MedMutual Advantage® Choice HMO

H6723-002-001



2027 Summary of Benefits

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

Things to know about MedMutual Advantage Choice HMO

Phone Numbers and Website

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

Hours of Operation

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

You have choices about how to get your Medicare benefits

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

Y0121_H_S3756_2027_M

C7978-MCA 9.26

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **MedMutual Advantage Choice (HMO)** covers and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on Medicare.gov.

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

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

Who can join?

To join, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. **Our service area includes the following counties in Ohio:** Ashland, Columbiana, Cuyahoga, Erie, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull and Wayne.

Which doctors, hospitals and pharmacies can I use?

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

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

What do we cover?

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

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

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

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

How will I determine my drug costs?

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



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

Out-of-Pocket Costs	
Monthly Plan Premium	$57 per month You must continue to pay your Medicare Part B premium.
Plan Deductible	$0
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs.)	$4,450 annually for services received from in-network providers. Includes copayments and other costs for medical services for the year. If you reach the limit on out-of-pocket costs, you will keep receiving covered hospital and medical services, and Medical Mutual will pay the full cost for the rest of the year.



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

Benefit	Your Costs in Our Plan
Inpatient	$335 copay per day for days 1 through 5. $0 copay per day for days 6 and thereafter. There is no limit to the number of days covered by the plan.
Outpatient Hospital Observation Services	$400 copay for observation services (per stay).
Outpatient Hospital Coverage	$320 copay for covered surgeries.
Ambulatory Surgical Center Services	$325 copay for covered surgeries.



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

Benefit	Your Costs in Our Plan
Primary Care Provider Visit	$0 copay for each covered PCP visit. You have the option to get these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. Copay applies to office visit charge.
Specialist Visit	$35 copay for each covered specialist visit.
Preventive Care	$0 copay For a full list of preventive services available, see your Evidence of Coverage. Some covered services may have an associated cost. There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.



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

Benefit	Your Costs in Our Plan
Emergency Care	$150 copay for each covered emergency room visit. If you are admitted to the hospital within 24 hours, you do not have to pay the $150 copay.
Urgently Needed Services	$40 copay for each covered urgent care center visit. An urgently needed service is a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care.
Ground Ambulance	$225 copay for each covered ground ambulance trip.
Air Ambulance	50% coinsurance for air ambulance services.
You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to $25,000 per calendar year. This applies if you are traveling outside the United States for less than six months. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay up front for the services rendered. You must submit receipts to Medical Mutual for reimbursement. See Evidence of Coverage for full benefit details.	



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

Benefit	Your Costs in Our Plan
Diagnostic Tests and Services	$10 copay for each covered diagnostic test and service.
Diagnostic Radiological Services (CT/MRI/PET Scans)	$100/$200/$200 copay for each covered service.
Lab services	$10 copay for each covered lab service.
Outpatient X-rays	$50 copay for each covered X-ray service.
Therapeutic radiology services (such as radiation therapy for cancer.)	20% coinsurance for each covered therapeutic radiology service.



Hearing Services

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

Benefit	Your Costs in Our Plan
Diagnostic Hearing Exam	$0 copay for each covered hearing exam to determine if you need medical treatment for a hearing condition.
Routine hearing exam (1 every year)	$0 copay
Hearing aid fitting-evaluation visits	$0 copay
TruHearing-branded hearing aids (1 per ear, per year)	$499 copay for each covered Standard hearing aid. $699 copay for each covered Advanced hearing aid. $999 copay for each covered Premium hearing aid. Any cost you pay for hearing aids will not count toward your maximum out-of-pocket.



Dental Services
(Diagnostic and preventive services.)

Benefit	Your Costs in Our Plan In-Network Costs
Diagnostic and Preventive Dental	$0 copay for: ▪ Oral exams (2 every year) ▪ Cleanings (2 every year) ▪ Dental bitewing X-ray (1 set every year) ▪ Fluoride treatment (1 every year)
If you want to purchase additional dental coverage, see Optional Supplemental Benefits.	



Vision Services

Benefit	Your Costs in Our Plan In-Network Costs
Vision Services	$0 copay for Original Medicare covered vision services, including a yearly glaucoma screening and diabetic eye exam. 20% coinsurance for Original Medicare covered eyeglasses or contact lenses after cataract surgery.
Routine Eye Exam	$0 copay (1 every year).
Contact Lenses or Eyeglasses	$130 allowance toward contact lenses or eyeglasses (frames and lenses, 1 pair every year). You are responsible for any amount more than $130.
If you want to purchase additional vision coverage, see Optional Supplemental Benefits.	



Mental Health Care and Outpatient Substance Use Disorder Services
(Services may require prior authorization.)

Benefit	Your Costs in Our Plan
Inpatient Visit	There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period starts the first day you go into the hospital. The benefit period ends when you haven't had any inpatient care for 60 days in a row. The plan covers 90 days each benefit period. You have 60 lifetime reserve days that can be used for an inpatient psychiatric admission. You have no copayment for these extra days. ▪ $370 copay per day for days 1 through 5 ▪ $0 copay per day for days 6 through 90
Outpatient Individual Therapy Visit	$35 copay for each covered therapy visit.
Outpatient Group Therapy Visit	$35 copay for each covered therapy visit.



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

Benefit	Your Costs in Our Plan
Skilled Nursing Facility Care	We will pay for skilled nursing facility care for up to 100 days per benefit period. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to how many benefit periods you can have. ▪ $0 copay per day for days 1 through 20 ▪ $221 copay per day for days 21 through 100



Outpatient Rehabilitation Services
(Services may require prior authorization.)

Benefit	Your Costs in Our Plan
Physical Therapy and Speech/Language Therapy	$40 copay for each covered visit.
Occupational Therapy Visit	$45 copay for each covered visit.
Cardiac (Heart) Rehabilitation Service	$40 copay for each covered service.
Pulmonary (Lung) Rehabilitation Service	$25 copay for each covered service.



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

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



Outpatient Prescription Drugs

Benefit	Your Costs in Our Plan
Part D Deductible	$55 deductible for Part D prescription drugs, except for drugs listed on Tiers 1, 2 and 6 which are excluded from the deductible. The deductible also does not apply to covered insulin products and most adult Part D vaccines.
Initial Coverage	You pay the following until your total out-of-pocket costs reach $2,400.
	Retail cost sharing (preferred/standard): Tier 1 (preferred generic drugs) ▪ One-month supply: $0/$6 copay ▪ Two-month supply: $0/$12 copay ▪ Three-month supply: $0/$14 copay Tier 2 (generic drugs): ▪ One-month supply: $5/$12 copay ▪ Two-month supply: $10/$24 copay ▪ Three-month supply: $13/$30 copay Tier 3 (preferred brand and generic drugs): ▪ One-month supply: 24%/24% coinsurance ▪ Two-month supply: 24%/24% coinsurance ▪ Three-month supply: 24%/24% coinsurance Tier 4 (non-preferred drugs): ▪ One-month supply: 36%/36% coinsurance ▪ Two-month supply: 36%/36% coinsurance ▪ Three-month supply: 36%/36% coinsurance Tier 5 (specialty tier drugs): ▪ One-month supply: 32%/32% coinsurance ▪ Two-month supply: Not covered ▪ Three-month supply: Not covered Tier 6 (select care drugs): ▪ One-month supply: $0/$0 copay ▪ Two-month supply: $0/$0 copay ▪ Three-month supply: $0/$0 copay **Mail-order cost sharing (preferred/standard):** Tier 1 (preferred generic drugs): ▪ One-month supply: $0/$5 copay ▪ Two-month supply: $0/$10 copay ▪ Three-month supply: $0/$10 copay Tier 2 (generic drugs): ▪ One-month supply: $5/$11 copay ▪ Two-month supply: $10/$22 copay ▪ Three-month supply: $10/$28 copay Tier 3 (preferred brand and generic drugs): ▪ One-month supply: 24%/24% coinsurance ▪ Two-month supply: 24%/24% coinsurance ▪ Three-month supply: 24%/24% coinsurance Tier 4 (non-preferred drugs):

	▪ One-month supply: 36%/36% coinsurance ▪ Two-month supply: 36%/36% coinsurance ▪ Three-month supply: 36%/36% coinsurance Tier 5 (specialty tier drugs): ▪ One-month supply: 32%/32% coinsurance ▪ Two-month supply: Not covered ▪ Three-month supply: Not covered Tier 6 (select care drugs): ▪ One-month supply: $0/$0 copay ▪ Two-month supply: $0/$0 copay ▪ Three-month supply: $0/$0 copay
You may get your drugs at any network retail or mail order pharmacy. You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't met your deductible. If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies.	
Catastrophic Coverage	When you (or those paying on your behalf) have spent a total of $2,400 in out-of-pocket costs within the benefit period, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.



Transportation Services
(Services may require prior authorization.)

Benefit	Your Costs in Our Plan
Transportation Services	0% coinsurance You may receive up to 24 one-way trips (12 roundtrips) with a limit of 35 miles per trip in our Ohio service area. This benefit covers transportation to approved medical locations by our contracted vendor. Trip requests must be made by the member at least three business days in advance. Basic Life Support and stretcher rides are not covered.



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

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



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

Benefit	Your Costs in Our Plan
Foot Exams and Treatment	$25 copay for each covered podiatry visit.



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

Benefit	Your Costs in Our Plan
Durable Medical Equipment (DME) (Wheelchairs, Oxygen, etc.)	20% coinsurance for durable medical equipment, diabetic monitors and insulin pumps.
Prosthetic and Orthotic Devices and Related Supplies (Braces, Artificial Limbs, etc.)	20% coinsurance for prosthetic devices and supplies.
You must get DME through participating suppliers. Continuous glucose monitors are only covered with an approved prior authorization. Coinsurance may apply. See your Evidence of Coverage for more information.	



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

Benefit	Your Costs in Our Plan
Blood Glucose Meter, Blood Glucose Test Strips, Lancing Devices and Glucose Lancets, Glucose Control Solutions (for checking accuracy)	0-20% coinsurance In order to qualify for 0% coinsurance, diabetic test strips and meters must be produced by a preferred manufacturer, Abbott or Trividia, and be purchased at an in-network retail or mail-order pharmacy. Preferred products include some Freestyle, Precision Xtra, True Metrix meters and Trividia test strips. Not ALL products from preferred manufacturers are considered preferred. Non-preferred diabetic test strips and meters are covered (with 0% coinsurance) when filled by an in-network durable medical equipment supplier.
Other Covered Diabetic Supplies	20% coinsurance
One-Month Supply of Insulin	No more than $35 copay
See Evidence of Coverage for more details.	



Alternative Medicine

Benefit	Your Costs in Our Plan
Chiropractic Care	$20 copay for each visit that Original Medicare covers to see a chiropractor. Only manual manipulation of the spine to correct subluxation is covered.



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

Benefit	Your Costs in Our Plan
Chronic Condition 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 call Customer Care at 1-800-982-3117 (TTY 711).
Home Meals Program	After a qualifying acute inpatient stay within 30 days of discharge, you are eligible to receive a one-week course of meals at no extra cost. You will receive two meals a day for seven days, delivered to your home.
Nurse Line	If you have questions about symptoms but aren't sure if you need to see your doctor, the Nurse Line may be able to help. Members can call our Nurse Line at 1-888-912-0636 (TTY 711), 24 hours a day, seven days per week for advice. Calls are kept confidential.
SilverSneakers® Fitness Program	SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note: Nonstandard fitness center services that usually have an extra fee are not included in this membership.
Tobacco and Smoking Cessation	You pay a $0 copay for smoking and tobacco use cessation support. This includes six coaching sessions, as well as a supply of nicotine therapy, in the form of patches or gum, at no cost.
WeightWatchers® Program	To help you meet your health goals, we partner with WeightWatchers, the world's leading provider of weight management services. Monthly fees for specified programs are reduced for MedMutual Advantage members. The benefit does not include food or meals. Note: You are responsible for paying your reduced WeightWatchers fees.



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

Benefit	Your Costs in Our Plan
Home Health Care Services	$0 copay
Hospice	When you enroll in a Medicare certified hospice program, your hospice services (and any Part A or Part B services related to your terminal prognosis) are paid for by Original Medicare.



Renal Dialysis
(Services may require prior authorization.)

Benefit	Your Costs in Our Plan
Dialysis Equipment	20% coinsurance for covered dialysis equipment.
Dialysis Supplies	20% coinsurance for covered dialysis supplies.
See Evidence of Coverage for more information.	



Optional Supplemental Benefits

Benefit	Your Costs in Our Plan
Optional Supplemental Benefits Package	**Dental** In addition to the preventive and comprehensive dental benefits included in your plan, the Optional Supplemental Benefits includes an increased dollar allowance of $1,000 towards comprehensive dental services. **Vision** In addition to the routine eye exam included in your plan, the Optional Supplemental Benefits Package includes an increased eyewear allowance of $150. For coverage and cost information for all dental and vision services, see this plan's Evidence of Coverage.
Monthly Premium	$30 per month. This premium is in addition to your plan premium. You must keep paying your Medicare Part B premium and your monthly plan premium.
Deductible	This package does not have a deductible.

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

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

WeightWatchers is a trademark of WW International, Inc.

SilverSneakers® is a registered trademark of Tivity Health, Inc.

TruHearing® is a registered trademark of TruHearing, Inc.