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.

H4497_SB2P_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 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 Preferreed (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

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: Adams, Allen, Auglaize, Champaign, Clinton, Coshocton, Crawford, Darke, Defiance, Erie, Fayette, Guernsey, Hardin, Harrison, Henry, Highland, Huron, Jackson, Knox, Lawrence, Logan, Mercer, Monroe, Noble, Ottawa, Paulding, Pike, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Shelby, Van Wert, Vinton, Washington and Williams.

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).
- 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.

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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)
How much is the monthly premium?	$89 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. ▪ $1,500 per year for out-of-network services. ▪ $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.
Is there any 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: ▪ $6,400 for services you receive from in-network providers. ▪ $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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 to how much the plan will pay?	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
$119 per month. In addition, you must keep paying your Medicare Part B premium.	$159 per month. In addition, you must keep paying your Medicare Part B premium.
This plan has deductibles for some hospital and medical services, and Part D prescription drugs. ▪ $1,000 per year for out-of-network services. ▪ This plan does not have a deductible for Part D prescription drugs.	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. ▪ $500 per year for out-of-network services. ▪ This plan does not have a deductible for 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: ▪ $4,800 for services you receive from in-network providers. ▪ $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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. ▪ $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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.
Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

Summary of Benefits

Covered Medical and Hospital Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Outpatient Care and Services	
Acupuncture	Not covered
Ambulance *(Services may require prior authorization)*	▪ In-network: $295 copay ▪ Out-of-network: 30% of the cost
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): ▪ In-network: $20 copay ▪ Out-of-network: 30% of the cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost 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) – In-network: $25 copay – Out-of-network: 50% of the cost

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Outpatient Care and Services	
Not covered	Not covered
▪ In-network: $250 copay ▪ Out-of-network: 30% of the cost	▪ In-network: $195 copay ▪ Out-of-network: 30% of the cost
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): ▪ In-network: $20 copay ▪ Out-of-network: 30% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): ▪ In-network: $20 copay ▪ Out-of-network: 30% of the cost
Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost 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) – In-network: $25 copay – Out-of-network: 50% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Peventive dental services: ▪ Cleaning (for up to 2 every year) – In-network: You pay nothing – Out-of-network: 50% of the cost ▪ Dental X-ray(s) (for up to 1 every year) – In-network: You pay nothing – Out-of-network: 50% of the cost ▪ Oral exam (for up to 2 every year) – In-network: You pay nothing – Out-of-network: 50% of the cost Or plan pays up to $1,000 every year for most dental services from any provider. For each calendar year, the following dental limits apply: ▪ Two diagnostic X-rays ▪ One denture repair, reline or adjustment ▪ One endodontic service ▪ One periodontic service You also have a limit of one crown every five years.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Outpatient Care and Services (cont.)	
Diabetes Supplies and Services	Diabetes monitoring supplies: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing Diabetes self-management training: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Therapeutic shoes or inserts: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing
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): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Diagnostic tests and procedures: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Lab services: ▪ In-network: $0 – 10 copay, depending on the service ▪ Out-of-network: 30% of the cost Outpatient X-rays: ▪ In-network: $50 copay ▪ Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Outpatient Care and Services (cont.)	
Diabetes monitoring supplies: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing Diabetes self-management training: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Therapeutic shoes or inserts: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing	Diabetes monitoring supplies: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing Diabetes self-management training: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Therapeutic shoes or inserts: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing
Diagnostic radiology services (such as MRIs, CT scans): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Diagnostic tests and procedures: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Lab services: ▪ In-network: $0–5 copay, depending on the service ▪ Out-of-network: 30% of the cost Outpatient X-rays: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Diagnostic tests and procedures: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Lab services: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Outpatient X-rays: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost

Summary of Benefits

<table>
<tr><th>Benefit Description</th><th>MedMutual Advantage Select (PPO)</th></tr>
<tr><td colspan="2">Outpatient Care and Services (cont.)</td></tr>
<tr><td>Doctor’s Office Visits
(Services may require prior authorization.)</td><td>Primary care physician visit:
▪ In-network: $10 copay
▪ Out-of-network: 30% of the cost

Specialist visit:
▪ In-network: $45 copay
▪ Out-of-network: 30% of the cost

If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.</td></tr>
<tr><td>Durable Medical Equipment (wheelchairs, oxygen, etc.)
(Services may require prior authorization.)</td><td>▪ In-network: 20% of the cost
▪ Out-of-network: 30% of the cost</td></tr>
<tr><td>Emergency Care</td><td>$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.</td></tr>
<tr><td>Foot Care (Podiatry Services)</td><td>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:
▪ In-network: $45 copay
▪ Out-of-network: 30% of the cost</td></tr>
<tr><td>Hearing Services</td><td>Exam to diagnose and treat hearing and balance issues:
▪ In-network: $45 copay
▪ Out-of-network: 30% of the cost</td></tr>
<tr><td>Home Health Care
(Services may require prior authorization.)</td><td>▪ In-network: You pay nothing
▪ Out-of-network: 30% of the cost</td></tr>
<tr><td>Mental Health Care
(Services may require prior authorization.)</td><td>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.</td></tr>
</table>

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Outpatient Care and Services (cont.)	
Primary care physician visit: ▪ In-network: $5 copay ▪ Out-of-network: 30% of the cost Specialist visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.	Primary care physician visit: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Specialist visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.
▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
$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 exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
Exam to diagnose and treat hearing and balance issues: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Exam to diagnose and treat hearing and balance issues: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost	▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost
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.	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.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Outpatient Care and Services (cont.)	
Mental Health Care (cont.) *(Services may require prior authorization.)*	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: – $295 copay per day for days 1 through 5 – You pay nothing per day for days 6 through 90 ▪ Out-of-network: – 30% of the cost per stay Outpatient group therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Outpatient individual therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost
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): ▪ 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

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	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	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)
Outpatient Care and Services (cont.)	
Outpatient Substance Abuse	Group therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Individual therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost
Outpatient Surgery *(Services may require prior authorization.)*	Ambulatory surgical center: ▪ In-network: $250 copay ▪ Out-of-network: 30% of the cost Outpatient hospital: ▪ In-network: $295 copay ▪ Out-of-network: 30% of the cost
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items.
Prosthetic Devices (braces, artificial limbs, etc.) *(Services may require prior authorization.)*	Prosthetic devices: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Related medical supplies: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Renal Dialysis	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Transportation	Not covered
Urgently Needed Services	$40 copay

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Outpatient Care and Services (cont.)	
Group therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost Individual therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Group therapy visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost Individual therapy visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
Ambulatory surgical center: ▪ In-network: $200 copay ▪ Out-of-network: 30% of the cost Outpatient hospital: ▪ In-network: $255 copay ▪ Out-of-network: 30% of the cost	Ambulatory surgical center: ▪ In-network: $150 copay ▪ Out-of-network: 30% of the cost Outpatient hospital: ▪ In-network: $195 copay ▪ Out-of-network: 30% of the cost
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.
Prosthetic devices: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Related medical supplies: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	Prosthetic devices: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Related medical supplies: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Not covered	Not covered
$40 copay	$40 copay

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Outpatient Care and Services (cont.)	
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): ■ In-network: $45 copay ■ Out-of-network: 30% of the cost Routine eye exam (for up to 1 every year): ■ In-network: $25 copay ■ Out-of-network: $50 copay Contact lenses (for up to 1 every year): ■ In-network: You pay nothing ■ Out-of-network: You pay nothing Eyeglasses (frames and lenses) (for up to 1 every year): ■ In-network: You pay nothing ■ Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: ■ In-network: 20% of the cost ■ Out-of-network: 30% of the cost Our plan pays up to $100 every year for contact lenses and eyeglasses (frames and lenses) from any provider.
Preventive Care	
Preventive Care	■ In-network: You pay nothing ■ Out-of-network: 30% of the cost 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

<table>
<tr><th>MedMutual Advantage Preferred (PPO)</th><th>MedMutual Advantage Premium (PPO)</th></tr>
<tr><th colspan="2">Outpatient Care and Services (cont.)</th></tr>
<tr><td>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):
▪ In-network: $35 copay
▪ Out-of-network: 30% of the cost

Routine eye exam (for up to 1 every year):
▪ In-network: $25 copay
▪ Out-of-network: $50 copay

Contact lenses (for up to 1 every year):
▪ In-network: You pay nothing
▪ Out-of-network: You pay nothing

Eyeglasses (frames and lenses) (for up to 1 every year):
▪ In-network: You pay nothing
▪ Out-of-network: You pay nothing

Eyeglasses or contact lenses after cataract surgery:
▪ In-network: 20% of the cost
▪ Out-of-network: 30% of the cost

Our plan pays up to $100 every year for contact lenses and eyeglasses (frames and lenses) from any provider.</td><td>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):
▪ In-network: $25 copay
▪ Out-of-network: 30% of the cost

Routine eye exam (for up to 1 every year):
▪ In-network: You pay nothing
▪ Out-of-network: $50 copay

Contact lenses (for up to 1 every year):
▪ In-network: You pay nothing
▪ Out-of-network: You pay nothing

Eyeglasses (frames and lenses) (for up to 1 every year):
▪ In-network: You pay nothing
▪ Out-of-network: You pay nothing

Eyeglasses or contact lenses after cataract surgery:
▪ In-network: 20% of the cost
▪ Out-of-network: 30% of the cost

Our plan pays up to $250 every year for contact lenses and eyeglasses (frames and lenses) from any provider.</td></tr>
<tr><th colspan="2">Preventive Care</th></tr>
<tr><td>▪ In-network: You pay nothing
▪ Out-of-network: 30% of the cost

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</td><td>▪ In-network: You pay nothing
▪ Out-of-network: 30% of the cost

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</td></tr>
</table>

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Preventive Care (cont.)	
Preventive Care (cont.)	■ 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.
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.
Inpatient Care	
Inpatient Hospital Care *(Services may require prior authorization.)*	Our plan covers an unlimited number of days for an inpatient hospital stay. ■ In-network: – $325 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 ■ Out-of-network: 30% of the cost per stay
Inpatient Mental Health Care	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. ■ In-network: – You pay nothing per day for days 1 through 20 – $160 copay per day for days 21 through 100 ■ Out-of-network: 30% of the cost per stay

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Preventive Care (cont.)	
▪ 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.	▪ 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.
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	
Our plan covers an unlimited number of days for an inpatient hospital stay. ▪ In-network: – $295 copay per day for days 1 through 6 – You pay nothing per day for days 7 through 90 – You pay nothing per day for days 91 and beyond ▪ Out-of-network: 30% of the cost per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. ▪ In-network: – $195 copay per day for days 1 through 6 – You pay nothing per day for days 7 through 90 – You pay nothing per day for days 91 and beyond ▪ Out-of-network: 30% of the cost per stay
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.
Our plan covers up to 100 days in a SNF. ▪ In-network: – You pay nothing per day for days 1 through 20 – $160 copay per day for days 21 through 100 ▪ Out-of-network: 30% of the cost per stay	Our plan covers up to 100 days in a SNF. ▪ In-network: – You pay nothing per day for days 1 through 20 – $160 copay per day for days 21 through 100 ▪ Out-of-network: 30% of the cost per stay

Summary of Benefits

Prescription Drug Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Prescription Drug Benefits	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost Other Part B drugs[1]: ▪ In-network: 20% of the cost ▪ Out-of-network: 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

1. Services may require prior authorization.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Prescription Drug Benefits	
For Part B drugs such as chemotherapy drugs[1]: ■ In-network: 20% of the cost ■ Out-of-network: 20% of the cost Other Part B drugs[1]: ■ In-network: 20% of the cost ■ Out-of-network: 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: ■ In-network: 20% of the cost ■ Out-of-network: 20% of the cost Other Part B drugs[1]: ■ In-network: 20% of the cost ■ Out-of-network: 20% 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.	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.

Summary of Benefits

<table>
<tr><th>Benefit Description</th><th>MedMutual Advantage Select (PPO)</th></tr>
<tr><td colspan="2">Prescription Drug Benefits (cont.)</td></tr>
<tr><td>Initial Coverage (cont.)</td><td>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.</td></tr>
<tr><td>Coverage Gap</td><td>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.</td></tr>
</table>

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.	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.
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Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Prescription Drug Benefits (cont.)	
Coverage Gap (cont.)	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
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.

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

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

Benefit Description	MedMutual Advantage Select (PPO)
Optional Benefits	
Package 1: Optional Dental and Vision Rider	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 $89 monthly plan premium.
How much is the 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 and $250 for vision benefits.

<table>
<tr><th>MedMutual Advantage Preferred (PPO)</th><th>MedMutual Advantage Premium (PPO)</th></tr>
<tr><th colspan="2">Optional Benefits</th></tr>
<tr><td>Benefits include:
■ Comprehensive dental
■ Preventive dental
■ Eye exams
■ Eyewear</td><td rowspan="4">Please note: The Optional Benefits are already included in the benefits at no additional cost.</td></tr>
<tr><td>Additional $25 per month. You must keep paying your Medicare Part B premium and your $119 monthly plan premium.</td></tr>
<tr><td>This package does not have a deductible.</td></tr>
<tr><td>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.</td></tr>
</table>

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.

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Z7955-MCA 4/15

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 ما يتحدث بمساعدتك. هذه خدمة مجانية.

Hindi
हमारे स्वास्य या दवा की योजना के बारे में आपके ककसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपबि्ध है. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-982-3117 *पर फोन करें. कोई व्यक्तत जो हहन्दी बोिता 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ございます。通訳をご用命になるには、1-800-982-3117。にお電話くださ 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®
2060 East Ninth Street
Cleveland, OH 44115-1355

MedMutual.com

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