MEDICAL MUTUAL®

2024 Annual Notice of Changes

MedMutual Advantage Signature HMO Plan

Youngstown Metro and Select Central Ohio Counties

(H6723-006-007)

Clark, Hancock, Mahoning, Marion, Morgan, Muskingum, Seneca, Trumbull, and Wyandot counties

MedMutual Advantage Signature HMO offered by Medical Mutual of Ohio (Medical Mutual)

Annual Notice of Changes for 2024

You are currently enrolled as a member of MedMutual Advantage Signature HMO. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at MedMutual.com/MAplaninfo. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

   ☐ Check the changes to our benefits and costs to see if they affect you.
   - Review the changes to Medical care costs (doctor, hospital).
   - Review the changes to our drug coverage, including authorization requirements and costs.
   - Think about how much you will spend on premiums, deductibles, and cost sharing.

   ☐ Check the changes in the 2024 “Drug List” to make sure the drugs you currently take are still covered.

   ☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies, will be in our network next year.

   ☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

   ☐ Check coverage and costs of plans in your area.
   - Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

   ☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
    - If you don’t join another plan by December 7, 2023, you will stay in MedMutual Advantage Signature HMO.
    - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with MedMutual Advantage Signature HMO.
    - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Customer Care number at 1-800-982-3117 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. This call is free.
- This document is available in alternate formats (e.g., braille, large print, audio).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About MedMutual Advantage Signature HMO

- MedMutual Advantage Signature HMO is an HMO plan offered by Medical Mutual of Ohio with a Medicare contract. Enrollment in the MedMutual Advantage Signature HMO plan depends on contract renewal.
- When this document says "we," "us," or "our," it means Medical Mutual of Ohio (Medical Mutual). When it says "plan" or "our plan," it means MedMutual Advantage Signature HMO.

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for MedMutual Advantage Signature HMO in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* *Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,800	$3,900
Doctor office visits	**In Network** Primary care visits: $0 copay per visit Specialist visits: $25 copay per visit	**In Network** Primary care visits: $0 copay per visit Specialist visits: $35 copay per visit
Inpatient hospital stays	**In Network** Days 1 - 6: $325 copay per day Day 7 and thereafter: $0 copay	**In Network** Days 1 - 6: $325 copay per day Day 7 and thereafter: $0 copay
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 **Copayment/Coinsurance during the Initial Coverage Stage:** Drug Tier 1: **Preferred** retail pharmacies	Deductible: $100 – except for covered insulin products and most adult Part D vaccines **Copayment/Coinsurance during the Initial Coverage Stage:** Drug Tier 1: **Preferred** retail pharmacies

Cost	2023 (this year)	2024 (next year)
	• $4 per prescription for up to a 30-day supply • $10 per prescription for up to a 90-day supply	• $0 per prescription for up to a 30-day supply • $0 per prescription for up to a 60-day supply • $0 per prescription for up to a 90-day supply
	Preferred mail-order pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up to a 90-day supply	**Preferred** mail-order pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up to a 60-day supply • $0 per prescription for up to a 90-day supply
	Standard network retail pharmacies • $12 per prescription for up to a 30-day supply • $30 per prescription for up to a 90-day supply	**Standard** network retail pharmacies • $12 per prescription for up to a 30-day supply • $24 per prescription for up to a 60-day supply • $30 per prescription for up to a 90-day supply
	Standard mail-order pharmacies • $11 per prescription for up to a 30-day supply • $28 per prescription for up to a 90-day supply	**Standard** mail-order pharmacies • $11 per prescription for up to a 30-day supply • $22 per prescription for up to a 60-day supply • $28 per prescription for up to a 90-day supply
	Drug Tier 2: **Preferred** retail pharmacies • $8 per prescription for up to a 30-day supply • $20 per prescription for up to a 90-day supply	Drug Tier 2: **Preferred** retail pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up to a 60-day supply • $0 per prescription for up to a 90-day supply
	Preferred mail-order pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up	**Preferred** mail-order pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up

Cost	2023 (this year)	2024 (next year)
	to a 90-day supply	to a 60-day supply • $0 per prescription for up to a 90-day supply
	Standard network retail pharmacies • $16 per prescription for up to a 30-day supply • $40 per prescription for up to a 90-day supply	**Standard** network retail pharmacies • $16 per prescription for up to a 30-day supply • $32 per prescription for up to a 60-day supply • $40 per prescription for up to a 90-day supply
	Standard mail-order pharmacies • $15 per prescription for up to a 30-day supply • $38 per prescription for up to a 90-day supply	**Standard** mail-order pharmacies • $15 per prescription for up to a 30-day supply • $30 per prescription for up to a 60-day supply • $38 per prescription for up to a 90-day supply
	Drug Tier 3: **Preferred** retail pharmacies • $42 per prescription for up to a 30-day supply • $118 per prescription for up to a 90-day supply	Drug Tier 3: **Preferred** retail pharmacies • $42 per prescription for up to a 30-day supply • $84 per prescription for up to a 60-day supply • $118 per prescription for up to a 90-day supply
	Preferred mail-order pharmacies • $40 per prescription for up to a 30-day supply • $110 per prescription for up to a 90-day supply	**Preferred** mail-order pharmacies • $40 per prescription for up to a 30-day supply • $80 per prescription for up to a 60-day supply • $110 per prescription for up to a 90-day supply
	Standard network retail pharmacies • $47 per prescription for up to a 30-day supply • $132 per prescription for up to a 90-day supply	**Standard** network retail pharmacies • $47 per prescription for up to a 30-day supply • $94 per prescription for up to a 60-day supply • $132 per prescription for up to a 90-day supply

Cost	2023 (this year)	2024 (next year)
	Standard mail-order pharmacies • $45 per prescription for up to a 30-day supply • $130 per prescription for up to a 90-day supply You pay no more than $35 per month supply of each covered insulin product on this tier.	**Standard** mail-order pharmacies • $45 per prescription for up to a 30-day supply • $90 per prescription for up to a 60-day supply • $130 per prescription for up to a 90-day supply You pay no more than $35 per month supply of each covered insulin product on this tier.
	Drug Tier 4: **Preferred** and **standard** network retail and mail-order pharmacies • 50% of the total cost for up to a 30-day supply or a 90-day supply	Drug Tier 4: **Preferred** and **standard** network retail and mail-order pharmacies • 50% of the total cost for up to a 30-day supply, a 60-day supply, or a 90-day supply
	Drug Tier 5: **Preferred** and **standard** network retail and mail-order pharmacies • 33% of the total cost for up to a 30-day supply	Drug Tier 5: **Preferred** and **standard** network retail and mail-order pharmacies • 31% of the total cost for up to a 30-day supply
	Drug Tier 6: **Preferred** retail and **preferred** mail-order pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up to a 90-day supply	Drug Tier 6: **Preferred** retail and **preferred** mail-order pharmacies • $0 per prescription for up to a 30-day supply • $0 per prescription for up to a 60-day supply • $0 per prescription for up to a 90-day supply
	Standard network retail pharmacies • $8 per prescription for up to a 30-day supply • $20 per prescription for up to a 90-day supply	**Standard** network retail pharmacies • $8 per prescription for up to a 30-day supply • $16 per prescription for up to a 60-day supply • $20 per prescription for up

Cost	2023 (this year)	2024 (next year)
		to a 90-day supply **Standard** mail-order pharmacies • $7 per prescription for up to a 30-day supply • $14 per prescription for up to a 60-day supply • $18 per prescription for up to a 90-day supply **Catastrophic Coverage:** • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0 (No change from 2023)
Optional supplemental benefits	You pay a $26 premium for optional supplemental benefits if you enroll in this additional coverage.	You pay a $34 premium for optional supplemental benefits if you enroll in this additional coverage.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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

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

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,800	$3,900 Once you have paid $3,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at MedMutual.com/MAplaninfo. You may also call Customer Care for updated provider directory and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2024 Pharmacy Directory to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Care so we may assist.

Section 1.4 Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Acupuncture for chronic low back pain	**In Network** You pay a $25 copay for each covered acupuncture service in a specialist's office.	**In Network** You pay a $35 copay for each covered acupuncture service in a specialist's office.
Additional hearing services – listed under "Hearing services"	You pay a $699 copay for each Advanced hearing aid.* You pay a $999 copay for each Premium hearing aid.* *Any cost you pay for hearing aids will not count toward your maximum out-of-pocket amount.	You pay a $499 copay for each Standard hearing aid.* You pay a $699 copay for each Advanced hearing aid.* You pay a $999 copay for each Premium hearing aid.* Advanced and Premium hearing aids are available in rechargeable style options for an additional $50 per aid. *Any cost you pay for hearing aids will not count toward your maximum out-of-pocket amount.

Cost	2023 (this year)	2024 (next year)
Cardiac rehabilitation services	**In Network** You pay a $40 copay for each covered therapy visit to treat you if you've had a heart condition.	**In Network** You pay a $35 copay for each covered therapy visit to treat you if you've had a heart condition.
Dental services – preventive and comprehensive services See Chapter 4, Section 2.1 of your *Evidence of Coverage* for more information.	**In Network** Your plan covers up to a maximum of $750 per calendar year for the Preventive and Comprehensive Dental Services shown in the Medical Benefits Chart of Chapter 4 of your *Evidence of Coverage*.	**In Network** Your plan covers up to a maximum of $3,000 per calendar year for the Preventive and Comprehensive Dental Services shown in the Medical Benefits Chart of Chapter 4 of your *Evidence of Coverage*.
Emergency care	**In Network and Out of Network** You pay a $90 copay for each covered emergency room visit. You pay a $90 copay for each emergency visit to a hospital outside the United States.	**In Network and Out of Network** You pay a $100 copay for each covered emergency room visit. You pay a $100 copay for each emergency visit to a hospital outside the United States.
MedMutual MyChoice™	**MedMutual MyChoice Option A – dental allowance** In addition to the Preventive Services (exams, cleanings, and x-ray) listed under "Dental Services" in the Medical Benefits Chart in Chapter 4, Section 2.1 of the *Evidence of Coverage*, Option A will also cover the Comprehensive Services listed below, up to a maximum of $1,000 per calendar year. Comprehensive Services: Diagnostic x-rays; restorative services, such as fillings; non-surgical extractions; denture repair, reline or adjustments; crowns; endodontic (root canal) services; and periodontic (treatment of gums) services. **In Network** You pay a $0 copay for	MedMutual MyChoice is **not** covered. See the "Dental Services" and "Over-the-Counter Supplies" changes shown above and below in this chart, and also in Chapter 4, Section 2.1 of your *Evidence of Coverage* for additional information about the newly increased calendar year maximum that applies to preventive and comprehensive dental services, and about a newly added benefit for over-the-counter supplies.

Cost	2023 (this year)	2024 (next year)
	MedMutual MyChoice Option A (up to the $1,000 per calendar year maximum). You will be responsible for paying any amount over the $1,000 per calendar year maximum.* *Any cost you pay for these dental services will not count toward your maximum out-of-pocket amount. **MedMutual MyChoice Option B – flex card** Under this option, your plan covers up to $350 per calendar year for over-the-counter health and wellness supplies, transportation, meal delivery, and vision and hearing services. You pay a $0 copay for MedMutual MyChoice Option B. You will be responsible for paying any amount for expenses over the $350 per calendar year maximum.* *Any cost you pay for these services will not count toward your maximum out-of-pocket amount.	
MedMutual Advantage Travel Plus™ See Chapter 4, Section 2.3 of your *Evidence of Coverage* for more information.	You pay the copay or coinsurance for the corresponding service you receive, shown in the Medical Benefits Chart of Chapter 4 of your *Evidence of Coverage*. Your plan will cover medically necessary services up to $2,500 per calendar year.	You pay the copay or coinsurance for the corresponding service you receive, shown in the Medical Benefits Chart of Chapter 4 of your *Evidence of Coverage*. Your plan will cover medically necessary services up to $7,500 per calendar year.

Cost	2023 (this year)	2024 (next year)
Opioid treatment program services	**In Network** You pay 20% of the total cost for FDA-approved agonist and antagonist treatment medications and dispensing. You pay a $25 copay for each covered outpatient counseling or therapy visit, including intake and periodic assessments. You pay a $10 copay for each covered outpatient toxicology test. (This copayment may not apply if you visit a PCP or specialist on the same date of service that the test was performed, and your plan has an office visit copay for that visit.)	**In Network** You pay 20% of the total cost for covered opioid treatment program services (including FDA-approved agonist and antagonist treatment medications and dispensing; outpatient counseling and therapy; and outpatient toxicology tests).
Outpatient mental health care	**In Network** You pay a $25 copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy.	**In Network** You pay a $35 copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy.
Outpatient rehabilitation services	**In Network** You pay a $40 copay for each covered physical therapy or speech/language therapy visit.	**In Network** You pay a $35 copay for each covered physical therapy or speech/language therapy visit.
Outpatient substance abuse	**In Network** You pay a $25 copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy.	**In Network** You pay a $30 copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy.
Outpatient surgery – listed under "Outpatient hospital services" and "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"	**In Network** You pay a $340 copay for each covered surgery or surgical procedure performed as an outpatient at a hospital.	**In Network** You pay a $400 copay for each covered surgery or surgical procedure performed as an outpatient at a hospital.

Cost	2023 (this year)	2024 (next year)
Over-the-counter supplies If your plan includes this benefit, select health and wellness items, such as bandages, aspirin and cough syrup can be purchased with your plan allowance. For more information, please call Customer Care at 1-800-982-3117.	Over-the-counter supplies are **not** covered.	You pay a $0 copay for the over-the-counter supplies benefit. Your plan includes a $70 quarterly allowance to be used toward the purchase of over-the-counter (OTC) health and wellness supplies. We will mail you a benefit card that can be used at any retail pharmacy or online for qualified items.
Partial hospitalization and Intensive outpatient services	**In Network** You pay a $25 copay for each covered partial hospitalization visit.	**In Network** You pay a $35 copay for each covered partial hospitalization visit or intensive outpatient service visit.
Physician/ Practitioner services, including doctor's office visits See Chapter 4, Section 2.1 of your *Evidence of Coverage* for more information.	**In Network** You pay a $25 copay for each covered specialist visit (including office visits to psychologists and psychiatrists; and non-routine dental care).	**In Network** You pay a $35 copay for each covered specialist visit (including office visits to psychologists and psychiatrists). You pay a $35 copay for each specialist visit for Medicare-covered non-routine dental care.
Podiatry services	**In Network** You pay a $25 copay for each covered podiatry visit.	**In Network** You pay a $35 copay for each covered podiatry visit.
Pulmonary rehabilitation services	**In Network** You pay a $20 copay for each covered visit.	**In Network** You pay a $15 copay for each covered visit.
Skilled nursing facility care	**In Network** You pay a $0 copay per day for days 1 through 20. You pay a $188 copay per day for days 21 through 100.	**In Network** You pay a $0 copay per day for days 1 through 20. You pay a $203 copay per day for days 21 through 100.

Cost	2023 (this year)	2024 (next year)
Urgently needed services	**In Network and Out of Network** You pay a $25 copay for each covered urgent care center visit. You pay a $25 copay for each urgent care center visit outside the United States.	**In Network and Out of Network** You pay a $35 copay for each covered urgent care center visit. You pay a $35 copay for each urgent care center visit outside the United States.
Vision care – eyewear allowance	**In Network** Your plan includes $100 toward the purchase of either one pair of eyeglasses or contact lenses (including standard contact lens fit and follow up) per calendar year at an optical provider.	**In Network** Your plan includes $250 toward the purchase of either one pair of eyeglasses or contact lenses (including standard contact lens fit and follow up) per calendar year at an optical provider.

Section 1.5 Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

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

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Care for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30th, please call Customer Care and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4 and Tier 5 drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Because we have no deductible, this payment stage does not apply to you.	The deductible is $100. During this stage, you pay: • $0 (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 1** • $12 (**standard** network retail pharmacy) or $11 (**standard** network mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 1** • $0 (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 1** • $24 (**standard** network retail pharmacy) or $22 (**standard** network mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 1** • $0 (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 1** • $30 (**standard** network retail pharmacy) or $28 (**standard** network mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 1** • $0 (**preferred** retail pharmacy) or $0 (**preferred** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 2** • $16 (**standard** network retail

Stage	2023 (this year)	2024 (next year)
		pharmacy) or $15 (**standard** network mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 2** • $0 (**preferred** retail pharmacy) or $0 (**preferred** mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 2** • $32 (**standard** network retail pharmacy) or $30 (**standard** network mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 2** • $0 (**preferred** retail pharmacy) or $0 (**preferred** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 2** • $40 (**standard** network retail pharmacy) or $38 (**standard** network mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 2** • $0 (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 6** • $8 (**standard** network retail pharmacy) or $7 (**standard** network mail-order pharmacy) cost sharing for up to a 30-day supply for drugs on **Tier 6** • $0 (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 6** • $16 (**standard** network retail

Stage	2023 (this year)	2024 (next year)
		pharmacy) or $14 (**standard** network mail-order pharmacy) cost sharing for up to a 60-day supply for drugs on **Tier 6** • $0 (**preferred** retail or **preferred** mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 6** • $20 (**standard** network retail pharmacy) or $18 (**standard** network mail-order pharmacy) cost sharing for up to a 90-day supply for drugs on **Tier 6** *and* **the full cost of drugs on Tier 3, Tier 4 and Tier 5** until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost**. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List." Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** ***Standard** cost sharing:* You pay $12 per prescription (retail) or $11 per prescription (mail order). ***Preferred** cost sharing:* You pay $4 per prescription (retail) or $0 per prescription (mail order). **Tier 2 (Generic Drugs):** ***Standard** cost sharing:* You pay $16 per prescription (retail) or $15 per prescription (mail order). ***Preferred** cost sharing:* You pay $8 per prescription (retail) or $0 per prescription (mail order). **Tier 3 (Preferred Brand and Generic Drugs):** ***Standard** cost sharing:* You pay $47 per prescription (retail) or $45 per prescription (mail order). ***Preferred** cost sharing:* You pay $42 per prescription (retail) or $40 per prescription (mail order). **Tier 4 (Non-Preferred Drugs):** ***Standard** cost sharing:* You pay 50% of the total cost (retail or mail order). ***Preferred** cost sharing:* You pay 50% of the total cost (retail or mail order).	Your cost for a one-month supply at a network pharmacy: **Tier 1 (Preferred Generic Drugs):** ***Standard** cost sharing:* You pay $12 per prescription (retail) or $11 per prescription (mail order). ***Preferred** cost sharing:* You pay $0 per prescription (retail) or $0 per prescription (mail order). **Tier 2 (Generic Drugs):** ***Standard** cost sharing:* You pay $16 per prescription (retail) or $15 per prescription (mail order). ***Preferred** cost sharing:* You pay $0 per prescription (retail) or $0 per prescription (mail order). **Tier 3 (Preferred Brand and Generic Drugs):** ***Standard** cost sharing:* You pay $47 per prescription (retail) or $45 per prescription (mail order). You pay no more than $35 per month supply of each covered insulin product on this tier. ***Preferred** cost sharing:* You pay $42 per prescription (retail) or $40 per prescription (mail order). You pay no more than $35 per month supply of each covered insulin product on this tier. **Tier 4 (Non-Preferred Drugs):** ***Standard** cost sharing:* You pay 50% of the total cost (retail or mail order). ***Preferred** cost sharing:* You pay 50% of the total cost (retail or mail order).

Stage	2023 (this year)	2024 (next year)
	Tier 5 (Specialty Drugs): ***Standard*** *cost sharing:* You pay 33% of the total cost (retail or mail order). ***Preferred*** *cost sharing:* You pay 33% of the total cost (retail or mail order). **Tier 6 (Select Care Drugs):** ***Standard*** *cost sharing:* You pay $8 per prescription (retail) or $7 per prescription (mail order). ***Preferred*** *cost sharing:* You pay $0 per prescription (retail or mail order). Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage) OR you have paid $7,400 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	**Tier 5 (Specialty Drugs):** ***Standard*** *cost sharing:* You pay 31% of the total cost (retail or mail order). ***Preferred*** *cost sharing:* You pay 31% of the total cost (retail or mail order). **Tier 6 (Select Care Drugs):** ***Standard*** *cost sharing:* You pay $8 per prescription (retail) or $7 per prescription (mail order). ***Preferred*** *cost sharing:* You pay $0 per prescription (retail or mail order). Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage) OR you have paid $8,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages
The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

The chart below shows some additional changes.

Description	2023 (this year)	2024 (next year)
Contact information for filing a complaint related to an advance directive See Chapter 8, Section 1.5 of your *Evidence of Coverage* for details.	Ohio Disability Rights Law and Policy Center, Inc. Disability Rights Ohio 50 W. Broad St., Suite 1400 Columbus, OH 43215-5923 614-466-7264 or 1-800-282-9181 (TTY) 614-728-2553 or 1-800-858-3542	For complaints regarding physicians, contact: State Medical Board of Ohio Public Inquiries 30 East Broad Street, 3rd Floor Columbus, Ohio 43215-6127 1-800-554-7717 (TTY 711 for hearing impaired) For complaints regarding hospital/health care facilities, contact: Ohio Department of Health Complaint Unit 246 N. High Street Columbus, Ohio 43215 1-800-342-0553 (TTY 711 for hearing impaired)
Contact information for Coverage Decisions for Medical Care See Chapter 2, Section 1 of your *Evidence of Coverage* for details.	For coverage determinations: Medical Mutual MZ 01-5B-4200 2060 E. 9th Street Cleveland, OH 44115-1355 For expedited determinations: Medical Mutual Attn: Care Management MZ 01-5B-4200 2060 E. 9th Street Cleveland, OH 44115-1355	For coverage determinations: Medical Mutual MZ 02-3P-7516 100 American Road Cleveland, OH 44144-2322 For expedited determinations: Medical Mutual Attn: Medicare Care Management MZ 02-3P-3982 100 American Road Cleveland, OH 44144-2322
Contact information for Civil Rights Coordinator See *Chapter 11, Section 2 of your Evidence of Coverage for details.*	The mailing address listed is: **Civil Rights Coordinator** Medical Mutual of Ohio 2060 E. 9th Street Cleveland, OH 44115-1355	The mailing address listed is: **Civil Rights Coordinator** Medical Mutual of Ohio 100 American Road Cleveland, OH 44144-2322

Description	2023 (this year)	2024 (next year)
Medicare Complaint Form URL Multiple references are given in your *Evidence of Coverage*.	www.medicare.gov/MedicareComplaintForm/home.aspx	www.medicare.gov/my/medicare-complaint
Optional Supplemental Benefits – electing to receive optional benefits See Chapter 4, Section 2.2 of your *Evidence of Coverage* for details.	New members can elect to receive optional benefits in writing as follows: • at the time of application to enroll in our plan (optional benefits will be effective the same date as other benefits). • or within 30 days of their effective date with our plan (optional benefits will be effective the first of the month following the selection). After the first month of coverage, existing members will have the option to elect optional coverage during any valid election period: a Special Election Period (SEP), annually during the Annual Enrollment Period (October 15 through December 7) or during the Medicare Advantage Open Enrollment Period (January 1 through March 31).	Members can elect to receive optional benefits in writing as follows: • at the time of application to enroll in our plan (optional benefits will be effective the same date as other benefits). • or within 30 days of their effective date with our plan (optional benefits will be effective the first of the month following the selection). After the first month of coverage, existing members will have the option to elect optional coverage during the Annual Enrollment Period (October 15 through December 7).
Part D prescription drug cost sharing in the Catastrophic Coverage Stage	You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, the plan will pay most of the cost for your drugs. **You will pay:**	You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Description	2023 (this year)	2024 (next year)
	• Tier 6 drugs filled at either a **preferred** retail or **preferred** mail order pharmacy will be $0. • Tier 1 and Tier 2 drugs filled a **preferred** mail order pharmacy will be $0. • For all other drugs, you will pay the *larger* amount: ○ - ***either*** - coinsurance of 5% of the cost of the drug ○ - ***or*** - $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs. • We will pay the rest.	
Plan service area	The service area for MedMutual Advantage Signature HMO includes the following Ohio counties: Ashland, Carroll, Columbiana, Geauga, Holmes, Lorain, Mahoning, Trumbull, Tuscarawas, and Wayne.	The service area for MedMutual Advantage Signature HMO includes the following Ohio counties: Clark, Hancock, Mahoning, Marion, Morgan, Muskingum, Seneca, Trumbull, and Wyandot.
State Health Insurance Assistance Program (SHIP) web address/URL See Chapter 2, Section 3 of your *Evidence of Coverage* for details.	The web address/URL to access SHIP and other resources is www.medicare.gov.	The web address/URL to access SHIP and other resources is https://www.shiphelp.org.

Description	2023 (this year)	2024 (next year)
WW®/ WeightWatchers® Program name See the “Health and Wellness education programs” listing in Chapter 4, Section 2.1 of your *Evidence of Coverage* for details.	This program uses the name “WW®”.	This program uses the name “WeightWatchers®”.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 If you want to stay in MedMutual Advantage Signature HMO

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our MedMutual Advantage Signature HMO.

Section 3.2 If you want to change plans

We hope to keep you as a member next year, but if you want to change plans for 2024, follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- --*OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Medical Mutual offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan,** enroll in the new plan. You will automatically be disenrolled from MedMutual Advantage Signature HMO.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from MedMutual Advantage Signature HMO.
- To **change to Original Medicare without a prescription drug plan,** you must either:
  - Send us a written request to disenroll. Contact Customer Care if you need more information on how to do so.
  - - or - Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

Are there other times of the year to make a change?
In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. OSHIIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call OSHIIP at 1-800-686-1578 (toll free). You can learn more about OSHIIP by visiting their website (https://insurance.ohio.gov/about-us/divisions/oshiip).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Prescription Cost Sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the Ohio AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-777-4775.

SECTION 7 Questions?

Section 7.1 Getting Help from MedMutual Advantage Signature HMO

Questions? We're here to help. Please call Customer Care at 1-800-982-3117. (TTY only, call 711). We are available for phone calls 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Calls to these numbers are free.

Read your 2024 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the 2024 *Evidence of Coverage* for MedMutual Advantage Signature HMO. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at MedMutual.com/MAplaninfo. You may also call Customer Care to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at MedMutual.com/MAplaninfo. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our List of Covered Drugs (Formulary/“Drug List”).

Section 7.2 Getting Help from Medicare

To get information directly from Medicare:

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

Visit the Medicare Website
Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans. You can find information about plans available in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*
Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

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

Spanish

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

Chinese

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

German

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

Arabic

تر الكتحدث اذامغة، فإن خدمات ال ةعدالمسلا غوية تتوافر لك
قرم هاتف الصم الب وكم 711). ما ذا إ: حوظة كنت
5729-382-800-1 برقم الاتصال. (برص تن)

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

Order Number: Z8188-MCA R8/23
Dept of Ins. Filing Number: Z8188-MCA R9/16

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

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

Nondiscrimination Notice

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

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

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

Civil Rights Coordinator
Medical Mutual of Ohio
100 American Road
Cleveland, OH 44144
Email: CivilRightsCoordinator@MedMutual.com

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

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

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