STRS OHIO HealthCare PROGRAM

275 East Broad Street
Columbus, OH 43215-3771
888-227-7877
www.strsoh.org

Health Care Assistance Program
NON-MEDICARE 2021 Plan Overview Chart

All STRS Ohio medical plans include hospital, medical and prescription drug coverage. This chart provides an overview of the main coverage features of the plans offered under the STRS Ohio Health Care Assistance Program. Questions about specific coverage features not listed and health care provider information should be directed to the plan administrators. This chart is for individuals without Medicare. Coverage features for individuals eligible for Medicare are listed on the reverse side. ***This plan overview chart is not a legal document. Your plan will send you a comprehensive description of your coverage after enrollment is confirmed.***

	Medical Mutual Health Care Assistance Plan (Indemnity or PPO)	
	In-Network and Indemnity[1]	**Out-of-Network[1]**
Major Hospital/Medical Plan Features	**Toll-free: 877-520-6727 www.medmutual.com**	
Enrollee Eligibility	Available to enrollees without Medicare	
Annual Deductible per Enrollee[2]	$300	$300
Out-of-Pocket Maximum[2] (Excludes prescription drug costs. Amounts included are noted.)	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Benefits Maximum per Enrollee	Unlimited	
Hospital Services (Inpatient and Outpatient)	Enrollee pays 20%	Enrollee pays 50%
Emergency Room	Enrollee pays $150; waived if admitted	
Urgent Care	Enrollee pays $40	
Primary Care Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays 20%	Enrollee pays 50%
Specialist Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays 20%	Enrollee pays 50%
Preventive Services (Limited designated services, e.g., routine physical, bone density screening, mammogram, colorectal screening, Pap smear and immunizations/inoculations; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations.)	Enrollee pays 0%; no deductible	
Prescription Drug Plan Features	**Express Scripts Prescription Drug Plan Toll-free: 866-685-2792 / www.express-scripts.com**	
Annual Brand-Name Deductible per Enrollee	Not applicable	
Standard Network Retail/Nursing Home Pharmacy Copayments per 31-day Supply (If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)	**Generic:** Enrollee pays $5 **Covered brand-name:** Enrollee pays $20	
Maximum Day Supply	**Retail:** 31 days; **Home delivery:** 90 days	
Home Delivery Copayments (If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)	**Low-Cost Generic Drug Program medications:** Enrollee pays $9 **Generic:** Enrollee pays $10 **Covered brand-name:** Enrollee pays $40	
Enrollee's Maximum Annual Expense	If an enrollee pays a total of **$500** out of pocket in copayments for generic and covered brand-name medications, that enrollee pays nothing for covered medications for the remainder of the year.	

[1] Indemnity and out-of-network payments are based on allowed/noncontracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for the excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise indicated. In-network and out-of-network accumulations are separate.

(Medicare enrollees: see reverse side)