



NATIVE
ADVANTAGE

2027

Summary of Benefits

Native Advantage (HMO)

Contract H2851 • Plan 001 • Contract Year 2027



Welcome to Native Advantage

Native Advantage (HMO) is a Medicare Advantage plan built for our members across northeastern Oklahoma. It brings together everything Original Medicare covers plus added dental, vision, hearing, prescription, and everyday-living benefits — most at **\$0 additional premium**.

A few of your plan's biggest advantages



\$0

Monthly Plan Premium

Part C + Part D combined



\$0

Primary Care Visits

See your PCP for \$0



\$0

Tier 1 Prescriptions

Preferred generic drugs



\$1,250

Dental Allowance

Preventive + major, per year



\$200

Eyewear Allowance

Glasses or contacts, per year



up to **\$70**

OTC + Healthy Food

Every 3 months



 Member Services

PHONE	TTY	ONLINE
1-888-230-4214	1-888-230-4215	https://www.nativeadvantage.com/

HOURS	
October 1 – March 31	April 1 – September 30
8 a.m. – 8 p.m., 7 days a week	8 a.m. – 8 p.m., Monday – Friday

This is a summary of benefits. Your Evidence of Coverage (EOC) is the complete, legally binding description of your benefits – see it at <https://www.nativeadvantage.com/> or call us.

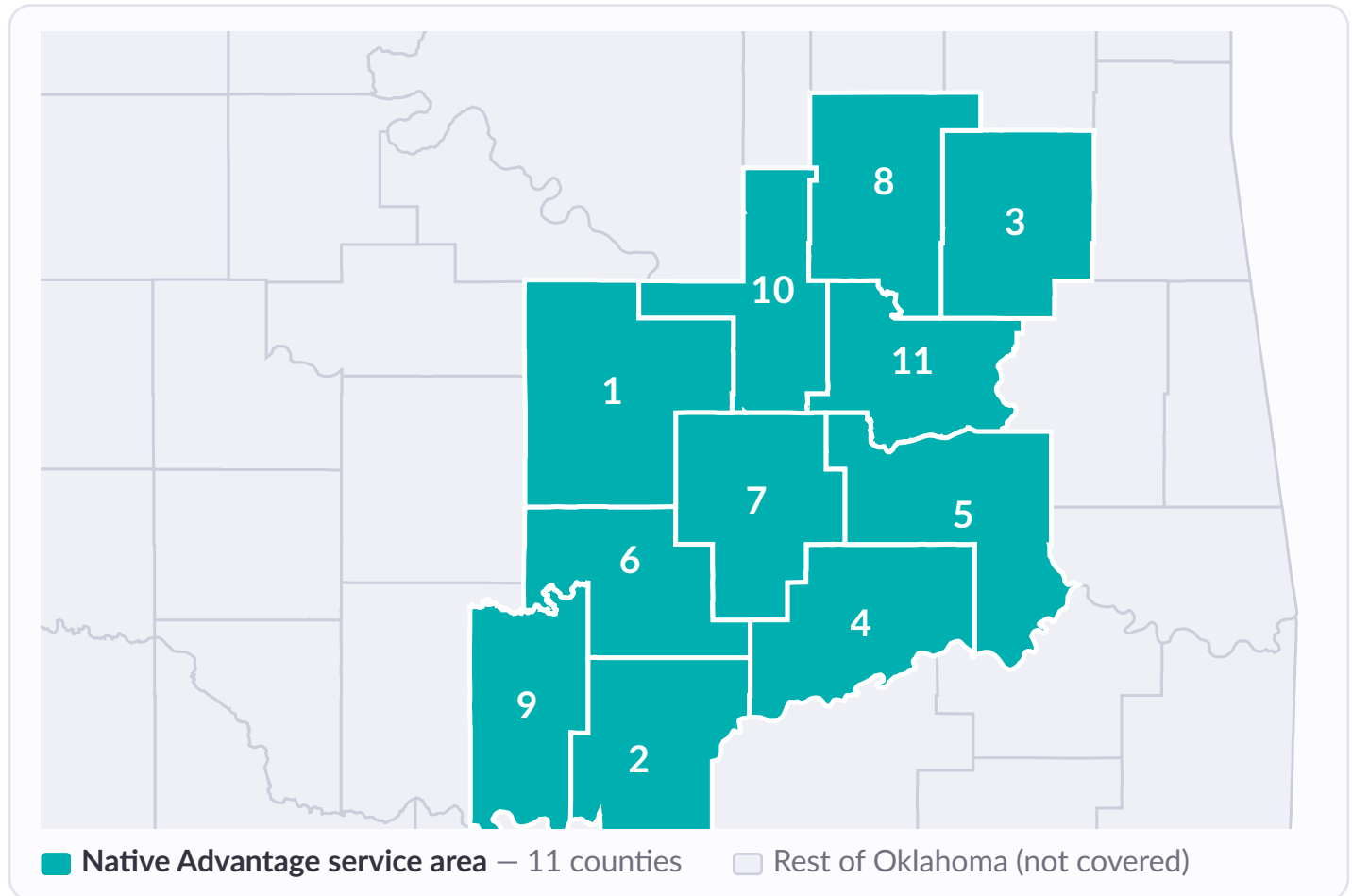


 What's Inside

Where We Cover Service-area counties & eligibility	Your Costs & Medical Benefits Premium, hospital & doctor visits	Dental, Vision & Hearing Everyday extra coverage
Prescription Drugs (Part D) Tiers & pharmacy costs	Extra Benefits OTC, food, transportation & more	Important Information Plan rules & disclaimers

Where We Cover

Native Advantage (HMO) serves 11 counties in northeastern Oklahoma.



✓ Am I Eligible?

To join Native Advantage (HMO), you must:

- ✓ Be enrolled in **Medicare Part A** and **Part B**
- ✓ Live in one of the **11 service-area counties**

Counties in the service area

- | | | |
|-------------------|-------------------|-------------------|
| 1 Creek | 5 Muskogee | 9 Seminole |
| 2 Hughes | 6 Okfuskee | 10 Tulsa |
| 3 Mayes | 7 Okmulgee | 11 Wagoner |
| 4 McIntosh | 8 Rogers | |

Using Your Plan

Use **network providers** for covered care (except emergencies, urgent care, and certain out-of-area services). **No referral** needed to see a network specialist. Many services need **prior authorization** — your provider usually handles this.

Your Costs at a Glance

All amounts are for In-Network services unless otherwise noted.

Cost Item	Your Cost	Notes
Monthly Plan Premium (Part C + Part D)	\$0	You must continue to pay your Medicare Part B premium.
Medical (Part C) Deductible	\$0	No deductible for covered medical services.
Maximum Out-of-Pocket (Medical only)	\$7,150 / year	In-Network Medicare-covered Part C services. After this limit you pay \$0 for covered medical services the rest of the year. Does not include Part D or premiums.

Medicare amounts (Part B premium, etc.) may change. Updated rates will be posted at <https://www.nativeadvantage.com/> when released.

♥ Medical Benefits (Part C) – In-Network

All cost sharing shown is In-Network. You generally must use network providers. Prior authorization (PA) is required for many services.

🏥 Inpatient Hospital Coverage (Acute & Psychiatric) Prior Authorization required

Service	Your Cost	Details
Inpatient Hospital – Acute	\$500/day (days 1–4) \$0/day (days 5+)	Per admission. You pay \$500 per day, days 1–4. You pay \$0 per day, days 5 and beyond, for each medically necessary covered inpatient stay. Lifetime reserve days follow Medicare rules.

Outpatient Hospital & Ambulatory Surgical Center (ASC)

Prior Authorization required for most services

Service	Your Cost	Notes
Outpatient Hospital Services	\$350	Per visit/encounter. PA required.
Observation Services	\$350	Per stay. PA not typically required.
Ambulatory Surgical Center (ASC)	\$250	Per procedure. PA required.

Doctor Visits

No referral required to see a network specialist. Some services may require PA.

Provider Type	Your Cost	Notes
Primary Care Physician (PCP)	\$0	Preventive and routine care.
Specialist Physician	\$40	Per visit. Includes most physician specialists. PA may be required.
Chiropractic Services	\$15	Medicare-covered services only.
Podiatry Services	\$40	Medicare-covered foot care.

Preventive Care

Service	Your Cost	Notes
Medicare-covered Zero-Dollar Preventive Services	\$0	Annual Wellness Visit, flu/pneumonia/shingles vaccines, cancer screenings, cardiovascular screenings, diabetes screening, bone mass measurement, and more.
Annual Physical Exam (Supplemental)	\$0	One additional routine physical exam per year with your PCP (in addition to the Medicare Annual Wellness Visit).
Kidney Disease Education Services	\$0	Medicare-covered.
Glaucoma Screening	\$0	Medicare-covered.
Diabetes Self-Management Training	\$0	Medicare-covered.
EKG following Welcome Visit	\$0	Medicare-covered.

Emergency Care & Urgently Needed Services

Service	Your Cost	Notes
Emergency Care (worldwide)	\$130 per visit	Copay waived if admitted as inpatient within 24 hours. PA not required for true emergencies. Subject to plan limits.
Urgently Needed Services (worldwide)	\$30 per visit	When network providers are not available or you are outside the service area. Subject to plan limits.

Diagnostic Services, Labs & Imaging

Prior Authorization required

Service	Your Cost	Notes
Lab Services	\$0	Most laboratory tests.
Diagnostic Procedures/ Tests	\$0 to \$100	\$100 for diagnostic colonoscopy, EGD, and bronchoscopy. \$0 for most other tests (e.g., blood work). One copay per visit. PA may be required.
Diagnostic Radiology (CT, MRI, PET, Nuclear)	\$100	One copay per visit. PA required. \$0 for standard X-rays and ultrasounds.
Therapeutic Radiology	\$0	Radiation therapy services. PA required.
Outpatient X-Ray Services	\$0	Standard X-rays and ultrasounds. PA required.

Prior Authorization is required for advanced imaging and some diagnostic procedures. One copay applies per visit regardless of number of studies performed on the same day at the same location.

Hearing Services (Medicare + Supplemental)

Service	Your Cost / Benefit	Notes
Diagnostic Medicare-covered Hearing Exam	\$0	Medicare-covered diagnostic hearing exam.
Routine Hearing Exam	\$0 (1 per year)	One routine hearing exam per year with network provider.
Hearing Aid Fitting/ Evaluation	\$0 (1 per year)	One fitting/evaluation per year.
Prescription Hearing Aids	\$600 – \$2,075 per aid	Up to 2 aids per year (1 per ear). Copay varies by model. Must use contracted vendor. Not subject to MOOP.

Dental Services (Medicare + Supplemental)

Service	Your Cost / Benefit	Notes
Medicare-Covered Dental	\$30	Limited to certain medically necessary dental services.
Comprehensive Dental (Preventive + Major)	Up to \$1,250 per year	Full debit card allowance for preventive (exams, cleanings, X-rays, fluoride) and major services (fillings, crowns, dentures, implants, etc.). Use at network dental providers.

Vision Services (Medicare + Supplemental)

Service	Your Cost / Benefit	Notes
Medicare-Covered Eye Exams	\$0	You pay nothing for Medicare-covered eye exams with a network provider.
Routine Eye Exam (Supplemental)	\$0 (1 per year)	One routine vision exam per year with network optometrist/ophthalmologist.
Eyewear (Glasses or Contacts)	Up to \$200 per year	Combined annual allowance for eyeglasses (lenses + frames) or contact lenses. Must use network providers or approved vendors. Contacts in lieu of eyeglasses.

Mental Health Services

Service	Your Cost	Notes
Inpatient Psychiatric Hospital	\$500/day (days 1–4) \$0/day (days 5+)	Per admission. You pay \$500 per day, days 1–4. You pay \$0 per day, days 5 and beyond, for each medically necessary covered inpatient psychiatric stay.
Mental Health Specialty – Individual	\$20	Outpatient individual therapy sessions.
Mental Health Specialty – Group	\$20	Outpatient group therapy sessions.

Skilled Nursing Facility (SNF) Prior Authorization required

Days	Your Cost	Notes
Days 1–20	\$0 per day	Per admission. You pay \$0 per day, days 1–20. You pay \$140 per day, days 21 and beyond, for each medically necessary covered SNF stay. (Up to 100 days per benefit period.)
Days 21–100	\$140 per day	Prior authorization required. Plan allows admission without a prior 3-day inpatient hospital stay.

Additional Required Medical Benefits

Physical Therapy & Speech-Language Pathology Prior Authorization required

Service	Your Cost	Notes
Physical Therapy and Speech-Language Pathology	\$55 per visit	Medically necessary services by a network therapist. PA required.

Occupational Therapy Prior Authorization required

Service	Your Cost	Notes
Occupational Therapy Services	\$50 per visit	Medically necessary services by a network therapist. PA required.

Ambulance Services Prior Authorization required for non-emergency transport

Service	Your Cost	Notes
Ground Ambulance	\$250	Per trip. Prior authorization required for non-emergency services.
Air Ambulance	\$250	Per trip. Prior authorization required for non-emergency services.

Transportation (Supplemental Non-Emergency)

Service	Your Cost	Notes
Plan-Approved Health-Related Transportation	\$0	Up to 24 one-way trips per year to plan-approved health-related locations (doctor visits, pharmacy, lab, etc.). Limited to 50 miles per one-way trip. Modes: Taxi, RideShare, Van, Medical Transport. No PA or referral required.

Medicare Part B Drugs Prior Authorization required

Service	Your Cost	Notes
Medicare Part B Drugs (most)	Up to 20% coinsurance	Infused or injected drugs administered in a doctor's office, hospital outpatient department, or by a pharmacy. You pay min 0% / max 20% coinsurance for covered drugs.
Part B Insulin Drugs	Maximum \$35 per month	Cost sharing will not exceed \$35 for a one-month supply of certain Part B insulin product.
Part B Chemotherapy / Radiation Drugs	Up to 20% coinsurance	You pay min 0% / max 20% coinsurance for covered drugs.

Durable Medical Equipment (DME), Prosthetics & Medical Supplies

Prior Authorization required for most items

Service	Your Cost	Notes
Durable Medical Equipment (DME)	20% coinsurance	Covered DME from a network supplier. PA required.
Prosthetic Devices	20% coinsurance	Covered Prosthetic Devices from a network supplier. PA required.
Medical Supplies	20% coinsurance	Covered Medical Supplies from a network supplier. PA required.
Diabetic Supplies, Therapeutic Shoes/ Inserts & Monitors	\$0	Limited to specified manufacturers. No PA required.

Part D Prescription Drug Coverage

You pay your Part D costs in addition to medical MOOP costs. Costs shown are for covered Part D drugs at network retail and mail-order pharmacies. Different costs may apply at out-of-network pharmacies (limited coverage) or long-term care (LTC) pharmacies. 100-day supplies are available for many drugs on Tiers 1–4.

How Your Part D Costs Work in 2027

Cost Item	Your Cost	Notes
Part D Deductible	\$600	Waived for Tier 1 (Preferred Generic) and Tier 2 (Generic) drugs.

- Deductible Phase:** You pay the full cost of your drugs until you reach the \$600 deductible. The deductible is waived for Tier 1 and Tier 2 — you pay the copay from the first fill.
- Initial Coverage Phase:** After the deductible (if applicable), you pay the copay or coinsurance listed below until total drug costs reach the Initial Coverage Limit.
- Coverage Gap (Donut Hole):** Not applicable under this plan's design. You move directly to Catastrophic Coverage after reaching the out-of-pocket threshold.
- Catastrophic Coverage:** Once your out-of-pocket drug costs reach \$2,400 (TrOOP), you pay \$0 for all covered Part D drugs for the rest of the year.

Insulin Coverage

For Tier 3 insulin, you pay no more than 20% of the total drug cost or a \$35 copay (whichever is lower) for each 1-month supply, even if you have not paid the deductible. For Tier 4 insulin, you pay no more than 25% or \$35 (whichever is lower). After reaching Catastrophic Coverage you pay \$0.

Part D Cost Sharing by Tier (Initial Coverage Phase)

Tier	Drug Type	30-Day Retail	100-Day Retail	100-Day Mail
Tier 1	Preferred Generic	\$0	\$0	\$0
Tier 2	Generic	\$5	\$15	\$15
Tier 3	Preferred Brand	20%	20%	20%
Tier 4	Non-Preferred Drug	25%	25%	25%
Tier 5	Specialty	25%	N/A	N/A

Costs shown are for standard network retail and mail-order pharmacies. LTC pharmacies are available. Out-of-network coverage is limited. Actual cost for brand tiers depends on the specific drug.

Help with Drug Costs

You may qualify for Extra Help from Medicare if you have limited income and resources. Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or visit ssa.gov. The Medicare Prescription Payment Plan (M3P) allows you to spread out-of-pocket Part D costs over the year. Contact us or visit medicare.gov for details.

Additional Supplemental Benefits

These benefits are included in your plan at no additional premium. They are subject to the plan's terms, limitations, and provider network requirements. See the Evidence of Coverage for full details.

Benefit	Your Cost / Allowance	Details
Over-the-Counter (OTC) Items & Healthy Food / Produce (Combined Allowance)	Up to \$70 every 3 months	Debit card, or catalog. Available to all members for approved OTC health and wellness items. Does not roll over if unused.
Special Supplemental Benefits for the Chronically Ill (SSBCI) – Healthy Food & Produce	Included in the \$70 quarterly combined allowance	See SSBCI details below. Eligible members may use the same quarterly allowance for OTC items, healthy food/produce, or a combination.
Annual Physical Exam (Supplemental)	\$0	One routine physical exam per year with your PCP (in addition to Medicare Annual Wellness Visit).
Worldwide Emergency, Urgent & Emergency Transportation	Up to \$25,000 lifetime maximum	Emergency care (\$130), urgently needed services (\$30), and emergency transportation (\$250) outside the United States. Same cost sharing as In-Network. Non-emergency care outside the U.S. is not covered.
Hospice	Covered under Original Medicare	You pay Original Medicare cost sharing for hospice care. Contact Member Services for coordination assistance.
Opioid Treatment Program Services	\$20	Medicare-covered opioid treatment program services.
Outpatient Substance Abuse Disorder Services	\$20 (individual or group)	Individual and group sessions for outpatient substance abuse.
Dialysis Services	20% coinsurance	You pay 20% coinsurance for Medicare-covered dialysis services.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

If you qualify for SSBCI, you may choose to use your quarterly OTC allowance of up to \$70 for approved OTC items, healthy food and produce, or a combination of both. This is one combined quarterly allowance, not a separate additional benefit. SSBCI benefits are available to members with certain chronic conditions who meet the eligibility criteria. Not all members will qualify for these benefits. Eligibility is determined by the plan based on the member's health status and needs. Contact Member Services for more information. SSBCI benefits may be available to some members. Benefits are based on each member's individual eligibility and may continue as long as eligibility criteria are met.

Qualifying chronic conditions include (but are not limited to): chronic alcohol use disorder and other substance use disorders, autoimmune disorders, cancer, cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, overweight/obesity/metabolic syndrome, chronic gastrointestinal disease, chronic kidney disease, severe hematologic disorders, HIV/AIDS, chronic lung disorders, chronic and disabling mental health conditions, neurologic disorders, stroke, post-organ transplantation, immunodeficiency and immunosuppressive disorders, conditions associated with cognitive impairment, conditions with functional challenges, chronic conditions that impair vision/hearing/taste/touch/smell, and conditions that require continued therapy services.



Important Disclaimers & Additional Information

This document is a Summary of Benefits only. It provides a general overview of covered benefits, cost sharing, and plan rules for Contract Year 2027. It is not a complete description of all benefits, limitations, exclusions, or conditions of coverage. The Evidence of Coverage (EOC) is the legally binding document that fully describes your benefits. If there is a conflict between this Summary of Benefits and the EOC, the EOC controls.

How to get the Evidence of Coverage (EOC)

You can view, download, or request a printed copy of the EOC at any time by visiting <https://www.nativeadvantage.com/> or by calling Member Services at 1-888-230-4214 (TTY 1-888-230-4215).

Medicare & You Handbook

You can get a free copy of the official "Medicare & You" handbook by visiting [medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Network Providers

You must generally use providers and pharmacies in the Native Advantage network to receive covered benefits at the lowest cost. Some benefits (emergency care, urgently needed services, and certain out-of-area services) are covered when obtained from non-network providers. A provider directory is available on our website or by request.

Prior Authorization & Referrals

Many services require prior authorization. No referrals are required to see network specialists. Your doctor or you can call us to request prior authorization. Failure to obtain required prior authorization may result in denial of coverage.

Out-of-Network / Out-of-Area

Routine care from out-of-network providers is generally not covered. Emergency and urgently needed services are covered worldwide (with limits). See the EOC for details on when out-of-network care is covered.

Changes to Benefits or Costs

Native Advantage may change plan benefits, premiums, deductibles, copays, or coinsurance for 2028. We will notify you of any changes before the Annual Election Period.

Language Assistance

Interpreter services and translated materials are available free of charge. Call Member Services for assistance.

Questions?

Call Member Services at 1-888-230-4214 (TTY 1-888-230-4215) or visit <https://www.nativeadvantage.com/>.

1-888-230-4214

TTY 1-888-230-4215 · <https://www.nativeadvantage.com/>



Native Advantage (HMO) is a Medicare Advantage plan with a Medicare contract. Enrollment in Native Advantage depends on contract renewal. This plan is offered by Native Advantage, Inc., a subsidiary of the Muscogee (Creek) Nation. The plan's service area includes the Oklahoma counties listed in this document.