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.

H6723_SB1H_2016_Sep15 CMS Accepted

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

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).
- You can see our plan's pharmacy directory at our website (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.
- 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)
How much is the monthly premium?	$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.
How much is the deductible?	$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.
Is there a limit on how much I will pay for my covered services?	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. Your yearly limit(s) in this plan: ▪ $3,950 for services you receive from in-network providers. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	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. Your yearly limit(s) in this plan: ▪ $3,500 for services you receive from in-network providers. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	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)
Outpatient Care and Services		
Acupuncture	Not covered	Not covered
Ambulance *(Services may require prior authorization.)*	$295 copay	$295 copay
Chiropractic Care	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
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): 20% of the cost Dental services: $25 copay for a single office visit that includes: ■ Cleaning (for up to 1 every year) ■ Dental X-ray(s) (for up to 1 every year) ■ Oral exam (for up to 1 every year)	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): 20% of the cost Dental services: $25 copay for a single office visit that includes: ■ Cleaning (for up to 1 every year) ■ Dental X-ray(s) (for up to 1 every year) ■ Oral exam (for up to 1 every year)
Diabetes Supplies and Services	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Outpatient Care and Services (cont.)		
Diagnostic Tests, Lab and Radiology Services and X-rays *(Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.*	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
Doctor's Office Visits *(Services may require prior authorization.)*	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.
Durable Medical Equipment (wheelchairs, oxygen, etc.) *(Services may require prior authorization.)*	20% of the cost	20% of the cost
Emergency Care	$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.
Foot Care (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
Hearing Services	Exam to diagnose and treat hearing and balance issues: $50 copay	Exam to diagnose and treat hearing and balance issues: $40 copay
Home Health Care *(Services may require prior authorization.)*	You pay nothing	You pay nothing

Summary of Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Outpatient Care and Services (cont.)		
Mental Health Care *(Services may require prior authorization.)*	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. 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 inpatient hospital coverage will be limited to 90 days. ■ $295 copay per day for days 1 through 5 ■ You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $40 copay Outpatient individual therapy visit: $40 copay	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. 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 inpatient hospital coverage will be limited to 90 days. ■ $295 copay per day for days 1 through 5 ■ You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $40 copay Outpatient individual therapy visit: $40 copay
Outpatient Rehabilitation	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 Occupational therapy visit: $40 copay Physical therapy and speech and language therapy visit: $40 copay	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 Occupational therapy visit: $40 copay Physical therapy and speech and language therapy visit: $40 copay
Outpatient Substance Abuse	Group therapy visit: $40 copay Individual therapy visit: $40 copay	Group therapy visit: $40 copay Individual therapy visit: $40 copay

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Outpatient Care and Services (cont.)		
Outpatient Surgery *(Services may require prior authorization.)*	Ambulatory surgical center: $250 copay Outpatient hospital: $315 copay	Ambulatory surgical center: $250 copay Outpatient hospital: $300 copay
Over-the-Counter Items	Not covered	Please visit our website to see our list of covered over-the-counter supplies.
Prosthetic Devices (braces, artificial limbs, etc.) *(Services may require prior authorization.)*	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
Renal Dialysis	20% of the cost	20% of the cost
Transportation	Not covered	Not covered
Urgently Needed Services	$40 copay	$40 copay
Vision Services	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)
	Preventive Care	
Preventive Care	You pay nothing Our plan covers many preventive services, including: ■ Abdominal aortic aneurysm screening ■ Alcohol misuse counseling ■ Bone mass measurement ■ Breast cancer screening (mammogram) ■ Cardiovascular disease (behavioral therapy) ■ Cardiovascular screenings ■ Cervical and vaginal cancer screening ■ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ■ Depression screening ■ Diabetes screenings ■ HIV screening ■ Medical nutrition therapy services ■ Obesity screening and counseling ■ Prostate cancer screenings (PSA) ■ Sexually transmitted infections screening and counseling ■ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ■ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots ■ Welcome to Medicare preventive visit (one-time) ■ Yearly wellness visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing Our plan covers many preventive services, including: ■ Abdominal aortic aneurysm screening ■ Alcohol misuse counseling ■ Bone mass measurement ■ Breast cancer screening (mammogram) ■ Cardiovascular disease (behavioral therapy) ■ Cardiovascular screenings ■ Cervical and vaginal cancer screening ■ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ■ Depression screening ■ Diabetes screenings ■ HIV screening ■ Medical nutrition therapy services ■ Obesity screening and counseling ■ Prostate cancer screenings (PSA) ■ Sexually transmitted infections screening and counseling ■ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ■ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots ■ Welcome to Medicare preventive visit (one-time) ■ Yearly wellness visit Any additional preventive services approved by Medicare during the contract year will be covered.

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Hospice		
Hospice	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.
Inpatient Care		
Inpatient Hospital Care *(Services may require prior authorization.)*	Our plan covers an unlimited number of days for an inpatient hospital stay. ■ $350 copay per day for days 1 through 5 ■ You pay nothing per day for days 6 through 90 ■ You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. ■ $350 copay per day for days 1 through 5 ■ You pay nothing per day for days 6 through 90 ■ You pay nothing per day for days 91 and beyond
Inpatient Mental Health Care	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.
Skilled Nursing Facility (SNF) *(Services may require prior authorization.)*	Our plan covers up to 100 days in a SNF. ■ You pay nothing per day for days 1 through 20 ■ $160 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. ■ You pay nothing per day for days 1 through 20 ■ $160 copay per day for days 21 through 100

Summary of Benefits

Prescription Drug Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Prescription Drug Benefits		
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost
Initial Coverage	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. You may get your drugs at network retail pharmacies and mail order pharmacies. Standard retail cost-sharing: ■ Tier 1 (preferred generic) – One-month supply: $4 copay – Two-month supply: $6 copay – Three-month supply: $8 copay ■ Tier 2 (non-preferred generic) – One-month supply: $17 copay – Two-month supply: $26 copay – Three-month supply: $34 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: 29% of the cost – Two-month supply: 29% of the cost – Three-month supply: 29% of the cost	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. You may get your drugs at network retail pharmacies and mail order pharmacies. Standard retail 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 This plan does not have a yearly deductible.

1. Services may require prior authorization.

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Prescription Drug Benefits (cont.)		
Initial Coverage (cont.)	Standard mail order cost-sharing: ■ Tier 1 (preferred generic) – One-month supply: $4 copay – Two-month supply: $6 copay – Three-month supply: $8 copay ■ Tier 2 (non-preferred generic) – One-month supply: $17 copay – Two-month supply: $26 copay – Three-month supply: $34 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: 29% of the cost – Two-month supply: 29% of the cost – Three-month supply: 29% 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.	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.
Coverage Gap	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.	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.

Summary of Benefits

Benefit Description	MedMutual Advantage Classic (HMO)	MedMutual Advantage Choice (HMO)
Prescription Drug Benefits (cont.)		
Coverage Gap (cont.)	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 retail cost-sharing: ■ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $4 copay – Two-month supply: $6 copay – Three-month supply: $8 copay ■ Tier 2 (non-preferred generic) – Drugs covered: All – One-month supply: $17 copay – Two-month supply: $26 copay – Three-month supply: $34 copay Standard mail order cost-sharing: ■ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $4 copay – Two-month supply: $6 copay – Three-month supply: $8 copay ■ Tier 2 (non-preferred generic) – Drugs covered: All – One-month supply: $17 copay – Two-month supply: $26 copay – Three-month supply: $34 copay	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 retail cost-sharing: ■ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ■ Tier 2 (non-preferred generic) – Drugs covered: All – One-month supply: $12 copay – Two-month supply: $18 copay – Three-month supply: $24 copay Standard mail order cost-sharing: ■ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ■ Tier 2 (non-preferred generic) – Drugs covered: All – One-month supply: $12 copay – Two-month supply: $18 copay – Three-month supply: $24 copay
Catastrophic Coverage	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: ■ 5% of the cost, or ■ $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.	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: ■ 5% of the cost, or ■ $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

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)
Optional Benefits		
Package 1: Optional Dental and Vision Rider	Benefits include: ■ Comprehensive dental ■ Preventive dental ■ Eye exams ■ Eyewear	Benefits include: ■ Comprehensive dental ■ Preventive dental ■ Eye exams ■ Eyewear
How much is the monthly premium?	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.
How much is the deductible?	This package does not have a deductible.	This package does not have a deductible.
Is there a limit on how much the plan will pay?	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.

Notes

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
我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-982-3117。我们的中文工作人员很乐意帮助您。这是一项免费服务。

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 quí vị cần thông dịch viên xin gọi 1-800-982-3117 sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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
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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
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Hindi
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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
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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
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