2027 Annual Notice of Change

MedMutual Advantage Elite Preferred (PPO) Plan

Greater Toledo OH

(H4497-006-000)

Fulton, Lucas, Ottawa, Sandusky and Wood counties

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

Annual Notice of Change for 2027

You're enrolled as a member of Paramount Elite 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 Elite Preferred (PPO).
- To change to a **different plan**, visit 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 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 Elite Preferred (PPO)

- MedMutual Advantage Elite Preferred (PPO) is a PPO plan offered by Medical Mutual of Ohio with a Medicare contract. Enrollment in the MedMutual Advantage Elite 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 Elite Preferred (PPO).
- **On January 1, 2027, Medical Mutual of Ohio will be combining Paramount Insurance Company's Paramount Elite Preferred (PPO) with one of our plans, MedMutual Advantage Elite Preferred (PPO). This material tells you about the differences between your current benefits in Paramount Elite Preferred (PPO) and the benefits you'll have January 1, 2027 as a member of Medical Mutual of Ohio's MedMutual Advantage Elite Preferred (PPO).**
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in MedMutual Advantage Elite Preferred (PPO).** Starting January 1, 2027, you'll get your medical and drug coverage through MedMutual Advantage Elite 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 than this amount. Go to Section 1.1 for details.	$0	**$0**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1 for details.)	From network providers: $5,300 From network and out-of-network providers combined: $8,800	From **network providers: $5,300** From **network and out-of-network providers** combined: **$8,800**
Primary care office visits	**In Network** $0 copayment per visit **Out of Network** $10 copayment per visit	**In Network** **$0** copayment per visit **Out of Network** **$10** copayment per visit
Specialist office visits	**In Network** $35 copayment per visit **Out of Network** $55 copayment per visit	**In Network** **$35** copayment per visit **Out of Network** **$55** copayment per visit
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.	**In Network** Days 1 - 5: $400 copayment per day Day 6 and thereafter: $0 copayment **Out of Network** $425 copayment per day	**In Network** Days **1** - **5**: **$400** copayment per day Day **6 and thereafter: $0** copayment **Out of Network** **$425** copayment per day
Part D drug coverage (Go to Section 1.6 for details, including Yearly Deductible, Initial Coverage, and	**Part D drug coverage deductible:** $300 – except for covered insulin products and most adult Part D vaccines **Copayment/Coinsurance**	**Part D drug coverage deductible: $300** – except for covered insulin products and most adult Part D vaccines **Copayment/Coinsurance**

	2026 (this year)	2027 (next year)
Catastrophic Coverage Stages.)	**during the Initial Coverage Stage:**	**during the Initial Coverage Stage:**
	Drug Tier 1: **Preferred** retail pharmacies ***N/A***	Drug Tier 1: **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 ***N/A***	**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 • $0 copayment per prescription for up to a 30-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 • **$15** copayment per prescription for up to a 90-day supply
	Standard mail-order pharmacies • $0 copayment per prescription for up to a 30-day supply • $0 copayment per prescription for up to a 90-day supply	**Standard** mail-order pharmacies • **$6** copayment per prescription for up to a 30-day supply • **$12** copayment per prescription for up to a 60-day supply • **$14** copayment per prescription for up to a 90-day supply
	Drug Tier 2: **Preferred** retail pharmacies	Drug Tier 2: **Preferred** retail pharmacies

	2026 (this year)	2027 (next year)
	N/A	• **$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 ***N/A***	**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 • $0 copayment per prescription for up to a 30-day supply • $0 copayment per prescription for up to a 90-day supply	**Standard** network retail pharmacies • **$8** copayment per prescription for up to a 30-day supply • **$16** copayment per prescription for up to a 60-day supply • **$20** copayment per prescription for up to a 90-day supply
	Standard mail-order pharmacies • $0 copayment per prescription for up to a 30-day supply • $0 copayment per prescription for up to a 90-day supply	**Standard** mail-order pharmacies • **$8** copayment per prescription for up to a 30-day supply • **$16** copayment per prescription for up to a 60-day supply • **$19** copayment per prescription for up to a 90-day supply
	<u>Drug Tier 3:</u> **Standard** network retail and mail-order pharmacies • 21% of the total cost for up to a 30-day supply or 90-day supply	<u>Drug Tier 3:</u> **Preferred** and **standard** network retail and mail-order pharmacies • **21%** of the total cost for up to a 30-day supply, 60-day supply, or 90-day supply

	2026 (this year)	2027 (next year)
	You pay no more than $35 per month supply of each covered insulin product on this tier. Drug Tier 4: **Standard** network retail and mail-order pharmacies • 41% of the total cost for up to a 30-day supply or 90-day supply *You pay no more than $35 per month supply of each covered insulin product on this tier.* Drug Tier 5: **Standard** network retail and mail-order pharmacies • 29% of the total cost for up to a 30-day supply *You pay no more than $35 per month supply of each covered insulin product on this tier.* Drug Tier 6: ***N/A*** **Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs.	*You pay no more than $35 per month supply of each covered insulin product on this tier.* Drug Tier 4: **Preferred** and **standard** network retail and mail-order pharmacies • **38%** of the total cost for up to a 30-day supply, 60-day supply, or 90-day supply *You pay no more than $35 per month supply of each covered insulin product on this tier.* Drug Tier 5: **Preferred** and **standard** network retail and mail-order pharmacies • **30%** of the total cost for up to a 30-day supply Drug Tier 6: **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.)	$0	**$0** (No change from 2026)

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.

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) 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.	$5,300	**$5,300** (No change from 2026) Once you've paid $5,300 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.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) 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.	$8,800	**$8,800** (No change from 2026) Once you've paid $8,800 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.

Our network of pharmacies has changed 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 and Section 2.2 of your *Evidence of Coverage* 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	**In Network and Out of Network** $10 copayment for each covered visit	**In Network** **$0** copayment for each covered acupuncture service in a primary care physician's office **$35** copayment for each covered acupuncture service in a specialist's office **Out of Network** **$10** copayment for each covered acupuncture service in a primary care physician's office **$55** copayment for each covered acupuncture service in a specialist's office
Allergy testing and treatment – listed under "Physician/Practitioner Services" in Chapter 4, Section 2 of the 2026 *Evidence of Coverage* and under "Outpatient Diagnostic Tests and Therapeutic Services and Supplies" in the 2027 *Evidence of Coverage*	**In Network** $0 copayment for each covered allergy test or treatment in a primary care physician's office $35 copayment for each covered allergy test or treatment in a specialist's office **Out of Network** $10 copayment for each covered allergy test or treatment in a primary care physician's office $55 copayment for each covered allergy test or treatment in a specialist's office	**In Network** **$0** copayment for each covered allergy test or treatment **Out of Network** **40%** of the total cost for each covered allergy test or treatment
Ambulance services outside the United States – listed under "Emergency care" and "Urgently needed services" in Chapter 4, Section 2 of the *Evidence of Coverage*	$130 copayment for each one-way ambulance trip outside the United States	Ambulance services outside the United States are **not** covered.

	2026 (this year)	2027 (next year)
Annual in-home health assessment See Chapter 4, Section 2 of your *Evidence of Coverage* for more information.	$0 copayment	**In Network** **$0** copayment **Out of Network** **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.
Bathroom Safety Devices	$0 copayment for approved bathroom safety devices, up to a maximum of $100 per calendar year	Bathroom safety devices are **not** covered.
Dental services – see Chapter 4, Section 2 of your *Evidence of Coverage* for details.	Your plan covers preventive, diagnostic and comprehensive dental services up to a maximum of $4,000 per calendar year (combined for both in network and out of network). Diagnostic and comprehensive services are listed with visit limits for each service. Service-specific dental codes are listed. **In Network** $0 copayment for the following covered preventive services: 2 oral exams including 2 cleanings, 1 set of bitewing x-rays and 2 fluoride treatments $0 copayment for the following diagnostic and comprehensive services: diagnostic services, restorative services, endodontic services, periodontic services, extractions, and prosthodontic services. **Out of Network** 30% of the total cost for the preventive, diagnostic and comprehensive services listed above	Your plan covers preventive, diagnostic and comprehensive dental services up to a maximum of **$2,500** per calendar year (combined for both in network and out of network). No visit limits are listed for diagnostic and comprehensive services. No specific dental codes are listed. Please contact Customer Care with questions about your dental coverage. **In Network** **$0** copayment for the following covered preventive services: 2 oral exams including 2 cleanings, 1 set of bitewing x-rays and 2 fluoride treatments **$0** copayment for the following diagnostic and comprehensive services: diagnostic services, restorative services, endodontic services, periodontic services, and extractions. Prosthodontic services are **not** covered. **Out of Network** **30%** of the total cost for the preventive, diagnostic and comprehensive services listed

	2026 (this year)	2027 (next year)
		above
Diabetes self-management training, diabetic services, and supplies See Chapter 4, Section 2 of your *Evidence of Coverage* for more information.	**In Network** 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 monitor We only cover Accu-Chek and True Metrix blood glucose meters and blood glucose test strips at 0% coinsurance**.** We exclude (do not cover) other brands of meters and test strips unless you or your provider requests a prior authorization and our plan approves it. A 20% coinsurance applies to approved non-preferred blood glucose meters and test strips. Without plan prior approval, items will not be covered. You can get Accu-Chek and True Metrix test strips through CVS/Caremark or other in-network pharmacy locations. 20% of the total cost for all other diabetic supplies **Out of Network** We only cover Accu-Check and True Metrix blood glucose meters and blood glucose test strips at 0% coinsurance. We exclude (do not cover) other brands of meters and test strips unless you or your provider requests a prior authorization and our plan approves it. A 20% coinsurance applies to approved non-preferred blood glucose meters and test strips. Without plan approval, items will not be covered.	**In Network** **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 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 Preferred syringes and pen needles are also covered at zero cost-sharing under your Part D benefit. See plan formulary for preferred products. **Out of Network** **20%** of the total cost for all covered diabetic supplies ***See the "Durable Medical Equipment" listing below for cost-sharing for insulin pumps and continuous glucose monitors.***

	2026 (this year)	2027 (next year)
	20% of the total cost for all other diabetic supplies ***See the "Durable Medical Equipment" listing below for cost-sharing for insulin pumps and continuous glucose monitors.***	
Durable medical equipment (DME) and related supplies	**In Network** 25% of the total cost for Medicare-covered DME items, including continuous glucose monitors. We only cover **Dexcom** continuous glucose monitors at 25% coinsurance. We exclude (do not cover) other brands of monitors. 0% of the total cost for insulin pumps 25% of the total cost for Medicare oxygen equipment **Out of Network** 50% of the total cost for all covered durable medical equipment. We only cover **Dexcom** continuous glucose monitors at 50% coinsurance. We exclude (do not cover) other brands of monitors.	**In Network** **0%** of the total cost for insulin pumps **25%** of the total cost for continuous glucose monitors **Continuous glucose monitors (CGMs) are only covered with an approved prior authorization through a network DME provider. Coinsurance will apply.** **25%** of the total cost for all other durable medical equipment, including Medicare oxygen equipment **Additional prior authorization rules may apply. Please contact the plan for details.** **Out of Network** **50%** of the total cost for all covered durable medical equipment
Emergency care outside the United States	$130 copayment for each covered emergency room visit outside the United States Your plan covers up to a combined maximum of $100,000 for emergency care, urgent care, and ambulance services outside the United States.	**$130** 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 services outside the United States.
Health and wellness education programs – Nurse Line See Chapter 4, Section 2 of your *Evidence of Coverage* for more information.	Nurse Line is **not** covered. ***See Section 2 for additional Administrative Changes.***	**$0** copayment for Nurse Line ***See Section 2 for additional Administrative Changes.***

	2026 (this year)	2027 (next year)
Hearing services	**In Network** $30 copayment for each Medicare-covered visit	**In Network** **$20** copayment for each Medicare-covered visit
Additional hearing services Listed under "Hearing services" in Chapter 4, Section 2 of your *Evidence of Coverage*.	$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	**In Network** **$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 **Out of Network** **$0** copayment for each covered routine hearing exam or hearing aid fitting-evaluation visit **80%** of the total cost for each covered hearing aid **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 meals See Chapter 4, Section 2 of your *Evidence of Coverage* for more information.	$0 copayment for home meals	**In Network** **$0** copayment **Out of Network** **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.

	2026 (this year)	2027 (next year)
Medical nutrition therapy – additional sessions See Chapter 4, Section 2 of your *Evidence of Coverage* for more information.	$0 copayment for 6 additional nutrition therapy sessions beyond what is covered by Original Medicare	Additional nutrition therapy sessions beyond what is covered by Original Medicare are **not** covered.
MedMutual Advantage Travel Plus™ See Chapter 4, Section 2.2 of your *Evidence of Coverage* for more information.	MedMutual Advantage Travel Plus is **not** covered.	You pay the copayment or coinsurance for the corresponding service you receive, shown in the Medical Benefits Chart of Chapter 4 of your *Evidence of Coverage*. Your plan will cover medically necessary services up to **$7,500** per calendar year.
Over-the-counter (OTC) supplies If your plan includes this benefit, select health and wellness items can be purchased with your plan allowance. For more information, please call Customer Care at 1-800-982-3117.	$0 copayment for the over-the counter supplies benefit. Your plan includes a $75 quarterly allowance to purchase over-the-counter (OTC) health and wellness supplies at participating retail locations. You can also order online at ParamountHealthcare.com/ OTCbenefit.	**In Network** **$0** copayment for the over-the-counter supplies benefit. Your plan includes a **$25 quarterly allowance** to purchase eligible over-the-counter (OTC) items at participating retail locations using your benefit card. You can also order online by logging in to My Health Plan at MedMutual.com/member. **Please note:** You will not be able to register for My Health Plan until January 1, 2027. **Out of Network** **$0** copayment **Note:** Your plan will cover out-of-network over-the-counter items up to your maximum allowance. If you choose to obtain OTC items from an out-of-network provider, you must pay up front for these items and submit itemized receipts for reimbursement. Contact Customer Care for information about eligibility.

	2026 (this year)	2027 (next year)
Personal Emergency Response System (PERS) See Chapter 4, Section 2 of your *Evidence of Coverage* for more information.	$0 copayment for PERS	**In Network** **$0** copayment **Out of Network** **$0** copayment **Note:** Your plan will cover out-of-network personal emergency response system with emergency alert services up to the value of the PERS benefit. If you use an out-of-network provider, you must pay up front for services rendered and submit for reimbursement. Contact Customer Care for information about eligibility.
SilverSneakers® Fitness Program – see "Health and wellness education programs" in Chapter 4, Section 2 of your *Evidence of Coverage* for details	$0 copayment for SilverSneakers	**In Network** **$0** copayment for SilverSneakers **Out of Network** **80%** 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	**In Network** Days 1 through 20: $0 copayment per day Days 21 through 100: $218 copayment per day	**In Network** 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 *Evidence of Coverage* for details.	$0 copayment for additional coaching sessions	Additional coaching sessions are **not** covered.

	2026 (this year)	2027 (next year)
Urgently needed services outside the United States	$130 copayment for each urgent care center visit outside the United States Your plan covers up to a combined maximum of $100,000 for emergency care, urgent care, and ambulance services outside the United States.	**$130** 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 services outside the United States.
Virtual health visits – additional services through remote access technologies – see Chapter 4, Section 2 of your *Evidence of Coverage* for details.	$0 copayment for each virtual PCP visit $30 copayment for each virtual behavioral health visit	Additional services through remote access technologies are **not** covered.
Vision care – Original Medicare-covered services	**Out of Network** 10% of the total cost for up to one Medicare-covered glaucoma screening each year $40 copayment per visit for all other Medicare-covered eye exams and screenings For Original Medicare-covered eyeglasses or contact lenses after cataract surgery, you pay: • Any amount over $25 for plastic eyeglass lenses ($25 maximum annual reimbursement) • Any amount over $150 for eyeglass frames ($150 maximum annual reimbursement) • Any amount over $100 for contact lenses ($100 maximum annual reimbursement)	**Out of Network** **$40** copayment per visit for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye **$40** copayment for each covered diabetic retinopathy screening **10%** of the total cost for Medicare-covered glaucoma screening For Original Medicare-covered eyeglasses or contact lenses after cataract surgery, you pay: • **$25** copayment for plastic eyeglass lenses • **$150** copayment for eyeglass frames • **$150** copayment for contact lenses

	2026 (this year)	2027 (next year)
Vision care – additional coverage beyond what Original Medicare covers – see Chapter 4, Section 2 of your *Evidence of Coverage* for details.	**In Network and Out of Network** Your plan includes $200 (combined for in network and out of network) 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.	**In Network and Out of Network** Your plan includes **$130** (combined for in network and out of network) 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. **Out of Network** **$200** copayment for eyeglasses or contact lenses

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, please 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 $300. During this stage, you pay: • $0 (**standard** network retail or **standard** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 1**	**The deductible is $300.** 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 or **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 **$12** (**standard** mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 1**

	2026 (this year)	2027 (next year)
	• $0 (**standard** network retail or **standard** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 1** • $0 (**standard** network retail pharmacy or **standard** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 2** • $0 (**standard** network retail pharmacy or $0 (**standard** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 2** *and* **the full cost of drugs on Tier 3, Tier 4, and Tier 5** until you've reached the yearly deductible.	• **$0** (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 1** • **$15** (**standard** network retail pharmacy) or **$14** (**standard** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 1** • **$0** (**preferred** retail pharmacy) or **$0** (**preferred** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 2** • **$8** (**standard** network retail pharmacy or **standard** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 2** • **$0** (**preferred** retail pharmacy) or **$0** (**preferred** mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 2** • **$16** (**standard** network retail pharmacy or **standard** mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 2** • **$0** (**preferred** retail pharmacy) or **$0** (**preferred** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 2** • **$20** (**standard** network retail pharmacy) or **$19** (**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** *and* **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 $0 per prescription (retail) or $0 per prescription (mail order). ***Preferred** cost sharing:* ***N/A***	***Standard** cost sharing:* You pay **$6** per prescription (retail) or **$6** 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 $0 per prescription (retail) or $0 per prescription (mail order). ***Preferred** cost sharing:* ***N/A***	***Standard** cost sharing:* You pay **$8** per prescription (retail) or **$8** per prescription (mail order). ***Preferred** cost sharing:* You pay **$0** per prescription (retail) or **$0** 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 21% of the total cost (retail or mail order). ***Preferred** cost sharing:* ***N/A*** *You pay no more than $35 per month supply of each covered insulin product on this tier.*	***Standard** cost sharing:* You pay **21%** of the total cost (retail or mail order). ***Preferred** cost sharing:* You pay **21%** of the total cost (retail or mail order). *You pay no more than $35 per month supply of each covered insulin product on this tier.*

	2026 (this year)	2027 (next year)
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 41% of the total cost (retail or mail order). ***Preferred** cost sharing:* ***N/A*** *You pay no more than $35 per month supply of each covered insulin product on this tier.*	***Standard** cost sharing:* You pay **38%** of the total cost (retail or mail order). ***Preferred** cost sharing:* You pay **38%** of the total cost (retail or mail order). *You pay no more than $35 per month supply of each covered insulin product on this tier.*
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 29% of the total cost (retail or mail order). ***Preferred** cost sharing:* ***N/A*** *You pay no more than $35 per month supply of each covered insulin product on this tier.*	***Standard** cost sharing:* You pay **30%** of the total cost (retail or mail order). ***Preferred** cost sharing:* You pay **30%** of the total cost (retail or mail order).
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.	***N/A***	***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)
Company and plan name	Your plan, Paramount Elite Preferred (PPO), is a Medicare Advantage plan offered by Paramount Insurance Company.	Your plan, MedMutual Advantage Elite Preferred (PPO), is a Medicare Advantage plan offered by Medical Mutual of Ohio. Paramount Insurance Company is a wholly owned subsidiary of Medical Mutual of Ohio.

	2026 (this year)	2027 (next year)
Customer Care/Member Services	The contact information given throughout the *Evidence of Coverage* lists Member Services as follows: Phone: 1-833-554-2335 (TTY 711) Website: ParamountHealthcare.com/ MAplaninfo Mailing address: P.O. Box 928, Toledo, OH 43697 Hours: Monday through Friday 8:00 a.m. to 8:00 p.m., and October 1 to March 31, 8:00 a.m. to 8:00 p.m., 7 days a week	The contact information given throughout the *Evidence of Coverage* lists Customer Care as follows: Phone: 1-800-982-3117 (TTY 711) Website: MedMutual.com/MAplaninfo Mailing address: P.O. Box 94563 Cleveland, OH 44101-4563 Hours: 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)
Dental and vision exclusions	No additional exclusions specific to dental and vision coverage are listed after the exclusions chart in Chapter 4, Section 3 of the *Evidence of Coverage*.	A list of dental and vision exclusions are listed after the exclusions chart in Chapter 4, Section 3 of the *Evidence of Coverage*.
Dental services See Chapter 4, Section 2 of the *Evidence of Coverage*.	A list of specific dental codes is included in Chapter 4.	Contact the Customer Care team for specific dental code coverage.
Filing a complaint regarding an advance directive	For members seeking to file a complaint about instructions that were not followed in an advance directive, Chapter 8, Section 1.5 of the *Evidence of Coverage* provides contact information for the state departments of health in Ohio and Michigan.	For members seeking to file a complaint about instructions that were not followed in an advance directive, Chapter 8, Section 1.5 of the *Evidence of Coverage* provides contact information for the Ohio State Medical Board and the Ohio Department of Health.
Health and wellness education programs See Chapter 4, Section 2 of the *Evidence of Coverage* for details.	Two wellness programs are listed under the names “Enhanced Disease Management Programs” and “Health Education Program”.	These two wellness programs have been combined under one name: “Chronic Condition Management Program”.
Insulin tiers	Insulin falls under Tiers 3, 4, and 5.	Insulin falls under Tiers 3 and 4.

	2026 (this year)	2027 (next year)
Legal Notices See Chapter 11 of the *Evidence of Coverage*.	The Legal Notices chapter of the *Evidence of Coverage* includes notices for Paramount Insurance Company.	The Legal Notices chapter of the *Evidence of Coverage* includes notices for Medical Mutual of Ohio.
Mail-order supply for Part D prescription drugs See Chapter 5, Section 2.2 of the *Evidence of Coverage* for details.	Our plan's mail-order service allows you to order **up to a 90-day supply**.	Our plan's mail-order service allows you to order **up to a 90-day supply**. Our plan's preferred mail order service may have a lower cost-share compared to a standard mail order pharmacy. However, to take advantage of the lower cost-sharing, you must fill your prescription for at least a two-month supply. Please contact Part D Customer Service at 1-844-404-7947 for information.
Medicare Clinical Research Studies	The URL listed for the Medicare publication *Medicare and Clinical Research Studies* is in Chapter 3 Section 5 of the *Evidence of Coverage* is www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf.	The URL listed for the Medicare publication *Medicare and Clinical Research Studies* is in Chapter 3 Section 5 of the *Evidence of Coverage* is Medicare.gov/coverage/clinical-research-studies.
Medicare Prescription Payment Program	The contact information listed in Chapter 2, Section 7 of the *Evidence of Coverage* directs members to call CVS Caremark for additional information about the Medicare Prescription Payment Program.	The contact information listed in Chapter 2, Section 7 of the *Evidence of Coverage* directs members to call Customer Care at 1-800-982-3117 for additional information about the Medicare Prescription Payment Program.
Notice of Privacy Practices	Chapter 8, Section 1.3 of the *Evidence of Coverage* does not include a Notice of Privacy Practices.	Chapter 8, Section 1.3 of the *Evidence of Coverage* includes a Notice of Privacy Practices with an effective date of February 16, 2026.
Payment information	The information given in Chapter 1, Section 5 of the *Evidence of Coverage* about how to pay your plan premium describes Paramount processes for your Paramount Elite Preferred (PPO) plan, effective through December 31, 2026.	The information given in Chapter 1, Section 5 of the *Evidence of Coverage* about how to pay your plan premium describes Medical Mutual processes for your MedMutual Advantage Elite Preferred (PPO) plan, effective beginning January 1, 2027.

	2026 (this year)	2027 (next year)
PCP referrals	Chapter 3, Section 2.3 of the *Evidence of Coverage* explains when a PCP referral is needed for you to obtain care from a specialist or other in-network provider.	Chapter 3, Section 2.2 of the *Evidence of Coverage* indicates that you do not need a PCP referral to see a specialist or other in-network provider.
Personal Emergency Response System (PERS)	The contact information given in the Medical Benefits Chart in Chapter 4, Section 2 of the *Evidence of Coverage* is for NationsResponse.	The contact information given in the Medical Benefits Chart in Chapter 4, Section 2 of the *Evidence of Coverage* is for Customer Care.
Pharmacy network changes See the 2026 *Pharmacy Directory* for details.	CVS is part of the pharmacy network.	**CVS is no longer part of the pharmacy network.**
Plan service area See Chapter 1, Section 2.2 of Chapter 4 of the *Evidence of Coverage* for details.	The service area for Paramount Elite Preferred (PPO) includes counties in Ohio and in Michigan. **In Michigan:** Branch, Hillsdale, Lenawee, Monroe and Washtenaw **In Ohio:** Fulton, Lucas, Ottawa, Sandusky, and Wood.	The service area for MedMutual Advantage Elite Preferred (PPO) includes counties in Ohio. **In Ohio:** Fulton, Lucas, Ottawa, Sandusky, and Wood.
Prescription drug benefits See Chapter 5 and Chapter 6 of the *Evidence of Coverage* for details.	Your plan has 5 cost-sharing drug tiers. Your pharmacy choices include pharmacies that offer standard cost sharing.	Your plan has 6 cost-sharing drug tiers. Your pharmacy choices include pharmacies that offer preferred cost sharing and pharmacies that offer standard cost sharing.
Prescription drug contact information See Chapter 2, Section 1, Chapter 5; Section 2.2; and Chapter 7, Sections 1 and 2 of the *Evidence of Coverage* for details.	The contact information related to your prescription drug benefits lists phone numbers and addresses for CVS Caremark.	The contact information related to your prescription drug benefits lists phone numbers and addresses for Express Scripts.

	2026 (this year)	2027 (next year)
Quality Improvement Organization (QIO) contact information	The QIO for Ohio is listed in Chapter 2, Section 4 of the *Evidence of Coverage* 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 *Evidence of Coverage* under the Commence Health name with the web address commencehealthqio.cms.gov.
Services not listed in the Medical Benefits Chart that require approval in advance	Chapter 4, Section 2 of the *Evidence of Coverage* does not list additional services not shown in the Medical Benefits Chart that require approval in advance.	Chapter 4, Section 2 of the *Evidence of Coverage* lists additional services not shown in the Medical Benefits Chart that require approval in advance: • Artificial Heart Systems • Artificial Limbs and Prosthetic Devices • Bone Growth Stimulators • Carotid Artery Stenting • Cochlear Implant • Electrical Stimulation and Electromagnetic Therapy for Ulcers • Genetic Testing • Hyperbaric Therapy • Lumbar Spinal Fusion • Transcatheter Valve Replacement/Implantation • Transplants - Bone Marrow, Organs and Stem Cell • Uterine Artery Embolization for Treatment of Fibroids • Varicose Vein: Surgical Treatment and Sclerotherapy • Ventricular Assist Devices
SilverSneakers® Fitness Program	The description of this program under Health and Wellness Education Programs in Chapter 4, Section 2 of the *Evidence of Coverage* 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 *Evidence of Coverage* 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 *Evidence of Coverage* 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 *Evidence of Coverage* for the Ohio Senior Health Insurance Information Program (OSHIIP) is https://insurance.ohio.gov/consumers/medicare/01-oshiip.

SECTION 3 How to Change Plans

To stay in MedMutual Advantage Elite 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, you'll automatically be enrolled in our MedMutual Advantage Elite 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 Elite 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 Elite 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:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day,7 days a week.
  - 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.
  - 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 Elite 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 Elite 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

MEDICAL MUTUAL®

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 Sprachassistenzdienste 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

العربيةتنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 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 tajaajilootni 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。

Order Number: Z8188-MCA R8.25
Dept of Ins. Filing Number: Z8188-MCA R10.25

Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten 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

WICHDICH: 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'įį', 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 ájík'ehgo. 1-800-382-5729 (TTY: 711) bich'į' hodíilnih dóó provider ni'doolníił.

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- 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.

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100 American Road
Cleveland, OH 44144

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

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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
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