2022 PrimeTime Health Plan
Summary of Benefits
State Teacher's Retirement System of Ohio
(HMO-POS) E20020 & E20025

This is a summary of drug and health services covered by PrimeTime Health Plan STRS Ohio for January 1, 2022 – December 31, 2022. This Summary of Benefits doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Customer Service and request the "Evidence of Coverage" or view it online at www.pthp.com. You can reach Customer Service at 330-363-7407 or 1-800-577-5084 (TTY users call 711). Our Call Center is open Monday through Friday, from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, the Call Center is open seven days a week, from 8:00 a.m. to 8:00 p.m. Or visit our website at www.pthp.com.

You are eligible for membership in our plan as long as you have both Medicare Part A and Part B, you are a United States citizen or are lawfully present in the United States, and you live in our service area. Our service area includes the following counties in Ohio: Carroll, Harrison, Holmes, Stark, Summit, Tuscarawas, & Wayne. Our service area also includes the zip codes below for select counties.

- Ashland - 44287, 44638, 44805, 44838, 44840, 44842, 44843, 44848, 44859, 44864, 44866, 44874, 44880, 44903
- Belmont – 43713, 43718, 43719, 43759, 43773, 43901, 43902, 43905, 43906, 43909, 43912, 43916, 43917, 43927, 43928, 43933, 43934, 43935, 43937, 43940, 43942, 43943, 43947, 43950, 43951, 43967, 43971, 43972, 43977, 43983, 43985
- Columbiana – 43920, 43930, 43932, 43945, 43962, 43968, 44408, 44413, 44415, 44423, 44427, 44431, 44432, 44441, 44443, 44445, 44454, 44455, 44460, 44490, 44492, 44493, 44601, 44609, 44625, 44634, 44657, 44665
- Coshocton – 43006, 43749, 43803, 43804, 43805, 43811, 43812, 43824, 43828, 43832, 43836, 43840, 43843, 43844, 43845, 44637, 44654
- Guernsey – 43722, 43723, 43725, 43733, 43736, 43749, 43750, 43755, 43768, 43772, 43773, 43778, 43780, 43832, 43837, 43973, 43983, 44699
- Jefferson – 43901, 43903, 43907, 43908, 43910, 43913, 43917, 43925, 43926, 43930, 43932, 43938, 43939, 43941, 43943, 43944, 43945, 43948, 43952, 43953, 43961, 43963, 43964, 43970, 43971
- Knox – 43006, 44628, 44842
- Mahoning – 44401, 44405, 44406, 44408, 44412, 44416, 44422, 44429, 44436, 44442, 44443, 44449, 44451, 44452, 44454, 44460, 44471, 44501, 44502, 44503, 44504, 44505, 44506, 44507, 44509, 44510, 44511, 44512, 44513, 44514, 44515, 44555, 44601, 44609, 44619, 44672
- Medina – 44203, 44212, 44214, 44215, 44217, 44230, 44233, 44235, 44251, 44253, 44254, 44256, 44258, 44270, 44273, 44274, 44275, 44280, 44281, 44282, 44287, 44321, 44333

- Portage – 44201, 44202, 44211, 44224, 44231, 44234, 44236, 44240, 44241, 44242, 44243, 44255, 44260, 44265, 44266, 44272, 44278, 44285, 44288, 44312, 44411, 44412, 44429, 44449, 44632
- Richland – 44805, 44813, 44822, 44843, 44862, 44864, 44875, 44878, 44901, 44902, 44903, 44904, 44905, 44906, 44907

PrimeTime Health Plan has a network of doctors, hospitals, pharmacies, and other providers. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will be covered but you may have increased cost-sharing. Out-of-network/non-contracted providers are under no obligation to treat PrimeTime Health Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. To find participating providers, please call us or visit our website at www.PTHP.com.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online www.Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. This information is available in alternative formats such as large print, audio CD, or other alternate formats. Please call Customer Service if you need plan information in another format or language.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Benefit category	What you pay	What you should know
Monthly Plan Premium	Contact STRS Ohio at 1- 888-227-7877	You must continue to pay your Medicare Part B premium.
Medical Deductible	In-network: $150 annually In-network & Out-of-Network combined: $500 annually	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	In-network: $1,500 annually In-network & Out-of-network combined: $2,500 annually	The maximum you will pay in copays and coinsurance for the year.
Inpatient Hospital Coverage	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	Prior authorization may be required for these services. Please contact the plan for more information. Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital Coverage	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	Prior authorization may be required for these services. Please contact the plan for more information.

Benefit category	What you pay	What you should know
Ambulatory Surgery Center	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	Prior authorization may be required for these services. Please contact the plan for more information.
Doctor Visits • Primary Care Physician	In-network: You pay a $15 copay per visit Out-of-network: You pay a $40 copay per visit	Deductible does not apply to office visits.
• Specialist	In-network: You pay a $25 copay per visit Out-of-network: You pay a $55 copay per visit	
Preventive Care	In-network & Out-of-network: You pay $0 copay	Deductible does not apply to preventive care. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	In-network & Out-of-network: You pay a $75 copay per visit	Deductible does not apply to emergency care. If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care. World-wide coverage.
Urgently Needed Services	In-network & Out-of-network: You pay a $40 copay per visit	Deductible does not apply to urgently needed services. If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for urgently needed services. World-wide coverage.
Diagnostic Services/ Labs/ Imaging • Diagnostic radiology services (such as MRIs, CT scans)	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	Prior authorization may be required for these services. Please contact the plan for more information. Deductible does not apply to lab services.
• Diagnostic tests and procedures	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	

Benefit category	What you pay	What you should know
• Lab services	In-network & Out-of-network: You pay a $0 copay	
• Outpatient x-rays	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	
• Therapeutic radiology services (such as radiation treatment for cancer)	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	
Hearing Services • **Medical exam***	In-network: You pay a $25 copay Out-of-network: You pay a $55 copay	*Exam to diagnose and treat hearing and balance issues. Deductible does not apply to hearing exams or hearing aids.
• **Routine exam[1]**	In-network & Out-of-network: You pay a $0 copay	[1]One routine exam annually.
• **Hearing aids**	You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. Call Amplifon at 1-866-921-2299 to access these copayment rates. Hearing aids purchased from a non-Amplifon provider are eligible for reimbursement of $100 per hearing aid.	We will allow two hearing aid devices every three years. Hearing aid copays do not count towards your out-of-pocket limit.
Dental Services • Medical exam	In-network: You pay a $25 copay Out-of-network: You pay a $55 copay	Prior authorization may be required for these services. Please contact the plan for more information.
• Routine dental coverage	Not covered	Deductible does not apply to medical dental exams.
Vision Services • Medical exam[1]	In-network: You pay a $25 copay Out-of-network: You pay a $55 copay	[1]Exam to diagnose and treat diseases and conditions of the eye. Deductible does not apply.
• Eyeglasses or contact lenses after cataract surgery	In-network & Out-of-network: You pay a $0 copay	

Benefit category	What you pay	What you should know
• Annual routine exam	In-network & Out-of-network: You pay a $0 copay	
• Eyeglasses or contact lenses (routine)	Not covered	
Mental Health Services • Inpatient visit	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required for these services. Please contact the plan for more information. Deductible does not apply to therapy visits.
• Outpatient group therapy visit	In-network: You pay a $25 copay Out-of-network: You pay a $55 copay	
• Outpatient individual therapy visit	In-network: You pay a $25 copay Out-of-network: You pay a $55 copay	
Skilled Nursing Facility (SNF)	In-network: You pay 0% of the cost. Deductible does not apply. Out-of-network: You pay 8% of the cost after deductible	Our plan covers up to 100 days in a SNF per benefit period. Prior authorization may be required for these services. Please contact the plan for more information.
Physical Therapy Visit	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	
Ambulance	In-network: You pay 4% of the cost Out-of-network: You pay 8% of the cost	Prior authorization may be required for non-emergency services. Please contact the plan for more information. Deductible does not apply. World-wide emergency coverage.
Transportation	Not covered	
Medicare Part B Drugs • Chemotherapy drugs	In-network: You pay 0% of the cost Out-of-network: You pay 0% of the cost	Prior authorization may be required for these services. Please contact the plan for more information. Deductible does not apply.
• Other Part B drugs	In-network: You pay 0% of the cost Out-of-network: You pay 0% of the cost	

Benefit category	What you pay	What you should know
Medical Equipment/ Supplies • Durable medical equipment (wheel-chairs, oxygen, etc)	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	Prior authorization may be required for these services. Please contact the plan for more information. Deductible does not apply to diabetic supplies.
• Prosthetics/Medical supplies	In-network: You pay 4% of the cost after deductible Out-of-network: You pay 8% of the cost after deductible	
• Diabetes supplies	In-network: You pay 0% of the cost Out-of-network: You pay 0% of the cost	
Wig/Toupee Benefit	In-network & Out-of-network: You pay 4% of the cost after the in-network deductible $300 annual benefit maximum	Prior authorization may be required for these services. Please contact the plan for more information.
Health and Wellness Education Programs • Tele-monitoring Services[1] • Stroke Prevention Program[2] • 24 Hour Nursing Hotline (330) 363-7600 or 1-800-686-9373 • Silver&Fit® Exercise & Healthy Aging Program[3] • In-Home Safety Assessment evaluates your home for potential safety concerns. For example: proper lighting, fall hazards, and grab bars.[4]	$0 copay Contact the plan for more information on these programs.	[1]Enrollees diagnosed with any of the conditions below may be eligible: o Heart Failure o Diabetes o Chronic Obstructive Pulmonary Disease (COPD) o Behavioral Health Conditions [2]Offered to members who have health conditions that put them at higher risk for stroke. [3]Offers members a fitness center membership at a participating fitness center or select YMCA and up to 2 home fitness kits each benefit year. [4] The benefit is available in our service area with the plan's contracted network.
Outpatient Part D Prescription Drugs PrimeTime Health Plan does not cover Part D prescription drugs. Please refer to the STRS Ohio Express Scripts Information for information on your Part D prescription drug coverage or call Express Scripts at 888-416-3326 (toll-free).		