

2021 Medical Plan Overview

This overview provides the main coverage features of the STRS Ohio medical plans. All plans include hospital, medical and prescription drug coverage. Questions about specific coverage features not listed and health care provider information should be directed to the plan administrators. *This is not a legal document. Your plan will send you a comprehensive description of your coverage after enrollment is confirmed.*

Prescription Drug Coverage for Medicare and Non-Medicare Enrollees

Express Scripts administers prescription drug coverage for all STRS Ohio medical plans. Enrollees with Medicare are covered by the Express Scripts Medicare Part D prescription drug plan. The amounts listed below are the same for Medicare and non-Medicare enrollees unless otherwise noted.

Maximum Annual Expense

This is the maximum annual amount an enrollee will pay in copayments/coinsurance/deductible for generic, covered brand-name and specialty medications. Once the maximum annual expense limit is met, that enrollee pays nothing for covered drugs for the remainder of the year. **Note:** Non-preferred pharmacy fees do not apply to the maximum annual expense.

- Medicare enrollees — \$6,550
- Non-Medicare enrollees — \$5,100

Annual Deductible

There is a \$275 annual deductible per enrollee for covered brand-name drugs, including specialty drugs. An enrollee pays the full cost of these drugs until the deductible is met. Once the deductible is met, that enrollee pays the applicable copayment/coinsurance for the remainder of the year. **The deductible resets every Jan. 1.** Accumulated amounts do not carry over to the next calendar year. **Note:** Generic drug costs and non-preferred pharmacy fees do not apply to the deductible.

Maximum Day Supply

- Medicare enrollees — Up to 90 days at retail; 90 days at home delivery. **Note:** Prior to acceptance in the Express Scripts Medicare Part D plan, the maximum retail supply is 31 days. The retail copayments listed below are per 31-day supply. (For a 90-day retail supply, the copayments will be three times the amount listed.)
- Non-Medicare enrollees — 31 days at retail; 90 days at home delivery

2021 Prescription Drug Copayments/Coinsurance

If the cost of the drug is less than the copayment, you pay the cost of the drug.

Express Scripts — Toll-free: 888-416-3326 (Medicare); 866-685-2792 (Non-Medicare) / www.express-scripts.com

	<u>Preferred Pharmacies</u>	<u>Non-Preferred Pharmacies</u>
Standard Network Retail/Nursing Home Pharmacy per 31-day Supply	<p>Generic: \$10</p> <p>Covered brand-name: \$30 (after deductible)</p> <p>Specialty: Lesser of 13% of the cost or \$450 for supply of 1–31 days, \$900 for supply of 32–60 days and \$1,350 for supply of 61–90 days (after deductible)*</p>	Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a \$10 fee per fill (does not apply to deductible or maximum annual expense)
Home Delivery	<p>Low-Cost Generic Drug Program medications: \$9</p> <p>Generic: \$25</p> <p>Covered brand-name: \$75 (after deductible)</p> <p>Specialty: Lesser of 13% of the cost or \$450 for supply of 1–31 days, \$900 for supply of 32–60 days and \$1,350 for supply of 61–90 days (after deductible)</p>	

*Non-Medicare enrollees must use Accredo specialty pharmacy. Medicare enrollees may use any specialty pharmacy (non-preferred pharmacy fees do not apply).

2021 Plans for MEDICARE Enrollees

	Aetna Medicare Plan¹ (Medicare Advantage PPO)		Medical Mutual Basic (Indemnity or PPO)		AultCare PrimeTime Health Plan (Medicare Advantage HMO-POS)		Paramount Elite (Medicare Advantage HMO)
	In-Network (PPO) or Extended Service Area (ESA PPO)	Out-of-Network (PPO)	In-Network and Indemnity ^{2,3}	Out-of-Network ^{2,3}	In-Network ⁴	Out-of-Network	
Major Hospital/Medical Plan Features	Toll-free: 866-282-0631 www.aetnamedicare.com		Toll-free: 877-520-6727 www.medmutual.com		Local: 330-363-7407 Toll-free: 800-577-5084 www.pthp.com		Toll-free: 800-462-3589 www.paramounthealthcare.com
Enrollee Eligibility <small>(STRS Ohio requires enrollment in Medicare Parts A & B or Part B-only.)</small>	Available in any U.S. location		Available in any U.S. location		Available in select northeastern Ohio area ZIP codes		Available in select northwestern Ohio and southern Michigan area ZIP codes
Annual Deductible per Enrollee⁴	\$150	\$500	\$2,500	\$5,000	\$150	\$500	\$150
Out-of-Pocket Maximum⁴ <small>(Excludes prescription drug costs. Amounts included are noted for each plan.)</small>	\$1,500 per enrollee (includes deductible, copayments and coinsurance)	\$2,500 per enrollee (includes deductible, copayments and coinsurance)	\$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	\$13,000 per enrollee (includes deductible and coinsurance)	\$1,500 per enrollee (includes deductible, copayments and coinsurance)	\$2,500 per enrollee (includes deductible, copayments and coinsurance)	\$1,500 per enrollee (includes deductible, copayments and coinsurance)
Lifetime Benefits Maximum per Enrollee	Unlimited		Unlimited		Unlimited		Unlimited
Hospital Services (Inpatient/Outpatient)	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20% ⁵	Enrollee pays 50% ⁵	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 4%
Emergency Room	Enrollee pays \$75; no deductible; waived if admitted		Enrollee pays \$150; waived if admitted		Enrollee pays \$75; no deductible; waived if admitted		Enrollee pays \$75; no deductible; waived if admitted
Urgent Care	Enrollee pays \$40; no deductible		Enrollee pays \$40, then 20% after deductible		Enrollee pays \$40; no deductible		Enrollee pays \$40; no deductible
Primary Care Physician Office Visit <small>(Includes in-person, phone and video visits.)</small>	Enrollee pays \$15; no deductible	Enrollee pays \$40 after deductible	Enrollee pays \$20 per visit for the first two visits per year (no deductible); thereafter 20% (after deductible)		Enrollee pays \$15; no deductible	Enrollee pays \$40; no deductible	Enrollee pays \$15; no deductible
Specialist Physician Office Visit <small>(Includes in-person, phone and video visits.)</small>	Enrollee pays \$25; no deductible	Enrollee pays \$55 after deductible	Enrollee pays 20%		Enrollee pays \$25; no deductible	Enrollee pays \$55; no deductible	Enrollee pays \$25; no deductible
Preventive Services <small>(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.)</small>	Enrollee pays 0%; no deductible		Enrollee pays 0%; no deductible		Enrollee pays 0%; no deductible		Enrollee pays 0%; no deductible
If you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, any applicable copayment/coinsurance/deductible will apply for care received for the existing medical condition.							

¹ If providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for the excess charges.

² 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 or providers that do not accept Medicare assignment charge in excess of these amounts, the enrollee is responsible for the excess charges.

³ Benefits are payable after Medicare payments.

⁴ Annual deductible must be met before plan begins making payments, unless otherwise indicated. In-network and out-of-network accumulations are separate, except for the Aetna Medicare Plan and AultCare plans.

⁵ Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

2021 Plans for NON-MEDICARE Enrollees

	Medical Mutual Basic Aetna Basic (Indemnity or PPO)		AultCare (PPO)		Paramount Health Care (HMO)
	In-Network and Indemnity ¹	Out-of-Network ¹	In-Network	Out-of-Network ¹	
Major Hospital/Medical Plan Features	Medical Mutual — Toll-free: 877-520-6727 www.medmutual.com Aetna — Toll-free: 800-645-5677 www.aetna.com		Local: 330-363-6360 Toll-free: 800-344-8858 www.aultcare.com		Toll-free: 800-462-3589 www.paramounthealthcare.com
Enrollee Eligibility	Medical Mutual Basic: Available in any location in Ohio Aetna Basic: Available in any U.S. location except Ohio		Available in select northeastern Ohio area ZIP codes		Available in select northwestern Ohio and southern Michigan area ZIP codes
Annual Deductible per Enrollee²	\$2,500	\$5,000	\$2,500	\$5,000	\$2,000
Out-of-Pocket Maximum² (Excludes prescription drug costs. Amounts included are noted for each plan.)	\$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	\$13,000 per enrollee (includes deductible and coinsurance)	\$6,500 per enrollee (includes deductible, copayments and coinsurance)	\$13,000 per enrollee (includes deductible, copayments and coinsurance)	\$4,000 per enrollee (includes deductible, copayments and coinsurance)
Lifetime Benefits Maximum per Enrollee	Unlimited		Unlimited		Unlimited
Hospital Services (Inpatient/Outpatient)	Enrollee pays 20%	Enrollee pays 50%	Enrollee pays 20%	Enrollee pays 50%	Enrollee pays 20%
Emergency Room	Enrollee pays \$150, then 20% after deductible; copayment waived if admitted		Enrollee pays \$150, then 20% after deductible; copayment waived if admitted		Enrollee pays \$150, then 20% after deductible; copayment waived if admitted
Urgent Care	Enrollee pays \$40, then 20% after deductible		Enrollee pays \$40, then 20% after deductible		Enrollee pays \$40, then 20% after deductible
Primary Care Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays \$20 per visit for the first two visits per year (no deductible); thereafter 20% (after deductible)	Enrollee pays 50% after deductible	Enrollee pays \$20 per visit for the first two visits per year (no deductible); thereafter 20% (after deductible)	Enrollee pays 50%	Enrollee pays \$10; no deductible
Specialist Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays 20%	Enrollee pays 50%	Enrollee pays 20%	Enrollee pays 50%	Enrollee pays \$20; no deductible
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		Enrollee pays 0%; no deductible		Enrollee pays 0%; no deductible
	If you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, any applicable copayment/coinsurance/deductible will apply for care received for the existing medical condition.				

¹ Indemnity and out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed 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.