2020 Summary of Benefits

January 1, 2020 – December 31, 2020

MedMutual Advantage HMO Plans

MedMutual Advantage Classic (HMO)
MedMutual Advantage Secure (HMO)
MedMutual Advantage Choice (HMO)
MedMutual Advantage Plus (HMO)

Region 1 Counties with MedMutual Advantage Secure HMO Plan

Cuyahoga, Medina, Summit

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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, call us and ask for the Evidence of Coverage. You can also 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 Classic (HMO), MedMutual Advantage Secure (HMO), MedMutual Advantage Choice (HMO) or MedMutual Advantage Plus (HMO).

Tips for comparing your Medicare choices

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

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at Medicare.gov or get a copy by calling 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 Classic (HMO), MedMutual Advantage Secure (HMO), MedMutual Advantage Choice (HMO) and MedMutual Advantage Plus (HMO).

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.
- If you are a member of this plan, you can also call us Saturday from 9 a.m. to 1 p.m.

Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-800-982-3117. TTY users should call 711.
- If you are not a member of one of these plans, call toll-free 1-866-406-8777. TTY users should call 711.
- Our website: MedMutual.com/Medicare

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: Cuyahoga, Medina and Summit.

Which doctors, hospitals and pharmacies can I use?

Our plans have a network of doctors, hospitals, pharmacies and other providers. With an HMO plan, you must see an in-network provider for the plan to pay any amount on claims submitted on your behalf. If you go out of network, you will have to pay all charges due to the provider up to the full amount.

- 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.

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

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Monthly Plan Premium	$0 per month You must continue to pay your Medicare Part B premium.	$15 per month You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	You pay no more than: ▪ $4,300 annually for services you receive from in-network providers 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.	You pay no more than: ▪ $3,700 annually for services you receive from in-network providers 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 Care (Services may require prior authorization)	There is no limit to the number of days covered by the plan. ▪ $375 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 and thereafter	There is no limit to the number of days covered by the plan. ▪ $375 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 and thereafter
Outpatient Hospital Services (Services may require prior authorization)	Ambulatory surgery center: ▪ $325 copay for each covered surgery Outpatient hospital: ▪ $385 copay for each covered surgery	Ambulatory surgery center: ▪ $250 copay for each covered surgery Outpatient hospital: ▪ $355 copay for each covered surgery
Doctor's Office Visits (Services may require prior authorization)	Primary care physician (PCP) visit: ▪ $5 copay for each covered PCP visit Specialist visit: ▪ $35 copay for each covered specialist visit There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.	Primary care physician (PCP) visit: ▪ $0 copay for each covered PCP visit Specialist visit: ▪ $30 copay for each covered specialist visit There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Monthly Plan Premium	$38 per month You must continue to pay your Medicare Part B premium.	$99 per month You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility (Does not include prescription drugs)	You pay no more than: ▪ $3,950 annually for services you receive from in-network providers 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.	You pay no more than: ▪ $3,400 annually for services you receive from in-network providers 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 Care (Services may require prior authorization)	There is no limit to the number of days covered by the plan. ▪ $375 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 and thereafter	There is no limit to the number of days covered by the plan. ▪ $375 copay per day for days 1 through 6 ▪ $0 copay per day for days 7 and thereafter
Outpatient Hospital Services (Services may require prior authorization)	Ambulatory surgery center: ▪ $300 copay for each covered surgery Outpatient hospital: ▪ $400 copay for each covered surgery	Ambulatory surgery center: ▪ $150 copay for each covered surgery Outpatient hospital: ▪ $200 copay for each covered surgery
Doctor's Office Visits (Services may require prior authorization)	Primary care physician (PCP) visit: ▪ $0 copay for each covered PCP visit Specialist visit: ▪ $40 copay for each covered specialist visit There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.	Primary care physician (PCP) visit: ▪ $0 copay for each covered PCP visit Specialist visit: ▪ $25 copay for each covered specialist visit There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Preventive Care	$0 copay 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.	$0 copay 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.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Preventive Care	$0 copay 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.	$0 copay 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

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
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.	$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.
Urgently Needed Services	$35 copay for each covered urgent care center visit	$30 copay for each covered urgent care center visit
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: ▪ $0-10 copay for each covered diagnostic test and service Diagnostic radiological services (CT/MRI/PET scans): ▪ $100/$175/$400 copay for each covered service Lab services: ▪ $0–10 copay for each covered lab service Outpatient X-rays: ▪ $50 copay for each covered X-ray service Therapeutic radiology services (such as radiation therapy for cancer): ▪ 20% coinsurance for each covered therapeutic radiology service	Diagnostic tests and services: ▪ $0-10 copay for each covered diagnostic test and service Diagnostic radiological services (CT/MRI/PET scans): ▪ $100/$175/$400 copay for each covered service Lab services: ▪ $0–10 copay for each covered lab service Outpatient X-rays: ▪ $50 copay for each covered X-ray service Therapeutic radiology services (such as radiation therapy for cancer): ▪ 20% coinsurance for each covered therapeutic radiology service

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
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.	$120 copay for each covered emergency room visit If you are admitted to the hospital within 24 hours, you do not have to pay the $120 copay.
Urgently Needed Services	$40 copay for each covered urgent care center visit	$25 copay for each covered urgent care center visit
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: ▪ $0-10 copay for each covered diagnostic test and service Diagnostic radiological services (CT/MRI/PET scans): ▪ $100/$175/$400 copay for each covered service Lab services: ▪ $0–10 copay for each covered lab service Outpatient X-rays: ▪ $50 copay for each covered X-ray service Therapeutic radiology services (such as radiation therapy for cancer): ▪ 20% coinsurance for each covered therapeutic radiology service	Diagnostic tests and services: ▪ $0-10 copay for each covered diagnostic test and service Diagnostic radiological services (CT/MRI/PET scans): ▪ $100/$175/$400 copay for each covered service Lab services: ▪ $0–10 copay for each covered lab service Outpatient X-rays: ▪ $50 copay for each covered X-ray service Therapeutic radiology services (such as radiation therapy for cancer): ▪ 20% coinsurance for each covered therapeutic radiology service

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Hearing Services (In-network additional services provided by TruHearing providers)	$0 copay for each covered hearing exam to determine if you need medical treatment for a hearing condition. **Additional hearing services** Routine hearing exam (1 every year): $0 copay Hearing aid fitting-evaluation visit (3 in first year of purchase): $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.	$0 copay for each covered hearing exam to determine if you need medical treatment for a hearing condition. **Additional hearing services** Routine hearing exam (1 every year): $0 copay Hearing aid fitting-evaluation visit (3 in first year of purchase): $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 in-network services provided by DenteMax providers)	Preventive Dental $0 copay for a routine office visit that includes: ▪ Cleaning (1 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (1 every year) If you want to purchase additional dental coverage, see Optional Supplemental Benefits on page 28.	Preventive Dental $0 copay for a routine office visit that includes: ▪ Cleaning (1 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (1 every year) If you want to purchase additional dental coverage, see Optional Supplemental Benefits on page 28.
Vision Services	$0 copay for Original Medicare covered vision services, including a yearly glaucoma screening and diabetic eye exam 20% coinsurance for Original Medicare covered eyeglasses or contact lenses after cataract surgery	$0 copay for Original Medicare covered vision services, including a yearly glaucoma screening and diabetic eye exam 20% coinsurance for Original Medicare covered eyeglasses or contact lenses after cataract surgery

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Hearing Services (In-network additional services provided by TruHearing providers)	$0 copay for each covered hearing exam to determine if you need medical treatment for a hearing condition. **Additional hearing services** Routine hearing exam (1 every year): $0 copay Hearing aid fitting-evaluation visit (3 in first year of purchase): $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.	$0 copay for each covered hearing exam to determine if you need medical treatment for a hearing condition. **Additional hearing services** Routine hearing exam (1 every year): $0 copay Hearing aid fitting-evaluation visit (3 in first year of purchase): $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 in-network services provided by DenteMax providers)	Preventive Dental $0 copay for a routine office visit that includes: ▪ Cleaning (1 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (1 every year) If you want to purchase additional dental coverage, see Optional Supplemental Benefits on page 29.	Preventive Dental $0 copay for a routine office visit that includes: ▪ Cleaning (1 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (1 every year) If you want to purchase additional dental coverage, see Optional Supplemental Benefits on page 29.
Vision Services	$0 copay for Original Medicare covered vision services, including a yearly glaucoma screening and diabetic eye exam 20% coinsurance for Original Medicare covered eyeglasses or contact lenses after cataract surgery	$0 copay for Original Medicare covered vision services, including a yearly glaucoma screening and diabetic eye exam 20% coinsurance for Original Medicare covered eyeglasses or contact lenses after cataract surgery

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Vision Services (Routine eye exam and contacts/glasses provided by EyeMed Insight providers)	$0 copay for each covered routine eye exam (1 every year) $100 allowance toward one pair of contact lenses or eyeglasses (frames and lenses) (1 every year) and you are responsible for any amount more than $100	$0 copay for each covered routine eye exam (1 every year) $100 allowance toward one pair of contact lenses or eyeglasses (frames and lenses) (1 every year) and you are responsible for any amount more than $100
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. ▪ $350 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 through 90 Outpatient group therapy visit: $35 copay Outpatient individual therapy visit: $35 copay	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. ▪ $350 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 through 90 Outpatient group therapy visit: $30 copay Outpatient individual therapy visit: $30 copay

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Vision Services (Routine eye exam and contacts/glasses provided by EyeMed Insight providers)	$0 copay for each covered routine eye exam (1 every year) $100 allowance toward one pair of contact lenses or eyeglasses (frames and lenses) (1 every year) and you are responsible for any amount more than $100	$0 copay for each covered routine eye exam (1 every year) $100 allowance toward one pair of contact lenses or eyeglasses (frames and lenses) (1 every year) and you are responsible for any amount more than $100
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. ▪ $350 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 through 90 Outpatient group therapy visit: $40 copay Outpatient individual therapy visit: $40 copay	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. ▪ $350 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 through 90 Outpatient group therapy visit: $25 copay Outpatient individual therapy visit: $25 copay

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
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. ▪ $0 copay per day for days 1 through 20 ▪ $178 copay per day for days 21 through 100	We will pay for skilled nursing facility care for up to 100 days per benefit period. ▪ $0 copay per day for days 1 through 20 ▪ $178 copay per day for days 21 through 100
Outpatient Rehabilitation Services	$40 copay for each covered physical therapy, occupational therapy and speech/language therapy visit	$40 copay for each covered physical therapy, occupational therapy and speech/language therapy visit
Ambulance (Services may require prior authorization)	$225 copay for each covered ground ambulance trip 50% for air ambulance services	$200 copay for each covered ground ambulance trip 50% for ambulance air 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.	$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.
Prescription Drug Benefits		
Medicare Part B Drugs (Part B drugs may require prior authorization and may be subject to step therapy requirements)	20% coinsurance for chemotherapy and other drugs covered by Medicare Part B 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. To view a list of Part B drugs that may be subject to Step Therapy, visit MedMutual.com/MAplaninfo.	20% coinsurance for chemotherapy and other drugs covered by Medicare Part B 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. To view a list of Part B drugs that may be subject to Step Therapy, visit MedMutual.com/MAplaninfo.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
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. ▪ $0 copay per day for days 1 through 20 ▪ $178 copay per day for days 21 through 100	We will pay for skilled nursing facility care for up to 100 days per benefit period. ▪ $20 copay per day for days 1 through 20 ▪ $178 copay per day for days 21 through 100
Outpatient Rehabilitation Services	$40 copay for each covered physical therapy, occupational therapy and speech/language therapy visit	$40 copay for each covered physical therapy, occupational therapy and speech/language therapy visit
Ambulance (Services may require prior authorization)	$210 copay for each covered ground ambulance trip 50% for air ambulance services	$190 copay for each covered ground ambulance trip 50% 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.	$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.
Prescription Drug Benefits		
Medicare Part B Drugs (Part B drugs may require prior authorization and may be subject to step therapy requirements)	20% coinsurance for chemotherapy and other drugs covered by Medicare Part B 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. To view a list of Part B drugs that may be subject to Step Therapy, visit MedMutual.com/MAplaninfo.	20% coinsurance for chemotherapy and other drugs covered by Medicare Part B 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. To view a list of Part B drugs that may be subject to Step Therapy, visit MedMutual.com/MAplaninfo.

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
	Outpatient Prescription Drugs	
Deductible	$95 for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible	$95 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 $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at preferred (retail and mail order) pharmacies and standard network retail pharmacies. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - One-month supply: $0/$8 - Three-month supply: $0/$16 ▪ Tier 2 copay (generic) - One-month supply: $15/$20 - Three-month supply: $38/$50 ▪ Tier 3 copay (preferred brand) - One-month supply: $42/$47 - Three-month supply: $118/$132 ▪ Tier 4 (non-preferred drug) - One-month supply: 50%/50% of the cost - Three-month supply: 50%/50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 31%/31% of the cost - Three-month supply: Not covered/Not covered	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at preferred (retail and mail order) pharmacies and standard network retail pharmacies. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - One-month supply: $0/$8 - Three-month supply: $0/$16 ▪ Tier 2 copay (generic) - One-month supply: $15/$20 - Three-month supply: $38/$50 ▪ Tier 3 copay (preferred brand) - One-month supply: $42/$47 - Three-month supply: $118/$132 ▪ Tier 4 (non-preferred drug) - One-month supply: 50%/50% of the cost - Three-month supply: 50%/50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 31%/31% of the cost - Three-month supply: Not covered/Not covered

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
	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	$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 $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at preferred (retail and mail order) pharmacies and standard network retail pharmacies. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - One-month supply: $0/$6 - Three-month supply: $0/$12 ▪ Tier 2 copay (generic) - One-month supply: $10/$15 - Three-month supply: $25/$38 ▪ Tier 3 copay (preferred brand) - One-month supply: $42/$47 - Three-month supply: $118/$132 ▪ Tier 4 (non-preferred drug) - One-month supply: 50%/50% of the cost - Three-month supply: 50%/50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 32%/32% of the cost - Three-month supply: Not covered/Not covered	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at preferred (retail and mail order) pharmacies and standard network retail pharmacies. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - One-month supply: $0/$6 - Three-month supply: $0/$12 ▪ Tier 2 copay (generic) - One-month supply: $10/$15 - Three-month supply: $25/$38 ▪ Tier 3 copay (preferred brand) - One-month supply: $42/$47 - Three-month supply: $118/$132 ▪ Tier 4 (non-preferred drug) - One-month supply: 50%/50% of the cost - Three-month supply: 50%/50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 32%/32% of the cost - Three-month supply: Not covered/Not covered

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
	Outpatient Prescription Drugs	
Initial Coverage (continued)	**Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - One-month supply: $14 - Three-month supply: $35 ▪ Tier 3 copay (preferred brand) - One-month supply: $40 - Three-month supply: $110 ▪ Tier 4 (non-preferred drug) - One-month supply: 50% of the cost - Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 31% of the cost - Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a retail pharmacy. In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.	**Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - One-month supply: $14 - Three-month supply: $35 ▪ Tier 3 copay (preferred brand) - One-month supply: $40 - Three-month supply: $110 ▪ Tier 4 (non-preferred drug) - One-month supply: 50% of the cost - Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 31% of the cost - Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a 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 $4,020.	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 $4,020.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Outpatient Prescription Drugs		
Initial Coverage (continued)	**Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - One-month supply: $9 - Three-month supply: $22 ▪ Tier 3 copay (preferred brand) - One-month supply: $40 - Three-month supply: $110 ▪ Tier 4 (non-preferred drug) - One-month supply: 50% of the cost - Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 32% of the cost - Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a retail pharmacy. In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.	**Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - One-month supply: $9 - Three-month supply: $22 ▪ Tier 3 copay (preferred brand) - One-month supply: $40 - Three-month supply: $110 ▪ Tier 4 (non-preferred drug) - One-month supply: 50% of the cost - Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) - One-month supply: 32% of the cost - Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a 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 $4,020.	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 $4,020.

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
	Outpatient Prescription Drugs	
Coverage Gap (continued)	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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0/$8 - Three-month supply: $0/$16 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $15/$20 - Three-month supply: $38/$50 **Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $14 - Three-month supply: $35	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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0/$8 - Three-month supply: $0/$16 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $15/$20 - Three-month supply: $38/$50 **Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $14 - Three-month supply: $35

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
	Outpatient Prescription Drugs	
Coverage Gap (continued)	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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0/$6 - Three-month supply: $0/$12 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $10/$15 - Three-month supply: $25/$38 **Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $9 - Three-month supply: $22	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 $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard retail cost sharing:** (preferred/standard) ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0/$6 - Three-month supply: $0/$12 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $10/$15 - Three-month supply: $25/$38 **Standard mail-order cost sharing:** ▪ Tier 1 copay (preferred generic) - Drugs covered: All - One-month supply: $0 - Three-month supply: $0 ▪ Tier 2 copay (generic) - Drugs covered: All - One-month supply: $9 - Three-month supply: $22

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
	Outpatient Prescription Drugs	
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $6,350, you pay: ▪ $0 copay for Tier 1 preferred generic drugs purchased at a preferred retail or mail order pharmacy or the greater of: – 5% coinsurance of the cost of the drug, or – $3.60 copay for generic (including brand drugs treated as generic) and $8.95 copay for all other drugs	After your yearly out-of-pocket drug costs reach $6,350, you pay: ▪ $0 copay for Tier 1 preferred generic drugs purchased at a preferred retail or mail order pharmacy or the greater of: – 5% coinsurance of the cost of the drug, or – $3.60 copay for generic (including brand drugs treated as generic) and $8.95 copay for all other drugs
Outpatient Substance Abuse	$35 copay for each covered therapy visit This applies to an individual therapy visit or if the visit is part of group therapy.	$30 copay for each covered therapy visit This applies to an individual therapy visit or if the visit is part of group therapy.
Foot Care (podiatry services)	$35 copay for each covered podiatry visit	$30 copay for each covered podiatry visit
Durable Medical Equipment (wheelchairs, oxygen, etc.) (Services may require prior authorization)	20% coinsurance for durable medical equipment	20% coinsurance for durable medical equipment
Prosthetic Devices (braces, artificial limbs, etc.) (Services may require prior authorization)	20% coinsurance for prosthetic devices and supplies	20% coinsurance for prosthetic devices and supplies

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Outpatient Prescription Drugs		
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $6,350, you pay: ▪ $0 copay for Tier 1 preferred generic drugs purchased at a preferred retail or mail order pharmacy or the greater of: – 5% coinsurance of the cost of the drug, or – $3.60 copay for generic (including brand drugs treated as generic) and $8.95 copay for all other drugs	After your yearly out-of-pocket drug costs reach $6,350, you pay: ▪ $0 copay for Tier 1 preferred generic drugs purchased at a preferred retail or mail order pharmacy or the greater of: – 5% coinsurance of the cost of the drug, or – $3.60 copay for generic (including brand drugs treated as generic) and $8.95 copay for all other drugs
Outpatient Substance Abuse	$40 copay for each covered therapy visit This applies to an individual therapy visit or if the visit is part of group therapy.	$25 copay for each covered therapy visit This applies to an individual therapy visit or if the visit is part of group therapy.
Foot Care (podiatry services)	$40 copay for each covered podiatry visit	$25 copay for each covered podiatry visit
Durable Medical Equipment (wheelchairs, oxygen, etc.) (Services may require prior authorization)	20% coinsurance for durable medical equipment	20% coinsurance for durable medical equipment
Prosthetic Devices (braces, artificial limbs, etc.) (Services may require prior authorization)	20% coinsurance for prosthetic devices and supplies	20% coinsurance for prosthetic devices and supplies

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
	Outpatient Prescription Drugs	
Diabetes Supplies and Services	0% coinsurance for a blood glucose meter or monitor and each 30-day supply of the following diabetic supplies: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Syringes and pen needles ▪ Glucose control solutions for checking the accuracy of test strips, meters and monitors. All other diabetes supplies and therapeutic shoes or inserts: ▪ 20% coinsurance for all other diabetes supplies and therapeutic shoes or inserts	0% coinsurance for a blood glucose meter or monitor and each 30-day supply of the following diabetic supplies: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Syringes and pen needles ▪ Glucose control solutions for checking the accuracy of test strips, meters and monitors. All other diabetes supplies and therapeutic shoes or inserts: ▪ 20% coinsurance for all other diabetes supplies and therapeutic shoes or inserts
Over-the-Counter Items	Not covered	Your plan includes a $20 quarterly allowance to be used toward the purchase of over-the-counter (OTC) health and wellness supplies to be delivered to your home. Please visit our website, MedMutual.com/SimplySupplies, to see our list of over-the-counter supplies.
Health and Wellness Education Programs	Wellness programs included at no additional cost, except WW® (formerly Weight Watchers). **Disease 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).	Wellness programs included at no additional cost, except WW® (formerly Weight Watchers). **Disease 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).

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
	Outpatient Prescription Drugs	
Diabetes Supplies and Services	0% coinsurance for a blood glucose meter or monitor and each 30-day supply of the following diabetic supplies: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Syringes and pen needles ▪ Glucose control solutions for checking the accuracy of test strips, meters and monitors. All other diabetes supplies and therapeutic shoes or inserts: ▪ 20% coinsurance for all other diabetes supplies and therapeutic shoes or inserts	0% coinsurance for a blood glucose meter or monitor and each 30-day supply of the following diabetic supplies: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Syringes and pen needles ▪ Glucose control solutions for checking the accuracy of test strips, meters and monitors. All other diabetes supplies and therapeutic shoes or inserts: ▪ 20% coinsurance for all other diabetes supplies and therapeutic shoes or inserts
Over-the-Counter Items	Your plan includes a $20 quarterly allowance to be used toward the purchase of over-the-counter (OTC) health and wellness supplies to be delivered to your home. Please visit our website, MedMutual.com/SimplySupplies, to see our list of over-the-counter supplies.	Your plan includes a $20 monthly allowance to be used toward the purchase of over-the-counter (OTC) health and wellness supplies to be delivered to your home. Please visit our website, MedMutual.com/SimplySupplies, to see our list of over-the-counter supplies.
Health and Wellness Education Programs	Wellness programs included at no additional cost, except WW® (formerly Weight Watchers). **Disease 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).	Wellness programs included at no additional cost, except WW® (formerly Weight Watchers). **Disease 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).

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Health and Wellness Education Programs (continued)	**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 enjoy access to more than 16,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. 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 (formerly Weight Watchers), the world's leading provider of weight management services. Monthly WW fees for specified programs are reduced for MedMutual Advantage HMO members. The benefit does not include food or meals.	**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 enjoy access to more than 16,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. 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 (formerly Weight Watchers), the world's leading provider of weight management services. Monthly WW fees for specified programs are reduced for MedMutual Advantage HMO members. The benefit does not include food or meals.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Health and Wellness Education Programs (continued)	**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 enjoy access to more than 16,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. 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 (formerly Weight Watchers), the world's leading provider of weight management services. Monthly WW fees for specified programs are reduced for MedMutual Advantage HMO members. The benefit does not include food or meals.	**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 enjoy access to more than 16,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. 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 (formerly Weight Watchers), the world's leading provider of weight management services. Monthly WW fees for specified programs are reduced for MedMutual Advantage HMO members. The benefit does not include food or meals.

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Chiropractic Care	$10 copay for each visit that Original Medicare covers to see a chiropractor We only cover manual manipulation of the spine to correct subluxation.	$10 copay for each visit that Original Medicare covers to see a chiropractor We only cover manual manipulation of the spine to correct subluxation.
Home Health Care (Services may require prior authorization)	$0 copay There is no coinsurance, copay or deductible for Medicare-covered home health agency care.	$0 copay There is no coinsurance, copay or deductible for Medicare-covered home health agency care.
Renal Dialysis	20% coinsurance for covered dialysis equipment and supplies	20% coinsurance for covered dialysis equipment and supplies
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.	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.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Chiropractic Care	$10 copay for each visit that Original Medicare covers to see a chiropractor We only cover manual manipulation of the spine to correct subluxation.	$10 copay for each visit that Original Medicare covers to see a chiropractor We only cover manual manipulation of the spine to correct subluxation.
Home Health Care (Services may require prior authorization)	$0 copay There is no coinsurance, copay or deductible for Medicare-covered home health agency care.	$0 copay There is no coinsurance, copay or deductible for Medicare-covered home health agency care.
Renal Dialysis	20% coinsurance for covered dialysis equipment and supplies	20% coinsurance for covered dialysis equipment and supplies
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.	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.

Summary of Benefits

Premiums and Benefits	MedMutual Advantage Classic (HMO)	MedMutual Advantage Secure (HMO)
Optional Benefits		
Optional Supplemental Benefits Package	**Dental** Preventive dental services include: ▪ Cleaning (up to 2 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (up to 2 every year) For each calendar year, the following dental limits apply: ▪ 2 diagnostic X-rays ▪ 1 denture repair, reline or adjustment ▪ 1 endodontic service ▪ 1 periodontic service **Vision** ▪ Routine eye exam ▪ Eyewear allowance For coverage and cost information for all dental and vision services see this plan's Evidence of Coverage.	**Dental** Preventive dental services include: ▪ Cleaning (up to 2 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (up to 2 every year) For each calendar year, the following dental limits apply: ▪ 2 diagnostic X-rays ▪ 1 denture repair, reline or adjustment ▪ 1 endodontic service ▪ 1 periodontic service **Vision** ▪ Routine eye exam ▪ Eyewear allowance For coverage and cost information for all dental and vision services see this plan's Evidence of Coverage.
Monthly Premium	Additional $22 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $22 per month. You must keep paying your Medicare Part B premium and your $15 monthly plan premium.
Deductible	This package does not have a deductible.	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,250 every year. Our plan has additional coverage limits for certain benefits. The $1,250 limit has separate limits of $1,000 for dental benefits and $250 for vision benefits (the $250 includes the $100 referenced on page 8).	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 8).

MedMutual Advantage 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 is 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.

Premiums and Benefits	MedMutual Advantage Choice (HMO)	MedMutual Advantage Plus (HMO)
Optional Benefits		
Optional Supplemental Benefits Package	**Dental** Preventive dental services include: ▪ Cleaning (up to 2 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (up to 2 every year) For each calendar year, the following dental limits apply: ▪ 2 diagnostic X-rays ▪ 1 denture repair, reline or adjustment ▪ 1 endodontic service ▪ 1 periodontic service **Vision** ▪ Routine eye exam ▪ Eyewear allowance For coverage and cost information for all dental and vision services see this plan's Evidence of Coverage.	**Dental** Preventive dental services include: ▪ Cleaning (up to 2 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (up to 2 every year) For each calendar year, the following dental limits apply: ▪ 2 diagnostic X-rays ▪ 1 denture repair, reline or adjustment ▪ 1 endodontic service ▪ 1 periodontic service **Vision** ▪ Routine eye exam ▪ Eyewear allowance For coverage and cost information for all dental and vision services see this plan's Evidence of Coverage.
Monthly Premium	Additional $22 per month. You must keep paying your Medicare Part B premium and your $38 monthly plan premium.	Additional $22 per month. You must keep paying your Medicare Part B premium and your $99 monthly plan premium.
Deductible	This package does not have a deductible.	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,250 every year. Our plan has additional coverage limits for certain benefits. The $1,250 limit has separate limits of $1,000 for dental benefits and $250 for vision benefits (the $250 includes the $100 referenced on page 9).	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 9).

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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). We are available 8 a.m. to 8 p.m. seven days a week from October 1 to March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Y0121_H_S1198_2020_C

MEDICAL MUTUAL®

Multi-Language Interpreter Services & Nondiscrimination Notice

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

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2020 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2020, Medical Mutual of Ohio received the following Overall Star Rating from Medicare.

★★★★ 4 Stars

We received the following Summary Star Rating for Medical Mutual of Ohio's health/drug plan services:

Health Plan Services:	★★★★	4 Stars
Drug Plan Services:	★★★★½	4.5 Stars

The number of stars shows how well our plan performs.

★★★★★ 5 stars – excellent
★★★★ 4 stars – above average
★★★ 3 stars – average
★★ 2 stars – below average
★ 1 star – poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 1-866-406-8777 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday from 8:00 a.m. to 8:00 p.m. Eastern time, Tuesday from 8:00 a.m. to 8:00 p.m. Eastern time, Wednesday from 8:00 a.m. to 8:00 p.m. Eastern time, Thursday from 8:00 a.m. to 8:00 p.m. Eastern time, Friday from 8:00 a.m. to 8:00 p.m. Eastern time, Saturday from 9:00 a.m. to 1:00 p.m. Eastern time.

Current members please call 1-800-982-3117 (toll-free) or 711 (TTY).

* Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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