



2027 Annual Notice of Change

MedMutual Advantage Preferred (PPO) Plan

**Central Ohio, Cincinnati/Dayton and Toledo
(H4497-002-003)**

Brown, Butler, Clark, Clermont, Delaware, Fairfield, Franklin, Fulton, Greene, Hamilton, Hocking, Licking, Lucas, Madison, Miami, Montgomery, Morrow, Ottawa, Perry, Pickaway, Sandusky, Union, Warren and Wood counties

MedMutual Advantage Preferred (PPO) offered by Medical Mutual of Ohio (Medical Mutual)

Annual Notice of Change for 2027

You're enrolled as a member of MedMutual Advantage Preferred (PPO).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2026, you'll stay in MedMutual Advantage Preferred (PPO).
- To change to a **different plan**, visit [Medicare.gov](https://www.medicare.gov) or review the list in the back of your Medicare & You 2027 handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [MedMutual.com/MAplaninfo](https://www.MedMutual.com/MAplaninfo) or call Customer Care at 1-800-982-3117 (TTY users call 711) to get a copy by mail.

More Resources

- Call Customer Care at 1-800-982-3117 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m. seven days a week from October 1 through 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). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. This call is free.
- This document is available in alternate formats (e.g., braille, large print, audio).

About MedMutual Advantage Preferred (PPO)

- MedMutual Advantage Preferred (PPO) is a PPO plan offered by Medical Mutual of Ohio with a Medicare contract. Enrollment in the MedMutual Advantage Preferred (PPO) plan depends on contract renewal.
- When this material says "we," "us," or "our," it means Medical Mutual of Ohio (Medical Mutual). When it says "plan" or "our plan," it means MedMutual Advantage Preferred (PPO).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in MedMutual Advantage Preferred (PPO).** Starting January 1, 2027, you'll get your medical and drug coverage through MedMutual Advantage Preferred (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* *Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	\$73	\$90
Deductible	\$1,750 for out-of-network services – except for insulin furnished through an item of durable medical equipment.	\$1,750 for out-of-network services – except for insulin furnished through an item of durable medical equipment.
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1 for details.)	From network providers: \$5,800 From network and out-of-network providers combined: \$10,100	From network providers: \$5,900 From network and out-of-network providers combined: \$10,100
Primary care office visits	<u>In Network</u> \$5 copayment per visit <u>Out of Network</u> After the \$1,750 yearly deductible is met, 30% of the total cost	<u>In Network</u> \$5 copayment per visit <u>Out of Network</u> After the \$1,750 yearly deductible is met, 30% of the total cost
Specialist office visits	<u>In Network</u> \$30 copayment per visit <u>Out of Network</u> After the \$1,750 yearly deductible is met, 30% of the total cost	<u>In Network</u> \$45 copayment per visit <u>Out of Network</u> After the \$1,750 yearly deductible is met, 30% of the total cost
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	<u>In Network</u> Days 1 - 5: \$365 copayment per day Day 6 and thereafter: \$0 copayment <u>Out of Network</u> After the \$1,750 yearly deductible is met, 30% of the total cost	<u>In Network</u> Days 1 - 5: \$390 copayment per day Day 6 and thereafter: \$0 copayment <u>Out of Network</u> After the \$1,750 yearly deductible is met, 30% of the total cost

	2026 (this year)	2027 (next year)
Part D drug coverage (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible: \$55 – except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: <u>Drug Tier 1:</u> Preferred retail pharmacies • \$0 copayment per prescription for up to a 30-day supply • \$0 copayment per prescription for up to a 60-day supply • \$0 copayment per prescription for up to a 90-day supply Preferred mail-order pharmacies • \$0 copayment per prescription for up to a 30-day supply • \$0 copayment per prescription for up to a 60-day supply • \$0 copayment per prescription for up to a 90-day supply Standard network retail pharmacies • \$6 copayment per prescription for up to a 30-day supply • \$12 copayment per prescription for up to a 60-day supply • \$12 copayment per prescription for up to a 90-day supply Standard mail-order pharmacies • \$5 copayment per prescription for up to a 30-day supply • \$10 copayment per prescription for up to a 60-day supply	Part D drug coverage deductible: \$55 – except for covered insulin products and most adult Part D vaccines Copayment/Coinsurance during the Initial Coverage Stage: <u>Drug Tier 1:</u> Preferred retail pharmacies • \$0 copayment per prescription for up to a 30-day supply • \$0 copayment per prescription for up to a 60-day supply • \$0 copayment per prescription for up to a 90-day supply Preferred mail-order pharmacies • \$0 copayment per prescription for up to a 30-day supply • \$0 copayment per prescription for up to a 60-day supply • \$0 copayment per prescription for up to a 90-day supply Standard network retail pharmacies • \$6 copayment per prescription for up to a 30-day supply • \$12 copayment per prescription for up to a 60-day supply • \$12 copayment per prescription for up to a 90-day supply Standard mail-order pharmacies • \$5 copayment per prescription for up to a 30-day supply • \$10 copayment per prescription for up to a 60-day supply

	2026 (this year)	2027 (next year)
	\$10 copayment per prescription for up to a 90-day supply <u>Drug Tier 2:</u> Preferred retail pharmacies \$5 copayment per prescription for up to a 30-day supply \$10 copayment per prescription for up to a 60-day supply \$13 copayment per prescription for up to a 90-day supply Preferred mail-order pharmacies \$4 copayment per prescription for up to a 30-day supply \$8 copayment per prescription for up to a 60-day supply \$10 copayment per prescription for up to a 90-day supply Standard network retail pharmacies \$12 copayment per prescription for up to a 30-day supply \$24 copayment per prescription for up to a 60-day supply \$30 copayment per prescription for up to a 90-day supply Standard mail-order pharmacies \$11 copayment per prescription for up to a 30-day supply \$22 copayment per prescription for up to a 60-day supply \$28 copayment per prescription for up to a 90-day supply <u>Drug Tier 3:</u> Preferred and standard network retail and mail-order	\$10 copayment per prescription for up to a 90-day supply <u>Drug Tier 2:</u> Preferred retail pharmacies \$5 copayment per prescription for up to a 30-day supply \$10 copayment per prescription for up to a 60-day supply \$13 copayment per prescription for up to a 90-day supply Preferred mail-order pharmacies \$5 copayment per prescription for up to a 30-day supply \$10 copayment per prescription for up to a 60-day supply \$10 copayment per prescription for up to a 90-day supply Standard network retail pharmacies \$12 copayment per prescription for up to a 30-day supply \$24 copayment per prescription for up to a 60-day supply \$30 copayment per prescription for up to a 90-day supply Standard mail-order pharmacies \$11 copayment per prescription for up to a 30-day supply \$22 copayment per prescription for up to a 60-day supply \$28 copayment per prescription for up to a 90-day supply <u>Drug Tier 3:</u> Preferred and standard network retail and mail-order

	2026 (this year)	2027 (next year)
	pharmacies • 22% of the total cost for up to a 30-day supply, 60-day supply, or 90-day supply <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i> <u>Drug Tier 4:</u> Preferred and standard network retail and mail-order pharmacies • 40% of the total cost for up to a 30-day supply, 60-day supply, or 90-day supply <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i> <u>Drug Tier 5:</u> Preferred and standard network retail and mail-order pharmacies • 32% of the total cost for up to a 30-day supply <u>Drug Tier 6:</u> Preferred and standard network retail and mail-order pharmacies • \$0 copayment per prescription for up to a 30-day supply, 60-day supply, or 90-day supply Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	pharmacies • 22% of the total cost for up to a 30-day supply, 60-day supply, or 90-day supply <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i> <u>Drug Tier 4:</u> Preferred and standard network retail and mail-order pharmacies • 37% of the total cost for up to a 30-day supply, 60-day supply, or 90-day supply <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i> <u>Drug Tier 5:</u> Preferred and standard network retail and mail-order pharmacies • 32% of the total cost for up to a 30-day supply <u>Drug Tier 6:</u> Preferred and standard network retail and mail-order pharmacies • \$0 copayment per prescription for up to a 30-day supply, 60-day supply, or 90-day supply Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Premium

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	\$73	\$90
Additional premium for optional supplemental benefits If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	\$28	\$47

Factors that could change your Part D Premium Amount

- **Late Enrollment Penalty** - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without Part D or other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- **Higher Income Surcharge** - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- **Extra Help** – Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from network providers count toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$5,800	\$5,900 Once you've paid \$5,900 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

	2026 (this year)	2027 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs don't count toward your maximum out-of-pocket amount for medical services.	\$10,100	\$10,100 (No change from 2026) Once you've paid \$10,100 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the *2027 Provider Directory* (MedMutual.com/MAplaninfo) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated Provider Directory:

- Visit our website at MedMutual.com/MAplaninfo.
- Call Customer Care at 1-800-982-3117 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Care at 1-800-982-3117 (TTY users call 711) for help. You may have a special enrollment period if your provider leaves the plan network.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are no changes to our network of pharmacies for next year. Review the *2027 Pharmacy Directory* at MedMutual.com/MAplaninfo to see which pharmacies are in our network. Here's how to get an updated *Pharmacy Directory*:

- Visit our website at MedMutual.com/MAplaninfo.
- Call Customer Care at 1-800-982-3117 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Care at 1-800-982-3117 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

	2026 (this year)	2027 (next year)
Prior authorization requirements – see Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for details.	Prior authorization rules may apply for Chiropractic Services. Contact the plan for details.	Prior authorization is not required for Chiropractic Services.
Acupuncture for chronic low back pain	<u>In Network</u> \$5 copayment for each covered acupuncture service in a primary care physician's office \$30 copayment for each covered acupuncture service in a specialist's office	<u>In Network</u> \$5 copayment for each covered acupuncture service in a primary care physician's office \$45 copayment for each covered acupuncture service in a specialist's office
Annual in-home health assessment See Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for more information.	\$0 copayment	<u>In Network</u> \$0 copayment <u>Out of Network</u> 80% of the total cost Please note: If you choose to obtain these services from an out-of-network provider, you must pay up front for services rendered and submit itemized receipts for reimbursement. Contact Customer Care for information about eligibility.
Continuous glucose monitors and insulin pumps – listed under “Durable Medical Equipment” in Chapter 4, Section 2 of the <i>Evidence of Coverage</i> .	<u>Out of Network</u> After the \$1,750 deductible is met, 30% of the total cost for insulin pumps and continuous glucose monitors	<u>Out of Network</u> After the \$1,750 deductible is met, 50% of the total cost for insulin pumps and continuous glucose monitors
Diabetes self-management training, diabetic services, and supplies See Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for more information.	<u>In Network</u> 0% of the total cost for the following diabetic supplies: • A blood glucose meter • Blood glucose test strips • Lancing devices and glucose lancets • Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors Please note: In order to qualify for 0% coinsurance, diabetic test strips and meters must be	<u>In Network</u> 0% of the total cost for the following diabetic supplies: • A blood glucose meter • Blood glucose test strips • Lancing devices and glucose lancets • Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors Please note: In order to qualify for 0% coinsurance, diabetic test strips and meters must be

	2026 (this year)	2027 (next year)
	produced by a preferred manufacturer, Abbott or Trividia, and be purchased at an in-network retail or mail order pharmacy. Preferred products include Freestyle, Precision Xtra, True Metrix meters and Trividia test strips. Non-preferred diabetic test strips and meters are covered (with 0% coinsurance) when filled by an in-network durable medical equipment supplier. 20% of the total cost for all other diabetic supplies See the “Continuous Glucose Monitors and Insulin Pumps” listing above for cost-sharing for insulin pumps and continuous glucose monitors.	produced by a preferred manufacturer, Abbott or Trividia, and be purchased at an in-network retail or mail order pharmacy. Preferred products include some Freestyle, Precision Xtra, True Metrix meters and Trividia test strips. Not ALL products from preferred manufacturers are considered preferred. Non-preferred diabetic test strips and meters are covered (with 0% coinsurance) when filled by an in-network durable medical equipment supplier. 20% of the total cost for all other diabetic supplies See the “Continuous Glucose Monitors and Insulin Pumps” listing above for cost-sharing for insulin pumps and continuous glucose monitors.
Diagnostic mammograms – listed under “Outpatient diagnostic tests and therapeutic services and supplies” in Chapter 4, Section 2 of <i>Evidence of Coverage</i>	<u>In Network</u> \$50 copayment for each diagnostic mammogram	<u>In Network</u> \$0 copayment for each diagnostic mammogram
Emergency care outside the United States	\$115 copayment for each covered emergency room visit outside the United States Your plan covers up to a combined maximum of \$50,000 for emergency care and urgent care outside the United States.	\$115 copayment for each covered emergency room visit outside the United States Your plan covers up to a combined maximum of \$25,000 for emergency care and urgent care outside the United States.
Health and wellness education programs – WeightWatchers® See Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for more information.	70% of the total cost for WeightWatchers Program	WeightWatchers Program is <u>not</u> covered.

	2026 (this year)	2027 (next year)
Additional hearing services Listed under “Hearing services” in Chapter 4, Section 2 of your <i>Evidence of Coverage</i> .	\$0 copayment for each covered routine hearing exam \$0 copayment for each covered hearing aid fitting-evaluation visit \$499 copayment for each covered Standard hearing aid \$699 copayment for each covered Advanced hearing aid \$999 copayment for each covered Premium hearing aid	<u>In Network</u> \$0 copayment for each covered routine hearing exam \$0 copayment for each covered hearing aid fitting-evaluation visit \$499 copayment for each covered Standard hearing aid \$699 copayment for each covered Advanced hearing aid \$999 copayment for each covered Premium hearing aid <u>Out of Network</u> \$0 copayment for each covered routine hearing exam or hearing aid fitting-evaluation visit 80% of the total cost Note: Your plan will cover these additional hearing services up to the value of the vendor-supplied benefit. If you choose to obtain these services from an out-of-network provider, you must pay up front for services rendered and submit itemized receipts for reimbursement.
Home-based palliative care See Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for more information.	\$0 copayment for home-based palliative care	Home-based palliative care is <u>not</u> covered.

	2026 (this year)	2027 (next year)
Home meals See Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for more information.	\$0 copayment for home meals	<u>In Network</u> \$0 copayment <u>Out of Network</u> 80% of the total cost Note: Your plan will cover out-of-network home meals up to the value of the vendor-supplied services. If you choose to obtain these services from an out-of-network provider, you must pay up front for services rendered and submit itemized receipts for reimbursement. Contact Customer Care for information about eligibility.
Inpatient hospital care	<u>In Network</u> Days 1 through 5: \$365 copayment per day Day 6 and thereafter: \$0 copayment	<u>In Network</u> Days 1 through 5 : \$390 copayment per day Day 6 and thereafter : \$0 copayment
Outpatient diagnostic radiology services – listed under “Outpatient diagnostic tests and therapeutic services and supplies” and “Outpatient hospital services” in Chapter 4, Section 2 of the <i>Evidence of Coverage</i>	<u>In Network</u> \$100 copayment for each covered Computed Tomography (CT) scan \$175 copayment for each covered Magnetic Resonance test (MRI and MRA) \$175 copayment for each covered nuclear medicine study, including PET scans	<u>In Network</u> \$100 copayment for each covered Computed Tomography (CT) scan \$200 copayment for each covered Magnetic Resonance test (MRI and MRA) \$200 copayment for each covered nuclear medicine study, including PET scans
Outpatient mental health care	<u>In Network</u> \$30 copayment for each covered individual or group therapy visit	<u>In Network</u> \$45 copayment for each covered individual or group therapy visit
Outpatient substance use disorder services	<u>In Network</u> \$30 copayment for each covered individual or group therapy visit	<u>In Network</u> \$45 copayment for each covered individual or group therapy visit

	2026 (this year)	2027 (next year)
Outpatient surgery – listed under “Outpatient hospital services” and “Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers” in Chapter 4, Section 2 of the <i>Evidence of Coverage</i>	<u>In Network</u> \$330 copayment for each covered surgery or surgical procedure performed as an outpatient at a hospital \$350 copayment for each covered surgery or surgical procedure performed as an outpatient at an Ambulatory Surgical Center	<u>In Network</u> \$350 copayment for each covered surgery or surgical procedure performed as an outpatient at a hospital \$350 copayment for each covered surgery or surgical procedure performed as an outpatient at an Ambulatory Surgical Center
Partial hospitalization and Intensive outpatient services	<u>In Network</u> \$30 copayment for each covered partial hospitalization visit or intensive outpatient service visit	<u>In Network</u> \$45 copayment for each covered partial hospitalization visit or intensive outpatient service visit
Physician/Practitioner services, including doctor's office visits See Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for more information.	<u>In Network</u> \$5 copayment for each covered PCP visit \$30 copayment for each covered specialist visit (including office visits to psychologists and psychiatrists)	<u>In Network</u> \$5 copayment for each covered PCP visit \$45 copayment for each covered specialist visit (including office visits to psychologists and psychiatrists)
SilverSneakers® Fitness Program – see “Health and wellness education programs” in Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for details	\$0 copayment for SilverSneakers	<u>In Network</u> \$0 copayment for SilverSneakers <u>Out of Network</u> 0% of the total cost for out-of-network fitness program services Note: Your plan will cover out-of-network fitness program services up to the value of the SilverSneakers membership. You must pay up front for services rendered and submit itemized receipts for reimbursement. Contact Customer Care for information about eligibility.
Skilled nursing facility care	<u>In Network</u> Days 1 through 20: \$0 copayment per day Days 21 through 100: \$218 copayment per day	<u>In Network</u> Days 1 through 20: \$0 copayment per day Days 21 through 100: \$221 copayment per day
Smoking and tobacco use cessation – additional coaching sessions – see Chapter 4, Section 2 of your <i>Evidence of Coverage</i> for details.	\$0 copayment for additional coaching sessions	Additional coaching sessions are <u>not</u> covered.

	2026 (this year)	2027 (next year)
Urgently needed services outside the United States	\$40 copayment for each urgent care center visit outside the United States Your plan covers up to a combined maximum of \$50,000 for emergency care and urgent care outside the United States.	\$40 copayment for each urgent care center visit outside the United States Your plan covers up to a combined maximum of \$25,000 for emergency care and urgent care outside the United States.
Vision care – eyewear allowance	<u>In Network</u> Your plan includes \$200 toward the purchase of either one pair of eyeglasses or contact lenses (including standard contact lens fit and follow up) per calendar year at an optical provider. You pay any amount over \$200 of approved eyewear.	<u>In Network</u> Your plan includes \$130 toward the purchase of either one pair of eyeglasses or contact lenses (including standard contact lens fit and follow up) per calendar year at an optical provider. You pay any amount over \$130 of approved eyewear.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically and posted online at MedMutual.com/MAPlaninfo.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your Evidence of Coverage and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Care at 1-800-982-3117 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, call Customer Care at 1-800-982-3117 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs until you reach the yearly deductible.

- **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach **\$2,400**.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	The deductible is \$55. During this stage, you pay: • \$0 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 1 • \$6 (standard network retail pharmacy) or \$5 (standard mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 1 • \$0 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 1 • \$12 (standard network retail pharmacy) or \$10 (standard mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 1 • \$0 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 1 • \$12 (standard network retail pharmacy) or \$10 (standard mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 1	The deductible is \$55. During this stage, you pay: • \$0 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 1 • \$6 (standard network retail pharmacy) or \$5 (standard mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 1 • \$0 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 1 • \$12 (standard network retail pharmacy) or \$10 (standard mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 1 • \$0 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 1 • \$12 (standard network retail pharmacy) or \$10 (standard mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 1

	2026 (this year)	2027 (next year)
	• \$5 (preferred retail pharmacy) or \$4 (preferred mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 2 • \$12 (standard network retail pharmacy) or \$11 (standard mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 2 • \$10 (preferred retail pharmacy) or \$8 (preferred mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 2 • \$24 (standard network retail pharmacy) or \$22 (standard mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 2 • \$13 (preferred retail pharmacy) or \$10 (preferred mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 2 • \$30 (standard network retail pharmacy) or \$28 (standard mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 2 • \$0 (preferred or standard network retail or mail-order pharmacy) cost sharing for up to a 30-day, 60-day, or 90-day supply for drugs on Tier 6 <i>and</i> the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you've reached the yearly deductible.	• \$5 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 2 • \$12 (standard network retail pharmacy) or \$11 (standard mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on Tier 2 • \$10 (preferred retail or preferred mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 2 • \$24 (standard network retail pharmacy) or \$22 (standard mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on Tier 2 • \$13 (preferred retail pharmacy) or \$10 (preferred mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 2 • \$30 (standard network retail pharmacy) or \$28 (standard mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on Tier 2 • \$0 (preferred or standard network retail or mail-order pharmacy) cost sharing for up to a 30-day, 60-day, or 90-day supply for drugs on Tier 6 <i>and</i> the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

Go to the following table for the changes from 2026 to 2027.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs: for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid **\$2,400** out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (next year)
Tier 1: Preferred Generic Drugs We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Standard cost sharing: You pay \$6 per prescription (retail) or \$5 per prescription (mail order). Preferred cost sharing: You pay \$0 per prescription (retail or mail order).	Standard cost sharing: You pay \$6 per prescription (retail) or \$5 per prescription (mail order). Preferred cost sharing: You pay \$0 per prescription (retail or mail order).
Tier 2: Generic Drugs We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Standard cost sharing: You pay \$12 per prescription (retail) or \$11 per prescription (mail order). Preferred cost sharing: You pay \$5 per prescription (retail) or \$4 per prescription (mail order).	Standard cost sharing: You pay \$12 per prescription (retail) or \$11 per prescription (mail order). Preferred cost sharing: You pay \$5 per prescription (retail) or \$5 per prescription (mail order).
Tier 3: Preferred Brand and Generic Drugs We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Standard cost sharing: You pay 22% of the total cost (retail or mail order). Preferred cost sharing: You pay 22% of the total cost (retail or mail order). <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i>	Standard cost sharing: You pay 22% of the total cost (retail or mail order). Preferred cost sharing: You pay 22% of the total cost (retail or mail order). <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i>
Tier 4: Non-Preferred Drugs We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Standard cost sharing: You pay 40% of the total cost (retail or mail order). Preferred cost sharing: You pay 40% of the total cost (retail or mail order). <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i>	Standard cost sharing: You pay 37% of the total cost (retail or mail order). Preferred cost sharing: You pay 37% of the total cost (retail or mail order). <i>You pay no more than \$35 per month supply of each covered insulin product on this tier.</i>
Tier 5: Specialty Drugs We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Standard cost sharing: You pay 32% of the total cost (retail or mail order). Preferred cost sharing: You pay 32% of the total cost (retail or mail order).	Standard cost sharing: You pay 32% of the total cost (retail or mail order). Preferred cost sharing: You pay 32% of the total cost (retail or mail order).

	2026 (this year)	2027 (next year)
Tier 6: Select Care Drugs We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Standard cost sharing: You pay \$0 per prescription (retail or mail order). Preferred cost sharing: You pay \$0 per prescription (retail or mail order).	Standard cost sharing: You pay \$0 per prescription (retail or mail order). Preferred cost sharing: You pay \$0 per prescription (retail or mail order).

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Medicare Clinical Research Studies	The URL listed for the Medicare publication <i>Medicare and Clinical Research Studies</i> is in Chapter 3 Section 5 of the <i>Evidence of Coverage</i> is www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf .	The URL listed for the Medicare publication <i>Medicare and Clinical Research Studies</i> is in Chapter 3 Section 5 of the <i>Evidence of Coverage</i> is Medicare.gov/coverage/clinical-research-studies .
MedMutual Advantage Travel Plus™ See Chapter 4, Section 2.2 of the <i>Evidence of Coverage</i> for details.	The contact information for activating this benefit is listed as follows: • Contact Customer Care at 1-800-982-3117 prior to leaving the plan service area and provide your travel dates to activate the MedMutual Advantage Travel Plus benefit.	The contact information for activating this benefit is listed as follows: • Contact Customer Care at 1-800-982-3117 prior to leaving the plan service area and provide your travel dates to activate the MedMutual Advantage Travel Plus benefit. This call must be made by the member.
Notice of Privacy Practices	The Notice of Privacy Practices in Chapter 6, Section 1.3 of your <i>Evidence of Coverage</i> has an effective date of April 14, 2003, with modifications effective September 23, 2013.	The Notice of Privacy Practices in Chapter 6, Section 1.3 of your <i>Evidence of Coverage</i> includes language updates, and has an effective date of February 16, 2026.
Quality Improvement Organization (QIO) contact information	The QIO for Ohio is listed in Chapter 2, Section 4 of the <i>Evidence of Coverage</i> under the Commence Health name with the web address www.livantaqio.cms.gov .	The QIO for Ohio is listed in Chapter 2, Section 4 of the <i>Evidence of Coverage</i> under the Commence Health name with the web address commencehealthqio.cms.gov .

	2026 (this year)	2027 (next year)
SilverSneakers® Fitness Program	The description of this program under Health and Wellness Education Programs in Chapter 4, Section 2 of the <i>Evidence of Coverage</i> notes that members have access to participating gyms and fitness centers, and to online resources to help them meet their personal wellness goals.	The description of this program under Health and Wellness Education Programs in Chapter 4, Section 2 of the <i>Evidence of Coverage</i> notes that members have access to participating gyms and fitness centers.
State Health Insurance Information Program	The URL listed in Chapter 2 and Chapter 2 and on the back cover of the <i>Evidence of Coverage</i> for the Ohio Senior Health Insurance Information Program (OSHIIP) is https://insurance.ohio.gov/about-us/divisions/oshiip .	The URL listed in Chapter 2 and Chapter 2 and on the back cover of the <i>Evidence of Coverage</i> for the Ohio Senior Health Insurance Information Program (OSHIIP) is https://insurance.ohio.gov/consumers/medicare/01-oshiip .
Transportation services See the Medical Benefits Chart in Chapter 4 of the <i>Evidence of Coverage</i> .	This benefit is described as below: You are eligible to receive limited health-related transportation services, at no extra cost to you. You may receive up to 24 one-way trips per year. Trips are limited to 35 miles per trip and must take place within our plan service area. For a full list of counties, go to Chapter 1, Section 2.2. This benefit is available for transportation provided by the contracted vendor to medical locations only. To use your transportation benefit or for more information, call Customer Care at 1-800-982-3117 (TTY 711 for hearing impaired). Non-urgent appointments should be scheduled at least three days in advance. Please note that urgent appointments requested with less than three days' notice will be accommodated based on the transportation network availability at that time and may not be guaranteed.	This benefit is described as below: You are eligible to receive limited health-related transportation services, at no extra cost to you. You may receive up to 24 one-way trips per year. Trips are limited to 35 miles per trip and must take place within our plan service area. For a full list of counties, go to Chapter 1, Section 2.2.

	2026 (this year)	2027 (next year)
		This benefit is available for transportation to medical locations only. You must use the contracted vendor for in-network cost sharing. To use your transportation benefit or for more information, call Customer Care at 1-800-982-3117 (TTY 711 for hearing impaired). All transportation requests must be made by the member. Non-urgent appointments should be scheduled at least three business days in advance. Please note that urgent appointments requested with less than three business days' notice will be accommodated based on the transportation network availability at that time and may not be guaranteed. Please note: Basic Life Support (BLS) and stretcher rides are not covered.

SECTION 3 How to Change Plans

To stay in MedMutual Advantage Preferred (PPO), you don't need to do anything. Unless you sign up for a different type of Medicare health plan or change to Original Medicare by December 7, 2026, you'll automatically be enrolled in our MedMutual Advantage Preferred (PPO).

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from MedMutual Advantage Preferred (PPO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage, you can** enroll in a Part D plan and you'll automatically be disenrolled from MedMutual Advantage Preferred (PPO).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Care at 1-800-982-3117 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).

To learn more about Original Medicare and the different types of Medicare plans, visit Medicare.gov, check the *Medicare & You 2027* handbook, call your State Health Insurance Assistance Program (go to Section 5, or call 1-800-MEDICARE (1-800-633-4227)). As a reminder, Medical Mutual offers other Medicare health plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2027, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2027.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
 - o 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
 - o Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
 - o Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Ohio AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 1-800-777-4775. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027 and you do not need to submit a new election request to continue participating in 2027. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-800-982-3117 (TTY users should call 711) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from MedMutual Advantage Preferred (PPO)

- **Call Customer Care at 1-800-982-3117. (TTY users call 711).**
We're available for phone calls 8 a.m. to 8 p.m. seven days a week from October 1 through 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). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Calls to these numbers are free.
- **Read your 2027 Evidence of Coverage**
This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the *2027 Evidence of Coverage* for MedMutual Advantage Preferred (PPO). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at MedMutual.com/MAplaninfo or call Customer Care at 1-800-982-3117 (TTY users call 711) to ask us to mail you a copy.
- **Visit MedMutual.com/MAplaninfo**
Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our List of Covered Drugs (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Ohio, the SHIP is called Ohio Senior Health Insurance Information Program (OSHIIP).

Call OSHIIP at 1-800-686-1578 (toll free) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call OSHIIP at 1-800-686-1578. Learn about OSHIIP by visiting <https://insurance.ohio.gov/consumers/medicare/01-oshiip>.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**
You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with Medicare.gov**
You can chat live at Medicare.gov/talk-to-someone.
- **Write to Medicare**
You can write to Medicare at PO Box 1270, Lawrence, KS 66044
- **Visit Medicare.gov**
The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.
- **Read *Medicare & You 2027***
The *Medicare & You 2027* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Notice of Availability of Language Assistance and Auxiliary Aids and Services



English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-382-5729 (TTY: 711) or speak to your provider.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-382-5729 (TTY: 711) o hable con su proveedor.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-382-5729 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Italian

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-800-382-5729 (TTY: 711) o parla con il tuo fornitore.

Russian

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-382-5729 (TTY: 1-711) или обратитесь к своему поставщику услуг.

French

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-382-5729 (TTY: 711) ou parlez à votre fournisseur.

Chinese

注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-800-982-3117 (文本电话: 711) 或咨询您的服务提供商。

Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-382-5729 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Arabic

،ةيبرعل اةغلل اةدحت تنك اذا :هينبتةيبرعلا امك .ةيناجملا ةيوعلل اةدعاسملا تامدخ كل رفوتتسف تامولعمل ري فوتل ةبسانم تامدخو ةدعاسم لئاسو رفوتت مقرلا يل ل لصتا .اناجم اهليل لوصولا نكمي تاقيسي ننتب 1-800-382-5729 (TTY: 711)

Korean

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-382-5729 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite/Oromo

HUBACHIISA: Yoo Afaan Oromoo dubbattu ta'e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajiloetni mijaa'oo ta'an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-382-5729 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-382-5729 (TTY: 711) o makipag-usap sa iyong provider.

Romanian

ATENȚIE: Dacă vorbiți Română, aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-382-5729 (TTY: 711) sau contactați-vă furnizorul.

Japanese

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-382-5729(TTY:711)までお電話ください。または、ご利用の事業者にご相談ください。

Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

Pennsylvania Dutch

WICHDIH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

Navajo

BAA'ÁKONÍNÍZIN: Diné bizaad bíyáti' nílt'íí', t'áá jíík'ehgo saad bee áká anilyeedígíí t'áá hóló. T'áá jíík'ehgo áká anilyeedígíí dóó bee haz'ánígíí t'áá hóló. t'áá íiyisí bee t'áá ájíík'ehgo. 1-800-382-5729 (TTY: 711) bich'í' hodíilnih dóó provider ní'doolnítł.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

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 (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>
- This notice is available at Medical Mutual's website:
www.MedMutual.com

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.

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.