

Oberlin College MedMutual Advantage® PPO

Group Number: 590467



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/MAGroup](https://www.MedMutual.com/MAGroup).** Enter group number, 590467.

Things to know about MedMutual Advantage PPO

Phone Numbers and Website

- If you are a member of one of these plans, call toll-free 1-800-801-4823 (TTY 711)
- Our website: [MedMutual.com/MAGroup](https://www.MedMutual.com/MAGroup). Enter group number, 590467.

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 (PPO)

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **MedMutual Advantage (PPO)** 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](https://www.medicare.gov) to search for other plans.

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](https://www.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 1-800-801-4823 (TTY 711).

Who can join?

To join, you and your Medicare-eligible spouse and/or dependent must be entitled to Medicare Part A, be enrolled in Medicare Part B, eligible for group coverage through your employer or retiree group and live in our service area, which includes the United States and all U.S. Territories.

Which doctors, hospitals and pharmacies can I use?

Our plans have in-network and out-of-network access to doctors, hospitals, pharmacies and other providers. If medically necessary, Medical Mutual provides coverage for all covered services, including out-of-network. For a list of network doctors, visit [Medicare.gov](https://www.medicare.gov) and use the “Find Care Providers” tool.

- 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/MAGroup](https://www.MedMutual.com/MAGroup). Enter group number, 590467.
- 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.

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/MAGroup](https://www.MedMutual.com/MAGroup). Enter group number, 590467.
- 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: Initial Coverage and Catastrophic Coverage.

PLEASE NOTE: your plan deductible must be met for copays and coinsurance to apply. All benefits apply after the deductible except for preventive services. Medicare-covered preventive services are covered at 100% with no cost to you.



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

Out-of-Pocket Costs	
Monthly Plan Premium	\$203.76 You must continue to pay your Medicare Part B premium.
Plan Deductible	This plan has a deductible for some hospital and medical services: \$500 per year for in-network and out-of-network services
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs.)	You'll pay no more than: \$3,000 annually for services you receive from in-network and out-of-network providers Includes copays 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
	In-network and Out-of-network
Inpatient	15% coinsurance per day applied days 1 and after (after deductible).
Outpatient Hospital Observation Services	15% coinsurance (after deductible) for observation services.
Outpatient Hospital Coverage	15% coinsurance for each covered surgery.
Ambulatory Surgical Center Services	15% coinsurance for each covered surgery.



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Primary Care Provider Visit	15% coinsurance 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.
Specialist Visit	15% coinsurance for each covered specialist visit. There is no coinsurance, copay or deductible for the Welcome to Medicare physical or annual wellness visit.
Preventive Care	\$0 copay For a full list of preventive services available, see the Evidence of Coverage (EOC). Some covered services may have an associated cost.



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Emergency Care	\$120 copay for each covered emergency room visit. If you are admitted to the hospital within 24 hours, you do not have to pay the \$120 copay.
Urgently Needed Services	\$30 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	15% coinsurance for each covered ground ambulance trip (after deductible)
Air Ambulance	15% coinsurance for air ambulance services (after deductible)
You may get covered emergency medical care/urgently needed services whenever you need it, anywhere in the world, up to \$50,000 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 this plan's EOC 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
	In-network and Out-of-network
Diagnostic Tests and Services	15% coinsurance for each covered diagnostic test and service.
Diagnostic Radiological Services (CT/MRI/PET Scans)	15% coinsurance for each covered service.
Lab Services	15% coinsurance for each covered lab service.
Outpatient X-rays	15% coinsurance for each covered X-ray service.
Therapeutic Radiology Services (such as radiation therapy for cancer.)	15% coinsurance for each covered therapeutic radiology service (after deductible)



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Original Medicare-covered Hearing Exam	15% coinsurance



Vision Services

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Original Medicare-covered Eye Exam	15% coinsurance Includes yearly glaucoma screening and diabetic eye exam. 15% coinsurance (after deductible) for Original Medicare covered eyeglasses or contact lenses after cataract surgery.



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
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. 15% coinsurance (after deductible)
Outpatient Individual or Group Therapy Visit	15% coinsurance (after deductible)



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
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 on benefit period has ended, a new benefit period begins. There is no limit to how many benefit periods you can have. 15% coinsurance per day applied days 1 through 100 (after deductible)



Outpatient Rehabilitation Services

(Services may require prior authorization.)

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Physical Therapy and Speech/Language Therapy	15% coinsurance for each covered visit.
Occupational Therapy Visit	15% coinsurance for each covered visit.
Cardiac (Heart) Rehabilitation Service	15% coinsurance for each covered service.
Pulmonary (Lung) Rehabilitation Service	15% coinsurance 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
	In-network and Out-of-network
Part B Drugs	Up to 15% coinsurance (after deductible) 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. If you receive a Part B drug at the pharmacy, you are responsible for 100% of the cost of the drug until you meet your medical deductible. Once you meet your medical deductible, you'll be responsible for paying up to 15% coinsurance until you reach your medical maximum out-of-pocket amount. From there, you will pay nothing.
Part B Insulin	You will pay no more than a \$35 copay for a one-month supply of insulin. The in-network and out-of-network deductibles don't apply to insulin delivered through an insulin pump.
To view a list of Part B drugs that may be subject to Step Therapy visit MedMutual.com/MAGroup. Enter group number, 590467.	



Outpatient Prescription Drugs

Benefit	Your Costs in Our Plan
Deductible	This plan does not have a Part D prescription drug deductible.
Initial Coverage	During the Initial Coverage Stage, the plan pays its share of the cost for your covered prescription drugs, and you pay your share. Your cost may vary depending on the drug and where you fill your prescription. You will pay the following amounts until your total out-of-pocket drug costs reach \$2,400. Retail cost sharing: Tier 1 (preferred generic drugs) ▪ One-month supply: \$10 copay ▪ Three-month supply: \$30 copay Tier 2 (generic drugs): ▪ One-month supply: \$10 copay ▪ Three-month supply: \$30 copay Tier 3 (preferred brand and generic drugs): ▪ One-month supply: \$50 copay ▪ Three-month supply: \$150 copay Tier 4 (non-preferred drugs): ▪ One-month supply: \$75 copay ▪ Three-month supply: \$225 copay Tier 5 (specialty tier drugs): ▪ One-month supply: \$100 copay ▪ Three-month supply: Not covered Tier 6 (select care drugs): ▪ One-month supply: \$10 copay ▪ Three-month supply: \$30 copay Mail-order cost sharing: Tier 1 (preferred generic drugs): ▪ One-month supply: \$20 copay ▪ Three-month supply: \$20 copay Tier 2 (generic drugs): ▪ One-month supply: \$20 copay ▪ Three-month supply: \$20 copay Tier 3 (preferred brand and generic drugs): ▪ One-month supply: \$100 copay ▪ Three-month supply: \$100 copay Tier 4 (non-preferred drugs): ▪ One-month supply: \$150 copay ▪ Three-month supply: \$150 copay Tier 5 (specialty tier drugs): ▪ One-month supply: \$100 copay ▪ Three-month supply: Not covered Tier 6 (select care drugs): ▪ One-month supply: \$20 copay ▪ Three-month supply: \$20 copay



Outpatient Prescription Drugs Continued

Benefit	Your Costs in Our Plan
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. If you reside in a long-term care facility, you pay the same as at a network 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.



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Foot Exams and Treatment	15% coinsurance for each covered podiatry visit.



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Durable Medical Equipment (DME) (Wheelchairs, Oxygen, etc.)	15% coinsurance (after deductible)
Prosthetic and Orthotic Devices and Related Supplies (Braces, Artificial Limbs, etc.)	15% coinsurance (after deductible)
You must get DME through participating plan suppliers. Continuous glucose monitors (CGMs) are only covered with an approved prior authorization. Coinsurance may apply. See this plan's EOC for more details.	



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Diabetic Supplies and Services	0% coinsurance for the following diabetic supplies: - A blood glucose meter (excluding CGMs) - Blood glucose test strips - Lancing devices and glucose lancets - Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors 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 DME supplier.
All Other Covered Diabetic Supplies	0% coinsurance
One-Month Supply of Insulin	No more than \$35 copay
See this plan's EOC for more details.	



Alternative Medicine

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Chiropractic Care	15% coinsurance
	Only manual manipulation of the spine to correct subluxation is covered.



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

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Home Health Care Services	15% coinsurance (after deductible)
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.



Health and Wellness Education Programs (Services may require prior authorization.)

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 1-800-801-4823 (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. 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.



Renal Dialysis (Services may require prior authorization.)

Benefit	Your Costs in Our Plan
	In-network and Out-of-network
Covered Dialysis Equipment and Supplies	15% coinsurance (after deductible)
See this plan's EOC for more details.	

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 registered trademark of WW International, Inc.

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

TruHearing® is a registered trademark of TruHearing, Inc.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call Medical Mutual Customer Care at 1-800-801-4823 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. To view a copy of the EOC, visit [MedMutual.com/MAGroup](https://www.MedMutual.com/MAGroup) and enter group number 590467 or call Medical Mutual at 1-800-801-4823 (TTY 711).
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor. To view a copy of the provider directory, visit [MedMutual.com/MAGroup](https://www.MedMutual.com/MAGroup) and enter group number 590467 or call Medical Mutual at 1-800-801-4823 (TTY 711).
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions. To view a copy of the pharmacy directory, visit [MedMutual.com/MAGroup](https://www.MedMutual.com/MAGroup) and enter group number 590467 or call Medical Mutual at 1-800-801-4823 (TTY 711).
- ☐ Review the formulary to make sure your drugs are covered. To view a copy of the formulary visit [MedMutual.com/MAGroup](https://www.MedMutual.com/MAGroup) and enter group number 590467 or call Medical Mutual at 1-800-801-4823 (TTY 711).

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copays/coinsurance may change on Jan. 1, 2028.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

IMPORTANT INFORMATION:

2026 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Medical Mutual of Ohio - H4497

For 2026, Medical Mutual of Ohio - H4497 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★

Health Services Rating: ★★★★★

Drug Services Rating: ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Medical Mutual of Ohio 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 800-801-4823 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 800-801-4823 (toll-free) or 711 (TTY).

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

Notice of Availability of Language Assistance and Auxiliary Aids and Services



English

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-382-5729 (TTY: 711) or speak to your provider.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-382-5729 (TTY: 711) o hable con su proveedor.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-382-5729 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Italian

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il 1-800-382-5729 (TTY: 711) o parla con il tuo fornitore.

Russian

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-382-5729 (TTY: 1-711) или обратитесь к своему поставщику услуг.

French

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-382-5729 (TTY: 711) ou parlez à votre fournisseur.

Chinese

注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-800-982-3117 (文本电话: 711) 或咨询您的服务提供商。

Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-382-5729 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

Arabic

،ةيبرعلا ةغللا ثدحت تنك اذا :ةيبن تةيبرعلا امك .ةين اجملا ةيوعلا ةدعاسملا تامدخ كل رفوتت سف تامول عمل ري رفوتل ةبسانم تامدخو ةدعاسم لئاسو رفوت مقررلا يل ل لصتا .ان اجم اهيل ل وصولا نكمي تاقيسي سن تب 1-800-382-5729 (TTY: 711)

Korean

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-382-5729 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Cushite/Oromo

HUBACHIISA: Yoo Afaan Oromoo dubbattu ta'e, tajaajiloonni gargaarsa afaanii bilisaa isiniif ni argamu. Deeggarsi dabalataa fi tajaajilootni mijaa'oo ta'an odeeffannoo bifa dhaqqabamaa ta'een kennuuf gargaaranis kaffaltii malee ni argamu. Gara 1-800-382-5729 (TTY: 711) tti bilbilaa ykn dhiyeessaa keessan haasofsiisaa.

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-382-5729 (TTY: 711) o makipag-usap sa iyong provider.

Romanian

ATENȚIE: Dacă vorbiți Română, aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-382-5729 (TTY: 711) sau contactați-vă furnizorul.

Japanese

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-382-5729(TTY:711)までお電話ください。または、ご利用の事業者にご相談ください。

Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

Pennsylvania Dutch

WICHDIH: Wann du Deutsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

Navajo

BAA'ÁKONÍNÍZIN: Diné bizaad bíyáti' nílt'íí', t'áá jíík'ehgo saad bee áká anilyeedígíí t'áá hóló. T'áá jíík'ehgo áká anilyeedígíí dóó bee haz'ánígíí t'áá hóló. t'áá íiyisí bee t'áá ájíík'ehgo. 1-800-382-5729 (TTY: 711) bich'í' hodíilnih dóó provider ní'doolnííł.

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Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at:
<http://www.hhs.gov/ocr/office/file/index.html>
- This notice is available at Medical Mutual's website:
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