

Medical Mutual of Ohio®

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE (COVER PAGE 1 OF 2)

BENEFIT PLANS A, C AND F

These charts show the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan A. Some plans may not be available in your state. **See Outlines of Coverage sections for details about ALL plans.**

Basic Benefits for Plans A–J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible					Part B Deductible	Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care not covered by Medicare							Preventive Care not covered by Medicare

* Plans F and J also have an option called a high-deductible Plan F and a high-deductible Plan J. These high-deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$1,900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE (COVER PAGE 2 OF 2)

BENEFIT PLANS K AND L

Basic Benefits for Plans K and L include similar services as plans A–J, but cost-sharing for the basic benefits is at different levels

	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 50% of Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% of Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 75% of Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% of Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care Not Covered by Medicare		
	\$4,440 Out-of-Pocket Annual Limit***	\$2,220 Out-of-Pocket Annual Limit***

**** Plans K and L provide for different cost-sharing for items and services than Plans A - J**

Once you reach the annual limit, the plan pays 100% of the Medicare copayment, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You will be responsible for payment of excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**

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MEDICARE SUPPLEMENT MONTHLY PREMIUM RATES

Age	Plan A Rates	Plan C Rates	Plan F Rates
65	\$87.88	\$121.67	\$126.33
66	\$90.16	\$131.77	\$136.82
67	\$92.12	\$145.34	\$150.90
68	\$96.30	\$151.95	\$157.77
69	\$100.43	\$158.46	\$164.51
70	\$104.80	\$165.35	\$171.68
71	\$109.16	\$172.24	\$178.84
72	\$113.45	\$179.00	\$185.84
73	\$117.82	\$185.88	\$193.01
74	\$122.10	\$192.66	\$200.03
75	\$126.05	\$198.88	\$206.46
76	\$129.99	\$205.09	\$212.95
77	\$133.91	\$211.31	\$219.39
78	\$137.87	\$217.52	\$225.85
79	\$141.53	\$223.34	\$231.90
80	\$144.82	\$228.49	\$237.21
81+	\$147.54	\$232.80	\$241.72

Medical Mutual of Ohio[®]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Premium Information

We, Medical Mutual of Ohio[®], can only raise your premium if we raise the premium for all policies like yours in Ohio. We determine your premium based upon attained age. This means your premium will increase each year.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully

This is only an outline describing your policies most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to Medical Mutual at our local address listed below. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

Policy Replacement

If you are replacing another health insurance policy, do not cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs. Neither Medical Mutual nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "*Medicare and You*" for more details.

Complete Answers Are Very Important

When you fill out your application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Medical Mutual may cancel your policy and refuse to pay any claims if you leave out or falsify important information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN A MEDICARE (PART A) HOSPITAL SERVICES—PER BENEFIT PERIOD

* **A benefit period begins on the first day you receive services in a an inpatient hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous supplies. First 60 days 61st through 90th day 91st day and after: • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$0 \$256 a day \$512 a day 100% of Medicare-eligible expenses \$0	\$1024 (Part A Deductible) \$0 \$0 \$0** All Costs
Skilled Nursing Facility Care* You must meet Medicare’s requirements, including having been in the hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$128 a day \$0	\$0 \$0 \$0	\$0 Up to \$128 a day All Costs
Blood First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN A MEDICARE (PART B) MEDICAL SERVICES—PER CALENDAR YEAR

* **Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the year.**

Services	Medicare Pays	Plan Pays	You Pay
Medicare Expenses In or out of the hospital and outpatient hospital treatment, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment. First \$135 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
Blood First 3 Pints Next \$135 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
Clinical Laboratory Services Tests for Diagnostic Services	100%	\$0	\$0

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN A PARTS A AND B

* **Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the year.**

Services	Medicare Pays	Plan Pays	You Pay
Home Healthcare (Medicare-approved services)			
Medically necessary skilled-care services	100%	\$0	\$0
Durable Medical Equipment <i>(First \$135 of Medicare approved amounts*)</i>	\$0	\$0	\$135 (Part B Deductible)
Durable Medical Equipment <i>(Remainder of Medicare-approved amounts)</i>	80%	20%	\$0

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN C MEDICARE (PART A) HOSPITAL SERVICES—PER BENEFIT PERIOD

* **A benefit period begins on the first day you receive services in a an inpatient hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous supplies. First 60 days 61st through 90th day 91st day and after: • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$1024 (Part A Deductible) \$256 a day \$512 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in the hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All Costs
Blood First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN C MEDICARE (PART B) MEDICAL SERVICES—PER CALENDAR YEAR

*** Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the year.**

Services	Medicare Pays	Plan Pays	You Pay
<p>Medicare Expenses In or out of the hospital and outpatient hospital treatment, such as: physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.</p> <p>First \$135 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$135 (Part B Deductible)</p> <p>Generally 20%</p>	<p>\$0</p> <p>\$0</p>
<p>Part B Excess Charges (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All Costs</p>
<p>Blood</p> <p>First 3 Pints</p> <p>Next \$135 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All Costs</p> <p>\$135 (Part B Deductible)</p> <p>20%</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>Clinical Laboratory Services</p> <p>Tests for Diagnostic Services</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN C

PARTS A AND B

* **Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the year.**

Services	Medicare Pays	Plan Pays	You Pay
Home Healthcare (Medicare-approved services)			
Medically necessary skilled-care services	100%	\$0	\$0
Durable Medical Equipment <i>(First \$135 of Medicare approved amounts*)</i>	\$0	\$135 (Part B Deductible)	\$0
Durable Medical Equipment <i>(Remainder of Medicare-approved amounts)</i>	80%	20%	\$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum lifetime benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN F MEDICARE (PART A) HOSPITAL SERVICES—PER BENEFIT PERIOD

* **A benefit period begins on the first day you receive services in a an inpatient hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.**

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous supplies. First 60 days 61st through 90th day 91st day and after: • While using 60 lifetime reserve days Once lifetime reserve days are used: • Additional 365 days • Beyond additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$1024 (Part A Deductible) \$256 a day \$512 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All Costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in the hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All Costs
Blood First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN F MEDICARE (PART B) MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the year.

Services	Medicare Pays	Plan Pays	You Pay
Medicare Expenses In or out of the hospital and outpatient hospital treatment, such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment. First \$135 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
Blood First 3 Pints Next \$135 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
Clinical Laboratory Services Tests for Diagnostic Services	100%	\$0	\$0

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE PLAN F PARTS A AND B

*** Once you have been billed \$135 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the year.**

Services	Medicare Pays	Plan Pays	You Pay
Home Healthcare (Medicare-approved services)			
Medically necessary skilled-care services	100%	\$0	\$0
Durable Medical Equipment <i>(First \$135 of Medicare approved amounts*)</i>	\$0	\$135 (Part B Deductible)	\$0
Durable Medical Equipment <i>(Remainder of Medicare-approved amounts)</i>	80%	20%	\$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum lifetime benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum