MEDICAL MUTUAL®

2017 Summary of Benefits

MedMutual Advantage PPO Plans

Region 1 Ohio Counties

Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood, Wyandot

[This page intentionally left blank]

Multi-Language Interpreter Services

MEDICAL MUTUAL®

ATTENTION: If you speak <insert language>, language assistance services, free of charge, are available to you. Call 1-800-382-5729 (TTY:711).

Spanish

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

Chinese

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

German

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

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك (بالمجان. اتصل برقم 1-800-283-008-9275 رقم هاتف الصم والبكم:117).

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

[This page intentionally left blank]

Nondiscrimination Notice

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

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

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can contact:

Paul Mancino, Vice President, Assistant General Counsel & Deputy Compliance Officer
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355

Phone: (216) 687-2675
Fax: (216) 687-2623
Email: paul.mancino@medmutual.com

You can file a grievance in person or by mail, fax or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

[This page intentionally left blank]

2017 Medicare Star Ratings*

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

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

Some of the areas Medicare reviews for these ratings include:

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

For 2017, Medical Mutual of Ohio received the following Overall Star Rating from Medicare.

Plan too new to be measured

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

Health Plan Services:	Plan too new to be measured
Drug Plan Services:	Plan too new to be measured

The number of stars shows how well our plan performs.

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

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

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 866-406-8777 (toll-free) or 711 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday from 8:00 a.m. to 8:00 p.m. Eastern time, Tuesday from 8:00 a.m. to 8:00 p.m. Eastern time, Wednesday from 8:00 a.m. to 8:00 p.m. Eastern time, Thursday from 8:00 a.m. to 8:00 p.m. Eastern time, Friday from 8:00 a.m. to 8:00 p.m. Eastern time, Saturday from 9:00 a.m. to 1:00 p.m. Eastern time.

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

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

Y0121_P_S0224_2017_Oct16 CMS Accepted
Z8250-MCA 10/16

[This page intentionally left blank]

MEDICAL MUTUAL®

Summary of Benefits

January 1, 2017 – December 31, 2017

MedMutual Advantage Select (PPO)
MedMutual Advantage Preferred (PPO)
MedMutual Advantage Premium (PPO)

MedMutual Advantage HMO and PPO plans are offered by Medical Mutual of Ohio under a contract with Medicare. Enrollment in these plans depends on contract renewal.

Y0121_P_S0022_2017_Aug16a CMS Accepted

Summary of Benefits

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the Evidence of Coverage.

You 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 Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO)).

Tips for comparing your Medicare choices

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

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at Medicare.gov or get a copy by calling (800) MEDICARE ((800) 633-4227), 24 hours a day, seven days a week. TTY users should call (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 (800) 982-3117.

Things to know about MedMutual Advantage Select (PPO), MedMutual Advantage Preferred (PPO) and MedMutual Advantage Premium (PPO)

Hours of Operation

- From October 1 to February 14 (except Thanksgiving and Christmas), you can call us seven days a week from 8 a.m. to 8 p.m.
- From February 15 to September 30 (except holidays), you can call us Monday through Friday from 8 a.m. to 8 p.m and Saturday from 9 a.m. to 1 p.m.
- Our automated telephone system is also available 24 hours a day, seven days a week for self-service options.

Phone Numbers and Website

- If you are a member of this plan, call toll-free (800) 982-3117. TTY users should call 711.
- If you are not a member of this plan, call toll-free (866) 406-8777. TTY users should call 711.
- Our website: MedMutual.com/Medicare

Who can join?

To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following counties in Ohio: Ashland, Brown, Butler, Carroll, Clark, Clermont, Columbiana, Cuyahoga, Delaware, Fairfield, Franklin, Fulton, Geauga, Greene, Hamilton, Hancock, Hocking, Holmes, Lake, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Miami, Montgomery, Morgan, Morrow, Perry, Pickaway, Portage, Seneca, Stark, Summit, Trumbull, Union, Warren, Wayne, Wood and Wyandot.

Which doctors, hospitals and pharmacies can I use?

Our plans have a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can see our plan's provider directory at our website, MedMutual.com/Medicare.
- You can see our plan's pharmacy directory at our website, MedMutual.com/Medicare.
- Or call us and we will send you a copy of the provider and pharmacy directories.

Summary of Benefits

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

- Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.
- Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

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

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

How will I determine my drug costs?
Our plan groups each medication into one of five tiers. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap and Catastrophic Coverage.

[This page intentionally left blank]

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
How much is the monthly premium?	$39 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. ▪ $1,500 per year for out-of-network services. ▪ $195 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: ▪ $6,350 for services you receive from in-network providers. ▪ $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year. Please note you will still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
$69 per month. In addition, you must keep paying your Medicare Part B premium.	$109 per month. In addition, you must keep paying your Medicare Part B premium.
This plan has deductibles for some hospital and medical services. ▪ $1,000 per year for out-of-network services. ▪ This plan does not have a deductible for Part D prescription drugs	This plan has deductibles for some hospital and medical services. ▪ $500 per year for out-of-network services. ▪ This plan does not have a deductible for Part D prescription drugs.
Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: ▪ $4,900 for services you receive from in-network providers. ▪ $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year. Please note you will still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: ▪ $3,600 for services you receive from in-network providers. ▪ $10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year. Please note you will still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.
Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Inpatient Hospital Care *(Services may require prior authorization.)*	Our plan covers an unlimited number of days for an inpatient hospital stay. ▪ In-network: – $325 copay per day for days 1 through 5 – You pay nothing per day for days 6 through 90 – You pay nothing per day for days 91 and beyond ▪ Out-of-network: 30% of the cost per stay
Doctor's Office Visits *(Services may require prior authorization.)*	Primary care physician visit: ▪ In-network: $10 copay ▪ Out-of-network: 30% of the cost Specialist visit: ▪ In-network: $45 copay ▪ Out-of-network: 30% of the cost If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.
Preventive Care	▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Our plan covers many preventive services, including: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Bone mass measurement ▪ Breast cancer screening (mammogram) ▪ Cardiovascular disease (behavioral therapy) ▪ Cardiovascular screenings ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▪ Depression screening ▪ Diabetes screenings ▪ HIV screening ▪ Medical nutrition therapy services ▪ Obesity screening and counseling ▪ Prostate cancer screenings (PSA)

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Our plan covers an unlimited number of days for an inpatient hospital stay. ▪ In-network: – $295 copay per day for days 1 through 6 – You pay nothing per day for days 7 through 90 – You pay nothing per day for days 91 and beyond ▪ Out-of-network: 30% of the cost per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. ▪ In-network: – $220 copay per day for days 1 through 6 – You pay nothing per day for days 7 through 90 – You pay nothing per day for days 91 and beyond ▪ Out-of-network: 30% of the cost per stay
Primary care physician visit: ▪ In-network: $5 copay ▪ Out-of-network: 30% of the cost Specialist visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.	Primary care physician visit: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Specialist visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost If you are having your Welcome to Medicare physical or yearly wellness visit, there is no copay.
▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Our plan covers many preventive services, including: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Bone mass measurement ▪ Breast cancer screening (mammogram) ▪ Cardiovascular disease (behavioral therapy) ▪ Cardiovascular screenings ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▪ Depression screening ▪ Diabetes screenings ▪ HIV screening ▪ Medical nutrition therapy services ▪ Obesity screening and counseling ▪ Prostate cancer screenings (PSA)	▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Our plan covers many preventive services, including: ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse counseling ▪ Bone mass measurement ▪ Breast cancer screening (mammogram) ▪ Cardiovascular disease (behavioral therapy) ▪ Cardiovascular screenings ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) ▪ Depression screening ▪ Diabetes screenings ▪ HIV screening ▪ Medical nutrition therapy services ▪ Obesity screening and counseling ▪ Prostate cancer screenings (PSA)

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Preventive Care (cont.)	▪ Sexually transmitted infections screening and counseling ▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▪ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots ▪ Welcome to Medicare preventive visit (one-time) ▪ Yearly wellness visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.
Urgently Needed Services	$40 copay
Diagnostic Tests, Lab and Radiology Services and X-rays *(Costs for these services may be different if received in an outpatient surgery setting. Services may require prior authorization.)*	Diagnostic radiology services (such as MRIs, CT scans): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Diagnostic tests and procedures: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Lab services: ▪ In-network: $0–10 copay, depending on the service ▪ Out-of-network: 30% of the cost Outpatient X-rays: ▪ In-network: $50 copay ▪ Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
▪ Sexually transmitted infections screening and counseling ▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▪ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots ▪ Welcome to Medicare preventive visit (one-time) ▪ Yearly wellness visit Any additional preventive services approved by Medicare during the contract year will be covered.	▪ Sexually transmitted infections screening and counseling ▪ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▪ Vaccines, including flu shots, hepatitis B shots, pneumococcal shots ▪ Welcome to Medicare preventive visit (one-time) ▪ Yearly wellness visit Any additional preventive services approved by Medicare during the contract year will be covered.
$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.	$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the Inpatient Hospital Care section of this booklet for other costs.
$40 copay	$40 copay
Diagnostic radiology services (such as MRIs, CT scans): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Diagnostic tests and procedures: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Lab services: ▪ In-network: $0–5 copay, depending on the service ▪ Out-of-network: 30% of the cost Outpatient X-rays: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, CT scans): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Diagnostic tests and procedures: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Lab services: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Outpatient X-rays: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Hearing Services	Exam to diagnose and treat hearing and balance issues: ▪ In-network: $45 copay ▪ Out-of-network: 30% of the cost
Dental Services *(In-network services provided by DenteMax providers.)*	Limited medically necessary dental services covered under Original Medicare (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). (If you want to purchase additional dental coverage, see the Optional Benefits on page 34): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost A single office visit that includes: ▪ Cleaning (1 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (1 every year) – In-network: $25 copay – Out-of-network: 50% of the cost

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Exam to diagnose and treat hearing and balance issues: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Exam to diagnose and treat hearing and balance issues: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
Limited medically necessary dental services covered under Original Medicare (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). (If you want to purchase additional dental coverage, see the Optional Benefits on page 35): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost A single office visit that includes: ▪ Cleaning (1 every year) ▪ Dental X-ray (1 every year) ▪ Oral exam (1 every year) – In-network: $25 copay – Out-of-network: 50% of the cost	Limited medically necessary dental services covered by Original Medicare (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Preventive dental services: ▪ Cleaning (up to 2 every year) – In-network: You pay nothing – Out-of-network: 50% of the cost ▪ Dental X-ray (1 every year) – In-network: You pay nothing – Out-of-network: 50% of the cost ▪ Oral exam (up to 2 every year) – In-network: You pay nothing – Out-of-network: 50% of the cost Our plan pays up to $1,000 every year for most dental services from any provider. For each calendar year, the following dental limits apply: ▪ 2 diagnostic X-rays ▪ 1 denture repair, reline or adjustment ▪ 1 endodontic service ▪ 1 periodontic service For coverage and cost information for all dental services, see this plan's Evidence of Coverage.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Vision Services *(In-network services provided by EyeMed Insight providers.)*	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): ▪ In-network: $45 copay ▪ Out-of-network: 30% of the cost Routine eye exam (1 every year): ▪ In-network: $25 copay ▪ Out-of-network: $50 copay Contact lenses (1 every year):* ▪ In-network/Out-of-network: You pay nothing up to $100. You are responsible for any amount more than $100. Eyeglasses (frames and lenses) (1 every year):* ▪ In-network/Out-of-network: You pay nothing up to $100. You are responsible for any amount more than $100. Eyeglasses or contact lenses after cataract surgery: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost *Our plan pays up to $100 every year for contact lenses or eyeglasses (frames and lenses) from any provider.
Mental Health Care *(Services may require prior authorization.)*	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost Routine eye exam (1 every year): ▪ In-network: $25 copay ▪ Out-of-network: $50 copay Contact lenses (1 every year):* ▪ In-network/Out-of-network: You pay nothing up to $100. You are responsible for any amount more than $100. Eyeglasses (frames and lenses) (1 every year):* ▪ In-network/Out-of-network: You pay nothing up to $100. You are responsible for any amount more than $100. Eyeglasses or contact lenses after cataract surgery: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost *Our plan pays up to $100 every year for contact lenses or eyeglasses (frames and lenses) from any provider.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost Routine eye exam (1 every year): ▪ In-network: You pay nothing ▪ Out-of-network: $50 copay Contact lenses (1 every year):* ▪ In-network/Out-of-network: You pay nothing up to $250. You are responsible for any amount more than $250. Eyeglasses (frames and lenses) (1 every year):* ▪ In-network/Out-of-network: You pay nothing up to $250. You are responsible for any amount more than $250. Eyeglasses or contact lenses after cataract surgery: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost *Our plan pays up to $250 every year for contact lenses or eyeglasses (frames and lenses) from any provider.
Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Mental Health Care (cont.) *(Services may require prior authorization.)*	Our plan also covers 60 "lifetime reserve days." These are "extra" days we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. ▪ In-network: – $315 copay per day for days 1 through 5 – You pay nothing per day for days 6 through 90 ▪ Out-of-network: – 30% of the cost per stay Outpatient group therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Outpatient individual therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost
Outpatient Substance Abuse	Group therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Individual therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost
Skilled Nursing Facility (SNF) *(Services may require prior authorization.)*	Our plan covers up to 100 days per benefit period in a SNF. ▪ In-network: – You pay nothing per day for days 1 through 20 – $164.50 copay per day for days 21 through 100 ▪ Out-of-network: 30% of the cost per stay
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Occupational therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Our plan also covers 60 "lifetime reserve days." These are "extra" days we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. ▪ In-network: – $315 copay per day for days 1 through 5 – You pay nothing per day for days 6 through 90 ▪ Out-of-network: – 30% of the cost per stay Outpatient group therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost Outpatient individual therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Our plan also covers 60 "lifetime reserve days." These are "extra" days we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. ▪ In-network: – $250 copay per day for days 1 through 6 – You pay nothing per day for days 7 through 90 ▪ Out-of-network: – 30% of the cost per stay Outpatient group therapy visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost Outpatient individual therapy visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
Group therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost Individual therapy visit: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Group therapy visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost Individual therapy visit: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
Our plan covers up to 100 days per benefit period in a SNF. ▪ In-network: – You pay nothing per day for days 1 through 20 – $164.50 copay per day for days 21 through 100 ▪ Out-of-network: 30% of the cost per stay	Our plan covers up to 100 days per benefit period in a SNF. ▪ In-network: – You pay nothing per day for days 1 through 20 – $164.50 copay per day for days 21 through 100 ▪ Out-of-network: 30% of the cost per stay
Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Occupational therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Occupational therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: ▪ In-network: $40 copay ▪ Out-of-network: 30% of the cost

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Ambulance *(Services may require prior authorization.)*	▪ In-network: $295 copay (20% for air ambulance) ▪ Out-of-network: 30% of the cost
Transportation	Not covered
Foot Care (Podiatry Services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: ▪ In-network: $45 copay ▪ Out-of-network: 30% of the cost
Durable Medical Equipment (wheelchairs, oxygen, etc.) *(Services may require prior authorization.)*	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Prosthetic Devices (braces, artificial limbs, etc.) *(Services may require prior authorization.)*	Prosthetic devices: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Related medical supplies: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Diabetes Supplies and Services	Diabetes monitoring supplies: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing Diabetes self-management training: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Therapeutic shoes or inserts: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing
Over-the-Counter Items	Please visit our website, MedMutual.com/SimplySupplies, to see our list of covered over-the-counter items.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
▪ In-network: $295 copay (20% for air ambulance) ▪ Out-of-network: 30% of the cost	▪ In-network: $195 copay (20% for air ambulance) ▪ Out-of-network: 30% of the cost
Not covered	Not covered
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: ▪ In-network: $35 copay ▪ Out-of-network: 30% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: ▪ In-network: $25 copay ▪ Out-of-network: 30% of the cost
▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Prosthetic devices: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Related medical supplies: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	Prosthetic devices: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost Related medical supplies: ▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Diabetes monitoring supplies: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing Diabetes self-management training: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Therapeutic shoes or inserts: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing	Diabetes monitoring supplies: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing Diabetes self-management training: ▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost Therapeutic shoes or inserts: ▪ In-network: You pay nothing ▪ Out-of-network: You pay nothing
Please visit our website, MedMutual.com/SimplySupplies, to see our list of covered over-the-counter items.	Please visit our website, MedMutual.com/SimplySupplies, to see our list of covered over-the-counter items.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Wellness Programs	**Disease Management Program** This program can help you stay healthy, manage your chronic conditions and maintain your independence. A trained health coach works with you to develop a personalized plan that supplements the care you get from your doctor. For more information or to find out if the program is right for you, call (800) 258-3175 and select option "4." $0 copayment for Disease Management Program **Nurse Line** If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, we can help. Call our Nurse Line at (888) 912-0636, 24 hours a day, seven days per week for advice.Your call is kept confidential. $0 copayment for Nurse Line **SilverSneakers® Fitness Program** SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members enjoy access to more than 13,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. Please note nonstandard fitness center services that usually have an extra fee are not included in your membership. To take advantage of the program, use the SilverSneakers ID card that will be mailed to your home. You will also receive a list of locations near you. Call (866) 584-7389 or go to SilverSneakers.com for more information. $0 copayment for SilverSneakers® **Weight Watchers® Reimbursement Program** To help you meet your health goals, we partner with Weight Watchers, the world's leading provider of weight management services. We will cover up to $150 of Weight Watchers' enrollment fees for a Weight Watchers series. The benefit does not include food or meals. The required forms must be submitted within 90 days of your series end date. For more information, contact Customer Care at the phone number shown on page 9.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Disease Management Program This program can help you stay healthy, manage your chronic conditions and maintain your independence. A trained health coach works with you to develop a personalized plan that supplements the care you get from your doctor. For more information or to find out if the program is right for you, call (800) 258-3175 and select option "4." $0 copayment for Disease Management Program	**Disease Management Program** This program can help you stay healthy, manage your chronic conditions and maintain your independence. A trained health coach works with you to develop a personalized plan that supplements the care you get from your doctor. For more information or to find out if the program is right for you, call (800) 258-3175 and select option "4." $0 copayment for Disease Management Program
Nurse Line If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, we can help. Call our Nurse Line at (888) 912-0636, 24 hours per day, seven days per week for advice.Your call is kept confidential. $0 copayment for Nurse Line	**Nurse Line** If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, we can help. Call our Nurse Line at (888) 912-0636, 24 hours per day, seven days per week for advice.Your call is kept confidential. $0 copayment for Nurse Line
SilverSneakers® Fitness Program SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members enjoy access to more than 13,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. Please note nonstandard fitness center services that usually have an extra fee are not included in your membership. To take advantage of the program, use the SilverSneakers ID card that will be mailed to your home. You will also receive a list of locations near you. Call (866) 584-7389 or go to SilverSneakers.com for more information. $0 copayment for SilverSneakers®	**SilverSneakers® Fitness Program** SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members enjoy access to more than 13,000 participating gyms and fitness centers, as well as to group exercise classes, health education and walking groups. Please note nonstandard fitness center services that usually have an extra fee are not included in your membership. To take advantage of the program, use the SilverSneakers ID card that will be mailed to your home. You will also receive a list of locations near you. Call (866) 584-7389 or go to SilverSneakers.com for more information. $0 copayment for SilverSneakers®
Weight Watchers® Reimbursement Program To help you meet your health goals, we partner with Weight Watchers, the world's leading provider of weight management services. We will cover up to $150 of Weight Watchers' enrollment fees for a Weight Watchers series. The benefit does not include food or meals. The required forms must be submitted within 90 days of your series end date. For more information, contact Customer Care at the phone number shown on page 9.	**Weight Watchers® Reimbursement Program** To help you meet your health goals, we partner with Weight Watchers, the world's leading provider of weight management services. We will cover up to $150 of Weight Watchers' enrollment fees for a Weight Watchers series. The benefit does not include food or meals. The required forms must be submitted within 90 days of your series end date. For more information, contact Customer Care at the phone number shown on page 9.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Prescription Drug Benefits	
How much do I pay? *(Part B drugs may require prior authorization.)*	$195 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2, which are excluded from the deductible. For Part B drugs such as chemotherapy drugs: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost Other Part B drugs: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. Standard retail cost sharing: ▪ Tier 1 (preferred generic) – One-month supply: $5 copay – Two-month supply: $8 copay – Three-month supply: $10 copay ▪ Tier 2 (generic) – One-month supply: $19 copay – Two-month supply: $29 copay – Three-month supply: $38 copay ▪ Tier 3 (preferred brand) – One-month supply: $47 copay – Two-month supply: $94 copay – Three-month supply: $118 copay ▪ Tier 4 (non-preferred drug) – One-month supply: 50% of the cost – Two-month supply: 50% of the cost – Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) – One-month supply: 29% of the cost – Two-month supply: Not covered – Three-month supply: Not covered

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Prescription Drug Benefits	
This plan does not have a deductible for Part D prescription drugs. For Part B drugs such as chemotherapy drugs: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost Other Part B drugs: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost	This plan does not have a deductible for Part D prescription drugs. For Part B drugs such as chemotherapy drugs: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost Other Part B drugs: ▪ In-network: 20% of the cost ▪ Out-of-network: 20% of the cost
You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. Standard retail cost sharing: ▪ Tier 1 (preferred generic) – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay ▪ Tier 3 (preferred brand) – One-month supply: $47 copay – Two-month supply: $94 copay – Three-month supply: $118 copay ▪ Tier 4 (non-preferred drug) – One-month supply: 50% of the cost – Two-month supply: 50% of the cost – Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) – One-month supply: 33% of the cost – Two-month supply: Not covered – Three-month supply: Not covered	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies. Standard retail cost sharing: ▪ Tier 1 (preferred generic) – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay ▪ Tier 3 (preferred brand) – One-month supply: $47 copay – Two-month supply: $94 copay – Three-month supply: $118 copay ▪ Tier 4 (non-preferred drug) – One-month supply: 50% of the cost – Two-month supply: 50% of the cost – Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) – One-month supply: 33% of the cost – Two-month supply: Not covered – Three-month supply: Not covered

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Prescription Drug Benefits (cont.)	
Initial Coverage (cont.)	Standard mail-order cost sharing: ▪ Tier 1 (preferred generic) – One-month supply: $5 copay – Two-month supply: $8 copay – Three-month supply: $10 copay ▪ Tier 2 (generic) – One-month supply: $19 copay – Two-month supply: $29 copay – Three-month supply: $38 copay ▪ Tier 3 (preferred brand) – One-month supply: $47 copay – Two-month supply: $94 copay – Three-month supply: $118 copay ▪ Tier 4 (non-preferred drug) – One-month supply: 50% of the cost – Two-month supply: 50% of the cost – Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) – One-month supply: 29% of the cost – Two-month supply: Not covered – Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Prescription Drug Benefits (cont.)	
Standard mail-order cost sharing: ▪ Tier 1 (preferred generic) – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay ▪ Tier 3 (preferred brand) – One-month supply: $47 copay – Two-month supply: $94 copay – Three-month supply: $117.50 copay ▪ Tier 4 (non-preferred drug) – One-month supply: 50% of the cost – Two-month supply: 50% of the cost – Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) – One-month supply: 33% of the cost – Two-month supply: Not covered – Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	Standard mail-order cost sharing: ▪ Tier 1 (preferred generic) – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay ▪ Tier 3 (preferred brand) – One-month supply: $47 copay – Two-month supply: $94 copay – Three-month supply: $118 copay ▪ Tier 4 (non-preferred drug) – One-month supply: 50% of the cost – Two-month supply: 50% of the cost – Three-month supply: 50% of the cost ▪ Tier 5 (specialty tier) – One-month supply: 33% of the cost – Two-month supply: Not covered – Three-month supply: Not covered If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.
Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Prescription Drug Benefits (cont.)	
Coverage Gap (cont.)	Standard retail cost sharing: ▪ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $5 copay – Two-month supply: $8 copay – Three-month supply: $10 copay ▪ Tier 2 (generic) – Drugs covered: All – One-month supply: $19 copay – Two-month supply: $29 copay – Three-month supply: $38 copay Standard mail-order cost sharing: ▪ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $5 copay – Two-month supply: $8 copay – Three-month supply: $10 copay ▪ Tier 2 (generic) – Drugs covered: All – One-month supply: $19 copay – Two-month supply: $29 copay – Three-month supply: $38 copay
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: ▪ 5% of the cost, or ▪ $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Prescription Drug Benefits (cont.)	
Standard retail cost sharing: ▪ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – Drugs covered: All – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay Standard mail-order cost sharing: ▪ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – Drugs covered: All – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay	Standard retail cost sharing: ▪ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – Drugs covered: All – One-month supply: $14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay Standard mail-order cost sharing: ▪ Tier 1 (preferred generic) – Drugs covered: All – One-month supply: $0 copay – Two-month supply: $0 copay – Three-month supply: $0 copay ▪ Tier 2 (generic) – Drugs covered: All – One-month supply:$14 copay – Two-month supply: $21 copay – Three-month supply: $28 copay
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: ▪ 5% of the cost, or ▪ $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: ▪ 5% of the cost, or ▪ $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.

Summary of Benefits

Benefit Description	MedMutual Advantage Select (PPO)
Additional Coverage Information	
Acupuncture	Not covered
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): ▪ In-network: $20 copay ▪ Out-of-network: 30% of the cost
Home Health Care *(Services may require prior authorization.)*	▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost
Outpatient Surgery *(Services may require prior authorization.)*	Ambulatory surgical center: ▪ In-network: $250 copay ▪ Out-of-network: 30% of the cost Outpatient hospital: ▪ In-network: $315 copay ▪ Out-of-network: 30% of the cost
Renal Dialysis	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Optional Benefits	
Package 1: Optional Dental and Vision Rider	Benefits include: ▪ Comprehensive dental ▪ Preventive dental ▪ Eye exam ▪ Eyewear
How much is the monthly premium?	Additional $25 per month. You must keep paying your Medicare Part B premium and your $39 monthly plan premium.
How much is the deductible?	This package does not have a deductible.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,250 every year. Our plan has additional coverage limits for certain benefits. The $1,250 limit has separate limits of $1,000 for dental and $250 for vision benefits.

MedMutual Advantage Preferred (PPO)	MedMutual Advantage Premium (PPO)
Additional Coverage Information	
Not covered	Not covered
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): ▪ In-network: $20 copay ▪ Out-of-network: 30% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): ▪ In-network: $20 copay ▪ Out-of-network: 30% of the cost
▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost	▪ In-network: You pay nothing ▪ Out-of-network: 30% of the cost
Ambulatory surgical center: ▪ In-network: $200 copay ▪ Out-of-network: 30% of the cost Outpatient hospital: ▪ In-network: $315 copay ▪ Out-of-network: 30% of the cost	Ambulatory surgical center: ▪ In-network: $150 copay ▪ Out-of-network: 30% of the cost Outpatient hospital: ▪ In-network: $195 copay ▪ Out-of-network: 30% of the cost
▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost	▪ In-network: 20% of the cost ▪ Out-of-network: 30% of the cost
You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Optional Benefits	
Benefits include: ▪ Comprehensive dental ▪ Preventive dental ▪ Eye exam ▪ Eyewear	Please note: The Optional Benefits are already included in the benefits at no additional cost.
Additional $25 per month. You must keep paying your Medicare Part B premium and your $69 monthly plan premium.	
This package does not have a deductible.	
Our plan pays up to $1,250 every year. Our plan has additional coverage limits for certain benefits. The $1,250 limit has separate limits of $1,000 for dental and $250 for vision benefits.	

[This page intentionally left blank]

[This page intentionally left blank]

MEDICAL MUTUAL®
2060 East Ninth Street
Cleveland, OH 44115-1355

Z8224-MCA R10/16