2023 Summary of Benefits

January 1, 2023 – December 31, 2023

MedMutual Advantage Preferred PPO (H4497-002-001)

Northeast Ohio

Ashland, Carroll, Columbiana, Cuyahoga, Geauga, Holmes, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Tuscarawas and Wayne counties

Y0121_P_S0197_2023_M
Z8973-MCA R2.23

MEDICAL MUTUAL®

Summary of Benefits

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, see our Evidence of Coverage at our website, MedMutual.com/MAplaninfo.

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 Preferred (PPO).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what MedMutual Advantage Preferred (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 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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 1-800-982-3117 (TTY 711).

Things to know about MedMutual Advantage Preferred (PPO)

Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-800-982-3117 (TTY 711).
- Our website: MedMutual.com/Medicare

Hours of Operation

- From October 1 to March 31 (except Thanksgiving and Christmas), you can call us seven days a week from 8 a.m. to 8 p.m.
- From April 1 to September 30 (except holidays), you can call us Monday through Friday from 8 a.m. to 8 p.m.

Who can join?

To join, 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, Carroll, Columbiana, Cuyahoga, Geauga, Holmes, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Tuscarawas and Wayne.

Which doctors, hospitals and pharmacies can I use?

Our plans have a network of doctors, hospitals, pharmacies and other providers. With a PPO plan, 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. Out-of-network/non-contracted providers are under no obligation to treat Medical Mutual members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network 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/MAplaninfo.
- You can see our plan's pharmacy directory at our website, MedMutual.com/MAplaninfo.
- Or call us and we will send you a copy of the provider and pharmacy directories.

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.
- Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Information on our Optional Supplemental Benefits is included 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/MAplaninfo.
- 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

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Monthly Plan Premium	$80 per month You must continue to pay your Medicare Part B premium.
Deductible	This plan has a deductible for some hospital and medical services. ▪ $1,750 per year for out-of-network services
Maximum Out-of-Pocket Responsibility (does not include Part D prescription drugs)	You pay no more than: ▪ $6,050 annually for services you receive from in-network providers ▪ $11,300 annually for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. Includes copayments and other costs for medical services for the year. 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.
Inpatient Hospital Coverage (services may require prior authorization)	There is no limit to the number of days covered by the plan. ▪ In-network: – $335 copay per day for days 1 through 5 – $0 copay per day for days 6 through 90 ▪ Out-of-network: 30% coinsurance per stay
Outpatient Hospital Coverage (services may require prior authorization)	Outpatient hospital: ▪ In-network: $380 copay ▪ Out-of-network: 30% coinsurance
Ambulatory Surgical Center (ASC) Services (services may require prior authorization)	Ambulatory surgery center: ▪ In-network: $350 copay ▪ Out-of-network: 30% coinsurance
Doctor's Office Visits (services may require prior authorization)	Option to get these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth.

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Doctor's Office Visits (continued) (services may require prior authorization)	Primary care physician visit: ▪ In-network: $5 copay ▪ Out-of-network: 30% coinsurance Specialist visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% coinsurance There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit when performed at an in-network provider.
Preventive Care	▪ In-network: $0 copay ▪ Out-of-network: 30% coinsurance Our plan covers many preventive services, including: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Annual wellness visit ▪ Bone mass measurement ▪ Breast cancer screening (mammogram) ▪ Cardiovascular disease testing ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▪ Depression screening ▪ Diabetes screening ▪ HIV screening ▪ Immunizations, including flu shots, hepatitis B shots, pneumonia shots ▪ Medical nutrition therapy services ▪ Medicare Diabetes Prevention Program (MDPP) ▪ Obesity screening and therapy ▪ Prostate cancer screenings (PSA) ▪ Sexually transmitted infections screening and counseling ▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▪ Welcome to Medicare preventive visit (one-time) Other preventive services are available. There are some covered services that have a cost.

Summary of Benefits

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Emergency Care	$90 copay for each covered emergency room visit If you are admitted to the hospital within 24 hours, you do not have to pay the $90 copay. You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to $50,000 per calendar year.
Urgently Needed Services	$40 copay for each covered urgent care center visit An urgently needed service is a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to $50,000 per calendar year.
Diagnostic Services, Labs and Imaging (Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.)	Diagnostic tests and services: ▪ In-network: $0-10 copay ▪ Out-of-network: 30% coinsurance Diagnostic radiological services (CT/MRI/PET scans): ▪ In-network: $100/$175/$175 copay for each covered service ▪ Out-of-network: 30% coinsurance Lab services: ▪ In-network: $0-10 copay ▪ Out-of-network: 30% coinsurance Outpatient X-rays: ▪ In-network: $50 copay ▪ Out-of-network: 30% coinsurance Therapeutic radiology services (such as radiation therapy for cancer): ▪ In-network: 20% coinsurance ▪ Out-of-network: 30% coinsurance

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Hearing Services (additional in-network services provided by TruHearing providers)	Original Medicare covered hearing services: ▪ In-network: $0 copay ▪ Out-of-network: 30% coinsurance Additional hearing services: ▪ Routine hearing exam (1 every year): $0 copay ▪ Hearing aid fitting-evaluation visits: $0 copay TruHearing-branded hearing aids (1 per ear per year): ▪ $699 copay for each covered hearing aid for Advanced aids ▪ $999 copay for each covered hearing aid for Premium aids Any cost you pay for hearing aids will not count toward your maximum out-of-pocket.
Dental Services (preventive services covered in-network)	Preventive Dental ▪ Cleanings (2 every year) ▪ Dental X-ray (1 every year) ▪ Oral exams (2 every year) – In-network: $0 copay – Out-of-network: 50% coinsurance If you want to purchase additional dental coverage, see Optional Supplemental Benefits on page 13.
Vision Services (routine eye exam and contacts/glasses provided by EyeMed Insight providers)	Original Medicare covered vision services, including yearly glaucoma screening and diabetic eye exam: ▪ In-network: $0 copay ▪ Out-of-network: 30% coinsurance Eyeglasses or contact lenses after cataract surgery: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% coinsurance Routine eye exam (1 every year): ▪ In-network: $0 copay ▪ Out-of-network: $50 copay Contact lenses or eyeglasses (frames and lenses) (1 every year): ▪ In-network/out-of-network: $100 allowance and you are responsible for any amount more than $100 If you want to purchase additional vision coverage, see Optional Supplemental Benefits on page 13.

Summary of Benefits

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Mental Health Care (services may require prior authorization)	Inpatient visit: there is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period starts on the first day you go into the hospital. The benefit period ends when you haven't had any inpatient hospital care for 60 days in a row. The plan covers 90 days each benefit period. You have 60 lifetime reserve days that can be used for an inpatient psychiatric admission. You have no copayment for these extra days. ▪ In-network: – $350 copay per day for days 1 through 5 – $0 copay per day for days 6 through 90 ▪ Out-of-network: 30% coinsurance per stay Outpatient group therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% coinsurance Outpatient individual therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% coinsurance
Skilled Nursing Facility (SNF) Care (services may require prior authorization)	We will pay for skilled nursing facility care for up to 100 days per benefit period. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit on how many benefit periods you can have. ▪ In-network: – $0 copay per day for days 1 through 20 – $188 copay per day for days 21 through 100 ▪ Out-of-network: 30% coinsurance per stay
Outpatient Rehabilitation Services (services may require prior authorization)	Physical therapy, occupational therapy or speech/language therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% coinsurance

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Ambulance (services may require prior authorization)	▪ In-network: $200 copay for each covered ground ambulance trip and 50% coinsurance for air ambulance services ▪ Out-of-network: $200 copay for each covered ground ambulance trip and 50% coinsurance for air ambulance services
Transportation Services (services may require prior authorization)	$0 copay After your inpatient stay in a hospital, you are eligible to receive health-related transportation services. You may receive up to 24 one-way limited trips within 90 days of each discharge from an acute inpatient hospital stay.
Prescription Drug Benefits	
Medicare Part B Drugs (Part B drugs may require prior authorization and may be subject to step therapy requirements)	Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your Part D initial coverage limit or out-of-pocket costs. For chemotherapy and other drugs covered by Medicare Part B: ▪ In-network: 20% coinsurance or less ▪ Out-of-network: 20% coinsurance or less To view a list of Part B drugs that may be subject to Step Therapy, visit MedMutual.com/MAplaninfo.

Summary of Benefits

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Outpatient Prescription Drugs	
Deductible	$55 for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at any preferred or standard network retail or mail order pharmacy. **Retail cost sharing:** (preferred/standard) ▪ Tier 1 (preferred generic drugs): – One-month supply: $0/$6 copay – Three-month supply: $0/$12 copay ▪ Tier 2 (generic drugs): – One-month supply: $5/$12 copay – Three-month supply: $13/$30 copay ▪ Tier 3 (preferred brand and generic drugs): – One-month supply: $42/$47 copay – Three-month supply: $118/$132 copay ▪ Tier 4 (non-preferred drugs): – One-month supply: 50%/50% coinsurance – Three-month supply: 50%/50% coinsurance ▪ Tier 5 (specialty tier drugs): – One-month supply: 32%/32% coinsurance – Three-month supply: not covered/not covered

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Outpatient Prescription Drugs	
Initial Coverage (continued)	**Mail-order cost sharing:** (preferred/standard) ▪ Tier 1 (preferred generic drugs): – One-month supply: $0/$5 copay – Three-month supply: $0/$10 copay ▪ Tier 2 (generic drugs): – One-month supply: $4/$11 copay – Three-month supply: $10/$28 copay ▪ Tier 3 (preferred brand and generic drugs): – One-month supply: $40/$45 copay – Three-month supply: $110/$130 copay ▪ Tier 4 (non-preferred drugs): – One-month supply: 50%/50% coinsurance – Three-month supply: 50%/50% coinsurance ▪ Tier 5 (specialty tier drugs): – One-month supply: 32%/32% coinsurance – Three-month supply: not covered/not covered If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means 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 $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, 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

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Outpatient Prescription Drugs	
Coverage Gap (continued)	**Retail cost sharing:** (preferred/standard) ▪ Tier 1 (preferred generic drugs): – Drugs covered: all – One-month supply: $0/$6 copay – Three-month supply: $0/$12 copay ▪ Tier 2 (generic drugs): – Drugs covered: all – One-month supply: $5/$12 copay – Three-month supply: $13/$30 copay **Mail-order cost sharing:** (preferred/standard) ▪ Tier 1 (preferred generic drugs): – Drugs covered: all – One-month supply: $0/$5 copay – Three-month supply: $0/$10 copay ▪ Tier 2 (generic drugs): – Drugs covered: all – One-month supply: $4/$11 copay – Three-month supply: $10/$28 copay
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $7,400, you pay: ▪ $0 copay for Tier 1 drugs filled at a preferred retail or preferred mail order pharmacy. For all other drugs, you will pay the larger amount of: – 5% coinsurance of the cost of the drug, or a – $4.15 copay for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs
MedMutual Advantage Travel Plus™	Up to a $2,500 maximum per calendar year. Through this benefit, you have coverage under this plan for medically necessary services you receive while you are temporarily outside of Ohio, but still within the United States. The actual benefits payable are based upon the services you receive. Although services received outside Ohio would normally be considered outside of our network, your coverage under this benefit is paid at the in-network level.

Premium and Benefits	MedMutual Advantage Preferred (PPO)
MedMutual Advantage Travel Plus™ (continued)	You must use a provider who accepts Medicare and contact Customer Care at 1-800-982-3117 (TTY 711) prior to your departure to activate this benefit. See your Evidence of Coverage for full benefit details and requirements.
Outpatient Substance Abuse Services	▪ In-network: $40 copay ▪ Out-of-network: 30% coinsurance This applies to an individual therapy visit or if the visit is part of group therapy.
Foot Care (podiatry services) (services may require prior authorization)	▪ In-network: $40 copay ▪ Out-of-network: 30% coinsurance
Durable Medical Equipment (wheelchairs, oxygen, etc.) (services may require prior authorization)	▪ In-network: 20% coinsurance ▪ Out-of-network: 30% coinsurance
Prosthetic Devices (braces, artificial limbs, etc.) (services may require prior authorization)	▪ In-network: 20% coinsurance ▪ Out-of-network: 30% coinsurance
Diabetes Supplies and Services (services may require prior authorization)	▪ In-network: 0% coinsurance ▪ Out-of-network: 20% coinsurance 0% coinsurance for the following diabetic supplies: ▪ A blood glucose meter (excluding continuous glucose monitors) ▪ Blood glucose test strips ▪ Lancing devices and glucose lancets ▪ Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors In order to qualify for 0% coinsurance, diabetic test strips and meters must be produced by a preferred manufacturer and purchased at an in-network retail or mail order pharmacy. Non-preferred diabetic test strips and meters are covered (with 0% coinsurance) when filled by an in-network durable medical equipment supplier. See the Evidence of Coverage for more details. 20% coinsurance for all other diabetic supplies

Summary of Benefits

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Health and Wellness Education Programs	Wellness programs included at no additional cost, except WW® (Weight Watchers Reimagined). **Chronic Condition Management Program** This 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. For more information call Customer Care at 1-800-982-3117 (TTY 711). **Nurse Line** If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, we can help. Call our Nurse Line at 1-888-912-0636 (TTY 711), 24 hours a day, seven days per week for advice. Your call is kept confidential. **SilverSneakers® Fitness Program** SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members will have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note: nonstandard fitness center services that usually have an extra fee are not included in your membership. **WW Program** (Note: you pay your reduced WW fees.) To help you meet your health goals, we partner with WW, the world's leading provider of weight management services. Monthly WW fees for specified programs are reduced for MedMutual Advantage PPO members. The benefit does not include food or meals.

Premium and Benefits	MedMutual Advantage Preferred (PPO)
Chiropractic Care	We only cover manual manipulation of the spine to correct subluxation: ▪ In-network: $20 copay ▪ Out-of-network: 30% coinsurance
Home Health Care (services may require prior authorization)	▪ In-network: $0 copay ▪ Out-of-network: 30% coinsurance
Renal Dialysis	Covered dialysis equipment and supplies: ▪ In-network: 20% coinsurance ▪ Out-of-network: 30% coinsurance
Hospice	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare.
Optional Benefits	
Optional Supplemental Benefits Package	**Dental** In addition to the preventive dental services included in your plan, comprehensive dental benefits such as diagnostic X-rays, denture repair, reline or adjustment, endodontic services and periodontic services are covered up to the plan's benefit amount (combined for both in network and out of network). **Vision** In addition to the routine eye exam included in your plan, the Optional Supplemental Benefits Package includes an increased eyewear allowance. For coverage and cost information for all dental and vision services see this plan's Evidence of Coverage.
Monthly Premium	Additional $26 per month. You must keep paying your Medicare Part B premium and your $80 monthly plan premium.
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 (the $250 includes the $100 referenced on page 5).

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

Please note: our Nurse Line and Chronic Condition Management Program are not intended to replace the medical care or advice you receive from your doctor. If you have a medical emergency, you should always seek treatment at the nearest medical facility or call 911.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-406-8777 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit MedMutual.com/MAPlanInfo or call 1-800-982-3117 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

[This page intentionally left blank]

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

2023 Medicare Star Ratings

Medical Mutual of Ohio - H6723

For 2023, Medical Mutual of Ohio - H6723 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★★
Health Services Rating:	★★★★★
Drug Services Rating:	★★★★☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

5 This plan got **MEDICARE'S HIGHEST RATING** (5 stars)

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact Medical Mutual of Ohio 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 877-368-0081 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 800-982-3117 (toll-free) or 711 (TTY).