

MEDICAL MUTUAL OF OHIO®

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE (COVER PAGE 1 OF 2)

Benefit chart of Medicare Supplement plans sold with effective dates for coverage on or After June 1, 2010.

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- Hospitalization –Part A Coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses –Part B Coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B Coinsurance or co-payments.
- Blood –First three pints of blood each year.
- Hospice –Part A Coinsurance

A	B	C	D	F/F*	G
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*	Basic, including 100% Part B Coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE (COVER PAGE 2 OF 2)

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- Medical Expenses –Part B Coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B Coinsurance or co-payments.
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- Hospice –Part A Coinsurance

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Coinsurance	Basic , including 100% Part B Coinsurance, except up to \$20 copayment for office visit and up to \$50 copayment for ER.
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit \$4,620; paid at 100% after limit reached	Out-of-Pocket limit \$2,310; paid at 100% after limit reached		

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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

PREMIUM INFORMATION

We, Medical Mutual of Ohio[®], can only raise your premium if we raise the premium for all policies like yours in Ohio. We determine your premium based upon attained age. This means your premium will increase each year on the anniversary date of your policy based upon your age on that date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies. **This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.**

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return the policy to Medical Mutual, 3737 Sylvania Avenue, Toledo, Ohio 43623. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **not** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Medical Mutual nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "*Medicare and You*" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Medical Mutual may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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MEDICARE SUPPLEMENT MONTHLY PREMIUM RATES

Age	Plan A Rates	Plan C Rates	Plan F Rates
65	\$88.00	\$125.00	\$126.00
66	\$97.00	\$137.00	\$138.00
67	\$103.00	\$146.00	\$147.00
68	\$110.00	\$155.00	\$157.00
69	\$116.00	\$165.00	\$166.00
70	\$123.00	\$174.00	\$176.00
71	\$130.00	\$184.00	\$186.00
72	\$137.00	\$194.00	\$196.00
73	\$145.00	\$205.00	\$207.00
74	\$152.00	\$215.00	\$217.00
75	\$159.00	\$225.00	\$228.00
76	\$165.00	\$233.00	\$236.00
77	\$170.00	\$240.00	\$243.00
78	\$175.00	\$247.00	\$250.00
79	\$180.00	\$254.00	\$256.00
80	\$184.00	\$260.00	\$263.00
81	\$187.00	\$265.00	\$268.00
82	\$190.00	\$268.00	\$271.00
83	\$192.00	\$271.00	\$274.00
84	\$194.00	\$274.00	\$277.00
85	\$196.00	\$277.00	\$280.00
86	\$198.00	\$280.00	\$283.00
87	\$200.00	\$283.00	\$286.00
88	\$202.00	\$286.00	\$289.00
89	\$205.00	\$290.00	\$292.00
90+	\$207.00	\$293.00	\$296.00

MEDICAL MUTUAL OF OHIO®

PLAN A

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$0 \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$1100 (Part A Deductible) \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to 137.50 a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and/or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and/or coinsurance	\$0

** **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

MEDICAL MUTUAL OF OHIO®

PLAN A

MEDICARE (PART B) MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment. First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 Pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN A PARTS A AND B

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTHCARE (MEDICARE-APPROVED SERVICES)			
Medically necessary skilled-care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment (First \$155 of Medicare approved amounts*)	\$0	\$0	\$155 (Part B Deductible)
Durable Medical Equipment (Remainder of Medicare-approved amounts)	80%	20%	\$0

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PLAN C

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment and/or coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment and/or coinsurance	\$0

** **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

MEDICAL MUTUAL OF OHIO®

PLAN C

MEDICARE (PART B) MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment. First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$155 (Part B Deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 Pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICAL MUTUAL OF OHIO®

PLAN C PARTS A AND B

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTHCARE (MEDICARE-APPROVED SERVICES)			
Medically necessary skilled-care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment (First \$155 of Medicare approved amounts*)	\$0	\$155 (Part B Deductible)	\$0
Durable Medical Equipment (Remainder of Medicare-approved amounts)	80%	20%	\$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st through 90th day 91st day and after: • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment and/or coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment and/or coinsurance	\$0

** **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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PLAN F

MEDICARE (PART B) MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment. First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$155 (Part B Deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 Pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PLAN F PARTS A AND B

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTHCARE (MEDICARE-APPROVED SERVICES)			
Medically necessary skilled-care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment (First \$155 of Medicare approved amounts*)	\$0	\$155 (Part B Deductible)	\$0
Durable Medical Equipment (Remainder of Medicare-approved amounts)	80%	20%	\$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum