2017 MedMutual Advantage Overview

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

Medical Mutual®

	MedMutual Advantage Classic HMO	MedMutual Advantage Choice HMO
MEDICAL BENEFITS		
Premium	$0 per month	$29 per month
Deductible (In Network)	$0 per year	$0 per year
Max. Out-of-Pocket (In Network)	$3,950 per year	$3,700 per year
Preventive Services	Covered in full	Covered in full
SilverSneakers®	No additional cost	No additional cost
PCP/Specialist Visit (In Network	$10 copay/$50 copay	$0 copay/$40 copay
PCP/Specialist Visit (Out of Network)	N/A	N/A
Emergency Room	$75 copay	$75 copay
Ambulance	$295 (one way)	$295 (one way)
Hospital Admission (mental health copays may differ)	Days 1-5: $350 per day Days 6+: $0 per day	Days 1-5: $350 per day Days 6+: $0 per day
Outpatient Surgery (In Network)	$315 copay	$295 copay
Outpatient Surgery (Out of Network)	N/A	N/A
Urgent Care	$40 copay	$40 copay
Skilled Nursing Facility	Days 1-20: $0 copay per day Days 21-100: $164.50 copay per day	Days 1-20: $0 copay per day Days 21-100: $164.50 copay per day
Home Health Care	Covered in full	Covered in full
Dental Care	$25 copay for one exam with bitewing X-ray and cleaning per year	$25 copay for one exam with bitewing X-ray and cleaning per year
Vision Care	$25 copay for one routine exam $100 for glasses or contacts per year	$25 copay for one routine exam $100 for glasses or contacts per year
Simply Supplies	N/A	$20 allowance per quarter
PART D PRESCRIPTION DRUGS		
Prescription Drug Deductible—Deductible excludes Tier 1, 2 and 5	$195 per year	$0 per year
Tier 1: Preferred Generic (30-day/90-day supply)	$5 copay/$10 copay	$0 copay/$0 copay
Tier 2: Generic (30-day/90-day supply)	$19 copay/$38 copay	$14 copay/$28 copay
Tier 3: Preferred Brand (30-day/90-day supply)	$47 copay/$118 copay	$47 copay/$118 copay
Tier 4: Non-Preferred Drug (30-day/90-day supply)	50% of the cost	50% of the cost
Tier 5: Specialty (30-day supply only)	29% of the cost	33% of the cost
Initial Coverage Limit	$3,700 per year	$3,700 per year
"Donut Hole" Gap Discount–You Pay:	51% generic/40% brand	51% generic/40% brand
Max. Total Out-of-Pocket Costs	$4,950 per year	$4,950 per year
Catastrophic Coverage	The greater of $3.30 copay generic/$8.25 copay brand or 5% coinsurance	The greater of $3.30 copay generic/$8.25 copay brand or 5% coinsurance

MedMutual Advantage Select PPO	MedMutual Advantage Preferred PPO	MedMutual Advantage Premium PPO
$39 per month	$69 per month	$109 per month
$0 per year	$0 per year	$0 per year
$6,350 per year	$4,900 per year	$3,600 per year
Covered in full	Covered in full	Covered in full
No additional cost	No additional cost	No additional cost
$10 copay/$45 copay	$5 copay/$35 copay	$0 copay/$25 copay
30% of the cost	30% of the cost	30% of the cost
$75 copay	$75 copay	$75 copay
$295 (one way)	$295 (one way)	$195 (one way)
Days 1-5: $325 per day Days 6+: $0 per day	Days 1-6: $295 per day Days 7+: $0 per day	Days 1-6: $220 per day Days 7+: $0 per day
$315 copay	$315 copay	$195 copay
30% of the cost	30% of the cost	30% of the cost
$40 copay	$40 copay	$40 copay
Days 1-20: $0 copay per day Days 21-100: $164.50 copay per day	Days 1-20: $0 copay per day Days 21-100: $164.50 copay per day	Days 1-20: $0 copay per day Days 21-100: $164.50 copay per day
Covered in full	Covered in full	Covered in full
$25 copay for one exam with bitewing X-ray and cleaning per year	$25 copay for one exam with bitewing X-ray and cleaning per year	$0 copay for two exams with two cleanings and one bitewing X-ray per year, 30% to 50% of the cost for additional services
$25 copay for one routine exam $100 for glasses or contacts per year	$25 copay for one routine exam $100 for glasses or contacts per year	$0 copay for one routine exam $250 for glasses or contacts per year
$20 allowance per quarter	$20 allowance per quarter	$20 allowance per month
$195 per year	$0 per year	$0 per year
$5 copay/$10 copay	$0 copay/$0 copay	$0 copay/$0 copay
$19 copay/$38 copay	$14 copay/$28 copay	$14 copay/$28 copay
$47 copay/$118 copay	$47 copay/$118 copay	$47 copay/$118 copay
50% of the cost	50% of the cost	50% of the cost
29% of the cost	33% of the cost	33% of the cost
$3,700 per year	$3,700 per year	$3,700 per year
51% generic/40% brand	51% generic/40% brand	51% generic/40% brand
$4,950 per year	$4,950 per year	$4,950 per year
The greater of $3.30 copay generic/$8.25 copay brand or 5% coinsurance	The greater of $3.30 copay generic/$8.25 copay brand or 5% coinsurance	The greater of $3.30 copay generic/$8.25 copay brand or 5% coinsurance

Medical Mutual
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Cleveland, OH 44115-1355

MedMutual.com/Medicare

Call with questions or to enroll

To speak with a licensed Medical Mutual insurance agent, call (866) 406-8777 (TTY 711 for hearing impaired). We are available 8 a.m. to 8 p.m. seven days a week from October 1 to February 14 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday and 9 a.m. to 1 p.m. Saturdays from February 15 through September 30 (except holidays).

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. Benefits, premiums and/or copayments/coinsurance may change on January 1 of per year. The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary. Out-of-network/non-contracted providers are under no obligation to treat Medical Mutual members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. You must continue to pay your Part B premium. Limitations, copayments and restrictions may apply. This information is not a complete description of benefits. Contact the plan for more information. SilverSneakers is a registered trademark of Healthways, Inc.

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