Medicare Supplement Insurance

Coverage That Fits Your Lifestyle

Plans A, C, F, High-Deductible F, G and N

Please Note: Medical Health Insuring Corporation of Ohio is a wholly-owned subsidiary of Medical Mutual. The plans described in this brochure are underwritten by Medical Health Insuring Corporation of Ohio, but may be marketed by Medical Mutual.

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MEDICAL MUTUAL®

Your Guide to Choosing a Medicare Supplement Insurance Plan

We know that choosing a Medicare plan can be overwhelming, so we are here to help you understand your options and make this process easy. Our Medicare Supplement Insurance policies will give you the peace of mind that your healthcare needs are covered.

Learn more about your options in this brochure. Information inside:

- Advantages of a Medicare Supplement Insurance policy
- Details of Medical Mutual's Medicare Supplement Insurance plans
- MedMutual Supplement Plus—optional dental, vision and hearing coverage
- Extras available to plan holders, including access to the SilverSneakers fitness program*
- Answers to frequently asked questions
- How to enroll, including three simple options

* Medical Mutual provides SilverSneakers membership at no extra cost to you. SilverSneakers is an additional member service apart from the Medical Mutual Medicare Supplement Insurance plan benefits. SilverSneakers is provided by a third party and you can choose to take or not take the service. SilverSneakers is a registered trademark of Tivity Health, Inc.

Helping Supplement Original Medicare

Why choose a Medicare Supplement Insurance plan?

While Original Medicare pays some of your healthcare expenses, it doesn't cover all of them. A Medicare Supplement Insurance policy from Medical Mutual can help you lower your related deductibles and other expenses, and even pay for benefits that Medicare doesn't cover. Plus, you'll have:

- Flexibility to choose the doctors and hospitals you are most familiar and comfortable with to meet your healthcare needs, as long as they accept Medicare
- A guaranteed renewable policy
- If you move after you enroll, your Medicare Supplement Insurance plan moves with you in most cases. Contact the Department of Insurance of the state to which you are moving for more information.

Advantages of Medical Mutual Medicare Supplement Insurance policies

- Peace of mind that your healthcare needs are covered
- Affordable and competitive monthly premiums
- Rates only change once each year
- No medical questions or underwriting required when you enroll within your six-month initial enrollment period
- No pre-existing condition waiting period
- All plans include the support of our local, experienced Customer Care team
- Convenient option to buy additional dental, vision and hearing coverage
- Extras like fitness programs

Medicare Supplement Insurance Plan Options to Meet Your Needs

We offer a variety of plan options to fit with your lifestyle, budget and healthcare needs. Choose from Medicare Supplement Insurance Plans A, C, F, High-Deductible F, G or N.

Things to consider when choosing a plan

- Plan G is our most popular plan because it covers most Medicare benefits, including Part A coinsurance and hospital coverage, Part B coinsurance or copayment and Part B excess charges
- Plan N offers Part B coverage similar to Plan G, but with copayments that apply for some services and no coverage for Part B excess charges
- Plans C, F and High-Deductible F are only available if you first became eligible for Medicare prior to January 1, 2020

For detailed information regarding Medicare Supplement Insurance rates, coverage and more, please review our Outline of Coverage on page 11.

Note: A ■ means 100% of the benefit is paid	Plans Available to All Applicants			Medicare first eligible before 2020 only	
Benefits	**Plan A**	**Plan G**	**Plan N**	**Plan C**	**Plan F***
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	■	■	■	■	■
Medicare Part B coinsurance or copayment	■	■	■ Copays apply**	■	■
Blood (first three pints)	■	■	■	■	■
Part A hospice care coinsurance or copayment	■	■	■	■	■
Skilled nursing facility coinsurance	–	■	■	■	■
Medicare Part A deductible	–	■	■	■	■
Medicare Part B deductible	–	–	–	■	■
Medicare Part B excess charges	–	■	–	–	■
Foreign travel emergency (up to plan limits)	–	80%	80%	80%	80%

* Plan F also has an option called High-Deductible F. If you choose High-Deductible Plan F, you must pay your plan deductible before the plan begins to pay. Once the deductible is met, the plan pays 100% of covered services for the rest of the calendar year.

**Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Extras Available to Plan Holders

Our Medicare Supplement Insurance plans include some additional benefits at no cost to you.

SilverSneakers® Fitness Program

SilverSneakers® helps you achieve your health and wellness goals by giving you access to thousands of fitness centers across the country. You can use as many facilities as you want.

In addition to fitness centers, the program includes:

- On-demand and online program options
- Cardio classes
- Access to pools
- Social activities
- Education
- Yoga
- Walking groups at local parks and other recreation centers
- Other fitness classes

Hearing Discounts

Medical Mutual has teamed up with Beltone,™ one of the nation's most trusted names in hearing care, to offer a special discount to our members and their families.

This special discount hearing program includes:

- A free hearing screening
- 20% discount on hearing aid models
- Minimum of one year free manufacturer's warranty on all products

Discounts are available to your extended family, including parents, grandparents, spouses and children.

Beltone is a trademark of GN Hearing Care Corporation.

Additional Dental, Vision and Hearing Coverage

MedMutual Supplement Plus provides an additional dental, vision and hearing policy to our Medicare Supplement Insurance plan members. The cost to add this optional policy is $28/month.

Dental Benefit

The plan provides coverage through the Medicare DenteMax network for the covered dental services listed below.

Preventive Dental Benefit Services	Member Pays
Covered routine dental services: ▪ Two routine dental examinations per calendar year ▪ Two routine cleanings per calendar year ▪ One X-ray per calendar year	$0 of covered charges

The plan also equips members with coverage up to $1,000 per calendar year for the covered dental services listed below.

Comprehensive Dental Benefit Services	Member Pays
Diagnostic X-rays	30% of covered charges
Restorative services (fillings)	30% of covered charges
Non-surgical extractions	30% of covered charges
Crowns	30% of covered charges
Denture repair, reline or adjustment	30% of covered charges
Endodontic (root canal) services	50% of covered charges
Periodontic (treatment of gums) services	50% of covered charges

Vision Benefit

The plan provides a $250 allowance toward the purchase of covered eyewear through the EyeMed Insight network.

Vision Benefit Services	Member Pays
Covered routine vision services: ▪ One routine eye exam per calendar year ▪ $250 toward the purchase and fitting of either one pair of eyeglasses or contact lenses per calendar year (in network)	$0 copayment

Hearing Benefit

MedMutual Supplement Plus includes coverage for one hearing aid per ear, per year through the TruHearing network for the covered services listed below.

Hearing Benefit Services	Member Pays
Covered routine hearing services: ▪ One routine hearing exam per calendar year ▪ Three additional visits for hearing aid fittings and adjustments	$0 copayment
TruHearing Advanced 19 (32 channels/6 programs)	$699 copay/aid
TruHearing Premium 19* (48 channels/6 programs)	$999 copay/aid

* Rechargeable battery upgrade option on TruHearing Premium 19 RIC Li hearing aid for $75 per aid.

Network Considerations

Coverage through Medicare DenteMax, EyeMed Insight and TruHearing requires the use of in-network providers and all care must be received within those networks to be covered. If you go out of network, you will be responsible for all charges. For a complete listing of network providers, go to MedMutual.com/SupplementPlusProviders.

Three follow-up visits must be used within one year after the date of initial purchase of a hearing aid. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant at 1-833-627-1484 (TTY:711). Monday through Friday 8:00 a.m. to 8:00 p.m.

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Frequently Asked Questions

Who is eligible?

In order to enroll in a Medicare Supplement Insurance plan from Medical Mutual, you must:

- Be age 65 or older
- Be eligible for and enrolled in both Medicare Part A (hospital) and Part B (medical)
- Live in Ohio when you apply for coverage

How and when do I enroll?

You are guaranteed to be accepted if you are age 65 or older, you apply for your Medicare Supplement Insurance policy within six months of your enrollment in Medicare Part B, or you qualify for a situation that gives you the right to purchase a policy (for example, involuntary loss of employer coverage). For these guaranteed acceptance situations, you do not need to answer any medical questions or meet any medical underwriting requirements.

Outside of the situations referenced above, you can still apply for Medicare Supplement Insurance from Medical Mutual. For acceptance, you must answer medical questions and meet medical underwriting requirements. However, you are not required to take a medical exam.

Enrollment details are included in the How to Enroll portion of this kit, which begins on the next page.

When can my premium change?

Your premium rate is subject to change each year but will only change once each year on your renewal date. This rate can only be raised if all premiums for policies like yours are also raised.

Will my policy automatically renew?

Medicare Supplement Insurance policies are guaranteed renewable. That means the Medicare Supplement policy you choose cannot be canceled for any other reason than non-payment of your premium or providing false information.

How to Enroll

Enrolling in one of our Medicare Supplement Insurance plans is easy.

We recommend that you start by reviewing our Outline of Coverage document, which begins on page 11.

When you're ready, we have three simple options for submitting your application:

1. Contact your broker. He or she will work with you to fill out the application and submit it on your behalf. We've included an application in this kit that you and your broker can use.
2. Call 1-844-546-3325 (TTY 711) and one of our licensed sales agents will help you enroll over the phone.
3. Visit MedMutual.com/MedicareSupplement to fill out and submit your application.

After You Enroll

Once we've received your application, here's what you can expect.

After we process and issue your policy, we will send your ID card and enrollment materials to you. You should receive these within 10 business days of your application's approval. Your ID card is similar to other insurance cards you may have had and you will need to bring it with you to use any of the plan's benefits.

Licensed Agent Verification

There are safeguards in place to help you make confident, informed decisions about selecting an insurance company. You may verify that an agent is licensed by contacting:

The Ohio Department of Insurance
50 West Town Street, Suite 300
Columbus, Ohio 43215
Toll-free: 1-800-686-1526 (TDD: 1-614-644-3745)
OhioInsurance.gov

This brochure contains a summary of benefits only describing our policies' most important features. It is not an insurance policy or contract. The Medical Mutual Medicare Supplement Insurance policy is the insurance contract. If there is any difference between this brochure and the policy, the provisions of the policy will control. **Neither Medical Mutual nor any of its agents or Medicare Supplement Insurance plans are connected with or endorsed by the U.S. or state government, Social Security or federal Medicare program.**

This policy has exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or Medical Mutual.

Medicare Supplement products marketed by Medical Mutual will be underwritten by Medical Health Insuring Corporation of Ohio. Contact will be made by a licensed insurance agent or insurer. The amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected. Medical Mutual is a registered trademark of Medical Mutual of Ohio.

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Outline of Coverage

Medical Health Insuring Corporation

Plans A, C, F, High-Deductible F, G and N

MEDICAL MUTUAL®
doing business as Medical Health Insuring Corporation of Ohio

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G*	K	L	M	N	C	F*
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply***	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2021					$6,220**	$3,110**				

* Plans F and G also have a high deductible options which require first paying a plan deductible of $2,370 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

** Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

***Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION

We, Medical Mutual®, can only raise your premium if we raise the premium for all policies like yours in this State. We determine your premium based upon attained age. This means your premium will increase each year on the anniversary date of your policy based upon your age on that date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's 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, 3737 Sylvania Avenue, Toledo, Ohio 43623. 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 the 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 medical information.

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

2021 MEDICARE SUPPLEMENT MONTHLY PREMIUM RATES - PREFERRED

Age	Plan A		Plan C		Plan F		High-Deductible Plan F		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	$94.63	$101.30	$152.82	$163.59	$153.95	$164.80	$64.63	$69.18	$116.81	$125.05	$111.91	$119.80
66	$94.63	$101.30	$152.82	$163.59	$153.95	$164.80	$64.63	$69.18	$116.81	$125.05	$111.91	$119.80
67	$99.84	$106.88	$161.21	$172.58	$162.41	$173.86	$68.18	$72.99	$123.24	$131.93	$118.07	$126.40
68	$105.84	$113.30	$170.88	$182.93	$172.16	$184.29	$72.27	$77.36	$130.63	$139.84	$125.15	$133.98
69	$112.20	$120.10	$181.14	$193.91	$182.49	$195.35	$76.61	$82.01	$138.47	$148.23	$132.66	$142.02
70	$118.35	$126.70	$191.10	$204.57	$192.53	$206.10	$80.83	$86.53	$146.09	$156.39	$139.96	$149.83
71	$124.52	$133.30	$201.04	$215.22	$202.53	$216.81	$85.01	$91.00	$153.68	$164.52	$147.24	$157.62
72	$129.50	$138.63	$209.08	$223.82	$210.64	$225.49	$88.42	$94.66	$159.83	$171.10	$153.13	$163.93
73	$134.68	$144.17	$217.44	$232.77	$219.07	$234.51	$91.97	$98.45	$166.22	$177.94	$159.26	$170.48
74	$140.06	$149.93	$226.13	$242.08	$227.83	$243.89	$95.64	$102.38	$172.87	$185.06	$165.62	$177.30
75	$145.66	$155.93	$235.19	$251.77	$236.94	$253.64	$99.46	$106.47	$179.78	$192.46	$172.24	$184.39
76	$151.49	$162.17	$244.60	$261.84	$246.42	$263.79	$103.44	$110.73	$186.97	$200.15	$179.13	$191.76
77	$156.03	$167.03	$251.93	$269.69	$253.82	$271.71	$106.55	$114.06	$192.60	$206.18	$184.52	$197.53
78	$160.70	$172.03	$259.50	$277.79	$261.44	$279.87	$109.74	$117.48	$198.37	$212.35	$190.06	$203.46
79	$165.54	$177.21	$267.27	$286.11	$269.28	$288.26	$113.03	$121.00	$204.32	$218.72	$195.75	$209.55
80	$170.50	$182.52	$275.30	$294.71	$277.36	$296.91	$116.42	$124.62	$210.44	$225.28	$201.62	$215.84
81	$175.10	$187.45	$282.73	$302.67	$284.85	$304.93	$119.57	$128.00	$216.12	$231.36	$207.07	$221.67
82	$178.61	$191.20	$288.38	$308.72	$290.54	$311.02	$121.96	$130.56	$220.45	$235.99	$211.20	$226.09
83	$182.19	$195.03	$294.16	$314.90	$296.35	$317.24	$124.40	$133.17	$224.87	$240.72	$215.44	$230.62
84	$185.83	$198.93	$300.03	$321.19	$302.28	$323.59	$126.88	$135.83	$229.35	$245.52	$219.74	$235.23
85	$189.55	$202.91	$306.04	$327.62	$308.33	$330.06	$129.43	$138.55	$233.94	$250.43	$224.14	$239.94
86	$191.83	$205.35	$309.71	$331.55	$312.03	$334.03	$130.98	$140.21	$236.76	$253.45	$226.83	$242.83
87	$193.75	$207.41	$312.80	$334.86	$315.14	$337.36	$132.29	$141.62	$239.12	$255.97	$229.09	$245.24
88	$195.69	$209.48	$315.93	$338.21	$318.29	$340.73	$133.62	$143.04	$241.51	$258.54	$231.39	$247.70
89	$197.63	$211.56	$319.10	$341.59	$321.48	$344.15	$134.96	$144.47	$243.93	$261.13	$233.71	$250.19
90+	$199.61	$213.68	$322.29	$345.01	$324.70	$347.59	$136.31	$145.92	$246.37	$263.73	$236.04	$252.68

Important Note:

The benefit amounts listed on the following pages for Plans A, C, F, High-Deductible F, G and N are set by Medicare and may change effective January 2022. We will send you an updated Outline of Coverage if there are any changes for 2022.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a 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 services and supplies			
First 60 days	All but $1,484	$0	$1,484 (Part A deductible)
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	$0	Up to $185.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL 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, durable medical equipment.			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a 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 services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL 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, durable medical equipment.			
First $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a 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 services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL 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, durable medical equipment.			
First $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a 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.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***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.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE** YOU PAY
MEDICAL 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, durable medical equipment.			
First $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$203 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a 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 services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL 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, durable medical equipment.			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts*	$0	$0	$203 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Plan G

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	$0	$0
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	$0	$0	$250
First $250 each calendar year	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
Remainder of charges			

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services as an inpatient in a 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 services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL 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, durable medical equipment.			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N (continued)

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	$0	$0
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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Enrollment Application

MEDICAL MUTUAL®

doing business as Medical Health Insuring Corporation of Ohio

Medicare Supplement Plan Enrollment Application

Important Information

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no long entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare "Part D" while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended. If requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare "Part D" while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

For Internal Use Only			
Effective Date	**Group Number**	**Sold (Account Executive and Code)**	**Service (Account Executive and Code)**

MEDICAL MUTUAL®
doing business as Medical Health Insuring Corporation of Ohio

Section 1: Contract Holder Information

Last Name	MI	First Name	Social Security Number

Birthdate	Sex ☐ Male ☐ Female		Phone Number

Address	County

City	State	ZIP Code	Email Address

Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date

Section 2: Effective Date

The effective date for your Medicare Supplement Plan is the first of the month following Medical Mutual's receipt of the completed application. When should coverage start:	Effective Date

Section 3: Products

Medicare Supplement Plans

- ☐ Medicare Supplement Plan A
- ☐ Medicare Supplement Plan C
- ☐ Medicare Supplement Plan F
- ☐ Medicare Supplement High-Deductible Plan F
- ☐ Medicare Supplement Plan G
- ☐ Medicare Supplement Plan N

Section 4: Billing Information

Please indicate how you would prefer to pay your premiums (Choose one).

☐ **1. Home** (Receive monthly premium billings)*

☐ **2. Different Billing Address** (Have home billing sent to a different address)

If your mailing address is different than your permanent address, please complete the following:

Last Name (C/O)	First Name	MI

Address	City	State	ZIP Code

☐ **3. Financial Institution** (Automatic monthly premium withdrawals)

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from my:

☐ Checking Account* ☐ Savings Account*

Account Holder Name

Account Number	Transit Routing Number

Attach cancelled check or deposit slip here.

* **Please Note**: Not all financial institutions allow deductions from a savings account. Please verify this information with your financial institution. In case of insufficient funds a $25 returned item fee may be applied.

Section 5: Other Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions to the best of your knowledge.**

☐ **Yes** ☐ **No** 1. (a) Did you turn age 65 in the last six (6) months?

☐ **Yes** ☐ **No** (b) Did you enroll in Medicare Part B in the last six (6) months? If "Yes," what is your effective date?

Effective Date	

☐ **Yes** ☐ **No** 2. Are you covered for medical assistance through the state Medicaid Program?
Note: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.

If yes,

☐ **Yes** ☐ **No** (a) Will Medicaid pay your premiums for this Medicare supplement policy?

☐ **Yes** ☐ **No** (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare "Part B" premium?

3. I had coverage within the past 63 days and that coverage **involuntarily** ended because:

☐ **Yes** ☐ **No** (a) My employer group health plan (including retiree or COBRA coverage) or union coverage (that paid after Medicare paid) stopped offering me coverage.

☐ **Yes** ☐ **No** (b) My insurance carrier stopped offering the Medigap/Medicare Supplement product that I was enrolled with.

☐ **Yes** ☐ **No** (c) I moved out of the service area for the plan that I was covered with.

☐ **Yes** ☐ **No** (d) I decided to switch to Original Medicare within the first year of joining the PACE or Medicare Advantage program.

☐ **Yes** ☐ **No** 4. If you had coverage from any Medicare plan other than original Medicare within the past 63 days? (e.g. a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End Date" blank.

Start Date	End Date	

☐ **Yes** ☐ **No** (a) If you are still covered under the Medicare Plan, do you intend to replace your current coverage with this new Medicare supplement policy?

☐ **Yes** ☐ **No** (b) Was this your first time in this type of Medicare plan?

☐ **Yes** ☐ **No** (c) Did you drop a Medicare supplement policy with this policy to enroll in the Medicare plan?

continued on next page

Section 5: Other Coverage Information (cont.)

☐ **Yes** ☐ **No** 5. (a) Do you have another Medicare supplement policy in force? If so, what company and what plan do you have?

Company	Plan

☐ **Yes** ☐ **No** (b) If you answered "Yes" to 5a, do you intend to replace your current Medicare Supplement policy with this policy?

☐ **Yes** ☐ **No** 6. (a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual health plan). If so, what company and what plan do you have?

Company	Plan

(b) If you answered "Yes" to 6a, what are your dates of coverage under the policy? If you are still covered under the policy, leave "End Date" blank.

Start Date	End Date	

7. Agent shall list any other health insurance policies agent has sold to the applicant.
   (a) List policies sold which are still in force.
   (b) List policies sold in the past five (5) years which are no longer in force.

Company Name (if applicable)	Plan Name (if applicable)

Start Date	End Date	

Name of Plan	Type of Coverage	Start Date	End Date

Section 6: Medical Eligibility

IMPORTANT NOTICE: You do not have to complete this section if:

- This application is being submitted within six (6) months from the month in which you first enrolled for benefits under Medicare Part B. **OR**
- You have answered Yes to the following questions in Section 5 of this application, 3a, 3b, 3c or 3d.

☐ **Yes** ☐ **No**	1. Have you been hospitalized two (2) or more times within the past 12 months?
☐ **Yes** ☐ **No**	2. Are you currently confined to a hospital, skilled nursing facility, extended care facility, wheel chair or have you been so confined for more than five consecutive days within the last twelve months?
☐ **Yes** ☐ **No**	3. Have you been advised that you will need to be admitted to a hospital, skilled nursing facility or extended care facility within the next six (6) months or have any condition for which surgery is pending?
☐ **Yes** ☐ **No**	4. Within the past three years have you been treated for or diagnosed as having AIDS, ARC or HIV?

5. Within the past five years have you been treated for, diagnosed as having, or been recommended for future surgery, diagnostic testing or medical treatment, or thought you should seek medical advice for any of the following conditions?

☐ **Yes** ☐ **No**	Cirrhosis of the Liver
☐ **Yes** ☐ **No**	Parkinson's Disease
☐ **Yes** ☐ **No**	Stroke or Transient Ischemic Attack (TIA)
☐ **Yes** ☐ **No**	End-Stage Renal Disease or Dialysis
☐ **Yes** ☐ **No**	Systemic Lupus
☐ **Yes** ☐ **No**	Cancer – *If Yes:* ☐ **Yes** ☐ **No** Are you currently in treatment? *If No*, answer question 5a below.
☐ **Yes** ☐ **No**	Organ Transplant– *If Yes:* ☐ **Yes** ☐ **No** Was it a Corneal only transplant? *If Yes*, answer question 5a below.
☐ **Yes** ☐ **No**	Heart Disease– *If Yes:* ☐ **Yes** ☐ **No** Have you had an angioplasty/stent bypass surgery, valve replacement, defibrillator/pacemaker, or have been diagnosed with a heart attack, congestive heart failure or cardiomyopathy? *If No*, answer question 5a below.
☐ **Yes** ☐ **No**	Aneurysm (any kind)– *If Yes:* ☐ **Yes** ☐ **No** Was the aneurysm corrected via surgery? *If Yes*, answer question 5a below.
☐ **Yes** ☐ **No**	Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease (COPD), etc.) – *If Yes:* ☐ **Yes** ☐ **No** Are you on oxygen? *If No*, answer question 5a below.

5a. Please tell us about your condition(s):

☐ **Yes** ☐ **No** 6. Are you currently taking any prescription medications? If yes, please complete the following. If additional medications, please attach a separate sheet.

Medication	Reason for taking	Dosage

Section 7: Tobacco Use

☐ **Yes** ☐ **No**	Have you used tobacco, in any form, in the last 12 months?

Section 8: Terms and Conditions

While I am a Medical Mutual subscriber, I hereby authorize the Medicare Part A and Part B carriers in Ohio to provide Medical Mutual with a copy of my Explanation of Medicare Benefits (EOMB) statements resulting from the payment of Medicare Part A and Part B claims.

I hereby authorize release of all information from any medical facility, prior health insurance carrier, the medical Information Bureau, prescription history database supplier, government agency or person to Medical Mutual and/or to any of its affiliates: to evaluate this Application; to adjudicate claims; for utilization review programs; and/or for credentialing purposes. I agree that any information obtained will not be released by Medical Mutual to any entity other than reinsuring companies or persons or organizations performing health care operations or business or legal services in connection with an application, a claim, or as may be otherwise lawfully required, or as we may further authorize. Once personal and health information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by federal and state privacy requirements. I understand this authorization extends to all medical records, including those for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis, and I consent to the release of such information.

A copy of this authorization is available to me or my legal representative upon written request. A photographic copy of this authorization will be as valid as the original. This authorization will be valid for two and one-half years. I may revoke this authorization at any time by sending written notice to Medical Mutual's Privacy Office. Any revocation will become effective after it is received by Medical Mutual's Privacy Office and will not apply to information already released. A revocation may adversely affect my Application, a claim or a pending insurance action.

I agree that no agent or broker has the authority: (1) to bind Medical Mutual in any way; (2) to waive any answers or questions or to add information on this Application; (3) to approve coverage; or (4) to alter any of Medical Mutual's rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.

I have read this Application and declare that all information contained herein is accurate and complete. I understand that my coverage may be cancelled or rescinded by Medical Mutual if I have misstated, omitted or provided false information. I have reviewed the Outline of Coverage before submitting this application.

I understand that I must be a resident of and live in the State of Ohio at least six (6) months of each year at the time of application, to be eligible for this coverage.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Print Name	Signature	Date

Agent of Record	**Tax ID**

Multi-Language Interpreter Services & Nondiscrimination Notice

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

Order Number: Z8188-MCA R4/19
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

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:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

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