

*Advantage Plan*  
from Medical Mutual of Ohio®

FAMILY OF PRODUCTS



## MA-PD FAMILY OF PRODUCTS

BENEFIT	STANDARD	VALUE	PREMIUM
Benefit Period	January 1 through December 31	January 1 through December 31	January 1 through December 31
Premium	\$25	\$55	\$80
Yearly Out-of-Pocket Limit/In Network	\$4,500	\$3,000	\$2,000
Must see In-Network Doctor/Hospital/Specialist?	Yes	Yes	Yes
For all Out-of-Network Services:	You pay 100%	You pay 20%	You pay 20%
Need Referral to See In-Network Doc/Hos/Spec?	No	No	No
Inpatient Hospital Care	\$200/day for days 1-8; after that unlimited. at a network hospital; except in emergency, doctor must receive prior authorization from Medical Mutual.	\$750 for each Medicare-covered stay; \$0 copay for additional days received at a network hospital; except in emergency, doctor must receive prior authorization from Medical Mutual.	\$250 for each Medicare-covered stay; \$0 copay for additional days received at a network hospital; except in emergency, doctor must receive prior authorization from Medical Mutual.
Skilled Nursing Facility	\$75 each day up to 100 days	\$50 each day up to 100 days	\$25 each day up to 100 days
Home Health Care	\$0 copay	\$0 copay	\$0 copay
Doctor Office Visits	\$20 copay for primary care physician visits; \$30 copay for specialists	\$15 copay for primary care physician visits; \$25 copay for specialists	\$10 copay for primary care physician visits; \$25 copay for specialists
<b>Outpatient Services/ Surgery</b>			
Medicare-covered visit to an ambulatory surgical center	\$150 copay for each	\$100 copay for each	\$75 copay for each
Medicare-covered visit to an outpatient hospital facility	\$250 copay for each	\$150 copay for each	\$100 copay for each

BENEFIT	STANDARD	VALUE	PREMIUM
<b>Emergency Care</b> Medicare-covered emergency room visit	\$50 copay for each	\$50 copay for each	\$50 copay for each
<b>Urgently Needed Care</b> Medicare-covered visits	\$30 copay	\$30 copay	\$30 copay
<b>Outpatient Medical Services and Supplies</b>			
Durable Medical Equipment	20% of each Medicare-covered item	20% of each Medicare-covered item	20% of each Medicare-covered item
Diagnostic Tests, X-rays and Lab Services	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services	\$0 copay for Medicare-covered services
<b>Preventive Services</b>			
Colorectal Screening Exams/Pap Smears and Pelvic Exams and Prostate Cancer Exams	\$0 copay for Medicare-covered screenings	\$0 copay for Medicare-covered screenings	\$0 copay for Medicare-covered screenings
Mammograms	\$0 copay for one annual screening	\$0 copay for one annual screening	\$0 copay for one annual screening
Immunizations	\$0 copay for pneumonia and flu vaccines	\$0 copay for pneumonia and flu vaccines	\$0 copay for pneumonia and flu vaccines
<b>Prescription Drug Coverage</b>			
Covered Drugs	Plan uses a formulary which lists the covered drugs	Plan uses a formulary which lists the covered drugs	Plan uses a formulary which lists the covered drugs
Deductible	\$0	\$0	\$0
<b>In-Network Retail Pharmacy</b>			
(30-day) supply of generic drugs	\$5	\$5	\$5
(30-day) supply of preferred brand drugs	\$33	\$33	\$33

BENEFIT	STANDARD	VALUE	PREMIUM
<b>In-Network Retail Pharmacy</b>			
(30-day) supply of non-preferred brand drugs	75% coinsurance	75% coinsurance	75% coinsurance
(30-day) supply of specialty drugs	33% coinsurance	33% coinsurance	33% coinsurance
(90-day) supply of generic drugs	\$15	\$15	\$15
(90-day) supply of preferred brand drugs	\$99	\$99	\$99
(90-day) supply of non-preferred brand drugs	75% coinsurance	75% coinsurance	75% coinsurance
(90-day) supply of specialty drugs	33% coinsurance	33% coinsurance	33% coinsurance
<b>Mail-Order</b>			
(90-day) supply of generic drugs	\$10	\$10	\$10
(90-day) supply of preferred brand drugs	\$80	\$80	\$80
(90-day) supply of non-preferred brand drugs	75% coinsurance	75% coinsurance	75% coinsurance
(90-day) supply of specialty drugs	33% coinsurance	33% coinsurance	33% coinsurance
<b>Coverage after Reaching Initial Limit</b>	After total yearly drug costs reach \$2400, you pay 100% until you reach \$3850	After total yearly drug costs reach \$2400, you pay 100% brand and \$5 generic until you reach \$3850	After total yearly drug costs reach \$2400, you pay 100% brand and \$5 generic until you reach \$3850
<b>Catastrophic Coverage</b>	After you reach \$3850 you pay \$2.15 for generic and \$5.35 for all other drugs, or 5% coinsurance	After you reach \$3850 you pay \$2.15 for generic and \$5.35 for all other drugs, or 5% coinsurance	After you reach \$3850 you pay \$2.15 for generic and \$5.35 for all other drugs, or 5% coinsurance

BENEFIT	STANDARD	VALUE	PREMIUM
<b>Hearing Services</b>			
Hearing Aids	You pay 100%	\$250 Allowance	\$0 Copay, you are covered up to \$250 up to three years
Hearing Exams	\$30 copay for each Medicare-covered hearing exam	\$25 copay for each Medicare-covered hearing exam	\$20 copay for each Medicare-covered hearing exam
	\$30 copay for each routine hearing test up to one per year	\$25 copay for each routine hearing test up to one per year	\$25 copay for each routine hearing test up to one per year
<b>Vision Services</b>			
Eyewear	You pay 100%	\$40 Allowance per year	\$40 Allowance per year
Exams	\$30 copay for each Medicare-covered eye exam	\$25 copay for each Medicare-covered eye exam	\$20 copay for each Medicare-covered eye exam
	\$30 copay for each routine eye exam, limited to one per year	\$25 copay for each routine eye exam, limited to one per year	\$20 copay for each routine eye exam, limited to one per year
<b>Physical Exams</b>			
Routine Physical Exams	\$0 copay for routine physical exam, limited to one exam per year	\$0 copay for routine physical exam, limited to one exam per year	\$0 copay for routine physical exam, limited to one exam per year

## PDP FAMILY OF PRODUCTS

BENEFIT	STANDARD DRUG	PREMIUM DRUG
Benefit Period	January 1 through December 31	January 1 through December 31
Premium	\$37	\$50.50
Drugs Covered	See Formulary	See Formulary
Deductible	\$0	\$0
<b>Initial coverage before your costs reach \$2400, you pay: In-Network Retail Pharmacy</b>		
(30-day) supply generic drugs	\$5	\$5
(30-day) supply of preferred brand drugs	\$33	\$33
(30-day) supply of specialty drugs	75% coinsurance	75% coinsurance
(90-day) supply of specialty drugs	33% coinsurance	33% coinsurance
(90-day) supply of generic drugs	\$15	\$15
(90-day) supply of preferred brand drugs	\$99	\$99
(90-day) supply of specialty drugs	75% coinsurance	75% coinsurance
(90-day) supply of specialty drugs	33% coinsurance	33% coinsurance
<b>Mail-Order</b>		
(90-day) supply of generic drugs	\$10	\$10
(90-day) supply of preferred brand drugs	\$80	\$80
(90-day) supply of non-preferred brand drugs	75% coinsurance	75% coinsurance
(90-day) supply of specialty drugs	33% coinsurance	33% coinsurance
<b>Coverage after Reaching Initial Limit</b>	After total yearly drug costs reach \$2400, you pay some of your prescription drug costs until you reach \$3850	After total yearly drug costs reach \$2400, you pay some of your prescription drug costs until you reach \$3850

BENEFIT	STANDARD DRUG	PREMIUM DRUG
In Network Retail Pharmacy	N/A	\$5 for a (30-day) supply of generic drugs
	N/A	\$15 for a (90-day) supply of generic drugs
Mail-Order	N/A	\$10 for a (90-day) supply of generic drugs
<b>Catastrophic Coverage</b>	After yearly total drug costs reach \$3850, you pay the greater of: \$2.15 for generic and \$5.35 for all other drugs or 5% coinsurance	After yearly total drug costs reach \$3850, you pay the greater of: \$2.15 for generic and \$5.35 for all other drugs or 5% coinsurance

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