharing for your Part D prescription drugs.	\$3,500 yearly limit for in-network Medicare-covered services	\$6,200 combined in-network/out-of-network Medicare-covered services
Inpatient Hospital Coverage+	Days 1-4: \$390 copay per day Days 5-90: \$0 copay per day	Days 1-6: \$450 copay per day Days 7-90: \$0 copay per day

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Outpatient Hospital Services+	\$350 copay per visit	20% coinsurance per visit
Outpatient Hospital Observation Services+	\$350 copay per stay	\$450 copay per stay
Ambulatory Surgical Center (ASC) Services+	\$275 copay per visit	20% coinsurance per visit
Doctor Visits Primary care providers Specialists	\$0 copay per visit \$35 copay per visit	\$25 copay per visit \$50 copay per visit
Preventive Care Such as immunizations, wellness visits, and diabetic screenings. See your Evidence of Coverage for a full list of covered services.	\$0 copay per visit for Medicare Covered Preventive care	\$0 copay per visit for Medicare Covered Preventive care
Emergency Care <i>ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.</i>	\$120 copay per visit	\$120 copay per visit
Urgently Needed Services <i>Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.</i>	\$35 copay per visit	\$35 copay per visit
Diagnostic Services / Labs / Imaging+ Lab services+ Diagnostic tests and procedures+	\$0 copay per lab visit \$25 copay per visit	\$20 copay per lab visit \$45 copay per visit

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Diagnostic radiology services (e.g. MRI, CAT Scan) +	\$175 copay per day for each type: • MRI scans • MRA scans • CT scans • PET scans • Echocardiograms • Nuclear medicine cardiac stress tests • You pay a \$25 copay per day for imaging services not listed above.	\$225 copay per day for each type: • MRI scans • MRA scans • CT scans • PET scans • Echocardiograms • Nuclear medicine cardiac stress tests • You pay a \$55 copay per day for imaging services not listed above.
Therapeutic radiology services+	20% coinsurance per visit	20% coinsurance per visit
Outpatient X-rays	\$20 copay per visit	\$50 copay per visit

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Hearing Services Medicare covered hearing exam Non-Medicare covered benefits: Routine Hearing Exam – 1 exam every year Hearing Aids: You must see a TruHearing provider to use this benefit. Up to two hearing aids from the applicable TruHearing catalog every year (limit 1 hearing aid per year). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models	\$0 copay per visit \$0 copay per visit You pay \$0 copay for fitting and evaluations within the first 12 months of the purchase of hearing aids. You pay a \$295 copayment per aid for Basic Aids You pay a \$695 copayment per aid for Standard Aids You pay a \$1,095 copayment per aid for Advanced Aids You pay a \$1,495 copayment per aid for Premium Aids Note: Cost-sharing for hearing aids is not included in the annual maximum out-of-pocket amount.	20% coinsurance per visit per visit There is no coverage out-of-network. You pay 100% of the cost and amounts are not included in the maximum out-of-pocket amount. There is no coverage out-of-network. You pay 100% of the cost and amounts are not included in the maximum out-of-pocket amount.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Comprehensive dental services: • Restorative • Endodontics • Periodontics (periodontal cleanings included in preventive; limits apply) • Prosthodontics, removable • Implant services • Prosthodontics, fixed • Oral and Maxillofacial Surgery • Adjunctive General Services IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network, YOU WILL BE RESPONSIBLE for the difference between Delta Dental's payment and the amount charged by the Nonparticipating dentist. Frequency limits and exclusions apply – refer to Delta Dental Medicare Advantage Certificate for details.	50% coinsurance for covered comprehensive dental services Note: Cost-sharing for non-Medicare covered dental services are not included in the annual maximum out-of-pocket amount.	50% coinsurance for covered comprehensive dental services Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage Network will result in your out-of-pocket costs being higher. Note: Cost-sharing for non-Medicare covered dental services are not included in the annual maximum out-of-pocket amount.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Vision Care Medicare covered eye exams Non-Medicare covered benefits: You must see a VSP provider to use these benefits. Routine Eye Exam: 1 per year Refraction and diagnostic eye exam services: 1 exam every year Eyeglass lenses: single vision, lined bifocal, lined trifocal and lenticular: 1 pair every year \$300 annual hardware allowance towards: • Eyeglass frames • Contact lenses (in lieu of eyeglasses)	\$0 copay per visit \$0 copay per covered annual visit \$0 copay per covered annual visit \$0 for eyeglass lenses VSP provides an annual hardware allowance of \$300 at in-network providers. You pay amounts over \$300, and the amounts do not apply to your maximum out-of-pocket amount.	20% coinsurance There is no coverage out-of-network. You pay 100% of the cost and amounts are not included in the maximum out-of-pocket amount.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Mental Health Services		
Inpatient psychiatric+	Days 1-4: \$390 copay per day Days 5-90: \$0 copay per day	Days 1-6: \$450 copay per day Days: 7-90: \$0 copay per day
Outpatient individual/group therapy visits (non-psychiatrist).	\$25 copay per visit	\$45 copay per visit
Outpatient individual/group therapy visits with a psychiatrist.	\$30 copay per visit	\$45 copay per visit
Ambulance Services		
Ground ambulance+	\$275 copay per trip	\$275 copay per trip
Air ambulance+	\$275 copay per trip	\$275 copay per trip
	<i>You must obtain prior authorization from MyAdvocate Medicare Advantage for any non-emergency transportation.</i>	<i>You must obtain prior authorization from MyAdvocate Medicare Advantage for any non-emergency transportation.</i>

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Skilled Nursing Facility (SNF) Care+ Coverage limited to 100 days per benefit period.	An inpatient hospital stay is not required prior to admission. Days 1-20: \$0 copay for each benefit period. Days 21-100: \$196 copay per day of each benefit period. Days 101 and beyond: You pay 100% of the cost.	An inpatient hospital stay is not required prior to admission. You pay the 2026 Medicare-defined cost-sharing amounts. These are the 2025 cost-sharing amounts and may change for 2026. Days 1-20: \$0 copay for each benefit period. Days 21-100: \$209.50 copay per day of each benefit period. Days 101 and beyond: You pay 100% of the cost. MyAdvocate Medicare Advantage will provide updated rates at www.MyAdvocateMA.com as soon as they are available.
Physical Therapy & Speech Therapy+	\$25 copay per visit	\$45 copay per visit
Occupational Therapy+	\$35 copay per visit	\$45 copay per visit
Transportation	Not covered	Not covered

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Worldwide Emergent/Urgent Coverage We will cover up to \$250 annually for world-wide services that include: • Emergency care • Urgently needed care • Emergency/urgently needed transportation services	\$0 for world-wide emergency and urgently needed care until the maximum annual reimbursement of \$250 has been reached. Once the \$250 annual maximum reimbursement is reached, you pay 100% of the costs over \$250 each year. Amounts you pay are not included in the annual maximum out-of-pocket amount.	\$0 for world-wide emergency and urgently needed care until the maximum annual reimbursement of \$250 has been reached. Once the \$250 annual maximum reimbursement is reached, you pay 100% of the costs over \$250 each year. Amounts you pay are not included in the annual maximum out-of-pocket amount.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Medicare Part B Prescription Drugs+ * Insulin Part B covered drugs and biologicals, including chemotherapy drugs+ Medicare identifies Part B “rebatable” drugs that have a price increasing at a rate higher than the rate of inflation. Your cost for Part B rebatable drugs is limited to the cost under Original Medicare and will be no more than 20% coinsurance. However, your cost could change each quarter and will be between \$0 and 20%. Medicare will notify MyAdvocate Health of your cost for these drugs on a quarterly basis. <i>*Select Part B drugs are subject to step therapy restrictions.</i>	Up to 20% coinsurance, limited to \$35 copay for a one-month supply. Up to 20% coinsurance <i>Prior authorization is required for some medications.</i>	

Benefits and Premiums	You Pay	
+Supplemental Benefits	In-network costs	Out-of-network costs
Fitness Program: Fitness – One Pass® The One Pass program is a fitness benefit that includes access to an expansive network of fitness locations near you and nationwide, exercise equipment and other gym amenities including group exercise classes led by certified instructors.* • Online resources include on-demand and live-streaming fitness classes as well as individual exercises. • An online platform with activities and training exercises that help improve attention, brain speed, memory and cognitive resilience. • Online listings of groups, clubs and social events where you can meet people with similar interests. Members get their One Pass code and find locations and classes at www.YourOnePass.com or contact MyAdvocate Medicare Advantage Member Services for more information.	\$0 copay per month	There is no coverage out-of-network. You pay 100% of the cost and amounts are not included in the maximum out-of-pocket amount.

Benefits and Premiums	You Pay	
+Supplemental Benefits	In-network costs	Out-of-network costs
You may pay extra fees for fitness center services and classes that are not included in your membership. All other fitness programs are not covered.		
*One Pass® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. One Pass is not responsible for the services or information provided by third parties. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them.		
Over the Counter (OTC) Benefit OTC items are drugs and health-related products that do not require a prescription. Covered benefits include but are not limited to: antacids, cough drops, denture adhesive, eye drops, ibuprofen, toothpaste and first aid items. Members can choose from thousands of eligible OTC products available online and in-store from plan authorized vendors.	Your Healthy Benefits+ Flex Card will provide you a quarterly OTC allowance up to \$95 maximum plan coverage amount every 3 months for OTC items. You pay 100% for costs over the \$95 per quarter and the amounts do not apply to your maximum out-of-pocket. Unused OTC Allowance dollars do not roll over to the next quarter or the next calendar year.	The OTC benefit is not available out of network.

Outpatient Prescription Drugs	
Deductible	\$0 per year for Tier 1 Preferred Generic, Tier 2 Generic, Tier 6 Select Care Drugs \$250 per year for Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$2,100. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. • This plan requires prior authorization and has quantity limit restrictions for certain drugs. Please refer to the formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website. • Cost sharing may differ based on whether the prescription is a short-term supply (34-day supply) or long-term supply (102-day supply). • You can choose from a variety of pharmacies to fill your prescriptions for covered Part D drugs. You may search for network providers and pharmacies on our website at www.MyAdvocateMA.com/pharmacy-and-drug-coverage, or call us and we will send you a copy of the provider and pharmacy directories.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (up to a 34-day supply)	Mail-order cost sharing (up to a 34-day supply)	Long-term care (LTC) cost sharing (up to a 34-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 34-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Cost-Sharing Tier 2 (Generic)	\$14 copay	\$14 copay	\$14 copay	\$14 copay
Cost-Sharing Tier 3* (Preferred Brand)	\$47 copay*	\$47 copay*	\$47 copay*	\$47 copay*
Cost-Sharing Tier 4* (Non-Preferred Drug)	50% coinsurance*	50% coinsurance*	50% coinsurance*	50% coinsurance*
Cost-Sharing Tier 5 (Specialty Tier)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Cost-Sharing Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay	\$0 copay	\$0 copay

* You pay no more than \$35 for a one-month supply of each covered insulin product in Tier 3 and 4, even if you haven't paid your deductible.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (102-day supply)	Mail-order cost sharing (102-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$0 copay	\$0 copay
Cost-Sharing Tier 2 (Generic)	\$42 copay	\$42 copay
Cost-Sharing Tier 3* (Preferred Brand)	\$141 copay*	\$141 copay*
Cost-Sharing Tier 4* (Non-Preferred Drug)	50% coinsurance*	50% coinsurance*
Cost-Sharing Tier 5 (Specialty Tier)	Not available	Not available
Cost-Sharing Tier 6 (Select Care Drugs)	\$0 copay	\$0 copay

* You pay no more than \$70 for up to a 2-month supply or \$105 for up to a 3-month supply of each covered insulin product in tier 3 or 4, even if you haven't paid your deductible.

Notice of Availability

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call 1-888-298-4650 (TTY: 711) or speak with your healthcare provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-298-4650 (TTY: 711) o hable con su proveedor.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-298-4650 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Karen: ဆို-နမ့်ကတိၤ ထၢန့ၣ်လီၤဖဲအံၤ အသိ, တၢ်အိၣ်ဒီး ကျိၣ်တၢ်ဆိၣ်ထွဲမၤစၢၤ လၢတလၢ် ဘျုးလၢန့ၣ်လီၤ. တၢ်အိၣ်ဒီး တၢ်မၤစၢၤတၢ်န့ၣ်ပီးလီၤဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအကြးအဘျုး လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၣ် လၢတၢ်မၤန့ၣ်အိၣ်သ့တဖၣ် လၢတလၢ်ဘျုးလၢန့ၣ်လီၤ. ကိး 1-888-298-4650 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပုၤလၢဟ့ၣ် နတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

Arabic:

نبیه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-888-298-4650 (711) أو تحدث إلى مقدم الخدمة.

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-298-4650 (TTY: 711) ou parlez à votre fournisseur.

Simplified Chinese: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-298-4650（文本电话：711）或咨询您的服务提供商。

Oromo: HUBADHAA: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa 1-888-298-4650 (TTY: 711) yookiin dhiyeessaa kee waliin haasa'aa.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-298-4650 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Nepali: सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-888-298-4650 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Swahili: MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-888-298-4650 (TTY: 711) au zungumza na mtoa huduma wako.

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-298-4650 (TTY: 711) o makipag-usap sa iyong provider.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-298-4650 (TTY: 711) или обратитесь к своему поставщику услуг.

Telegu: తెలుగు సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-888-298-4650 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రావైడర్‌తో మాట్లాడండి.

Farsi:

توجه: اگر [وارد کردن زبان] صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-888-298-4650 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

Ukrainian: УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-888-298-4650 (TTY: 711) або зверніться до свого постачальника.

Large print – If you require materials in large print, please call 1-888-298-4650 (TTY 711).

Notice of Nondiscrimination

Discrimination is against the law. MyAdvocate Medicare Advantage complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

MyAdvocate Medicare Advantage:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, please contact Member Services at 1-888-298-4650 (TTY 711)

If you believe that MyAdvocate Medicare Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation, you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57103

Telephone Number: (877) 473-0911 (TTY 711)

Fax: (605) 312-9886

Email: compliance@MyAdvocateMA.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Section 504 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/portal/lobby.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

Phone: 1-800-368-1019 (TDD 800-537-7697)

More information is available at <http://www.hhs.gov/ocr/index.html>.