

## MedMutual Advantage® Elite Preferred PPO

H4497-006-000



### 2027 Summary of Benefits

This booklet gives you a summary of what we cover, from Jan. 1, 2027, through Dec. 31, 2027, and what you are responsible for. **It doesn't list every service we cover or list every limitation or exclusion.** To get a **complete list of covered services**, see our Evidence of Coverage by visiting **MedMutual.com/MAPlanInfo**.

### Things to know about MedMutual Advantage Elite Preferred PPO

#### Phone Numbers and Website

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

#### Hours of Operation

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

### You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the federal government
- Another choice is to get your Medicare benefits by joining a Medicare health plan such as MedMutual Advantage Elite Preferred (PPO)

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## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **MedMutual Advantage Elite Preferred (PPO)** covers and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on [Medicare.gov](https://www.medicare.gov).

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at [Medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille and large print. This document may be available in a non-English language. For additional information, call us at 1-800-982-3117 (TTY 711).

## Who can join?

To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. **Our service area includes the following counties in Ohio:** Fulton, Lucas, Ottawa, Sandusky and Wood.

## Which doctors, hospitals and pharmacies can I use?

Our plans have a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan’s provider and pharmacy directories at our website [MedMutual.com/MAplaninfo](https://www.MedMutual.com/MAplaninfo).
- Or call us and we will send you a copy of the provider and pharmacy directories.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers — and more.

- Our plan members get all the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.
- Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. Information on our Optional Supplemental Benefits is included in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs, such as chemotherapy and insulin, as well as some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website [MedMutual.com/MAplaninfo](https://www.MedMutual.com/MAplaninfo).
- Or call us and we will send you a copy of the formulary.

## How will I determine my drug costs?

Our plan groups each medication into one of six tiers. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier and what stage of the benefit you have reached. Later in this document, we discuss the following benefit stages: Deductible, Initial Coverage and Catastrophic Coverage.



## Plan Premium, Deductible and Max Out-of-Pocket (MOOP)

| Out-of-Pocket Costs                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly Plan Premium</b>                                                               | \$0 per month<br>You must continue to pay your Medicare Part B premium.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Plan Deductible</b>                                                                    | This plan does not have a deductible.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs.)</b> | <p>You'll pay no more than:</p> <ul style="list-style-type: none"> <li>\$5,300 annually for services you receive from in-network providers</li> <li>\$8,800 annually for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit</li> </ul> <p>Includes copayments and other costs for medical services for the year. If you reach the limit on out-of-pocket costs, you will keep receiving covered hospital and medical services, and Medical Mutual will pay the full cost for the rest of the year.</p> |



## Medical and Hospital Benefits (Services may require prior authorization.)(Services may require prior authorization.)

| Benefit                                         | Your Costs in Our Plan                                                                                                                                    |                      |
|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                 | In-Network                                                                                                                                                | Out-of-Network       |
| <b>Inpatient</b>                                | \$400 copay per day for days 1 through 5.<br>\$0 copay per day for days 6 and thereafter.<br>There is no limit to the number of days covered by the plan. | \$425 copay per stay |
| <b>Outpatient Hospital Observation Services</b> | \$360 copay for observation services per stay.                                                                                                            | 40% coinsurance      |
| <b>Outpatient Hospital Coverage</b>             | \$375 copay for all covered surgeries.                                                                                                                    | 40% coinsurance      |
| <b>Ambulatory Surgical Center Services</b>      | \$375 copay for all covered surgeries.                                                                                                                    | 40% coinsurance      |



## Doctor's Office Visits (Services may require prior authorization.)

| Benefit                            | Your Costs in Our Plan                                                                                                                                                                                                                                  |                |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|                                    | In-Network                                                                                                                                                                                                                                              | Out-of-Network |
| <b>Primary Care Provider Visit</b> | \$0 copay for each covered PCP visit.<br>You have the option to get these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. | \$10 copay     |
| <b>Specialist Visit</b>            | \$35 copay for each covered specialist visit.                                                                                                                                                                                                           | \$55 copay     |
| <b>Preventive Care</b>             | \$0 copay                                                                                                                                                                                                                                               | 0% coinsurance |

|  |                                                                                                                                                                                                                                                               |  |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
|  | <p>For a full list of preventive services available, see your Evidence of Coverage. Some covered services may have an associated cost.</p> <p>There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.</p> |  |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|



### Emergency and Urgent Care (Services may require prior authorization.)

| Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Your Costs in Our Plan                                                                                                                                                                        |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | In-Network                                                                                                                                                                                    | Out-of-Network |
| <b>Emergency Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$130 copay for each covered emergency room visit.<br>If you are admitted to the hospital within 24 hours, you do not have to pay the \$130 copay.                                            |                |
| <b>Urgently Needed Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$35 copay for each covered urgent care center visit.<br>An urgently needed service is a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. |                |
| <b>Ground Ambulance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$295 copay for each covered ground ambulance trip.                                                                                                                                           | \$295 copay    |
| <b>Air Ambulance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$295 copay for air ambulance services.                                                                                                                                                       | \$295 copay    |
| <p><b>You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to \$25,000 per calendar year. This applies if you are traveling outside the United States for less than six months. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay up front for the services rendered. You must submit receipts to Medical Mutual for reimbursement. See Evidence of Coverage for full benefit details.</b></p> |                                                                                                                                                                                               |                |



### Diagnostic Services, Labs and Imaging (Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.)

| Benefit                                                                       | Your Costs in Our Plan                                          |                 |
|-------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------|
|                                                                               | In-Network                                                      | Out-of-Network  |
| <b>Diagnostic Tests and Services</b>                                          | \$50 copay for each covered diagnostic test and service.        | 10% coinsurance |
| <b>Diagnostic Radiological Services (CT/MRI/PET Scans)</b>                    | \$130 copay for each covered service.                           | 10% coinsurance |
| <b>Lab services</b>                                                           | \$0 copay for each covered lab service.                         | 40% coinsurance |
| <b>Outpatient X-rays</b>                                                      | \$50 copay for each covered X-ray service.                      | 10% coinsurance |
| <b>Therapeutic radiology services (such as radiation therapy for cancer.)</b> | 20% coinsurance for each covered therapeutic radiology service. | 40% coinsurance |



## Hearing Services (Additional in-network services provided by TruHearing providers.)

| Benefit                                                      | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diagnostic Hearing Exam</b>                               | \$20 copay for each covered hearing exam to determine if you need medical treatment for a hearing condition. <ul style="list-style-type: none"> <li>Out-of-network: 10% coinsurance</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Routine hearing exam (1 every year)</b>                   | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Hearing aid fitting-evaluation visits</b>                 | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>TruHearing-branded hearing aids (1 per ear, per year)</b> | \$499 copay for each covered Standard hearing aid.<br>\$699 copay for each covered Advanced hearing aid.<br>\$999 copay for each covered Premium hearing aid.<br>Any cost you pay for hearing aids will not count toward your maximum out-of-pocket. <ul style="list-style-type: none"> <li>Out-of-network: 80% coinsurance. Your plan will cover out-of-network hearing aids up to the value of the in-network benefit. If you use an out-of-network provider, you must pay up front for services rendered and submit itemized receipts including date(s) of service to Medical Mutual for reimbursement.</li> </ul> |



## Dental Services (Diagnostic, preventive and comprehensive services.) (Diagnostic, preventive and comprehensive services.)

| Benefit                                 | Your Costs in Our Plan                                                                                                                                                                                                     |                                                                  |
|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
|                                         | In-Network Costs                                                                                                                                                                                                           | Out-of-Network Costs                                             |
| <b>Diagnostic and Preventive Dental</b> | \$0 copay for: <ul style="list-style-type: none"> <li>Oral exams (2 every year)</li> <li>Cleanings (2 every year)</li> <li>Dental bitewing X-ray (1 set every year)</li> <li>Fluoride treatments (2 every year)</li> </ul> | 30% coinsurance for all covered dental services.                 |
| <b>Comprehensive Dental</b>             | 0% coinsurance for restorative services and extractions                                                                                                                                                                    | 30% coinsurance for covered restorative services and extractions |

This plan covers up to a maximum of \$2,500 (combined amount for both in and out-of-network providers) per calendar year for select comprehensive and preventive dental services, including diagnostic X-rays; restorative services, such as fillings; non-surgical extractions; denture repair, reline or adjustment; crowns; endodontic services; and periodontic services. For coverage and cost information, see this plan's Evidence of Coverage.



## Vision Services

| Benefit                             | Your Costs in Our Plan                                                                                                                                               |                                                                                                                              |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
|                                     | In-Network Costs                                                                                                                                                     | Out-of-Network                                                                                                               |
| <b>Vision Services</b>              | <p>\$30 copay for Original Medicare covered vision services.</p> <p>\$0 copay for Original Medicare covered eyeglasses or contact lenses after cataract surgery.</p> | <p>\$40 copay</p> <p>\$25-\$150 copay for Original Medicare covered eyeglasses or contact lenses after cataract surgery.</p> |
| <b>Routine Eye Exam</b>             | \$0 copay (1 every year).                                                                                                                                            | \$30 copay                                                                                                                   |
| <b>Contact Lenses or Eyeglasses</b> | \$130 allowance toward contact lenses or eyeglasses (frames and lenses, 1 pair every year). You are responsible for any amount more than \$130.                      |                                                                                                                              |



## Mental Health Care (Services may require prior authorization.)

| Benefit                                    | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
|                                            | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Out-of-Network                    |
| <b>Inpatient Visit</b>                     | <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period starts the first day you go into the hospital. The benefit period ends when you haven't had any inpatient care for 60 days in a row.</p> <p>The plan covers 90 days each benefit period. You have 60 lifetime reserve days that can be used for an inpatient psychiatric admission. You have no copayment for these extra days.</p> <ul style="list-style-type: none"> <li>\$295 copay per day for days 1 through 5</li> <li>\$0 copay per day for days 6 through 90</li> </ul> | \$295 copay for days 1 through 90 |
| <b>Outpatient Individual Therapy Visit</b> | \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$60 copay                        |
| <b>Outpatient Group Therapy Visit</b>      | \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$60 copay                        |



### Outpatient Substance Use Disorder Services (Services may require prior authorization.)

| Benefit                     | Your Costs in Our Plan                                                                           |                 |
|-----------------------------|--------------------------------------------------------------------------------------------------|-----------------|
|                             | In-Network                                                                                       | Out-of-Network  |
| Individual or Group Therapy | \$40 copay for each covered therapy visit. This applies to an individual or group therapy visit. | 40% coinsurance |



### Skilled Nursing Facility (SNF) Care (Services may require prior authorization.)

| Benefit                       | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
|                               | In-Network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Out-of-Network           |
| Skilled Nursing Facility Care | <p>We will pay for skilled nursing facility care for up to 100 days per benefit period. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to how many benefit periods you can have.</p> <ul style="list-style-type: none"> <li>\$0 copay per day for days 1 through 20</li> <li>\$221 copay per day for days 21 through 100</li> </ul> | 40% coinsurance per stay |



### Outpatient Rehabilitation Services (Services may require prior authorization.)

| Benefit                                      | Your Costs in Our Plan               |                 |
|----------------------------------------------|--------------------------------------|-----------------|
|                                              | In-Network                           | Out-of-Network  |
| Physical Therapy and Speech/Language Therapy | \$15 copay for each covered visit.   | 10% coinsurance |
| Occupational Therapy Visit                   | \$15 copay for each covered visit.   | \$30 copay      |
| Cardiac (Heart) Rehabilitation Service       | \$25 copay for each covered service. | 10% coinsurance |
| Pulmonary (Lung) Rehabilitation Service      | \$35 copay for each covered service. | 10% coinsurance |



## Medicare Part B Drugs

(Part B drugs may require prior authorization and may be subject to step therapy requirements.)

| Benefit                                                                                              | Your Costs in Our Plan                                                                                                                                                                                                                               |                   |
|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
|                                                                                                      | In-Network                                                                                                                                                                                                                                           | Out-of-Network    |
| Part B Drugs                                                                                         | <p>0 – 20% coinsurance for chemotherapy and other drugs covered by Medicare Part B.</p> <p>Some drugs are covered by Medicare Part B, and some are covered by Medicare Part D. Part B drugs do not count toward your Part D out-of-pocket costs.</p> | 0-20% coinsurance |
| Part B Insulin                                                                                       | You will pay no more than a \$35 copay for a one-month supply of insulin.                                                                                                                                                                            |                   |
| To view a list of Part B drugs that may be subject to Step Therapy visit<br>MedMutual.com/MAplaninfo |                                                                                                                                                                                                                                                      |                   |



## Outpatient Prescription Drugs

| Benefit                 | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b>       | \$300 for Part D prescription drugs, except for drugs listed on Tiers 1, 2 and 6 which are excluded from the deductible. The deductible also does not apply to covered insulin products and most adult Part D vaccines.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Initial Coverage</b> | <p>You pay the following until your total out-of-pocket costs reach \$2,400.</p> <p><b>Retail cost sharing (preferred/standard):</b></p> <p>Tier 1 (preferred generic drugs)</p> <ul style="list-style-type: none"> <li>One-month supply: \$0/\$6 copay</li> <li>Two-month supply: \$0/\$12 copay</li> <li>Three-month supply: \$0/\$15 copay</li> </ul> <p>Tier 2 (generic drugs):</p> <ul style="list-style-type: none"> <li>One-month supply: \$0/\$8 copay</li> <li>Two-month supply: \$0/\$16 copay</li> <li>Three-month supply: \$0/\$20 copay</li> </ul> <p>Tier 3 (preferred brand and generic drugs):</p> <ul style="list-style-type: none"> <li>One-month supply: 21%/21% coinsurance</li> <li>Two-month supply: 21%/21% coinsurance</li> <li>Three-month supply: 21%/21% coinsurance</li> </ul> <p>Tier 4 (non-preferred drugs):</p> <ul style="list-style-type: none"> <li>One-month supply: 38%/38% coinsurance</li> <li>Two-month supply: 38%/38% coinsurance</li> <li>Three-month supply: 38%/38% coinsurance</li> </ul> <p>Tier 5 (specialty tier drugs):</p> <ul style="list-style-type: none"> <li>One-month supply: 30%/30% coinsurance</li> <li>Two-month supply: Not covered</li> <li>Three-month supply: Not covered</li> </ul> <p>Tier 6 (select care drugs):</p> <ul style="list-style-type: none"> <li>One-month supply: \$0/\$0 copay</li> <li>Two-month supply: \$0/\$0 copay</li> <li>Three-month supply: \$0/\$0 copay</li> </ul> |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Mail-order cost sharing (preferred/standard):</b><br>Tier 1 (preferred generic drugs): <ul style="list-style-type: none"> <li>One-month supply: \$0/\$6 copay</li> <li>Two-month supply: \$0/\$12 copay</li> <li>Three-month supply: \$0/\$14 copay</li> </ul> Tier 2 (generic drugs): <ul style="list-style-type: none"> <li>One-month supply: \$0/\$8 copay</li> <li>Two-month supply: \$0/\$16 copay</li> <li>Three-month supply: \$0/\$19 copay</li> </ul> Tier 3 (preferred brand and generic drugs): <ul style="list-style-type: none"> <li>One-month supply: 21%/21% coinsurance</li> <li>Two-month supply: 21%/21% coinsurance</li> <li>Three-month supply: 21%/21% coinsurance</li> </ul> Tier 4 (non-preferred drugs): <ul style="list-style-type: none"> <li>One-month supply: 38%/38% coinsurance</li> <li>Two-month supply: 38%/38% coinsurance</li> <li>Three-month supply: 38%/38% coinsurance</li> </ul> Tier 5 (specialty tier drugs): <ul style="list-style-type: none"> <li>One-month supply: 30%/30% coinsurance</li> <li>Two-month supply: Not covered</li> <li>Three-month supply: Not covered</li> </ul> Tier 6 (select care drugs): <ul style="list-style-type: none"> <li>One-month supply: \$0/\$0 copay</li> <li>Two-month supply: \$0/\$0 copay</li> <li>Three-month supply: \$0/\$0 copay</li> </ul> |
| <p>You may get your drugs at any network retail or mail order pharmacy.</p> <p>You won't pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't met your deductible.</p> <p>If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.</p> <p>In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Catastrophic Coverage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              | When you (or those paying on your behalf) have spent a total of \$2,400 in out-of-pocket costs within the benefit period, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |



### Over-the-Counter Items

| Benefit                                          | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Quarterly Over-the-Counter Allowance</b>      | This plan includes a \$25 quarterly allowance to be used toward the purchase of eligible over-the-counter (OTC) health and wellness supplies. Please note: unused amounts in your OTC allowance do NOT carry over from quarter to quarter or to the next calendar year. For more information, visit <a href="https://www.MedMutual.com/OTC">MedMutual.com/OTC</a> . |
| <b>Personal Emergency Response System (PERS)</b> | \$0 copay.<br>This plan includes access to a PERS offering featuring: <ul style="list-style-type: none"> <li>Two-way voice communication to monitoring center</li> <li>Water-resistant pendant or wristband</li> <li>24/7/365 monitoring service</li> </ul> See your Evidence of Coverage for full benefit details and requirements.                                |



**MedMutual Advantage Travel Plus™**  
(Services may require prior authorization.)

| Benefit                                | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MedMutual Advantage Travel Plus</b> | Up to \$7,500 maximum per calendar year.<br>Through this benefit, you have coverage under this plan for medically necessary services you receive while you are temporarily outside Ohio, but still within the United States. The actual benefits payable are based upon the services you receive. Although services received outside Ohio would normally be considered outside of our network, your coverage under this benefit is paid at the in-network level.<br><b>You must use a provider who accepts Medicare and contact Customer Care at 1-800-982-3117 (TTY 711) prior to your departure to activate this benefit.</b> See your Evidence of Coverage for full benefit details and requirements. |



**Foot Care (Podiatry Services)**  
(Services may require prior authorization.)

| Benefit                         | Your Costs in Our Plan                      |                 |
|---------------------------------|---------------------------------------------|-----------------|
|                                 | In-Network                                  | Out-of-Network  |
| <b>Foot Exams and Treatment</b> | \$25 copay for each covered podiatry visit. | 40% coinsurance |



**Medical Equipment and Supplies**  
(Services may require prior authorization.)

| Benefit                                                                                                                                                                                                                | Your Costs in Our Plan                                                                                 |                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                        | In-Network                                                                                             | Out-of-Network                                                                      |
| <b>Durable Medical Equipment (DME) (Wheelchairs, Oxygen, etc.)</b>                                                                                                                                                     | 0% coinsurance for insulin pumps.<br>25% coinsurance for durable medical equipment, diabetic monitors. | 50% coinsurance for durable medical equipment, diabetic monitors and insulin pumps. |
| <b>Prosthetic and Orthotic Devices and Related Supplies (Braces, Artificial Limbs, etc.)</b>                                                                                                                           | 20% coinsurance                                                                                        | 20% coinsurance                                                                     |
| <b>You must get DME through participating suppliers. Continuous glucose monitors are only covered with an approved prior authorization. Coinsurance may apply. See your Evidence of Coverage for more information.</b> |                                                                                                        |                                                                                     |



## Diabetic Supplies and Services (Services may require prior authorization.)

| Benefit                                           | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Diabetic Supplies and Services</b>             | 0-20% coinsurance (In-Network)<br>20% coinsurance (Out-of-Network)<br><br>0% coinsurance for the following diabetic supplies: <ul style="list-style-type: none"><li>- A blood glucose meter</li><li>- Blood glucose test strips</li><li>- Lancing devices and glucose lancets</li><li>- Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors</li></ul><br>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. |
| <b>Other Covered Diabetic Supplies</b>            | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>One-Month Supply of Insulin</b>                | No more than \$35 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>See Evidence of Coverage for more details.</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



## Alternative Medicine

| Benefit                  | Your Costs in Our Plan                                                   |                |
|--------------------------|--------------------------------------------------------------------------|----------------|
|                          | In-Network                                                               | Out-of-Network |
| <b>Chiropractic Care</b> | \$15 copay                                                               | \$60 copay     |
|                          | Only manual manipulation of the spine to correct subluxation is covered. |                |



## Health and Wellness Education Programs (Services may require prior authorization. See your Evidence of Coverage for more information.)

| Benefit                                     | Your Costs in Our Plan                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Chronic Condition Management Program</b> | This program can help you stay healthy, manage your chronic conditions and maintain your independence. A trained health coach works with you to develop a personalized plan that supplements the care you get from your doctor. For more information call Customer Care at 1-800-982-3117 (TTY 711).                                                                                                   |
| <b>Home Meals Program</b>                   | After a qualifying acute inpatient stay within 30 days of discharge, you are eligible to receive a one-week course of meals at no extra cost. You will receive two meals a day for seven days, delivered to your home. <ul style="list-style-type: none"><li>▪ Out-of-network: 80% coinsurance. Your plan will cover out-of-network home meals up to the value of the in-network benefit. If</li></ul> |

|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        | you use an out-of-network provider, you must pay up front for services rendered and submit itemized receipts including date(s) of service to Medical Mutual for reimbursement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Nurse Line</b>                      | If you have questions about symptoms but aren't sure if you need to see your doctor, the Nurse Line may be able to help. Members can call our Nurse Line at 1-888-912-0636 (TTY 711), 24 hours a day, seven days per week for advice. Calls are kept confidential.                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>SilverSneakers® Fitness Program</b> | <p>SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members have access to participating gyms and fitness centers to help them meet their personal wellness goals.</p> <p>Please note: Nonstandard fitness center services that usually have an extra fee are not included in this membership.</p> <ul style="list-style-type: none"> <li>▪ Out-of-network: 80% coinsurance. Your plan will cover out-of-network fitness programs up to the value of the in-network benefit. If you use an out-of-network provider, you must pay up front for services rendered and submit itemized receipts including date(s) of service for reimbursement.</li> </ul> |



### Home Health and Hospice Care (Services may require prior authorization.)

| Benefit                          | Your Costs in Our Plan                                                                                                                                                                   |                 |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
|                                  | In-Network                                                                                                                                                                               | Out-of-Network  |
| <b>Home Health Care Services</b> | \$0 copay                                                                                                                                                                                | 10% coinsurance |
| <b>Hospice</b>                   | When you enroll in a Medicare certified hospice program, your hospice services (and any Part A or Part B services related to your terminal prognosis) are paid for by Original Medicare. |                 |



### Renal Dialysis (Services may require prior authorization.)(Services may require prior authorization.)

| Benefit                                               | Your Costs in Our Plan |                 |
|-------------------------------------------------------|------------------------|-----------------|
|                                                       | In-Network             | Out-of-Network  |
| <b>Covered Dialysis Equipment</b>                     | 25% coinsurance        | 50% coinsurance |
| <b>Covered Dialysis Supplies</b>                      | 20% coinsurance        | 20% coinsurance |
| <b>See Evidence of Coverage for more information.</b> |                        |                 |

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

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

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TruHearing® is a registered trademark of TruHearing, Inc.