



MEDICAL MUTUAL®



## 2016 Medicare Advantage Plans

### MedMutual Advantage

#### Region 1 Ohio Counties

This region for MedMutual Advantage HMO and PPO plans includes: Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood, Wyandot





# MedMutual Advantage Plans

**Our Medicare Advantage plans give you hospital, medical and prescription drug coverage, all in one plan. You can be confident you will have access to quality healthcare providers when you choose Medical Mutual.**

We offer:

- \$0 premium plans
- \$0 primary care provider (PCP) office visit copay plans
- \$0 prescription drug deductible plans
- \$0 generic drug copay plans
- SilverSneakers fitness program
- A statewide network of doctors, hospitals and other health providers
- Over-the-counter medical supplies delivered to your home at no additional cost to you
- Dental and vision coverage

For more than 80 years, Medical Mutual has been serving Ohioans. We offer high-quality, affordable insurance plans and take pride in serving our neighbors with outstanding customer service.

# Comparing Your Options

## All MedMutual Advantage plans go beyond Original Medicare.

In HMO plans, you must get your care and services from doctors, hospitals or other health providers in the HMO provider network. Exceptions include emergency care, out-of-area urgent care or out-of-area dialysis.

Coverage Details	Original Medicare (Parts A and B)
<b>Monthly Premium</b>	<p><b>Part A</b> Most people do not have to pay for Part A</p> <p><b>Part B</b> \$104.90 paid to the U.S. government <i>(Those with higher income may pay more)</i></p>
<b>Deductible</b>	<p><b>Part A</b> \$1,260 each deductible period <i>(Multiple hospitalizations could result in multiple deductible periods)</i></p> <p><b>Part B</b> \$147 each year</p>
<b>Hospital Coverage</b>	Yes (Part A only)
<b>Medical Coverage</b>	Yes (Part B only)
<b>Office Visit Copay</b> (PCP/Specialist)	N/A (You pay 20% coinsurance)
<b>Prescription Drug Coverage</b>	No
<b>Prescription Drug Copay</b> (30-Day Supply) <i>This doesn't represent all coverage options.</i>	N/A (No prescription drug coverage)
<b>Prescription Drug Deductible</b>	N/A (No prescription drug coverage)
<b>Out-of-Network Coverage</b>	Yes
<b>Annual Maximum Out-of-Pocket</b>	No limit on what you may pay
<b>Dental Benefits</b> (DenteMax Network)	No
<b>Vision Benefits</b> (EyeMed Network)	No
<b>SilverSneakers</b>	No

With PPO plans, we always encourage you to use our network. PPO plans give you the flexibility to go to doctors, specialists or hospitals not in the plan’s network, but it will usually cost more.

MedMutual Advantage Classic HMO	MedMutual Advantage Choice HMO	MedMutual Advantage Select PPO	MedMutual Advantage Preferred PPO	MedMutual Advantage Premium PPO
\$0 You must continue to pay your Part B premium	\$29 You must continue to pay your Part B premium	\$39 You must continue to pay your Part B premium	\$69 You must continue to pay your Part B premium	\$109 You must continue to pay your Part B premium
\$0 each year	\$0 each year	\$0 each year	\$0 each year	\$0 each year
Yes	Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes	Yes
\$10/\$50	\$0/\$40	\$10/\$45	\$5/\$35	\$0/\$25
Yes	Yes	Yes	Yes	Yes
\$4 or \$17 Generic \$47 or \$100 Brand	\$0 or \$12 Generic \$47 or \$100 Brand	\$4 or \$17 Generic \$47 or \$100 Brand	\$0 or \$12 Generic \$47 or \$100 Brand	\$0 or \$12 Generic \$47 or \$100 Brand
\$165 each year	\$0 each year	\$165 each year	\$0 each year	\$0 each year
No	No	Yes	Yes	Yes
\$3,950	\$3,500	\$6,400	\$4,800	\$3,500
\$25 Copay Basic Coverage	\$25 Copay Basic Coverage	\$25 Copay Basic Coverage	\$25 Copay Basic Coverage	\$0 Copay Extra Coverage
\$25 Copay Basic Coverage	\$25 Copay Basic Coverage	\$25 Copay Basic Coverage	\$25 Copay Basic Coverage	\$0 Copay Extra Coverage
Yes	Yes	Yes	Yes	Yes

See the MedMutual Advantage Summary of Benefits or [MedMutual.com/sb](http://MedMutual.com/sb) for more details.

# Programs at \$0 Extra Cost to You

**Many health and wellness programs and services are included in your MedMutual Advantage coverage at no extra cost to you.**

## SilverSneakers

SilverSneakers is a program for healthy living, giving you access to more than 13,000 fitness centers across the country. You can use as many facilities as you like. The program also includes cardio, yoga and other fitness classes; access to pools; health education; and walking groups.

## Home Meals Program

Members who have returned home from an inpatient hospital stay are eligible for our Home Meals program. This program delivers two meals a day for seven days directly to you while you continue to recover at home.

## Simply Supplies from Medical Mutual

(Not available to members of the MedMutual Advantage Classic HMO plan.)

Get up to \$20 each quarter in over-the-counter medical supplies delivered to your home at no cost to you. Members of the MedMutual Advantage Premium PPO plan get up to \$20 per month in supplies. Choose from a wide range of supplies including bandages, aspirin and cough medicine.

## Disease Management Program

Our program can help you stay healthy, manage your chronic conditions and maintain your independence. A trained health coach works with you to develop a personalized plan that supplements the care you get from your doctor.

## 24-Hour Nurse Line

Get answers to your health questions from a clinical expert. Call 24 hours a day, seven days a week.

## QuitLine (Tobacco Quit Line)

A trained coach will work with you on a quit plan and provide one-on-one support. You can call as many times as you need for additional support.

# Dental and Vision Benefits

## Basic Coverage

Our Classic HMO, Choice HMO, Select PPO and Preferred PPO MedMutual Advantage plans include basic dental and vision benefits, which include one eye exam, \$100 allowance for frames/lenses, and one dental exam, one cleaning and one X-ray per year.

## Extra Coverage

If you choose to add the optional dental and vision benefits or choose the MedMutual Advantage Premium PPO plan, you will get more extra dental and vision coverage. This extra coverage includes one eye exam, \$250 allowance for frames/lenses, two dental exams, two cleanings and one X-ray per year.

# Reimbursement and Rewards Programs

**It pays to make smart health choices. These programs help you keep more money in your pocket.**

## Weight Watchers Reimbursement Program

When you pay for and participate in a Weight Watchers series, we will reimburse part of your program fee up to \$150 per calendar year.

## Wellness Rewards Program

You can earn up to a \$50 credit to Simply Supplies for making smart health choices. These activities include:

- Choosing a primary care physician
- Completing a health survey
- Getting your Welcome to Medicare Visit or your Annual Wellness Visit
- Getting other preventive screenings
- Enrolling in our health and wellness programs



## Online Tools and Resources

### My Health Plan

Our secure member site can help you get the most out of your membership. You can:

- Find doctors, hospitals and other healthcare providers in our network
- See your claims information
- Access your plan documents
- Track your Wellness Rewards program goals
- Learn more about making smart health choices with features like:
  - Online Symptom Checker
  - Videos to help you stay healthy, manage chronic conditions and keep your independence
  - Health Resource Center with senior-focused health information

### Mobile App

You can download our free mobile app for your smart phone to help you better manage your health plan information—anytime, anywhere. With our mobile app, you can:

- View your claims
- Check your deductible and out-of-pocket spending
- Search our network of health providers
- View your ID card on your smart phone and email or fax it to your health provider

# Enrollment

## How to Enroll

You can enroll in a MedMutual Advantage plan in several ways.

- **Phone**

Call us at (866) 406-8777 (TTY 711 for hearing impaired). Our licensed insurance agents can answer your questions and help you enroll.

From October 1 through February 14:

– 7 days a week, 8 a.m. to 8 p.m.

From February 15 through September 30:

– Monday through Friday, 8 a.m. to 8 p.m.

– Saturday, 9 a.m. to 1 p.m.

Our automated telephone system is also available 24 hours a day, seven days a week for self-service options.

- **Online**

Go to [MedMutual.com/Medicare](https://www.MedMutual.com/Medicare). You can compare plans and enroll with our safe and secure online application.

Medicare beneficiaries may also enroll in MedMutual Advantage plans through the Medicare Online Enrollment Center at [Medicare.gov](https://www.Medicare.gov).

- **In-Person Consultation**

Call (866) 406-8777 (TTY 711 for hearing impaired) to ask for an in-person consultation with one of our licensed and certified agents.

- **Mail**

Fill out the enrollment application and mail to:

Medical Mutual  
P.O. Box 94563  
Cleveland, OH 44101

## After You Enroll

When we receive your signed enrollment application, here's what you can expect.

- We will review your information and confirm with the Centers for Medicare & Medicaid Services that you qualify for Medicare.
- Once your application is approved, we will send you a letter within 10 days to confirm you are a member. Call us at (800) 982-3117 (TTY 711 for hearing impaired) if you do not receive your letter before your coverage is scheduled to begin.
- We will send you the following:
  - Member ID card
  - Quick Start Guide
  - Evidence of Coverage
  - Summary of Benefits
  - Provider and pharmacy directories
  - List of covered drugs
  - Mail-order prescription form



## Questions and Answers

### Can I get financial help?

If you have low income or limited financial resources, you may qualify for help to pay for Medicare.

- **Extra Help Paying For Your Prescriptions**

The Social Security Administration offers Extra Help to pay for Part D coverage, including premiums, deductibles and copays. Call (800) 772-1213 (TTY [800] 325-0778 for hearing impaired) to find out if you qualify. They are open Monday through Friday, 7 a.m. to 7 p.m. Or, visit [SocialSecurity.gov](https://www.SocialSecurity.gov).

- **Help Paying For Medical Coverage**

The Ohio Medicare Savings Programs can help you pay your Part B premium. Visit [Insurance.Ohio.gov/OSHIIP](https://Insurance.Ohio.gov/OSHIIP) to learn more.

For questions about Medicare, visit [Medicare.gov](https://www.Medicare.gov) or call (800) 633-4227. They are open seven days a week, 24 hours a day.

## Why is it important to choose a network provider?

In HMO plans, if you don't get your care and services from in-network healthcare providers, you must pay all costs out-of-pocket. Exceptions include emergency care, out-of-area urgent care or out-of-area dialysis.

With PPO plans, we always encourage you to use our network. PPO plans give you the flexibility to go to doctors, specialists or hospitals that are not in the plan's network, but it will usually cost more.

Check to see if your doctor is in our network. If not, choose from one of the many quality providers in the MedAdvantage network. Go to [MedMutual.com/Medicare](https://www.MedMutual.com/Medicare) and click on Find a Provider.

## Why should I choose a primary care provider (PCP)?

A primary care provider:

- Knows your health history and can help improve or maintain your quality of life
- Helps you coordinate your care with any specialists you need to see
- Helps address health concerns before they become health issues
- Gives you advice about health issues based on your own health history

## How can I get more information?

Call us at (866) 406-8777 (TTY 711 for hearing impaired). We can answer your questions and help you enroll. We can also:

- Tell you about benefits
- Help you find a health provider
- Review covered medications

You can always visit our website at [MedMutual.com/Medicare](https://www.MedMutual.com/Medicare) for more information.

# Healthcare Terms

## **Coinsurance**

An amount you may be required to pay as your share of the cost for the services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

## **Condition**

An injury, ailment, disease, illness or disorder.

## **Copayment (Copay)**

The amount you pay to a health provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

## **Covered Service**

A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

## **Deductible**

The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time).

*Example:*

*If your plan has a \$2,000 annual deductible, you will be expected to pay the first \$2,000 toward your healthcare services. After you reach \$2,000, your health insurer will cover the rest of the costs. You still must pay a copay.*

## **Medicare Advantage Plans** (like an HMO or PPO)

Also called Part C. Health plans run by Medicare-approved private insurance companies. Medicare Advantage plans include Part A, Part B and usually other coverage like Medicare prescription drug coverage (Part D).

## **Network Provider** (In-Network Provider)

A health provider who is part of a plan's network.

## **Non-Network Provider** (Out-of-Network Provider)

A health provider who is not part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

## **Optional Supplemental Benefits**

Services not covered by Medicare that enrollees can choose to buy or reject. Enrollees who choose these benefits pay for them directly, usually in the form of premiums and/or copayments or coinsurance.

**Original Medicare**

Fee-for-service health coverage through the federal government. Under Original Medicare, the government pays your health providers directly for your Part A and/or Part B benefits.

**Out-of-Pocket Cost**

Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out-of-pocket (MOOP) cost. Consult your plan for more information.

**Premium**

Payments you make to your insurance provider to keep your coverage. The payments are due at certain times.

**Prescription Drug**

Any medicine that may not be given without a prescription because of federal or state law.

**Provider (Health Provider)**

A hospital, facility, physician or other licensed healthcare professional.







**MEDICAL MUTUAL**<sup>®</sup>  
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Cleveland, OH 44115-1355



MEDICAL MUTUAL®



# Understanding Medicare

**Your Guide to Medicare Coverage Options**





## We Have Your Medicare Answers

**As one of the millions of Americans eligible for Medicare, you are likely among the many who are overwhelmed with the volume of information about your healthcare coverage choices.**

**At Medical Mutual, we want to make it easy for you to break through the clutter. It is our goal to help you get the right facts about the right coverage for your lifestyle.**

**Whether you're just becoming eligible for Medicare, still insured through work and contemplating retirement or thinking about a change in Medicare coverage, this guide will get you on your way to understanding your options and making the choice that is best for you.**

# Understanding Medicare Parts and Plan Types

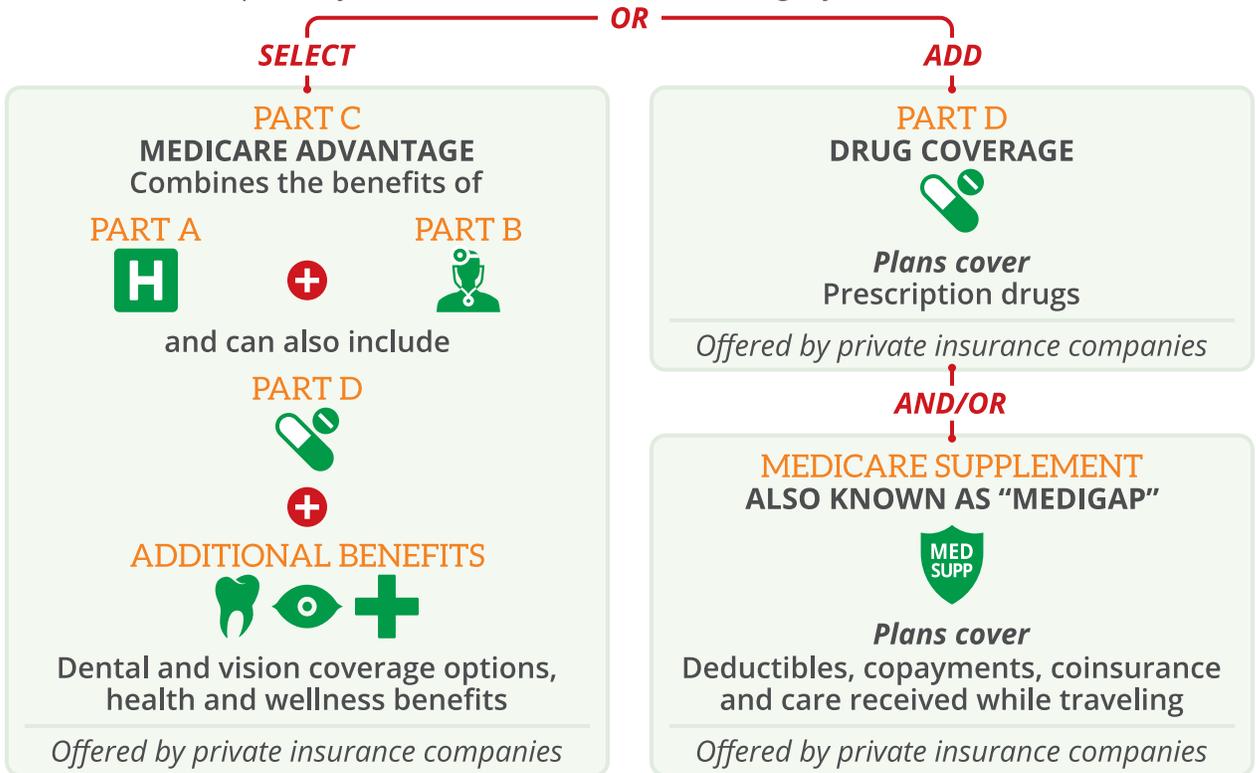
Medicare has several different parts, plus additional plan options, to help you get the best coverage for your needs. This section shows how the Medicare parts and plan types work together, with a brief description of each one.

## The Parts of Medicare

Step 1—Enroll in Original Medicare



Step 2—If you want more Medicare coverage, you have choices:



*You cannot enroll in both a Medicare Advantage plan and a Medicare Supplement insurance plan.*

## Part A and Part B (also called Original Medicare)

Original Medicare is provided by the federal government. It includes Medicare Part A and Part B. You cannot be turned down for Original Medicare coverage once you meet Medicare eligibility requirements.

Some people are automatically enrolled in Medicare Part A\* (hospital insurance). If you or your spouse paid Medicare taxes while working for at least 10 years, you will likely not have to pay a monthly premium for this coverage. You must have Part A to have Part B.

Some people are also automatically enrolled in Medicare Part B\* (medical insurance). You will pay a premium each month for Part B. Most people will pay the standard premium amount. However, you may pay more if your income is above a certain amount.

If you're not sure if you have Part A or Part B, look on your red, white and blue Medicare card. Look for "Hospital (Part A)" and/or "Medical (Part B)" printed on the lower left corner of your card. If you need to enroll in Part A or Part B, the easiest and most common way to enroll is to contact your local Social Security office or go online at [ssa.gov/medicare](http://ssa.gov/medicare).

### Part A and Part B at a Glance

Medicare Part	Plan Type	Coverage and Cost Considerations
Part A	Hospital coverage	<p><b>Coverage for medically necessary care requiring:</b></p> <ul style="list-style-type: none"> <li>■ An overnight stay in the hospital</li> <li>■ Follow-up nursing care after a hospital stay</li> <li>■ Hospice care</li> <li>■ Some home healthcare for the homebound</li> </ul> <p><b>Cost considerations:</b></p> <ul style="list-style-type: none"> <li>■ No premium (\$0) for most people</li> <li>■ Coverage automatically at age 65 if you worked and paid into Medicare for 40 quarters (10 years)</li> <li>■ Deductible, copays and coinsurance apply to services received</li> </ul>
Part B	Medical coverage	<p><b>Coverage for medically necessary services that don't require an overnight hospital stay, such as:</b></p> <ul style="list-style-type: none"> <li>■ Doctors' office visits</li> <li>■ Outpatient hospital or clinical care</li> <li>■ Lab tests and some screenings</li> </ul> <p><b>Cost considerations:</b></p> <ul style="list-style-type: none"> <li>■ \$104.90 monthly premium for 2015</li> <li>■ Premium can be automatically deducted from your Social Security checks, if applicable</li> <li>■ Deductible, copays and coinsurance apply to services received</li> </ul>

\*If you are automatically enrolled in Medicare Part A and Part B, you'll get your red, white and blue Medicare card in the mail three months before your 65th birthday.

## Medicare Supplement Insurance Plans (also called Med Supp or Medigap)

Medicare Part A and Part B do not cover every health expense. Medicare Supplement insurance plans are sold by private insurance companies and can help pay some of the healthcare costs that Original Medicare doesn't cover. You must have Medicare Part A and Part B to purchase a Medicare Supplement plan.

For 2015, there were 11 Medicare Supplement insurance plan options in Ohio, each offering a different combination of benefits with different levels of coverage. All Medicare Supplement insurance plans are standardized, and the plans are identified by letters. This means no matter which company is selling the plan, all plans identified with the same letter must have identical coverage. The only difference is the monthly premium.

Unlike some other types of insurance plans, Medicare Supplement insurance plans are not associated with a set network of doctors and hospitals. With this coverage, you can go to any doctor or hospital that accepts Medicare. Medicare Supplement insurance plans do not include prescription drug coverage (Part D). Most people who choose a Medicare Supplement insurance plan also buy a stand-alone Part D plan (see next section).

### Medicare Supplement Insurance Plans at a Glance

Medicare Part	Plan Type	Coverage and Cost Considerations
NA	Supplemental coverage	<p><b>Coverage for some costs that Original Medicare does not pay, such as:</b></p> <ul style="list-style-type: none"> <li>■ Deductibles</li> <li>■ Copayments</li> <li>■ Coinsurance</li> <li>■ Care while traveling outside the country</li> </ul> <p><b>No coverage for:</b></p> <ul style="list-style-type: none"> <li>■ Long-term care</li> <li>■ Vision care</li> <li>■ Dental care</li> <li>■ Prescription drugs</li> <li>■ Private-duty nursing</li> <li>■ Hearing aids</li> </ul> <p><b>Cost considerations:</b></p> <ul style="list-style-type: none"> <li>■ Monthly premium varies by company and age</li> <li>■ Usually ranges between \$100 and \$250 a month</li> <li>■ Some plans have an annual deductible</li> <li>■ Not all Medicare Supplement insurance plans cover 100 percent of the gaps in Original Medicare. Depending on the plan or coverage level selected, some deductibles, copays and coinsurance may still apply. Review each plan's coverage carefully.</li> </ul>

## Part D—Prescription Drug Coverage

In addition to medical coverage gaps, Original Medicare does not cover Part D prescription drugs. (Note: a limited number of outpatient prescription drugs are covered under limited conditions.) If you take prescription drugs and you are enrolled in Original Medicare, you can choose to enroll in a Part D plan offered by a private insurer. In general, there is a penalty if you delay enrolling in Part D when you are first eligible. If you have equal or better coverage from another source, such as a retirement plan, you will not be subject to the penalty.

If you have Original Medicare and/or a Medicare Supplement insurance plan, you can purchase a stand-alone Medicare Part D plan. You will pay a separate monthly premium for this. You can also get Part D prescription drug benefits through a Medicare Advantage (Part C) plan that includes built-in Part D coverage. When choosing a Part D plan, pay attention to its list of covered drugs, called the formulary. This will help ensure you have coverage for the medications you take.

### Part D at a Glance

Medicare Part	Plan Type	Coverage and Cost Considerations
Part D	Prescription drug	<p><b>Coverage for generic and brand prescription drugs, typically grouped in tiers:</b></p> <ul style="list-style-type: none"><li>■ Lower-tiered drugs most often cost less than higher-tiered drugs</li></ul> <p><b>Cost considerations:</b></p> <ul style="list-style-type: none"><li>■ Monthly premium varies by company and coverage level</li><li>■ Some plans include an annual deductible and/or coinsurance</li><li>■ Copays apply</li><li>■ No separate premium when purchased through a Medicare Advantage plan that includes Part D coverage</li></ul>

## Part C — Medicare Advantage (also called MA or MAPD)

If you have Original Medicare, plus a Medicare Supplement insurance plan, plus a Part D plan, you are responsible for paying three separate premiums each month. You may have to call up to three separate organizations for assistance. A Medicare Advantage plan offers all of your Medicare benefits and customer service through a single plan. You still have to pay your Part B premium.

Medicare Advantage plans are offered by private insurance companies that contract with Medicare to provide you with all of your Part A and Part B benefits. Medicare Advantage plans replace Original Medicare as your primary insurance. In other words, if you join a Medicare Advantage plan, you still have Medicare, but all of your benefits are managed by one plan. You will only need to show your Medicare Advantage plan member card to receive all of your Medicare services.

Medicare Advantage plans include the benefits of Original Medicare and often the benefits of Medicare Supplement insurance plans, plus Part D drug coverage. Most plans also include extra benefits like vision, hearing, dental and/or health and wellness programs not featured in any other stand-alone plan option, sometimes at no additional cost beyond your Part B premium.

Medicare Advantage plans are associated with a set network of doctors and hospitals. When choosing a Medicare Advantage plan, pay attention to its list of doctors and hospitals to make sure you can continue to go to the providers you know and trust.

### Part C — Medicare Advantage at a Glance

Medicare Part	Plan Type	Coverage and Cost Considerations
Part C	Medicare Advantage HMO, PPO, PFFS, SNP or MMSA*	<b>Coverage in most plans for:</b> <ul style="list-style-type: none"><li>■ Medical services</li><li>■ Hospitalization</li><li>■ Prescription drugs</li><li>■ Wellness and additional benefits not available with other plan types</li></ul> <b>Cost considerations:</b> <ul style="list-style-type: none"><li>■ Monthly premium varies by company and coverage level</li><li>■ Some plans have an annual deductible</li><li>■ Copays apply</li></ul>

\*HMO: Health Maintenance Organization; PPO: Preferred Provider Organization; PFFS: Private Fee-for-Service Plan; SNP: Special Needs Plan; MMSA: Medicare Medical Savings Account Plan.

# Enrolling in Medicare

Depending on your situation, there are several different opportunities to enroll in Medicare. The scenarios described in this section apply to enrolling in Original Medicare, as well as Part D and Medicare Advantage plans. Keep in mind you must have Medicare Part A and Part B before you can enroll in a Medicare Advantage plan or Medicare Supplement insurance plan. If you're entitled to Part A and/or enrolled in Part B, you can enroll in a Part D plan. (For more information on plan combinations, see the table on page 11.)

The best time to enroll in a Medicare Supplement insurance plan is during your six-month Medicare Supplement open enrollment period, which starts the month you are both more than 65 years old and enrolled in Medicare Part B.

## Enrolling at 65—Your Initial Enrollment Period

If you're approaching 65, you will likely be eligible to enroll in Medicare for the first time. There is a window of time around your 65th birthday, called the Initial Enrollment Period (IEP), to enroll. This window runs from three months before the month of your 65th birthday to three months after your 65th birthday. Talk to your employer if you have a group insurance plan.

*If you are enrolling in Medicare at 65 and will not be covered by a group insurance plan, enter the months of your IEP in the shapes below to see your seven-month eligibility window.*



## Enrolling at a Later Retirement Age

If you are still working and covered under your employer's plan when you turn 65, you may choose not to enroll in Medicare during your IEP. If this is the case, you will be eligible to enroll at a later age when you retire. When you retire, you have eight months to enroll in Medicare after your employment ends or after your group coverage ends, whichever comes first. There is no penalty for waiting until this time to enroll in Medicare.

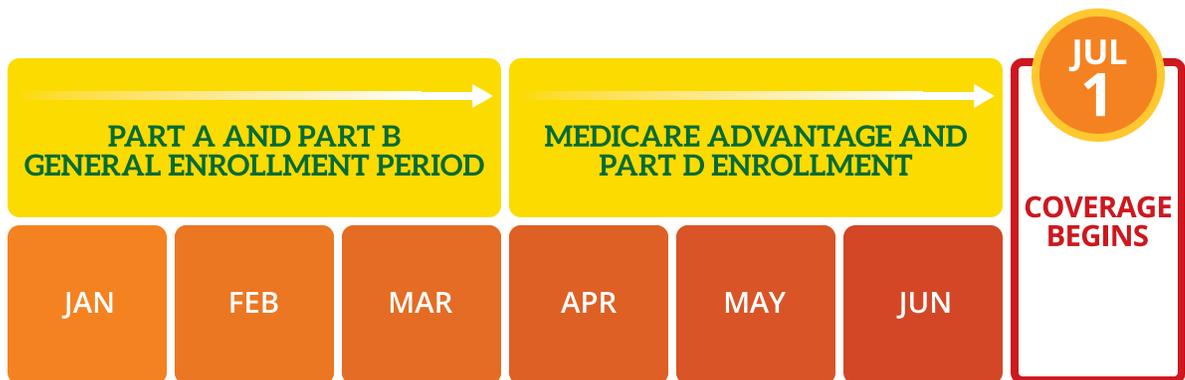
*If you are enrolling in Medicare when you retire after 65, enter the last month of your employment or group coverage, whichever comes first, and the next eight months in the shapes below to see your eligibility window.*



## General Enrollment Period

If you miss your initial eligibility window, you have another opportunity to enroll. You can enroll in Original Medicare again during the next General Enrollment Period, which occurs January 1 through March 31 each year.

*If you enroll in Original Medicare during the General Enrollment Period, you will then be eligible to enroll in a Medicare Advantage plan or a Part D plan from April 1 through June 30.*



If you enroll in Medicare during the General Enrollment Period, your coverage will start on July 1 of the same year. You may have to pay a higher premium for late enrollment in Medicare Part A and/or a higher premium for late enrollment in Medicare Part B.

## Changing Medicare Plans

If you are enrolled in Original Medicare, a Medicare Advantage plan or a stand-alone Part D plan, you may change or add plans during the Annual Enrollment Period (AEP). This period runs from October 15 through December 7 each year. With few exceptions, this is the only time you may add or switch Medicare Advantage or stand-alone Part D plans for coverage beginning January 1 of the next calendar year. It's ideal to choose your plan during this time because it is when the most options are available.



## Special Enrollment Periods (SEP)

Outside of your Initial Enrollment Period and the Annual Enrollment Period, you can make changes to your Medicare Advantage and Medicare prescription drug coverage when certain events happen in your life. These opportunities to make changes are called Special Enrollment Periods (SEP). Rules about when you can make changes and the type of changes you can make are different for each SEP. Here are some examples of situations that may grant you a SEP:

- You move
- You lose your current coverage
- You have a chance to get coverage outside of Medicare, e.g., through a spouse or employer
- Your plan changes its contract with Medicare
- You become eligible for both Medicare and Medicaid
- You qualify for extra help paying for Medicare prescription drug coverage
- You are enrolled in a State Pharmaceutical Assistance Program or lose eligibility for one
- You have a severe or disabling condition, and there's a Medicare Chronic Care Special Needs Plan available that serves people with your condition
- You are enrolled in a Special Needs Plan and no longer have a condition that qualifies as a special need that the plan serves

If you have any questions, or have a unique situation that is not on this list, call Medical Mutual at (866) 406-8777 (TTY 711 for hearing impaired). We can help determine if you qualify for a Special Enrollment Period.

# Choosing a Plan

**Once you understand your Medicare options, choose the level of coverage that best meets your needs.**

## Factors to Consider

### **How much you pay in monthly premiums**

Monthly premiums may include costs for Part B, in addition to costs associated with the plan(s) you select for additional coverage. Premiums for Medicare Advantage, Medicare Supplement insurance plans and stand-alone Part D plans will vary by level of coverage and insurance provider. There are often \$0 premium plans available with Medicare Advantage. If you are considering your total out-of-pocket costs, generally, the higher your monthly premiums, the lower your copays and deductibles will be. Consider how often you may need to see your doctor and what would be a better value for you.

### **Prescription drug coverage**

Original Medicare and Medicare Supplement insurance plans do not include prescription drug coverage. You can get Part D prescription drug coverage with most Medicare Advantage plans, or you can purchase a stand-alone Part D plan. If you regularly take prescription medication, it may make sense to choose a plan that provides Part D coverage.

### **Selecting your own doctor**

Original Medicare and Medicare Supplement insurance plans allow you to go to any doctor or hospital as long as they accept Medicare. Medicare Advantage plans have networks of providers, and some plans are more flexible than others. If you have a primary care physician or a specialist you would like to see, check the network associated with each plan to make sure they are included.

### **SilverSneakers® and other benefits**

Benefits like SilverSneakers fitness program membership, over-the-counter drugs and supplies, a 24-hour nurse line and wellness programs like those designed to help members quit smoking are included in some Medicare Advantage plans at no extra charge. Determine how much you're paying out of pocket for these costs and determine if these benefits are included in the Medicare Advantage plan you are considering. You may save money if they are included.

## Plan Combinations for Optimal Coverage

In addition to considering these factors in your coverage choice, also consider the different combinations of coverage that best meet your needs.

SilverSneakers is a registered trademark of Healthways, Inc.

## Calculating Costs

When you start to consider your plan options, one of the best ways to compare them is to look at the benefits and costs side by side. Although this guide does not show specific plans from private carriers, the chart below provides a general comparison by Medicare Part/Plan. See the definitions on page 12 to help you understand the costs shown in the chart.

Medicare Part/Plan	Monthly Premium	Deductible	Copays	Coinsurance
Part A	\$0 for most people	\$1,260 per benefit period	\$315 per day begins after 60 days in the hospital per benefit period	Only for certain services
Part B	\$104.90 standard premium	\$147 per year	Required for outpatient services	You pay 20%; Part B pays 80%
<b>Most Common Additions — Scenario 1</b>				
Medicare Advantage (HMO/PPO, including Part D)	As low as \$0	As low as \$0	As low as \$0, but can vary widely	0% in most cases, however coinsurance for Part D drugs and out-of-network services apply
<b>Most Common Additions — Scenario 2</b>				
Medicare Supplement Insurance Plans	From \$116 to \$215 for Plan F, age 65–69 (most popular)	Varies from plan to plan	\$0, however copays for Parts A and B apply to some plans	0%, however coinsurance for services covered by Parts A and B apply to some plans
Stand-alone Part D	From \$15.60 without gap coverage to \$114 with gap coverage	From \$0 to \$320	From \$1 for generics to \$90 for brand-name drugs	As low as 0% or as high as 100%; often applied to higher-tiered drugs

This chart does not include a comprehensive list of benefit/cost details for the plan types shown. For more information, contact Medical Mutual or go to [medicare.gov](http://medicare.gov). All costs are for 2015 from the federal government and Ohio providers and may change for 2016.

## Helpful Medicare Definitions

### **Premium**

Payments you make to your insurance provider to keep your coverage. The payments are due at certain times.

### **Deductible**

The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time).

*Example: If your plan has a \$2,000 annual deductible, you will be expected to pay the first \$2,000 toward your healthcare services. After you reach \$2,000, your health insurer will cover the rest of the costs. You still must pay a copay.*

### **Copayment (Copay)**

The amount you pay to a health provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

### **Coinsurance**

An amount you may be required to pay as your share of the cost for the services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

## The Right Coverage Is about the Right Choices

Choosing the level of Medicare coverage and plans that best suit your needs can be challenging. Medical Mutual can help you navigate your options, no matter what your situation. We can help you make sure your priorities are covered and choose a plan that has your best interests in mind.

## Ohioans Serving Ohioans

For more than 80 years, Ohioans have trusted Medical Mutual to provide quality health insurance coverage for their different needs. As the oldest and largest health insurance company headquartered in the state of Ohio, we are constantly looking for ways to improve and better respond to your needs.

We have Medicare experts on staff, and we're always available by phone to answer your questions.

To learn more, call toll free (866) 406-8777 (TTY 711 for hearing impaired)

October 1 – February 14, 7 days a week, 8 a.m. – 8 p.m.

February 15 – September 30, Monday through Friday, 8 a.m. – 8 p.m.; Saturday 9 a.m. – 1 p.m.

Or visit us online at [MedMutual.com/Medicare](https://www.MedMutual.com/Medicare).

MedMutual Advantage HMO and PPO plans are offered by Medical Mutual of Ohio under a contract with Medicare. Enrollment in these plans depends on contract renewal. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. This information is not a complete description of benefits. Contact the plan for more information. You must continue to pay your Medicare Part B premium. Limitations, copayments and restrictions may apply.



MEDICAL MUTUAL®  
2060 East Ninth Street  
Cleveland, OH 44115-1355



MEDICAL MUTUAL®

# Enrollment Application

Please contact Medical Mutual at (866) 406-8777 (TTY 711 for hearing impaired) if you need information in another format or language.

Return completed application by fax to (800) 542-2583 or by mail to:

Medical Mutual  
P.O. Box 94563  
Cleveland, OH 44101

**Note: If you are working with an agent/broker, he or she may provide different submission instructions.**

## MedMutual Advantage HMO and PPO Plans

### Region 1 Counties

Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood, Wyandot

# MedMutual Advantage Enrollment Application

To enroll in a Medicare Advantage plan, please provide the following information:

## 1. Plan Selection Information (Region 1)

Please check the MedMutual Advantage plan you want to enroll in:

- MedMutual Advantage Classic HMO** (\$0 per month)
  - Add Optional Supplemental Benefits Package to this plan for an additional \$25 per month
- MedMutual Advantage Choice HMO** (\$29 per month)
  - Add Optional Supplemental Benefits Package to this plan for an additional \$25 per month
- MedMutual Advantage Select PPO** (\$39 per month)
  - Add Optional Supplemental Benefits Package to this plan for an additional \$25 per month
- MedMutual Advantage Preferred PPO** (\$69 per month)
  - Add Optional Supplemental Benefits Package to this plan for an additional \$25 per month
- MedMutual Advantage Premium PPO** (\$109 per month)

**Please Note:** The Optional Supplemental Benefits Package is not available to add to MedMutual Advantage Premium PPO, as this plan already includes extra vision and dental benefits.

## 2. Applicant Information

<b>Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Title</b> <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
<b>Birthdate</b> (MM/DD/YYYY)	<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Primary Phone Number</b> ( ) -		<b>Secondary Phone Number</b> ( ) -	
<b>Permanent Residence Street Address</b> (P.O. Box is not allowed)					
<b>City</b>		<b>State</b>	<b>ZIP Code</b>	<b>County</b>	
<b>Mailing Address</b> (Only if different from your Permanent Residence Address)					
<b>City</b>				<b>State</b>	<b>ZIP Code</b>
<b>Email Address</b>					
<b>Please Note:</b> By providing this email address, you are giving Medical Mutual permission to send you an email message (e.g., confirming we received your application and/or information about how to opt in to receive additional plan-related email communications).					

## 3. Primary Care Physician Information (Optional)

<b>Physician Name</b>	<b>Physician Phone Number</b> ( ) -	<b>Physician's NPI Number</b>
<b>Physician's Street Address</b>		
<b>City</b>	<b>State</b>	<b>ZIP Code</b>



# MedMutual Advantage Enrollment Application

6. Please read and answer these important questions (Please check all that apply below)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1. Do you have or have you ever had End-Stage Renal Disease (ESRD)?</b> If yes, you will need to supply us with a note from your doctor or records to show you have had a successful kidney transplant and/or you don't need regular dialysis anymore. Please include this with your application or fax to (800) 542-2583 or mail to: P.O. Box 94563, Cleveland, OH 44101. Otherwise, we may need to contact you to obtain additional information.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2. Some individuals may have other drug coverage including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to the MedMutual Advantage plan you selected?</b> If yes, please list your other coverage and your identification (ID) number(s) for this coverage:	
	Name of Coverage	ID Number
		Group Number
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>3. Are you enrolled in your state Medicaid program?</b> If yes, please provide your Medicaid number:	
	Medicaid Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>4. Do you or your spouse work?</b>	

# MedMutual Advantage Enrollment Application

## 7. Attestation of Eligibility (Please check all that apply)

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I recently left a PACE program on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare coverage). I lost my drug coverage on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) \_\_\_\_/\_\_\_\_/\_\_\_\_.

If none of these statements apply to you or you're not sure, please contact Medical Mutual at (866) 406-8777 (TTY 711 for hearing impaired) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m. seven days a week from October 1 to February 14 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturdays from February 15 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options.



## PLEASE READ THIS IMPORTANT INFORMATION

If you currently have health coverage from an employer or union, joining a MedMutual Advantage HMO or PPO plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join a MedMutual Advantage HMO or PPO plan. Read the communications your employer or union sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

# MedMutual Advantage Enrollment Application

## 8. Terms and Conditions (Please read and sign below)

### By completing this enrollment application, I agree to the following:

MedMutual Advantage HMO and PPO plans are Medicare Advantage plans offered by Medical Mutual through a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Each MedMutual Advantage plan serves a specific service area. If I move out of the area that my plan serves, I need to notify Medical Mutual so I can disenroll and find a new plan in my new area. Once I am a member of Medical Mutual, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medical Mutual when I get it to know which rules I must follow to get coverage with this plan. I understand people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

For HMO plans, I understand I must get all my healthcare from network providers, except for emergency or urgently needed services or out-of-area dialysis services. For PPO plans, I understand using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Medical Mutual provides refunds for all covered services, even if I get services out of network. For HMO and PPO plans, to get in-network coverage for out-of-area dialysis services, I understand I must be temporarily outside the plan's service area and use a Medicare-certified dialysis facility. Services authorized by Medical Mutual and in my Evidence of Coverage will be covered. **Without authorization, neither Medicare nor Medical Mutual will pay for the services.**

I understand if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Medical Mutual, he/she may be paid based on my enrollment in Medical Mutual.

### Proxy

I appoint the Secretary of Medical Mutual of Ohio as my proxy to act for me at any annual or special meeting of the members of Medical Mutual of Ohio. The Secretary will act as fully and to the same extent that I could act if personally present at the meeting. This proxy will be in effect for 10 years from the date of my signature below or the effective date of my coverage, whichever date is later. This proxy may be taken back at any time by mailing a letter to the Secretary.

### Email Address

I understand if I have included my email address in this application, I am authorizing Medical Mutual to send me an email confirming it received my application and/or information about how to opt in to receive additional email communications. All other communications, including whether or not my application was approved for coverage will be sent by mail to the permanent address or mailing address I provided in Section 2. Medical Mutual will not sell my email information and will only send me email communications that I agree to receive by email.

### Release of Information

By joining this Medicare health plan, I acknowledge that Medical Mutual will release my information to Medicare and other plans as is necessary for treatment, payment and healthcare operations. I also acknowledge that Medical Mutual will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan.

Medical Mutual will use and disclose your information as permitted by law and consistent with Medical Mutual's Notice of Privacy Practices (available at MedMutual.com or by calling (800) 982-3117 (TTY 711 for hearing impaired)).

I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. My actual effective date will be based on my eligibility.

**Signature**

**Today's Date**

**Preferred Effective Date**

# MedMutual Advantage Enrollment Application

## 9. Authorized Representative Information (If applicable)

**Please Note:** If signed by an authorized individual (as described in Section 8), this signature certifies 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare. If you are the authorized representative, you must sign page 5 and provide the following information:

**Authorized Representative's Name**

**Address**

**City**

**State**

**ZIP Code**

**Relationship to Enrollee**

**Home Phone Number**

(     )     -

**Please Note:** All mail will be sent to the permanent address or mailing address provided in Section 2 of this application.



The following section should be completed only by the insurance agent/broker assisting with this application.

## Agent/Broker Use Only (If applicable)

Yes    No   **Was this an individual one-on-one (e.g., face-to-face, conference call) appointment? If yes, the Scope of Appointment form must be attached.**

**Agent/Broker's Name** (Please print)

**Today's Date**

**Date Application Received by Agent/Broker**

**National Producer Number (NPN)**



MEDICAL MUTUAL®

# 2016 Summary of Benefits

## MedMutual Advantage HMO and PPO Plans

### Region 1 Ohio Counties

This region for MedMutual Advantage HMO and PPO plans includes: Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood, Wyandot





MEDICAL MUTUAL®

## Multi-Language Interpreter Services

### English

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-982-3117. Someone who speaks English/Language can help you. This is a free service.

### Spanish

Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-982-3117. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

### Chinese Mandarin

我們提供免費的翻譯服務, 幫助您解答關於健康或藥物保險的任何疑問。如果您需要此翻譯服務, 請致電 1-800-982-3117。我們的中文工作人員很樂意幫助您。這是一項免費服務。

### Chinese Cantonese

您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-800-982-3117。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

### Tagalog

Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-982-3117. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

### French

Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-982-3117. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

### Vietnamese

Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-982-3117 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

### German

Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-982-3117. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

## Korean

당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-982-3117. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

## Russian

Если у вас возникнут вопросы относительно страхового или медикаментного плана, Вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-982-3117. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

## Arabic

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. العربية للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-982-3117. سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث

## Hindi

हमारे स्वास्थ्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपब्धि हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-982-3117 पर फोन करें. कोई व्यक्त जो हहन्दी बोता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

## Italian

È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-982-3117. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

## Portugués

Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-982-3117. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

## French Creole

Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-982-3117. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

## Polish

Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-982-3117. Ta usługa jest bezpłatna.

## Japanese

当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-982-3117。にお電話ください 日本語を話す人 者が支援いたします。これは無料のサービスです。



MEDICAL MUTUAL®

# Summary of Benefits

January 1, 2016 – December 31, 2016

**MedMutual Advantage Select (PPO)**

**MedMutual Advantage Preferred (PPO)**

**MedMutual Advantage Premium (PPO)**

MedMutual Advantage HMO and PPO plans are offered by Medical Mutual of Ohio under a contract with Medicare. Enrollment in these plans depends on contract renewal.

# Summary of Benefits

**This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the Evidence of Coverage.**

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO)).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO) covers and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on Medicare.gov.

If you want to know more about the 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 (800) MEDICARE (800) 633-4227, 24 hours a day, seven days a week. TTY users should call (877) 486-2048.

## Sections in this booklet

- Things to Know About MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO).
- Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at (800) 982-3117.

## Things to Know About MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO)

### Hours of Operation

- From October 1 to February 14 (except Thanksgiving and Christmas), you can call us seven days a week from 8 a.m. to 8 p.m.
- From February 15 to September 30 (except holidays), you can call us Monday through Friday from 8 a.m. to 8 p.m and Saturday from 9 a.m. to 1 p.m.
- Our automated telephone system is also available 24 hours a day, seven days a week for self-service options.

### MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Premium (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free (800) 982-3117. TTY users should call 711.
- If you are not a member of this plan, call toll-free (866) 406-8777. TTY users should call 711.
- Our website: [MedMutual.com/Medicare](http://MedMutual.com/Medicare)

### Who can join?

To join MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) or MedMutual Advantage Premium (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 Ohio: Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood and Wyandot.

### Which doctors, hospitals and pharmacies can I use?

MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO) have a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan's provider directory at our website ([MedMutual.com/Medicare](http://MedMutual.com/Medicare)).
- You can see our plan's pharmacy directory at our website ([MedMutual.com/Medicare](http://MedMutual.com/Medicare)).
- Or call us and we will send you a copy of the provider and pharmacy directories.

# Summary of Benefits

## **What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers—and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [MedMutual.com/medicare](http://MedMutual.com/medicare).
- Or call us and we will send you a copy of the formulary.

## **How will I determine my drug costs?**

Our plan groups each medication into one of five tiers. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap and Catastrophic Coverage.

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# Summary of Benefits

## Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services

Benefit Description	MedMutual Advantage Select (PPO)
<b>How much is the monthly premium?</b>	\$39 per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	<p>This plan has deductibles for some hospital and medical services, and Part D prescription drugs.</p> <ul style="list-style-type: none"> <li>▪ \$1,500 per year for out-of-network services.</li> <li>▪ \$165 per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2 and Tier 5, which are excluded from the deductible.</li> </ul>
<b>Is there any limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$6,400 for services you receive from in-network providers.</li> <li>▪ \$10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Is there a limit to how much the plan will pay?</b>	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

<b>MedMutual Advantage Preferred (PPO)</b>	<b>MedMutual Advantage Premium (PPO)</b>
<p>\$69 per month. In addition, you must keep paying your Medicare Part B premium.</p>	<p>\$109 per month. In addition, you must keep paying your Medicare Part B premium.</p>
<p>This plan has deductibles for some hospital and medical services, and Part D prescription drugs.</p> <ul style="list-style-type: none"> <li>▪ \$1,000 per year for out-of-network services.</li> <li>▪ This plan does not have a deductible for Part D prescription drugs.</li> </ul>	<p>This plan has deductibles for some hospital and medical services, and Part D prescription drugs.</p> <ul style="list-style-type: none"> <li>▪ \$500 per year for out-of-network services.</li> <li>▪ This plan does not have a deductible for Part D prescription drugs.</li> </ul>
<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$4,800 for services you receive from in-network providers.</li> <li>▪ \$10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$3,500 for services you receive from in-network providers.</li> <li>▪ \$10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<p>Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.</p>	<p>Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.</p>

# Summary of Benefits

## Covered Medical and Hospital Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Outpatient Care and Services</b>	
<b>Acupuncture</b>	Not covered
<b>Ambulance</b> <i>(Services may require prior authorization)</i>	<ul style="list-style-type: none"> <li>▪ In-network: \$295 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Chiropractic Care</b>	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$20 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Dental Services</b>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>A single office visit that includes:</p> <ul style="list-style-type: none"> <li>▪ Cleaning (for up to 1 every year)</li> <li>▪ Dental X-ray(s) (for up to 1 every year)</li> <li>▪ Oral exam (for up to 1 every year)               <ul style="list-style-type: none"> <li>– In-network: \$25 copay</li> <li>– Out-of-network: 50% of the cost</li> </ul> </li> </ul>

<b>MedMutual Advantage Preferred (PPO)</b>	<b>MedMutual Advantage Premium (PPO)</b>
<b>Outpatient Care and Services</b>	
Not covered	Not covered
<ul style="list-style-type: none"> <li>▪ In-network: \$250 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<ul style="list-style-type: none"> <li>▪ In-network: \$195 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$20 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$20 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>A single office visit that includes:</p> <ul style="list-style-type: none"> <li>▪ Cleaning (for up to 1 every year)</li> <li>▪ Dental X-ray(s) (for up to 1 every year)</li> <li>▪ Oral exam (for up to 1 every year) <ul style="list-style-type: none"> <li>– In-network: \$25 copay</li> <li>– Out-of-network: 50% of the cost</li> </ul> </li> </ul>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Preventive dental services:</p> <ul style="list-style-type: none"> <li>▪ Cleaning (for up to 2 every year) <ul style="list-style-type: none"> <li>– In-network: You pay nothing</li> <li>– Out-of-network: 50% of the cost</li> </ul> </li> <li>▪ Dental X-ray(s) (for up to 1 every year) <ul style="list-style-type: none"> <li>– In-network: You pay nothing</li> <li>– Out-of-network: 50% of the cost</li> </ul> </li> <li>▪ Oral exam (for up to 2 every year) <ul style="list-style-type: none"> <li>– In-network: You pay nothing</li> <li>– Out-of-network: 50% of the cost</li> </ul> </li> </ul> <p>Or plan pays up to \$1,000 every year for most dental services from any provider.</p> <p>For each calendar year, the following dental limits apply:</p> <ul style="list-style-type: none"> <li>▪ Two diagnostic X-rays</li> <li>▪ One denture repair, reline or adjustment</li> <li>▪ One endodontic service</li> <li>▪ One periodontic service</li> </ul> <p>You also have a limit of one crown every five years.</p>

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Outpatient Care and Services (cont.)</b>	
<b>Diabetes Supplies and Services</b>	Diabetes monitoring supplies: <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> Diabetes self-management training: <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Therapeutic shoes or inserts: <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul>
<b>Diagnostic Tests, Lab and Radiology Services and X-rays</b> <i>(Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.)</i>	Diagnostic radiology services (such as MRIs, CT scans): <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Diagnostic tests and procedures: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Lab services: <ul style="list-style-type: none"> <li>▪ In-network: \$0–10 copay, depending on the service</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Outpatient X-rays: <ul style="list-style-type: none"> <li>▪ In-network: \$50 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Therapeutic radiology services (such as radiation treatment for cancer): <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>

<b>MedMutual Advantage Preferred (PPO)</b>	<b>MedMutual Advantage Premium (PPO)</b>
<b>Outpatient Care and Services (cont.)</b>	
<p>Diabetes monitoring supplies:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Diabetes self-management training:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Therapeutic shoes or inserts:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul>	<p>Diabetes monitoring supplies:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Diabetes self-management training:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Therapeutic shoes or inserts:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul>
<p>Diagnostic radiology services (such as MRIs, CT scans):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Diagnostic tests and procedures:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Lab services:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$0–5 copay, depending on the service</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Outpatient X-rays:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Diagnostic radiology services (such as MRIs, CT scans):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Diagnostic tests and procedures:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Lab services:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Outpatient X-rays:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Therapeutic radiology services (such as radiation treatment for cancer):</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Outpatient Care and Services (cont.)</b>	
<b>Doctor's Office Visits</b> <i>(Services may require prior authorization.)</i>	Primary care physician visit: <ul style="list-style-type: none"> <li>▪ In-network: \$10 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Specialist visit: <ul style="list-style-type: none"> <li>▪ In-network: \$45 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.
<b>Durable Medical Equipment</b> (wheelchairs, oxygen, etc.) <i>(Services may require prior authorization.)</i>	<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Emergency Care</b>	\$75 copay  If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.
<b>Foot Care</b> (Podiatry Services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: <ul style="list-style-type: none"> <li>▪ In-network: \$45 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues: <ul style="list-style-type: none"> <li>▪ In-network: \$45 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Home Health Care</b> <i>(Services may require prior authorization.)</i>	<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Mental Health Care</b> <i>(Services may require prior authorization.)</i>	Inpatient visit:  Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

<b>MedMutual Advantage Preferred (PPO)</b>	<b>MedMutual Advantage Premium (PPO)</b>
<b>Outpatient Care and Services (cont.)</b>	
<p>Primary care physician visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$5 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Specialist visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.</p>	<p>Primary care physician visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Specialist visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.</p>
<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p>\$75 copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.</p>	<p>\$75 copay</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.</p>
<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p>Exam to diagnose and treat hearing and balance issues:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Exam to diagnose and treat hearing and balance issues:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p>

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Outpatient Care and Services (cont.)</b>	
<p><b>Mental Health Care (cont.)</b>  <i>(Services may require prior authorization.)</i></p>	<p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>▪ In-network: <ul style="list-style-type: none"> <li>– \$295 copay per day for days 1 through 5</li> <li>– You pay nothing per day for days 6 through 90</li> </ul> </li> <li>▪ Out-of-network: <ul style="list-style-type: none"> <li>– 30% of the cost per stay</li> </ul> </li> </ul> <p>Outpatient group therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Outpatient individual therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p><b>Outpatient Rehabilitation</b></p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Occupational therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Physical therapy and speech and language therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>

**MedMutual Advantage Preferred (PPO)****MedMutual Advantage Premium (PPO)****Outpatient Care and Services (cont.)**

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

- In-network:
  - \$250 copay per day for days 1 through 6
  - You pay nothing per day for days 7 through 90
- Out-of-network:
  - 30% of the cost per stay

Outpatient group therapy visit:

- In-network: \$35 copay
- Out-of-network: 30% of the cost

Outpatient individual therapy visit:

- In-network: \$35 copay
- Out-of-network: 30% of the cost

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

- In-network: \$40 copay
- Out-of-network: 30% of the cost

Occupational therapy visit:

- In-network: \$40 copay
- Out-of-network: 30% of the cost

Physical therapy and speech and language therapy visit:

- In-network: \$40 copay
- Out-of-network: 30% of the cost

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

- In-network:
  - \$195 copay per day for days 1 through 6
  - You pay nothing per day for days 7 through 90
- Out-of-network:
  - 30% of the cost per stay

Outpatient group therapy visit:

- In-network: \$25 copay
- Out-of-network: 30% of the cost

Outpatient individual therapy visit:

- In-network: \$25 copay
- Out-of-network: 30% of the cost

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

- In-network: \$40 copay
- Out-of-network: 30% of the cost

Occupational therapy visit:

- In-network: \$40 copay
- Out-of-network: 30% of the cost

Physical therapy and speech and language therapy visit:

- In-network: \$40 copay
- Out-of-network: 30% of the cost

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Outpatient Care and Services (cont.)</b>	
<b>Outpatient Substance Abuse</b>	Group therapy visit: <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Individual therapy visit: <ul style="list-style-type: none"> <li>▪ In-network: \$40 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Outpatient Surgery</b> <i>(Services may require prior authorization.)</i>	Ambulatory surgical center: <ul style="list-style-type: none"> <li>▪ In-network: \$250 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Outpatient hospital: <ul style="list-style-type: none"> <li>▪ In-network: \$295 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Over-the-Counter Items</b>	Please visit our website to see our list of covered over-the-counter items.
<b>Prosthetic Devices</b> (braces, artificial limbs, etc.) <i>(Services may require prior authorization.)</i>	Prosthetic devices: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> Related medical supplies: <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Renal Dialysis</b>	<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<b>Transportation</b>	Not covered
<b>Urgently Needed Services</b>	\$40 copay

<b>MedMutual Advantage Preferred (PPO)</b>	<b>MedMutual Advantage Premium (PPO)</b>
<b>Outpatient Care and Services (cont.)</b>	
<p>Group therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Individual therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Group therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Individual therapy visit:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<p>Ambulatory surgical center:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$200 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Outpatient hospital:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$255 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Ambulatory surgical center:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$150 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Outpatient hospital:</p> <ul style="list-style-type: none"> <li>▪ In-network: \$195 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
Please visit our website to see our list of covered over-the-counter items.	Please visit our website to see our list of covered over-the-counter items.
<p>Prosthetic devices:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Related medical supplies:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<p>Prosthetic devices:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Related medical supplies:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>	<ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul>
Not covered	Not covered
\$40 copay	\$40 copay

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Outpatient Care and Services (cont.)</b>	
<b>Vision Services</b>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$45 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Routine eye exam (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: \$50 copay</li> </ul> <p>Contact lenses (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Eyeglasses (frames and lenses) (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Eyeglasses or contact lenses after cataract surgery:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Our plan pays up to \$100 every year for contact lenses and eyeglasses (frames and lenses) from any provider.</p>
<b>Preventive Care</b>	
<b>Preventive Care</b>	<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> </ul>

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
<b>Outpatient Care and Services (cont.)</b>	
<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$35 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Routine eye exam (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: \$50 copay</li> </ul> <p>Contact lenses (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Eyeglasses (frames and lenses) (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Eyeglasses or contact lenses after cataract surgery:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Our plan pays up to \$100 every year for contact lenses and eyeglasses (frames and lenses) from any provider.</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):</p> <ul style="list-style-type: none"> <li>▪ In-network: \$25 copay</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Routine eye exam (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: \$50 copay</li> </ul> <p>Contact lenses (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Eyeglasses (frames and lenses) (for up to 1 every year):</p> <ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: You pay nothing</li> </ul> <p>Eyeglasses or contact lenses after cataract surgery:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Our plan pays up to \$250 every year for contact lenses and eyeglasses (frames and lenses) from any provider.</p>
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> </ul>	<ul style="list-style-type: none"> <li>▪ In-network: You pay nothing</li> <li>▪ Out-of-network: 30% of the cost</li> </ul> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> </ul>

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Preventive Care (cont.)</b>	
<b>Preventive Care (cont.)</b>	<ul style="list-style-type: none"> <li>▪ Diabetes screenings</li> <li>▪ HIV screening</li> <li>▪ Medical nutrition therapy services</li> <li>▪ Obesity screening and counseling</li> <li>▪ Prostate cancer screenings (PSA)</li> <li>▪ Sexually transmitted infections screening and counseling</li> <li>▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>▪ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>▪ Welcome to Medicare preventive visit (one-time)</li> <li>▪ Yearly wellness visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Hospice</b>	
<b>Hospice</b>	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p>
<b>Inpatient Care</b>	
<b>Inpatient Hospital Care</b> <i>(Services may require prior authorization.)</i>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>▪ In-network:               <ul style="list-style-type: none"> <li>– \$325 copay per day for days 1 through 5</li> <li>– You pay nothing per day for days 6 through 90</li> <li>– You pay nothing per day for days 91 and beyond</li> </ul> </li> <li>▪ Out-of-network: 30% of the cost per stay</li> </ul>
<b>Inpatient Mental Health Care</b>	<p>For inpatient mental health care, see the Mental Health Care section of this booklet.</p>
<b>Skilled Nursing Facility (SNF)</b> <i>(Services may require prior authorization.)</i>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>▪ In-network:               <ul style="list-style-type: none"> <li>– You pay nothing per day for days 1 through 20</li> <li>– \$160 copay per day for days 21 through 100</li> </ul> </li> <li>▪ Out-of-network: 30% of the cost per stay</li> </ul>

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
<b>Preventive Care (cont.)</b>	
<ul style="list-style-type: none"> <li>■ Diabetes screenings</li> <li>■ HIV screening</li> <li>■ Medical nutrition therapy services</li> <li>■ Obesity screening and counseling</li> <li>■ Prostate cancer screenings (PSA)</li> <li>■ Sexually transmitted infections screening and counseling</li> <li>■ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>■ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>■ Welcome to Medicare preventive visit (one-time)</li> <li>■ Yearly wellness visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<ul style="list-style-type: none"> <li>■ Diabetes screenings</li> <li>■ HIV screening</li> <li>■ Medical nutrition therapy services</li> <li>■ Obesity screening and counseling</li> <li>■ Prostate cancer screenings (PSA)</li> <li>■ Sexually transmitted infections screening and counseling</li> <li>■ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>■ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>■ Welcome to Medicare preventive visit (one-time)</li> <li>■ Yearly wellness visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
<b>Hospice</b>	
<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p>	<p>You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.</p>
<b>Inpatient Care</b>	
<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>■ In-network: <ul style="list-style-type: none"> <li>– \$295 copay per day for days 1 through 6</li> <li>– You pay nothing per day for days 7 through 90</li> <li>– You pay nothing per day for days 91 and beyond</li> </ul> </li> <li>■ Out-of-network: 30% of the cost per stay</li> </ul>	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <ul style="list-style-type: none"> <li>■ In-network: <ul style="list-style-type: none"> <li>– \$195 copay per day for days 1 through 6</li> <li>– You pay nothing per day for days 7 through 90</li> <li>– You pay nothing per day for days 91 and beyond</li> </ul> </li> <li>■ Out-of-network: 30% of the cost per stay</li> </ul>
<p>For inpatient mental health care, see the Mental Health Care section of this booklet.</p>	<p>For inpatient mental health care, see the Mental Health Care section of this booklet.</p>
<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>■ In-network: <ul style="list-style-type: none"> <li>– You pay nothing per day for days 1 through 20</li> <li>– \$160 copay per day for days 21 through 100</li> </ul> </li> <li>■ Out-of-network: 30% of the cost per stay</li> </ul>	<p>Our plan covers up to 100 days in a SNF.</p> <ul style="list-style-type: none"> <li>■ In-network: <ul style="list-style-type: none"> <li>– You pay nothing per day for days 1 through 20</li> <li>– \$160 copay per day for days 21 through 100</li> </ul> </li> <li>■ Out-of-network: 30% of the cost per stay</li> </ul>

# Summary of Benefits

## Prescription Drug Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Prescription Drug Benefits</b>	
<p><b>How much do I pay?</b></p>	<p>For Part B drugs such as chemotherapy drugs<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Other Part B drugs<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<p><b>Initial Coverage</b></p>	<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> <li>▪ Tier 3 (preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>▪ Tier 4 (non-preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>▪ Tier 5 (specialty tier)               <ul style="list-style-type: none"> <li>– One-month supply: 29% of the cost</li> <li>– Two-month supply: 29% of the cost</li> <li>– Three-month supply: 29% of the cost</li> </ul> </li> </ul>

1. Services may require prior authorization.

<b>MedMutual Advantage Preferred (PPO)</b>	<b>MedMutual Advantage Premium (PPO)</b>
<b>Prescription Drug Benefits</b>	
<p>For Part B drugs such as chemotherapy drugs<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Other Part B drugs<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>	<p>For Part B drugs such as chemotherapy drugs<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul> <p>Other Part B drugs<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>▪ In-network: 20% of the cost</li> <li>▪ Out-of-network: 20% of the cost</li> </ul>
<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> <li>▪ Tier 3 (preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>▪ Tier 4 (non-preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>▪ Tier 5 (specialty tier) <ul style="list-style-type: none"> <li>– One-month supply: 33% of the cost</li> <li>– Two-month supply: 33% of the cost</li> <li>– Three-month supply: 33% of the cost</li> </ul> </li> </ul> <p>This plan does not have a yearly deductible.</p>	<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> <li>▪ Tier 3 (preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>▪ Tier 4 (non-preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>▪ Tier 5 (specialty tier) <ul style="list-style-type: none"> <li>– One-month supply: 33% of the cost</li> <li>– Two-month supply: 33% of the cost</li> <li>– Three-month supply: 33% of the cost</li> </ul> </li> </ul> <p>This plan does not have a yearly deductible.</p>

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Prescription Drug Benefits (cont.)</b>	
<p><b>Initial Coverage (cont.)</b></p>	<p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> <li>▪ Tier 3 (preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>▪ Tier 4 (non-preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>▪ Tier 5 (specialty tier)               <ul style="list-style-type: none"> <li>– One-month supply: 29% of the cost</li> <li>– Two-month supply: 29% of the cost</li> <li>– Three-month supply: 29% of the cost</li> </ul> </li> </ul> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p>
<p><b>Coverage Gap</b></p>	<p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.</p>

**MedMutual Advantage Preferred (PPO)****MedMutual Advantage Premium (PPO)****Prescription Drug Benefits (cont.)**

Standard mail order cost-sharing:

- Tier 1 (preferred generic)
  - One-month supply: \$0 copay
  - Two-month supply: \$0 copay
  - Three-month supply: \$0 copay
- Tier 2 (non-preferred generic)
  - One-month supply: \$12 copay
  - Two-month supply: \$18 copay
  - Three-month supply: \$24 copay
- Tier 3 (preferred brand)
  - One-month supply: \$47 copay
  - Two-month supply: \$71 copay
  - Three-month supply: \$94 copay
- Tier 4 (non-preferred brand)
  - One-month supply: \$100 copay
  - Two-month supply: \$150 copay
  - Three-month supply: \$200 copay
- Tier 5 (specialty tier)
  - One-month supply: 33% of the cost
  - Two-month supply: 33% of the cost
  - Three-month supply: 33% of the cost

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.

After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.

Standard mail order cost-sharing:

- Tier 1 (preferred generic)
  - One-month supply: \$0 copay
  - Two-month supply: \$0 copay
  - Three-month supply: \$0 copay
- Tier 2 (non-preferred generic)
  - One-month supply: \$12 copay
  - Two-month supply: \$18 copay
  - Three-month supply: \$24 copay
- Tier 3 (preferred brand)
  - One-month supply: \$47 copay
  - Two-month supply: \$71 copay
  - Three-month supply: \$94 copay
- Tier 4 (non-preferred brand)
  - One-month supply: \$100 copay
  - Two-month supply: \$150 copay
  - Three-month supply: \$200 copay
- Tier 5 (specialty tier)
  - One-month supply: 33% of the cost
  - Two-month supply: 33% of the cost
  - Three-month supply: 33% of the cost

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.

After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.

# Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
<b>Prescription Drug Benefits (cont.)</b>	
<b>Coverage Gap (cont.)</b>	<p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic)               <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic)               <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> </ul> <p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic)               <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic)               <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> </ul>
<b>Catastrophic Coverage</b>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.</li> </ul>

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Prescription Drug Benefits (cont.)	
<p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> </ul> <p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> </ul>	<p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> </ul> <p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> </ul>
<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.</li> </ul>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.</li> </ul>

# Summary of Benefits

Optional Benefits (You must pay an extra premium each month for these benefits)

Benefit Description	MedMutual Advantage Select (PPO)
<b>Optional Benefits</b>	
<b>Package 1: Optional Dental and Vision Rider</b>	Benefits include: <ul style="list-style-type: none"> <li>▪ Comprehensive dental</li> <li>▪ Preventive dental</li> <li>▪ Eye exams</li> <li>▪ Eyewear</li> </ul>
<b>How much is the monthly premium?</b>	Additional \$25 per month. You must keep paying your Medicare Part B premium and your \$39 monthly plan premium.
<b>How much is the deductible?</b>	This package does not have a deductible.
<b>Is there a limit on how much the plan will pay?</b>	Our plan pays up to \$1,250 every year. Our plan has additional coverage limits for certain benefits.  The \$1,250 limit has separate limits of \$1,000 for dental and \$250 for vision benefits.

**MedMutual Advantage Preferred (PPO)****MedMutual Advantage Premium (PPO)****Optional Benefits**

Benefits include:

- Comprehensive dental
- Preventive dental
- Eye exams
- Eyewear

Additional \$25 per month. You must keep paying your Medicare Part B premium and your \$69 monthly plan premium.

This package does not have a deductible.

Our plan pays up to \$1,250 every year. Our plan has additional coverage limits for certain benefits.

The \$1,250 limit has separate limits of \$1,000 for dental and \$250 for vision benefits.

Please note: The Optional Benefits are already included in the benefits at no additional cost.

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MEDICAL MUTUAL®

# Summary of Benefits

January 1, 2016 – December 31, 2016

**MedMutual Advantage Classic (HMO)**  
**MedMutual Advantage Choice (HMO)**

MedMutual Advantage HMO and PPO plans are offered by Medical Mutual of Ohio under a contract with Medicare. Enrollment in these plans depends on contract renewal.

# Summary of Benefits

**This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the Evidence of Coverage.**

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as MedMutual Advantage Classic (HMO) or MedMutual Advantage Choice (HMO)).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what MedMutual Advantage Classic (HMO) and MedMutual Advantage Choice (HMO) cover and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on Medicare.gov.

If you want to know more about the 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 (800) MEDICARE ((800) 633-4227), 24 hours a day, seven days a week. TTY users should call (877) 486-2048.

## Sections in this booklet

- Things to Know About MedMutual Advantage Classic (HMO) and MedMutual Advantage Choice (HMO).
- Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at (800) 982-3117.

## Things to Know About MedMutual Advantage Classic (HMO) and MedMutual Advantage Choice (HMO)

### Hours of Operation

- From October 1 to February 14 (except Thanksgiving and Christmas), you can call us seven days a week from 8 a.m. to 8 p.m.
- From February 15 to September 30 (except holidays), you can call us Monday through Friday from 8 a.m. to 8 p.m and Saturday from 9 a.m. to 1 p.m.
- Our automated telephone system is also available 24 hours a day, seven days a week for self-service options.

### MedMutual Advantage Classic (HMO) and MedMutual Advantage Choice (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free (800) 982-3117. TTY users should call 711.
- If you are not a member of this plan, call toll-free (866) 406-8777. TTY users should call 711.
- Our website: [MedMutual.com/Medicare](http://MedMutual.com/Medicare)

### Who can join?

To join MedMutual Advantage Classic (HMO) or MedMutual Advantage Choice (HMO), 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 Ohio: Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood and Wyandot.

### Which doctors, hospitals and pharmacies can I use?

MedMutual Advantage Classic (HMO) and MedMutual Advantage Choice (HMO) have a network of doctors, hospitals, pharmacies and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan's provider directory at our website ([MedMutual.com/Medicare](http://MedMutual.com/Medicare)).
- You can see our plan's pharmacy directory at our website ([MedMutual.com/Medicare](http://MedMutual.com/Medicare)).
- Or call us and we will send you a copy of the provider and pharmacy directories.

# Summary of Benefits

## **What do we cover?**

Like all Medicare health plans, we cover everything that Original Medicare covers—and more.

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [MedMutual.com/medicare](https://www.MedMutual.com/medicare).
- Or call us and we will send you a copy of the formulary.

## **How will I determine my drug costs?**

Our plan groups each medication into one of five tiers. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap and Catastrophic Coverage.

# Summary of Benefits

## Monthly Premium, Deductible and Limits on How Much You Pay for Covered Services

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>How much is the monthly premium?</b>	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	\$29 per month. In addition, you must keep paying your Medicare Part B premium.
<b>How much is the deductible?</b>	\$165 per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2 and Tier 5, which are excluded from the deductible.	This plan does not have a deductible.
<b>Is there a limit on how much I will pay for my covered services?</b>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$3,950 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>▪ \$3,500 for services you receive from in-network providers.</li> </ul> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Is there a limit on how much the plan will pay?</b>	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

# Summary of Benefits

## Covered Medical and Hospital Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Outpatient Care and Services</b>		
<b>Acupuncture</b>	Not covered	Not covered
<b>Ambulance</b> <i>(Services may require prior authorization.)</i>	\$295 copay	\$295 copay
<b>Chiropractic Care</b>	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): \$20 copay
<b>Dental Services</b>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): 20% of the cost</p> <p>Dental services: \$25 copay for a single office visit that includes:</p> <ul style="list-style-type: none"> <li>▪ Cleaning (for up to 1 every year)</li> <li>▪ Dental X-ray(s) (for up to 1 every year)</li> <li>▪ Oral exam (for up to 1 every year)</li> </ul>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): 20% of the cost</p> <p>Dental services: \$25 copay for a single office visit that includes:</p> <ul style="list-style-type: none"> <li>▪ Cleaning (for up to 1 every year)</li> <li>▪ Dental X-ray(s) (for up to 1 every year)</li> <li>▪ Oral exam (for up to 1 every year)</li> </ul>
<b>Diabetes Supplies and Services</b>	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: You pay nothing</p>	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: You pay nothing</p>

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Outpatient Care and Services (cont.)</b>		
<b>Diagnostic Tests, Lab and Radiology Services and X-rays</b> <i>(Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.)</i>	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost  Diagnostic tests and procedures: 20% of the cost  Lab services: \$0–10 copay, depending on the service  Outpatient X-rays: \$50 copay  Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost  Diagnostic tests and procedures: 20% of the cost  Lab services: \$0–10 copay, depending on the service  Outpatient X-rays: \$50 copay  Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
<b>Doctor's Office Visits</b> <i>(Services may require prior authorization.)</i>	Primary care physician visit: \$10 copay  Specialist visit: \$50 copay  If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.	Primary care physician visit: You pay nothing  Specialist visit: \$40 copay  If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.
<b>Durable Medical Equipment</b> (wheelchairs, oxygen, etc.) <i>(Services may require prior authorization.)</i>	20% of the cost	20% of the cost
<b>Emergency Care</b>	\$75 copay  If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.	\$75 copay  If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.
<b>Foot Care</b> (Podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$50 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$40 copay
<b>Hearing Services</b>	Exam to diagnose and treat hearing and balance issues: \$50 copay	Exam to diagnose and treat hearing and balance issues: \$40 copay
<b>Home Health Care</b> <i>(Services may require prior authorization.)</i>	You pay nothing	You pay nothing

# Summary of Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Outpatient Care and Services (cont.)</b>		
<p><b>Mental Health Care</b> <i>(Services may require prior authorization.)</i></p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>▪ \$295 copay per day for days 1 through 5</li> <li>▪ You pay nothing per day for days 6 through 90</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p>	<p>Inpatient visit:</p> <p>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These inpatient hospital coverage will be limited to 90 days.</p> <ul style="list-style-type: none"> <li>▪ \$295 copay per day for days 1 through 5</li> <li>▪ You pay nothing per day for days 6 through 90</li> </ul> <p>Outpatient group therapy visit: \$40 copay</p> <p>Outpatient individual therapy visit: \$40 copay</p>
<p><b>Outpatient Rehabilitation</b></p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$40 copay</p> <p>Occupational therapy visit: \$40 copay</p> <p>Physical therapy and speech and language therapy visit: \$40 copay</p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): \$40 copay</p> <p>Occupational therapy visit: \$40 copay</p> <p>Physical therapy and speech and language therapy visit: \$40 copay</p>
<p><b>Outpatient Substance Abuse</b></p>	<p>Group therapy visit: \$40 copay</p> <p>Individual therapy visit: \$40 copay</p>	<p>Group therapy visit: \$40 copay</p> <p>Individual therapy visit: \$40 copay</p>

<b>Benefit Description</b>	<b>MedMutual Advantage Classic (HMO)</b>	<b>MedMutual Advantage Choice (HMO)</b>
<b>Outpatient Care and Services (cont.)</b>		
<b>Outpatient Surgery</b> <i>(Services may require prior authorization.)</i>	Ambulatory surgical center: \$250 copay Outpatient hospital: \$315 copay	Ambulatory surgical center: \$250 copay Outpatient hospital: \$300 copay
<b>Over-the-Counter Items</b>	Not covered	Please visit our website to see our list of covered over-the-counter supplies.
<b>Prosthetic Devices</b> <i>(braces, artificial limbs, etc.) (Services may require prior authorization.)</i>	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
<b>Renal Dialysis</b>	20% of the cost	20% of the cost
<b>Transportation</b>	Not covered	Not covered
<b>Urgently Needed Services</b>	\$40 copay	\$40 copay
<b>Vision Services</b>	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$50 copay  Routine eye exam (for up to 1 every year): \$25 copay  Contact lenses (for up to 1 every year): You pay nothing  Eyeglasses (frames and lenses) (for up to 1 every year): You pay nothing  Eyeglasses or contact lenses after cataract surgery: 20% of the cost  Our plan pays up to \$100 every year for contact lenses and eyeglasses (frames and lenses)	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$40 copay  Routine eye exam (for up to 1 every year): \$25 copay  Contact lenses (for up to 1 every year): You pay nothing  Eyeglasses (frames and lenses): You pay nothing  Eyeglasses or contact lenses after cataract surgery: 20% of the cost  Our plan pays up to \$100 every year for contact lenses and eyeglasses (frames and lenses)

# Summary of Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Preventive Care</b>		
<p><b>Preventive Care</b></p>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> <li>▪ Diabetes screenings</li> <li>▪ HIV screening</li> <li>▪ Medical nutrition therapy services</li> <li>▪ Obesity screening and counseling</li> <li>▪ Prostate cancer screenings (PSA)</li> <li>▪ Sexually transmitted infections screening and counseling</li> <li>▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>▪ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>▪ Welcome to Medicare preventive visit (one-time)</li> <li>▪ Yearly wellness visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p>You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> <li>▪ Abdominal aortic aneurysm screening</li> <li>▪ Alcohol misuse counseling</li> <li>▪ Bone mass measurement</li> <li>▪ Breast cancer screening (mammogram)</li> <li>▪ Cardiovascular disease (behavioral therapy)</li> <li>▪ Cardiovascular screenings</li> <li>▪ Cervical and vaginal cancer screening</li> <li>▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>▪ Depression screening</li> <li>▪ Diabetes screenings</li> <li>▪ HIV screening</li> <li>▪ Medical nutrition therapy services</li> <li>▪ Obesity screening and counseling</li> <li>▪ Prostate cancer screenings (PSA)</li> <li>▪ Sexually transmitted infections screening and counseling</li> <li>▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>▪ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>▪ Welcome to Medicare preventive visit (one-time)</li> <li>▪ Yearly wellness visit</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Hospice</b>		
<b>Hospice</b>	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
<b>Inpatient Care</b>		
<b>Inpatient Hospital Care</b> <i>(Services may require prior authorization.)</i>	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> <li>▪ \$350 copay per day for days 1 through 5</li> <li>▪ You pay nothing per day for days 6 through 90</li> <li>▪ You pay nothing per day for days 91 and beyond</li> </ul>	Our plan covers an unlimited number of days for an inpatient hospital stay. <ul style="list-style-type: none"> <li>▪ \$350 copay per day for days 1 through 5</li> <li>▪ You pay nothing per day for days 6 through 90</li> <li>▪ You pay nothing per day for days 91 and beyond</li> </ul>
<b>Inpatient Mental Health Care</b>	For inpatient mental health care, see the Mental Health Care section of this booklet.	For inpatient mental health care, see the Mental Health Care section of this booklet.
<b>Skilled Nursing Facility (SNF)</b> <i>(Services may require prior authorization.)</i>	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> <li>▪ You pay nothing per day for days 1 through 20</li> <li>▪ \$160 copay per day for days 21 through 100</li> </ul>	Our plan covers up to 100 days in a SNF. <ul style="list-style-type: none"> <li>▪ You pay nothing per day for days 1 through 20</li> <li>▪ \$160 copay per day for days 21 through 100</li> </ul>

# Summary of Benefits

## Prescription Drug Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Prescription Drug Benefits</b>		
<b>How much do I pay?</b>	For Part B drugs such as chemotherapy drugs <sup>1</sup> : 20% of the cost  Other Part B drugs <sup>1</sup> : 20% of the cost	For Part B drugs such as chemotherapy drugs <sup>1</sup> : 20% of the cost  Other Part B drugs <sup>1</sup> : 20% of the cost
<b>Initial Coverage</b>	<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> <li>▪ Tier 3 (preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>▪ Tier 4 (non-preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>▪ Tier 5 (specialty tier)               <ul style="list-style-type: none"> <li>– One-month supply: 29% of the cost</li> <li>– Two-month supply: 29% of the cost</li> <li>– Three-month supply: 29% of the cost</li> </ul> </li> </ul>	<p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic)               <ul style="list-style-type: none"> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> <li>▪ Tier 3 (preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>▪ Tier 4 (non-preferred brand)               <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>▪ Tier 5 (specialty tier)               <ul style="list-style-type: none"> <li>– One-month supply: 33% of the cost</li> <li>– Two-month supply: 33% of the cost</li> <li>– Three-month supply: 33% of the cost</li> </ul> </li> </ul> <p>This plan does not have a yearly deductible.</p>

1. Services may require prior authorization.

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Prescription Drug Benefits (cont.)		
<p><b>Initial Coverage (cont.)</b></p>	<p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>■ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>■ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> <li>■ Tier 3 (preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>■ Tier 4 (non-preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>■ Tier 5 (specialty tier) <ul style="list-style-type: none"> <li>– One-month supply: 29% of the cost</li> <li>– Two-month supply: 29% of the cost</li> <li>– Three-month supply: 29% of the cost</li> </ul> </li> </ul> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p>	<p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>■ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>■ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> <li>■ Tier 3 (preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$47 copay</li> <li>– Two-month supply: \$71 copay</li> <li>– Three-month supply: \$94 copay</li> </ul> </li> <li>■ Tier 4 (non-preferred brand) <ul style="list-style-type: none"> <li>– One-month supply: \$100 copay</li> <li>– Two-month supply: \$150 copay</li> <li>– Three-month supply: \$200 copay</li> </ul> </li> <li>■ Tier 5 (specialty tier) <ul style="list-style-type: none"> <li>– One-month supply: 33% of the cost</li> <li>– Two-month supply: 33% of the cost</li> <li>– Three-month supply: 33% of the cost</li> </ul> </li> </ul> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p>
<p><b>Coverage Gap</b></p>	<p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>	<p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,310.</p> <p>After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total \$4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>

# Summary of Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Prescription Drug Benefits (cont.)</b>		
<b>Coverage Gap (cont.)</b>	<p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> </ul> <p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$4 copay</li> <li>– Two-month supply: \$6 copay</li> <li>– Three-month supply: \$8 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$17 copay</li> <li>– Two-month supply: \$26 copay</li> <li>– Three-month supply: \$34 copay</li> </ul> </li> </ul>	<p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.</p> <p>Standard retail cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> </ul> <p>Standard mail order cost-sharing:</p> <ul style="list-style-type: none"> <li>▪ Tier 1 (preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$0 copay</li> <li>– Two-month supply: \$0 copay</li> <li>– Three-month supply: \$0 copay</li> </ul> </li> <li>▪ Tier 2 (non-preferred generic) <ul style="list-style-type: none"> <li>– Drugs covered: All</li> <li>– One-month supply: \$12 copay</li> <li>– Two-month supply: \$18 copay</li> <li>– Three-month supply: \$24 copay</li> </ul> </li> </ul>
<b>Catastrophic Coverage</b>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.</li> </ul>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,850, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ 5% of the cost, or</li> <li>▪ \$2.95 copay for generic (including brand drugs treated as generic) and a \$7.40 copayment for all other drugs.</li> </ul>

# Summary of Benefits

Optional Benefits (You must pay an extra premium each month for these benefits)

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
<b>Optional Benefits</b>		
<b>Package 1: Optional Dental and Vision Rider</b>	Benefits include: <ul style="list-style-type: none"> <li>▪ Comprehensive dental</li> <li>▪ Preventive dental</li> <li>▪ Eye exams</li> <li>▪ Eyewear</li> </ul>	Benefits include: <ul style="list-style-type: none"> <li>▪ Comprehensive dental</li> <li>▪ Preventive dental</li> <li>▪ Eye exams</li> <li>▪ Eyewear</li> </ul>
<b>How much is the monthly premium?</b>	Additional \$25 per month. You must keep paying your Medicare Part B premium and your \$0 monthly plan premium.	Additional \$25 per month. You must keep paying your Medicare Part B premium and your \$29 monthly plan premium.
<b>How much is the deductible?</b>	This package does not have a deductible.	This package does not have a deductible.
<b>Is there a limit on how much the plan will pay?</b>	Our plan pays up to \$1,250 every year. Our plan has additional coverage limits for certain benefits.  The \$1,250 limit has separate limits of \$1,000 for dental benefits and \$250 for vision benefits.	Our plan pays up to \$1,250 every year. Our plan has additional coverage limits for certain benefits.  The \$1,250 limit has separate limits of \$1,000 for dental benefits and \$250 for vision benefits.







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