



**STATE TEACHERS RETIREMENT SYSTEM  
OF OHIO (STRS OHIO)  
Medical Plan Description  
Effective 1/1/19**

**For Basic Plans and Health Care Assistance Plans  
Administered by Medical Mutual**

**GROUP NO: 229010**



Dear STRS Ohio Health Care Program Enrollee:

This is the medical plan description for your STRS Ohio Health Care Plan effective Jan. 1, 2019. This document describes the features of the Basic Plans and Health Care Assistance Program Plans (HCAPs) administered by Medical Mutual. The information within this document applies to all of these plans, unless otherwise noted.

Many features of the Basic Plans and HCAP Plans are the same. However, deductibles and out-of-pocket maximums vary by plan.

When reviewing this document, please refer to the descriptions that apply to the plan in which you are enrolled. If a description of a plan feature does not reference a specific plan, the information applies to all plans. **If you are not sure which plan you are enrolled in, please call Medical Mutual at 877-520-6727 or contact STRS Ohio's Member Services Center toll-free at 888-227-7877.**

It is important for you to read this document carefully. The charts in the Schedule of Coverage section detail your coverage for various medical expenses. Please keep this medical plan description in your permanent records for future reference.

If you have questions about your health care coverage, please call Medical Mutual toll-free at 877-520-6727.

Medical Mutual

## INTRODUCTION

This booklet describes certain medical plans available to Eligible Beneficiaries of the State Teachers Retirement System of Ohio (STRS Ohio) and their Eligible Dependents. The Plan information applies to Enrollees in the Basic Plans and Health Care Assistance Plans (HCAPs) administered by Medical Mutual. These plans are among the health plans available through the STRS Ohio Health Care Program. The Plan is authorized by Chapter 3307 of the Ohio Revised Code, which may be amended at any time by the Ohio General Assembly. An amendment could revoke authorization of the STRS Ohio Health Care Program. Furthermore, coverage under the Plan may be modified or eliminated at any time by the State Teachers Retirement Board. Health care coverage from STRS Ohio is not guaranteed. STRS Ohio hopes to continue the Plan, but reserves the right to change or discontinue all or part of the Plan for all or a class of eligible benefit recipients and covered dependents at any time. Premiums, Copayments, Coinsurance, Deductibles and all other charges or fees paid by an Enrollee may change from year to year.

This booklet states the terms and conditions under which health care coverage is available through the Plan. The terms and conditions stated in this booklet shall control in the case of any question or dispute concerning such coverage.

The coverage provided by the Plan is not insured by Medical Mutual or any of its affiliates; it is paid from STRS Ohio funds. Medical Mutual provides certain administrative services under the Plan. The Plan is not an ERISA-covered plan.

This Plan is separate and distinct from any other health care plan available while the Enrollees in this Plan were actively employed by any employer. This Plan does not constitute a continuation of any health plan through active employment.

Proceeds received by STRS Ohio as a result of any contract for health care goods or services are used for purposes related to the Plan, including developing clinical management programs and offsetting costs of health plan claims and the administration of the health plan to the benefit of all Enrollees.

**Notice:** If you or your Eligible Dependents are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules of the Plan very carefully, including the Coordination of Benefits section in this document, and compare them with the rules of any other plan that covers you or your family.

## AUTHORIZATION TO RELEASE INFORMATION

By accepting coverage under an STRS Ohio health care plan, all Enrollees, including any enrolled dependents, agree that they shall: (1) furnish STRS Ohio or its designees (the term "designees" specifically includes, but is not limited to Medical Mutual or any person or entity acting on its behalf) any and all information and proof STRS Ohio or such designees may reasonably require pertaining to health care coverage and the operations of its health care plan; and (2) authorize and direct any person or organization that has provided services to the Enrollee to furnish STRS Ohio or its designees any and all information and records (or copies of records) relating to care or services provided directly or indirectly to the Enrollee or relating to the administration of the health care program. Such information and records may be requested by STRS Ohio or its designees as part of the claims submission, claims adjudication or claims payment process or as part of any subsequent audit or investigation or any legal actions.

STRS Ohio will protect, use and disclose information pertaining to your protected health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to the extent that HIPAA applies to the Plan. HIPAA permits the Plan to use and disclose your protected health information (1) in connection with medical treatment you receive; (2) for payment purposes, which include uses and/or disclosures related to payment for services you receive, payments of premiums to the Plan, determining eligibility for coverage, claims management and/or utilization review; and (3) to conduct health care operations. Health care operations of the plan include quality assessment and health improvement activities including case management and care coordination. The Plan may also disclose protected health information for other purposes permitted under HIPAA, which are more fully described in the Notice of Privacy Practices section of this document. Your rights regarding your protected health information are also addressed in the Notice of Privacy Practices section.

## **FRAUD**

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against the provider of coverage, submits an application or files a claim containing a false or deceptive statement, is guilty of a crime or fraud against the legal entity providing coverage under this Plan and such conduct may result in the termination of any or all coverage under this Plan. Any person who commits fraud will be responsible for repaying costs of coverage provided and could be liable for civil and/or criminal penalties.

## **RECOVERY OF COSTS**

In addition to any other remedies that may be available, STRS Ohio shall be entitled to recover the costs of any claims paid on behalf of an Enrollee if it is determined that the individual was not eligible for coverage at the time the claims were incurred, regardless of the amount of time that has passed.

# TABLE OF CONTENTS

<b>INTRODUCTION</b> .....	ii
AUTHORIZATION TO RELEASE INFORMATION.....	ii
FRAUD.....	iii
RECOVERY OF COSTS.....	iii
<b>DEFINITIONS</b> .....	1
<b>ENROLLMENT PROVISIONS</b> .....	10
<b>CHANGING PLANS OR TERMINATING COVERAGE</b> .....	13
<b>SCHEDULE OF COVERAGE</b> .....	14
Enrollee Without Medicare.....	16
Enrollee With Medicare Parts A & B.....	19
Enrollee With Medicare Part B Only.....	22
<b>DESCRIPTION OF COVERAGE</b> .....	25
Alcoholism and Drug Abuse.....	25
Allergy Tests and Treatment.....	26
Ambulance Services.....	26
Autism Services.....	26
Case Management.....	26
Certification for Hospital Admissions.....	27
Christian Science Practitioners, Nurses or Sanatoria.....	27
Diagnostic Services.....	28
Emergency Services.....	28
Experimental Treatment.....	28
Gender Dysphoria Treatment.....	29
Home Health Care.....	29
Hospice Care.....	29
Hospital Expenses.....	30
Mental Disorders and Mental Illness.....	32
Mouth, Jaws and Teeth.....	32
Other Covered Medical Expenses.....	33
Outpatient Rehabilitative and Habilitative Services.....	35
Plastic, Reconstructive or Cosmetic Surgery.....	36
Precertification.....	36
Preventive Health Care Services.....	36
Prescription Drug Expenses.....	38
Private Duty Nursing Services.....	38
Skilled Nursing Facility Expenses.....	39
Surgical Services.....	39
Transplant Services.....	40
<b>EXCLUSIONS</b> .....	42
<b>IMPORTANT PLAN PROVISIONS</b> .....	46
Adjustment Rule.....	46
Non-Assignment.....	46
Benefit Payment.....	46
Out-of-Pocket Maximum for Medical Plans.....	47
Basic Plans.....	47
Health Care Assistance Program Plan (HCAP Plans).....	47
Lifetime Benefit.....	48
Changes in Benefits or Provisions.....	48
Foreign Travel.....	48
Monthly Premiums.....	48
Coordination of Benefits.....	48
Effect of Medicare.....	50

Effect of Prior Coverage.....	51
Subrogation and Right of Recovery Provision.....	51
Recovery of Overpayment.....	53
Reporting Claims.....	54
Automatic Claims-Filing by Medicare (Medicare Crossover).....	54
Keeping Records of Expenses.....	54
Explanation of Benefits.....	54
Claim Review.....	54
Benefit Determination for Claims.....	55
Filing a Complaint.....	56
Filing an Appeal.....	57
Termination of Coverage.....	60
Continuation of Medical Expense Benefits After Termination.....	61
Continuing Dependent Coverage Upon the Death of Eligible Beneficiary.....	61
COBRA Continuation of Coverage Options.....	61
Other General Provisions.....	61
<b>NOTICE OF PRIVACY PRACTICES.....</b>	<b>63</b>

# DEFINITIONS

Certain words and phrases used in this booklet have a special meaning and these words are capitalized and defined in this section.

**Allowed Amount** - For Contracting Institutional Providers, In-Network Providers and Participating Providers, this means the lesser of the Negotiated Amount or Covered Medical Expenses.

**Beneficiary** - A Person designated to receive a benefit.

**Benefit Period** - the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, and Out-of-Pocket Maximums are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the effective date and the date your coverage terminates.

**Billed Charges** - Charges for all services and supplies that the covered Person has received from a Provider, whether or not they are Covered Medical Expenses.

**Board and Room** - Charges made by an institution for Board and Room and other Necessary services and supplies. These charges must be regularly incurred at a daily or weekly rate.

**Case Management** - A collaborative, voluntary process that promotes and attempts to facilitate the delivery of the most clinically appropriate care to patients in the most cost-efficient manner.

**Charges** - The Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Institutional Provider in the state of Ohio, charges are the master charge list uniformly applicable to all payers before discounts, allowances, incentives or settlements.

**Claims Administrator** - Medical Mutual, which has contracted with STRS Ohio to provide certain administrative services under the Plan.

**Coinsurance** - A percentage of the amount Medical Mutual has determined is the maximum amount payable to the Provider for which you are responsible after you have met your Deductible.

**Condition** - An injury, ailment, disease, illness or disorder.

**Confinement Period** - the period of time beginning when you enter a Skilled Nursing Facility and ending when you have been out of the Skilled Nursing Facility for 60 days.

**Contract** - The respective agreements between Medical Mutual and STRS Ohio to administer health plan benefits.

**Contracting** - A Hospital or Other Facility Provider is Contracting if it has an agreement with Medical Mutual about payment for Covered Medical Expenses or has been designated by Medical Mutual as a provider with which Medical Mutual has an arrangement for payment for Covered Medical Expenses.

**Contracting Institutional Provider** - A Hospital or Other Facility Provider that has an agreement with Medical Mutual regarding payment for Covered Medical Expenses or is designated by Medical Mutual as Contracting.

**Copayment** - a dollar amount that you are required to pay at the time Covered Services are rendered. For example, a \$150 Copayment for Emergency Services.

**Covered Medical Expense** - An expense for certain Hospital or other medical services and supplies provided to an Enrollee that is incurred for the treatment of a Condition and for which coverage is provided under the Plan.

**Covered Provider** - The following practitioners or entities that are legally qualified and licensed and/or certified as required by law will be considered a Covered Provider:

- Certified nurse practitioner;
- Dentist;
- Doctor of chiropractic medicine;
- Durable medical equipment or prosthetic appliance vendor;
- Hospital;
- Laboratory (for Medicare plans, must be Medicare approved);
- Licensed Clinical Mental Health Counselor



- Licensed dietician;
- Licensed Practical Nurse (L.P.N.);
- Licensed Professional Counselor (L.P.C.);
- Mechanotherapist (if licensed or certified in Ohio);
- Nurse-midwife;
- Occupational therapist;
- Other Facility Provider;
- Physical therapist;
- Physician;
- Physician assistant;
- Podiatrist;
- Professional ambulance service;
- Psychologist;
- Registered Nurse (R.N.); and
- Urgent Care Provider.

Certain Providers may not bill on their own behalf. They are required by licensing standards to be under the employment or supervision of a Physician.

**Custodial Care** - Services and supplies furnished mainly to help a Person in the activities of daily life. Custodial Care includes Board and Room and other institutional care. The Person does not have to be disabled. Such services and supplies are custodial regardless of who prescribes or recommends them, or how and by whom they are performed.

**Deductible** - The amount of Covered Medical Expenses each Person pays per calendar year before benefits are paid. The Deductible amount is shown in the Schedule of Coverage section of this booklet.

**Dentist** - A Dentist legally qualified to provide covered services in the state in which such services are provided. Dentist also includes a Physician who is licensed to do dental work.

**Directory** - A listing of all In-Network Providers. Copies of the Directory may be obtained by calling Medical Mutual or visiting its website at [www.MedMutual.com](http://www.MedMutual.com).

**DRG Amount** - A predetermined charge for each diagnostic related group (DRG) as determined by any applicable law or regulation, or as otherwise determined by Medical Mutual.

**Durable Medical Equipment** - No more than one item of equipment for the same or similar purpose and the accessories needed to operate it will be covered. Equipment must be:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to Persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Not included is equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, communication aids, vision aids and telephone alert systems.

**Effective Date** - 12:01 a.m. on the date when your health care coverage begins, as determined by STRS Ohio and Medical Mutual.

**Effective Treatment of a Mental Disorder** - A program that is prescribed and supervised by a physician for a Mental Disorder or Mental Illness that can be favorably changed.

**Eligible Beneficiary** - An individual who is receiving, or is eligible to receive, a monthly pension benefit payment from STRS Ohio and is properly enrolled in the Plan as determined by STRS Ohio.

**Eligible Beneficiary Coverage** - Coverage for an Eligible Beneficiary only.

**Eligible Dependent** - An Eligible Beneficiary's spouse, eligible child(ren) or disabled adult child, as described in the Enrollment Provisions section of this booklet, who meets the terms and conditions for coverage under the Plan and who is properly enrolled in the Plan as determined by STRS Ohio.

**Eligible Dependent Coverage** - Coverage for an Eligible Beneficiary's dependent only.

**Emergency Medical Condition** - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

**Emergency Services** - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

**Enrollee** - An Eligible Beneficiary or Eligible Dependent, as determined by STRS Ohio, who has met all conditions of eligibility and has successfully enrolled under this Plan. (Enrollee is the same as a Person.)

**Essential Health Benefits** - Defined under the federal law Patient Protection and Affordable Care Act (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your Plan may contain some or all of these types of benefits.

**Excess Charges** - The difference between Billed Charges and the Allowed Amount. You may be responsible for Excess Charges when you receive services from a Noncontracting or Nonparticipating Provider.

**Experimental or Investigational Services** - A drug, device, medical treatment or procedure is Experimental or Investigational if:

- There is insufficient outcome data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the Condition;
- Required by the FDA, approval has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes;
- Written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

Expenses that do not meet the above definition may be considered for coverage. See the Experimental Treatment section of this booklet.

**Home Health Care Agency** - An agency that meets all the following criteria:

- Provides mainly skilled nursing and other therapeutic services;
- Is associated with a professional group that makes policy. This group must have at least one Physician and one R.N.;
- Has full-time supervision by a Physician or an R.N.;
- Keeps complete medical records on each Person;
- Has a full-time administrator;
- Meets licensing standards; and
- Submits charges.

**Home Health Care Plan** - A plan that provides for continued care and treatment of a Condition. The care and treatment must be:

- Prescribed in writing by the attending Physician; and
- An alternative to staying in the Hospital or Skilled Nursing Facility.

**Hospice Care** - Care given to a patient with a reduced life expectancy due to an advanced illness, by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

**Hospice Care Agency** - An agency or organization that:

- Has Hospice Care available 24 hours a day;
- Meets any licensing or certification standards set forth by local jurisdiction;
- Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the Immediate Family;
- Provides or arranges for other services, including:
  - Services of a Physician;
  - Physical or occupational therapy;
  - Part-time home health aide services that consist mainly of caring for a patient with a reduced life expectancy due to advanced illness; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel that include at least one:
  - Physician;
  - R.N.;
  - Licensed or certified social worker employed by the agency; or
  - Pastoral or other counselor.
- Establishes policies governing the provision of Hospice Care;
- Assesses the patient's medical and social needs;
- Develops a Hospice Care Program to meet those needs;
- Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient;
- Utilizes volunteers trained in providing services for nonmedical needs;
- Has a full-time administrator; and
- Submits charges.

**Hospice Care Program** - Hospice Care that:

- Is established by and reviewed from time to time by a Physician attending the Person and appropriate personnel of a Hospice Care Agency;
- Is designed to provide palliative and supportive care to a patient with a reduced life expectancy due to advanced illness and supportive care to their families; and
- Includes an assessment of the Person's medical and social needs and a description of the care to be given to meet those needs.

**Hospice Facility** - A facility, or distinct part of one, that:

- Provides mainly Inpatient Hospice Care to a patient with a reduced life expectancy due to advanced illness;
- Charges its patients;
- Meets any licensing or certification standards set forth by local jurisdiction;
- Keeps a medical record on each patient;
- Provides an ongoing quality assurance program, including reviews by Physicians other than those who own or direct the facility;
- Is run by a staff of Physicians, one of whom must be on call at all times;
- Provides 24-hour-a-day nursing services under the direction of an R.N.; and
- Has a full-time administrator.

**Hospital** - An institution that meets all the following criteria:

- Provides mainly Inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick Persons;
- Is supervised by a staff of Physicians;
- Provides R.N. services 24 hours a day;
- Is not a place mainly for rest, for the aged, for drug addicts, for alcoholics or a nursing home;
- Submits charges; and
- Meets all licensing standards.

**Immediate Family** - The Eligible Beneficiary and the Eligible Beneficiary's spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren by blood, marriage or adoption.

**Indemnity Plan (Traditional)** - A health care plan in which any Provider can be used. The Enrollee is reimbursed for expenses or assigns reimbursement to the Provider. The Indemnity Plan applies to Eligible Beneficiaries and Eligible Dependents who are eligible for Medicare Parts A & B regardless of their state of residence and to Eligible Beneficiaries and Eligible Dependents who live in areas designated as Out-of-Network.

**In-Network Area** - A geographical area designated by Medical Mutual and STRS Ohio as meeting specific standards pertaining to access to In-Network Providers.

**In-Network Care** - A health care service or supply furnished by:

- An In-Network Provider; or
- A health care Provider other than an In-Network Provider that treats an Emergency Condition when travel to an In-Network Provider is not feasible.

**In-Network Provider** - A health care Provider that has contracted to furnish services for a Negotiated Amount, but only if the Provider is, with Medical Mutual's consent, included in the Directory as an In-Network Provider for:

- The service or supply involved; and
- The class of Eligible Beneficiaries to which you belong.

In-Network Providers include primary care Physicians and a variety of specialists and facilities. For a list of Providers, contact Medical Mutual or visit Medical Mutual's website at [www.MedMutual.com](http://www.MedMutual.com).

**Inpatient** - A Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a Board and Room charge is made.

**Legal Guardian** - An individual who is either the natural guardian of another or who was appointed a guardian in a legal proceeding by a court having appropriate jurisdiction.

**Lifetime Benefit** - The highest amount that will be paid for Covered Medical Expenses under this Plan for any Person during his or her lifetime.

**L.P.N.** - A Licensed Practical Nurse.

**Maintenance Care** - Services or supplies that are furnished principally to maintain rather than improve a level of physical or mental function or to provide a protected environment free from exposure that can worsen the Person's physical or mental Condition.

**Medical Care** - Professional services received from a Covered Provider to treat a Condition.

**Medical Plan Description** - This document.

**Medicare** - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

**Medicare Approved** - The status of a Provider that is certified by the U.S. Department of Health and Human Services to receive payment under Medicare for all Medicare enrollees.

**Mental Disorder and/or Mental Illness** - A disease commonly understood to be a Mental Disorder, whether or not it has a physiological or organic basis, for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, psychologist or psychiatric social worker.

**Necessary** - A service or supply furnished by a particular Provider is Necessary if Medical Mutual determines that it is appropriate for the diagnosis, or for the care or the treatment of the Condition involved.

To be appropriate, the service or supply must:

- Be care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Condition involved and the Person's overall health Condition;
- Be a diagnostic procedure, indicated by the health status of the Person, that is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Condition involved and the Person's overall health Condition; and
- Be no more costly as to diagnosis, care and treatment (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Medical Mutual will consider:

- Information provided on the affected Person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Medical Mutual's attention.

In no event will the following services or supplies be considered to be Necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional;
- Those furnished mainly for the personal comfort or convenience of:
  - The Person;
  - Any Person who cares for him or her;
  - Any Person who is part of his or her family; or
  - Any health care Provider or health care facility.
- Those furnished solely because the Person is an Inpatient on any day on which the Person's Condition could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a less costly setting.

**Negotiated Amount** - The amount a Covered Provider has agreed with Medical Mutual to accept as payment in full for Covered Medical Expenses.

- The Negotiated Amount for Providers does not include adjustments and/or settlements due to prompt payment discounts, maximum charge increase limitation violations, or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.
- In certain circumstances, Medical Mutual may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of Medical Mutual contracting directly with the Covered Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement Medical Mutual has with the vendor and not upon the vendor's actual negotiated price with the Covered Provider, subject to further Conditions and limitations set forth herein.

**Noncontracting** - A Hospital or Other Facility Provider that does not have a contract with Medical Mutual.

**Noncontracting Amount** - The maximum amount determined as payable and allowed by Medical Mutual for a Covered Medical Expense provided by a Noncontracting Hospital or Other Facility Provider or a Nonparticipating Physician or Covered Provider. For Nonparticipating Physicians and Covered Providers, this amount is based upon certain factors, including, but not limited to, the following:

- The Centers for Medicare & Medicaid Services (CMS) Resource Based Value Scale (RBRVS);
- Other fee schedules;
- Input from PPO Network and Contracting Physicians and wholesale prices (where applicable);
- Geographic considerations;
- Other economic, market and statistical indicators.

**Noncovered Charges** - Billed Charges for services and supplies that are not Covered Medical Expenses.

**Nonoccupational Coverage** - Only nonoccupational injuries and diseases are covered. A nonoccupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury which does. A nonoccupational disease is a disease that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from a disease that does. However, if proof is furnished that the Person is covered under a workers' compensation law or similar law but is not covered for a particular disease under such law, that disease will be considered nonoccupational regardless of cause. Any reference in this booklet to Condition means only one that is nonoccupational.

**Nonparticipating** - The status of a Physician or Covered Provider (other than a Hospital or Other Facility Provider) that does not have an agreement with Medical Mutual about payment for Covered Medical Expense.

**Nonurgent Admission** - An admission that is not an Emergency Admission or an Urgent Admission.

**Ohio Retirement Systems** - Includes State Teachers Retirement System of Ohio, Ohio Public Employees Retirement System, School Employees Retirement System of Ohio, Highway Patrol Retirement System and Ohio Police & Fire Pension Fund.

**Orthodontic Treatment** - Any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite, jaws or jaw-joint relationships, whether or not for the purpose of relieving pain. It does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.

**Other Facility Provider** - Institutions that are licensed, when required, and where covered services are rendered that require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Covered Provider. Medical Mutual will provide benefits only for services or supplies for which a charge is made. Other Facility Providers include but are not limited to Alcoholism and Drug Abuse Treatment Facilities, Home Health Care Agencies and Skilled Nursing Facilities.

**Out-of-Area** - An area not designated as In-Network by STRS Ohio and Medical Mutual.

**Out-of-Network Care** - A health service or supply furnished by a health care Provider that is not an In-Network Provider.

**Out-of-Network Provider** - A health care Provider that has not contracted with Medical Mutual to furnish services for a Negotiated Amount.

**Out-of-Pocket Maximum** - The maximum amount of Deductibles, Coinsurance and primary care Physician Copayments that a covered Person will have to pay annually. Your Out-of-Pocket Maximum does not apply to Excess Charges. In other words, if you receive services from a Noncontracting or Nonparticipating Provider and you are balance billed, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

**Outpatient** - The status of a Person who receives services or supplies through a Hospital, Other Facility Provider, Physician or Covered Provider while not confined as an Inpatient.

**Participating Provider** - The status of a Physician or Covered Provider that has an agreement with Medical Mutual about payment for Covered Medical Expenses but is not part of the PPO network.

**Payment Percentage** - After any applicable Deductible, health benefits are paid at the Payment Percentage that applies to Covered Medical Expenses incurred. Benefits may vary depending on whether an In-Network Provider is used.

**Person** - An Eligible Beneficiary or Eligible Dependent, as determined by STRS Ohio, who has met all conditions of eligibility and has successfully enrolled under this Plan. (Person is the same as an Enrollee.)

**Physician** - A person licensed to practice medicine or other licensed medical professionals authorized to write prescriptions.

**Plan** - The health care plans sponsored by the State Teachers Retirement System of Ohio. The Plan includes the Basic Plans and Health Care Assistance Plans administered by Medical Mutual, unless otherwise noted.

**PPACA** - Patient Protection and Affordable Care Act. A United States federal statute signed into law on March 23, 2010.

**Preferred Provider Organization (PPO)** - A health care plan that contracts with select Providers who agree to offer health care services to Enrollees at contractually set reimbursement levels. The Preferred Provider Organization applies to Eligible Beneficiaries and Eligible Dependents who are not eligible for Medicare Part A and who reside in designated In-Network Areas.

**Provider** - A Hospital, other Facility Provider, Physician or other Covered Provider.

**Residential Treatment Facility** - a facility that meets all of the following:

- An accredited facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders who do not require care in an acute or more intensive medical setting.
- The facility must provide room and board as well as provide an individual treatment plan for the chemical, psychological and social needs of each of its residents.
- The facility must meet all regional, state and federal licensing requirements.
- The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.

**Respite Care** - Care furnished during a period of time when the Person's family or usual caretaker cannot, or will not, attend to the Person's needs. Respite Care is of short-term duration.

**R.N.** - A Registered Nurse.

**Semiprivate Rate** - The charge for Board and Room that an institution applies to the majority of beds in semiprivate rooms with two or more beds. If there are no such rooms, Medical Mutual will determine the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

**Skilled Nursing Care** - Care that requires the skill, knowledge or training of a Physician or of a Registered Nurse, Licensed Practical Nurse, or physical therapist performed under the supervision of a Physician. In the absence of such care, the Covered Person's health would be seriously impaired. Such care cannot be taught to or administered by a layperson.

**Skilled Nursing Facility** - An institution that meets all the following criteria:

- Is licensed to provide, and does provide, the following services on an Inpatient basis for Persons convalescing from a Condition:
  - Professional 24-hour-a-day nursing care by an R.N. or L.P.N. and directed by a full-time R.N.; and
  - Physical restoration services to help patients meet a goal of self-care in daily living activities.
- Is supervised full time by a Physician or R.N.;
- Keeps a complete medical record on each patient;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for the mentally incompetent, for custodial or educational care, or for care of Mental Disorders; and
- Submits charges.

**Stabilize** - with respect to an Emergency Medical Condition, to provide such medical treatment of the Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

**Surgery** - Is defined as:

- Performance of generally accepted operative and other invasive procedures;
- Correction of fractures and dislocations;
- Usual and related preoperative and postoperative care; or
- Other procedures as reasonably approved by Medical Mutual.

**Surgery Center** - A freestanding ambulatory surgical facility that:

- Meets licensing standards;
- Is set up, equipped and operated to provide surgical services;
- Submits Covered Medical Expenses;
- Is directed by a staff of Physicians, one of whom must be on the premises when Surgery is performed and during the recovery period;
- Has at least one certified anesthesiologist on the premises when Surgery requiring general or spinal anesthesia is performed and during the recovery period;
- Extends surgical staff privileges to Physicians who practice Surgery in an area Hospital and Dentists who perform oral Surgery;
- Has at least two operating rooms and one recovery room;

- Provides, or arranges with a medical facility in the area, for diagnostic X-ray and lab services needed in connection with Surgery;
- Does not have a place for patients to stay overnight;
- Provides, in the operating and recovery rooms, full-time Skilled Nursing Care directed by an R.N.;
- Is equipped and has:
  - Trained staff to handle medical emergencies;
  - Physician trained in cardiopulmonary resuscitation;
  - Defibrillator;
  - Tracheotomy set; and
  - Blood volume expander.
- Has a written agreement with a Hospital in the area for immediate emergency transfer of patients. Written procedures for such a transfer must be displayed and the staff must be aware of them;
- Provides an ongoing quality assurance program, including reviews by Physicians who do not own or direct the facility; and
- Keeps a medical record on each patient.

**Urgent Admission** - An admission to the Hospital because of the onset of or a change in a disease, or the diagnosis of a Condition caused by an accident that, while not needing an Emergency Admission, is severe enough to require confinement as an Inpatient in a Hospital within two weeks from the date the need for the confinement becomes apparent.

**Urgent Care Provider** - A freestanding medical facility that:

- Provides unscheduled medical services to treat an urgent Condition if the person's Physician is not reasonably available.
- Routinely provides ongoing unscheduled medical services for more than eight consecutive hours.
- Makes Charges.
- Is licensed and certified as required by any state or federal law or regulation.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the facility.
- Is run by a staff of Physicians. At least one Physician must be on call at all times.
- Has a full-time administrator who is a licensed Physician.

A Physician's office, but only one that:

- Has contracted with Medical Mutual to provide urgent care; and
- Is, with Medical Mutual's consent, included in the Directory as a preferred Urgent Care Provider.

An Urgent Care Provider does not include the emergency room or outpatient department of a Hospital.



# ENROLLMENT PROVISIONS

*Unless otherwise noted, the information in this section applies to Persons enrolled in the Basic Plans and HCAPs Plans administered by Medical Mutual.*

Eligibility requirements and the Effective Date of coverage will be determined by STRS Ohio. Beginning Jan. 1, 2019, the eligible enrollee's permanent residence must be in one of the U.S. 50 states or U.S. territories to be eligible for coverage.

## **Eligible Beneficiary**

You are considered to be an Eligible Beneficiary if you are receiving, or you are eligible to receive and have applied to receive, a monthly benefit payment from STRS Ohio and are properly enrolled in the Plan as determined by STRS Ohio.

Coverage under the STRS Ohio Health Care Program is limited for non-Medicare enrollees employed in public or private positions. Under State Teachers Retirement Board Rule 3307:1-11-02, employed enrollees are eligible for only secondary health care coverage through STRS Ohio's Medical Mutual plans if they: (1) are eligible for health care coverage through their employer, or (2) hold positions for which similarly situated employees are eligible for health care coverage at the same cost as full-time employees. The rule applies to all employed enrollees who are not eligible for Medicare, regardless of hire date or type of employment. Eligible Beneficiaries may be required to certify employment status annually. If an Eligible Beneficiary qualifies for primary health care coverage through an employer by meeting the previously stated requirements and he or she does not enroll in the employer health care plan, the Eligible Beneficiary will not be eligible to enroll in the STRS Ohio Health Care Program.

## **Beneficiaries Eligible to Receive Health Care Coverage From More Than One Ohio Retirement System**

If an Eligible Beneficiary is eligible for health care coverage through more than one Ohio public retirement system, guidelines determine which system is responsible for health care coverage. Contact STRS Ohio for details.

## **Eligible Dependents**

An Eligible Dependent is defined as:

- The Eligible Beneficiary's spouse.
- The Eligible Beneficiary's disabled adult child. For more information, see "Disabled Adult Child" in this section.
- The Eligible Beneficiary's biological child(ren) or a nonbiological child(ren) who is legally adopted, a stepchild or a child for whom you have been appointed Legal Guardian and who has not yet attained age 26.

Expenses incurred for newborns are covered as of the date of birth if the newborn is enrolled in the Plan according to the guidelines described under "Enrolling Dependents."

Individuals who meet STRS Ohio's Eligible Dependent Coverage guidelines and are also receiving a pension benefit from another Ohio Retirement System can enroll as an Eligible Dependent in the STRS Ohio Plan.

You must notify STRS Ohio in writing when a dependent no longer meets eligibility requirements and indicate the date your dependent is no longer eligible. Monthly contributions do not guarantee coverage if your dependent no longer meets the eligibility requirements. You are financially responsible for all claims paid during any period of ineligibility.

## **Disabled Adult Child:**

A person age 26 or older who meets the following requirements:

- Has never been married; and
- Is a biological child, legally adopted child prior to age 18 or a stepchild of a living or deceased primary benefit recipient or member or a child for whom a primary benefit recipient has been legally appointed as guardian prior to the child attaining age 18; and
- Continually meets the requirements for physical or mental incompetency as set forth in Administrative Code Rule 3307:1-8-01; and
- Either was adjudged physically or mentally incompetent by a court prior to age 22; or was continually physically or mentally incompetent and continuously unable to earn a living where both conditions occurred prior to age 22.

Eligibility for coverage of a disabled adult child may be evaluated annually by STRS Ohio. You must notify STRS Ohio in writing when a disabled adult child no longer meets eligibility requirements and indicate the date your dependent is no longer eligible. Monthly contributions do not guarantee coverage if your disabled adult child no longer meets the eligibility requirements. You are financially responsible for all claims paid during any period of ineligibility.

### **Enrolling as a Benefit Recipient**

Verify the date your employer sponsored health care coverage will end. Knowing this information will help you determine an accurate start date for STRS Ohio health care coverage. The effective date of your STRS Ohio health care coverage cannot be changed after premium deductions and coverage have begun. Keep in mind, any amounts you have accumulated toward an annual Deductible or Out-of-Pocket Maximum do not carry over from your employer plan when you retire and enroll in an STRS Ohio health care plan.

### **When Monthly Benefits Begin**

Before you begin receiving service retirement or disability benefits, you must complete a pension benefit application. A section of this application asks whether you want to enroll in an STRS Ohio health care plan. If you elect to enroll and have not previously selected a plan, information about your plan options and monthly premiums will be mailed to you after your benefit application has been processed. Review your health care plan options and the monthly premiums charged for coverage. If you have not previously selected a plan in writing, call STRS Ohio to select your plan. (Refer to your 2019 STRS Ohio Health Care Program Guide for more information.)

The date health care coverage begins will be determined as follows:

- **Service retirement recipients** - For recipients who elect coverage within 31 days of their benefit effective date, coverage begins on their benefit effective date. For recipients with a retroactive benefit effective date who elect coverage within 31 days of the first of the month following receipt of the retirement application, coverage begins the first of the month following the date the retirement application is received.
- **Disability recipients** - For recipients who elect coverage within 31 days from the end of the month when disability benefits are granted, coverage is effective the first of the month following the date the retirement board grants disability benefits.
- **Survivor and service retirement beneficiary recipients** - For recipients who elect coverage when benefits are granted or within three months from the end of the month of the member's date of death, coverage begins the first of the month following the member's date of death. For a service retirement beneficiary recipient who was enrolled as a dependent of a member at the time of the member's death, coverage will continue at the same level on the first of the month following the member's date of death.

### **Enrolling Dependents**

An enrollment application is required for dependents. Please call STRS Ohio toll-free at 1-888-227-7877 to request an enrollment application, or visit [www.strsoh.org](http://www.strsoh.org) to print the form.

#### **Spouse**

Service retirement or disability benefit recipients can enroll a spouse by submitting an enrollment application. Coverage for a spouse may be effective the first of the month following the marriage, if a request to enroll is received within 31 days of the marriage date.

#### **Child**

You can enroll an eligible child who is under age 26 by submitting a health care enrollment application. If STRS Ohio receives the enrollment application within 31 days of the birth, adoption, or legal guardianship, coverage for the dependent child may be effective the first of the month of the date of birth or legal adoption or legal guardianship.

#### **Disabled Adult Child**

Call STRS Ohio to begin the eligibility determination process. Once enrolled in a plan, the disabled adult child will be reevaluated annually to determine eligibility.

#### **Medicare Eligibility**

STRS Ohio requires all eligible medical plan participants to enroll in Medicare Part B and pay a monthly premium to Medicare. If you qualify for premium-free Medicare Part A coverage, you must also sign up for Medicare Part A. **If you do not enroll in Medicare, you may not be eligible for STRS Ohio medical coverage.**

## **Preexisting Conditions**

There are no preexisting Condition limitations under the Plan. An Eligible Beneficiary and his/her Eligible Dependents can enroll in or change plans with continued coverage for Covered Medical Expenses regardless of their current or past medical Condition(s).

## **Health Care Assistance Program Eligibility**

The Health Care Assistance program (HCAP) is designed to help qualified benefit recipients who need financial assistance to pay for their STRS Ohio medical plan. The assistance program currently includes a \$0 monthly premium for the benefit recipient and often lower out-of-pocket costs for all enrollees in the plan. Although covered family members may receive the same plan of coverage as the qualifying benefit recipient, they are not eligible for the \$0 premium and must pay the full cost of their coverage.

The assistance program is currently available to:

- Service retirement benefit recipients with 25 or more qualifying service credit;
- Disability benefit recipients receiving STRS Ohio benefits; and
- Beneficiaries and survivors who are otherwise eligible for subsidized premiums.

New applicants must be eligible for a subsidy under the STRS Ohio Health Care Program to qualify for HCAP enrollment. Benefit recipients, beneficiaries and survivors who were enrolled in HCAP as of Dec. 31, 2015, are not subject to the subsidy requirement - as long as they continue to meet all other HCAP requirements and remain continuously enrolled in the program.

Depending on Medicare status, approved individuals may enroll in the Medical Mutual Health Care Assistance Plan or the Aetna Medicare Plan. Medicare-eligible participants must maintain their Medicare Parts A & B or Part B-only enrollment to remain eligible for HCAP.

### **To be eligible for the program:**

- Your total annual family gross income (including any annual pension benefits and cost-of-living adjustments) must be at or below \$23,800 for you, your spouse and any dependent children; and
- Liquid assets or funds readily available to your family, such as cash, savings, money market and checking accounts, trust funds, publicly traded securities and other investment vehicles, must not exceed \$23,800 per calendar year. (A home is not considered a liquid asset.)

To apply for the program, you must submit a completed application to STRS Ohio, a copy of the previous year's federal tax return and a copy of your Medicare card if applicable. Applications must be received no later than the 15th of the month to be considered for approval for an effective date starting the next month. STRS Ohio will requalify participants annually. For more information about the program, please call STRS Ohio or visit our website for an application.

## CHANGING PLANS OR TERMINATING COVERAGE

*Unless otherwise noted, the information in this section applies to Persons enrolled in the Basic Plans and HCAP Plans administered by Medical Mutual.*

When you enroll in an STRS Ohio health care plan, you must remain in the health care plan you select for the calendar year. You will not be permitted to change health care plans during the calendar year unless you experience a qualifying event. The following information provides details about changing plans during the calendar year.

### **Changing Plans (Does Not Apply to HCAP Plans)**

Certain qualifying events allow Enrollees to change plans during the calendar year. This means Enrollees can switch to any STRS Ohio health care plan for which they are eligible that is available in their area.

The following events allow Enrollees to change plans. Please note that any plan change may apply to both the Eligible Beneficiary and any Eligible Dependents:

- Enrollee experiences one of the following events and requests to change plans within 31 days of the event: marriage, divorce, dissolution or legal separation; birth; adoption; or legal guardianship of a child; death; or full loss of premium subsidy.
- Enrollee becomes eligible for and enrolls in Medicare. Enrollee must request to change plans within three months after the effective date of Medicare.
- Enrollee is a new retiree. The Enrollee must request to change plans within 31 calendar days of receiving the first monthly benefit payment.
- PPO or HMO enrollee experiences the loss of a key provider from the network.
- Enrollee moves to another service area, which results in different plan options being available.

**Important: If you experience a qualifying event during the calendar year and choose to change plan administrators, your medical Deductible and Out-of-Pocket Maximums will transfer to the new plan only if you move between the Aetna Medicare Plan and a Medical Mutual plan.**

### **Terminating Coverage**

You may terminate your STRS Ohio health care coverage at any time by calling STRS Ohio. All termination requests must be received by the 15th of the month to stop the next month's premium deduction from your STRS Ohio benefit payment.

In the event of a divorce, your spouse's health care coverage will terminate the first day of the month following finalization of the divorce, provided the termination request is received by the 15th of the month to become effective the first of the following month. However, your spouse may be eligible for COBRA continuation coverage. Call STRS Ohio for more information. It is the Beneficiary's responsibility to notify STRS Ohio when a divorce is finalized.

# SCHEDULE OF COVERAGE

*Unless otherwise noted, the information in this section applies to Persons enrolled in the Basic Plans and HCAP Plans administered by Medical Mutual. Coverage is provided only for charges for services and supplies furnished to a Person while covered.*

## **Indemnity Plan**

Plan names: Medical Mutual Basic Indemnity and Medical Mutual Health Care Assistance Plan Indemnity

The Indemnity Plan applies to:

- Eligible Beneficiaries and Eligible Dependents who are eligible for Medicare Parts A & B, regardless of the state of residence.
- Eligible Beneficiaries and Eligible Dependents who live outside a PPO service area, regardless of Medicare status. In some states, some areas are PPO service areas while other areas have only the Indemnity Plan available. STRS Ohio may expand the ZIP codes included in the PPOs; contact STRS Ohio for specific ZIP codes. Under the Indemnity Plan, you may use any Provider to receive benefits up to the Allowed Amount or the Noncontracting Amount as applicable. You are responsible for any charges exceeding the Allowed Amount or Noncontracting Amount.

## **Preferred Provider Organization**

Plan names: Medical Mutual Basic PPO and Medical Mutual Health Care Assistance Plan PPO

The Preferred Provider Organization (PPO) applies to Eligible Beneficiaries and Eligible Dependents who are not eligible for Medicare Part A (Hospital benefits) and who reside in Ohio and areas outside Ohio designated as a PPO area; contact STRS Ohio for specific ZIP codes or anytime your address changes.

PPOs contract with select Providers representing primary care Physicians, a variety of specialists and facilities. In-Network Providers agree to offer health care services to STRS Ohio's membership at preset reimbursement levels or Negotiated Amounts. In return, these Providers receive patient referrals and prompt payment from the PPO. PPOs allow Enrollees to receive health care services outside the network, usually in exchange for a higher Coinsurance amount. Under the STRS Ohio health care plan, such services would be considered under Out-of-Network benefits.

You and your Eligible Dependents will be covered no matter which Physicians or Hospitals you choose. However, if you live in an In-Network Area and wish to receive the maximum available benefit, you must use an In-Network Provider. If you use a Noncontracting or Nonparticipating Provider, you may be responsible for the difference between the Noncontracting Amount and the Provider's Billed charges. This can result in significant liability for you. Always check with your Provider or Medical Mutual prior to receiving services to make sure the Provider is in the network.

Medical Mutual contracts with an extensive network of selected Hospitals and Physicians. The network includes a broad range of Physicians in general practice, family practice and internal medicine, and in specialties such as gynecology, cardiovascular services, neurology, radiology and cancer treatment. For a Directory of In-Network Providers, call Medical Mutual at 1-877-520-6727 or check Medical Mutual's website at [www.MedMutual.com](http://www.MedMutual.com).

## **In-Network Providers**

If you use In-Network Providers, you will receive the benefits described under the "In-Network" column listed in the tables on the following pages. All In-Network Providers have agreed to accept Medical Mutual's reimbursements as payment in full, less applicable Deductible and Coinsurance amounts that are payable by you. You will not be balance billed the difference between Medical Mutual's negotiated reimbursement with the In-Network Provider and his/her billed amount.

## **Out-of-Network Providers**

If you choose an Out-of-Network Provider (other than hospital-based Physicians as described on the following page), even if the services are provided at an In-Network Hospital, the benefits for that Physician's services will be paid at the Out-of-Network benefit levels listed in the Schedule of Coverage. If the Provider is Noncontracting or Nonparticipating you may be responsible for charges exceeding the Allowed Amount or Noncontracting Amount in addition to any Deductible or Coinsurance amounts. Additionally, you are responsible for ensuring that precertification is obtained by your Out-of-Network Provider to avoid an Inpatient Certification Penalty (see Certification for Hospital Admissions section). Any charges exceeding the Allowed Amount or Noncontracting Amount do not apply toward the Deductible or Out-of-Pocket Maximum.

If you are hospitalized and require the services of hospital-based Physicians such as radiologists, pathologists, anesthesiologists or emergency room Physicians, payment for those services at In-Network or Out-of-Network Hospitals will be based upon a determination of the Allowed Amount or Noncontracting Amount. The Payment Percentage at an In-Network Hospital will be at the In-Network level for Physicians' charges even though these Physicians may not be In-Network Providers. The Payment Percentage at an Out-of-Network Hospital will be paid at the Out-of-Network benefit level. You may be responsible for charges exceeding Medical Mutual's determination of the Allowed Amount or Noncontracting Amount in addition to any Deductible or Coinsurance.

In the case of a life-threatening emergency, you should seek care at the nearest Hospital. When such an emergency requires air ambulance services, payment for Covered Medical Expenses will be based upon a determination of Medical Mutual's Allowed Amount if it has a contract with the air ambulance service or the Noncontracting Amount if it does not have a contract.

In the event of any of the following scenarios, contact Medical Mutual's Customer Care department. Coverage details vary by scenario.

- No network provider within 50 miles of Participant's permanent residence.
- Participant experiences a true medical emergency and is balance-billed by a non-network provider.
- Participant is balance billed after receiving treatment from a non-network hospital-based physician at an in-network facility.
- Participant is being balance billed by a non-network specialist at an in-network facility for a test interpretation.
- Participant is being balance billed after receiving treatment from a non-network hospitalist at an in-network facility.  
A hospitalist is a provider who primarily performs services in a hospital/facility setting and does not practice in an office setting.
- Participant is being balance billed after receiving treatment from a non-network provider on call for a network provider.
- Participant's lab results are determined by technical readings (computer generated) for out-of-state providers.

## Enrollee Without Medicare

*Unless otherwise noted, the coverage listed below applies to Persons enrolled in the Basic Plan and HCAP administered by Medical Mutual.*

PLAN FEATURES	Preferred Provider Organization (PPO)		
	In-Network	Out-of-Network (4)	Indemnity Plan (4)
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted."</b>			
Benefit Period	Calendar Year	Calendar Year	Calendar Year
Annual Deductible per Enrollee (1)(3)	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$2,500</li> <li>• <b>HCAP:</b> \$300</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$5,000</li> <li>• <b>HCAP:</b> \$300</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$2,500</li> <li>• <b>HCAP:</b> \$300</li> </ul>
Annual Out-of-Pocket Maximum per Enrollee (2)(3)	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$6,500/single</li> <li>• <b>HCAP:</b> \$1,100/single</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$13,000/single</li> <li>• <b>HCAP:</b> \$3,300/single</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$6,500/single</li> <li>• <b>HCAP:</b> \$1,100/single</li> </ul>
Lifetime Benefit per Individual	Unlimited	Unlimited	Unlimited
Health Provider Access	Use any In-Network Provider	Use any Provider	Use any Provider
<b>EMERGENCY SERVICES</b>			
Hospital Charges for the Emergency Room	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment</li> </ul> <p>Copayment waived if admitted, subject to the Deductible, then 80%</p>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment</li> </ul> <p>Copayment waived if admitted, subject to the Deductible, then 80%</p>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment</li> </ul> <p>Copayment waived if admitted, subject to the Deductible, then 80%</p>
<b>HOSPITAL, SKILLED NURSING AND HOSPICE SERVICES</b>			
Hospital Inpatient Certification Penalty	None	\$200	\$200
Hospital Inpatient Board and Room, Including Ancillary Charges	80%	50%	80%
Inpatient Physician Visits and Surgical Procedures, Including Anesthesiologist	80%	50%	80%
Hospital Charges for Outpatient Surgery and Preadmission Testing	80%	50%	80%
Other Hospital Outpatient Services	80%	50%	80%
Private Duty Nurse	80%	50%	80%
Skilled Nursing Facility	80% 90 days per Confinement Period	50% 90 days per Confinement Period	80% 90 days per Confinement Period
Inpatient Hospice Services	80%	50%	80%
Inpatient Alcohol, Drug Abuse Treatment	80%	50%	80%

PLAN FEATURES	Preferred Provider Organization (PPO)		
	In-Network	Out-of-Network (4)	Indemnity Plan (4)
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted.</b>			
Inpatient Mental Health	80%	50%	80%
<b>MEDICAL SERVICES</b>			
Primary Care Physician Office Visit	<b>HCAP:</b> 80% <b>Basic:</b> First two visits per year \$20 Copayment All other visits: 80% after Deductible	50%	<b>HCAP:</b> 80% <b>Basic:</b> First two visits per year \$20 Copayment All other visits: 80% after Deductible
Consultation and Treatment by Specialist	80%	50%	80%
Preventive Care Services <ul style="list-style-type: none"> <li>Physical Exam</li> <li>Immunizations and Inoculations</li> <li>Colorectal Cancer Screening</li> <li>Mammogram</li> <li>Prostate Specific Antigen (PSA)</li> <li>Pap Smear</li> <li>Bone Density Screening</li> <li>Womens Preventive Services</li> </ul>	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply
Allergy Testing and Treatment	80%	50%	80%
Diagnostic X-Ray, Lab Testing and Medical Tests	80%	50%	80%
Urgent Care Facility	\$40 Copayment, subject to the Deductible, then 80%	\$40 Copayment, subject to the Deductible, then 80%	\$40 Copayment, subject to the Deductible, then 80%
<b>ADDITIONAL SERVICES</b>			
Autism Spectrum Disorder Services (to age 21) <ul style="list-style-type: none"> <li>Applied Behavioral Analysis - 20 hours per week limit per Benefit Period</li> <li>Occupational Therapy - 20 visits per Benefit Period</li> <li>Speech and Language Therapy - 20 visits per Benefit Period</li> </ul>	Benefit paid upon corresponding medical benefits.		
Outpatient Physical, Speech and Occupational Therapy Services	80% (Maintenance Care not covered)	50% (Maintenance Care not covered)	80% (Maintenance Care not covered)
Durable Medical Equipment	80%	50%	80%



PLAN FEATURES	Preferred Provider Organization (PPO)		Indemnity Plan (4)
	In-Network	Out-of-Network (4)	
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted.</b>			
Ambulance			
• Nonurgent	80%	50%	80%
• Urgent/Emergency	80%	80%	80%
Home Health Care Visits	80%	50%	80%
Outpatient Hospice Services	80%	50%	80%
Outpatient Alcoholism Treatment	80%	50%	80%
Outpatient Drug Abuse Treatment	80%	50%	80%
Outpatient Mental Health Care	80%	50%	80%
Medically Necessary Endoscopic Services - First procedure every two Benefit Periods	100%	50%	100%
Chiropractic Visits/Spinal Manipulation Services	80% (Maintenance Care not covered)	50% (Maintenance Care not covered)	80% (Maintenance Care not covered)
Experimental Treatment (5) Experimental Treatment Lifetime Maximum	80% \$10,000	50% \$10,000	80% \$10,000
Wig/Toupee Benefit	80% (One wig every three years)	80% (One wig every three years)	80% (One wig every three years)
All Other Covered Medical Expenses	80%	50%	80%

**Notes:**

1. Annual Deductible must be met before benefits are payable.
2. Includes annual Deductible, Coinsurance and primary care Physician Copayments.
3. In-Network and Out-of-Network accumulations are separate.
4. Payments are based on the Allowed Amount or Noncontracting Amount for medically Necessary services as established by Medical Mutual. If Out-of-Network Providers charge in excess of these payments, you are responsible for the excess charges.
5. This coverage does not include any charges for services covered under any other part of the Plan.

## Enrollee With Medicare Parts A & B

*Benefits are payable after Medicare Parts A & B payment. Unless otherwise noted, the coverage listed below applies to Persons enrolled in the Basic Plan and HCAP Plans administered by Medical Mutual.*

PLAN FEATURES	Indemnity Plan (3)
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted."</b>	
Benefit Period	Calendar Year
Annual Deductible per Enrollee (1)	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$2,500</li> <li>• <b>HCAP:</b> \$300</li> </ul>
Annual Out-of-Pocket Maximum per Enrollee (2)	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$6,500/single</li> <li>• <b>HCAP:</b> \$1,100/single</li> </ul>
Lifetime Benefit per Individual	Unlimited
Health Provider Access	Use any Provider
EMERGENCY SERVICES	
Hospital Charges for the Emergency Room	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment</li> </ul> <p style="text-align: center;">Copayment waived if admitted, subject to the Deductible, then 80%</p>
HOSPITAL, SKILLED NURSING AND HOSPICE SERVICES	
Hospital Inpatient Certification Penalty	None
Hospital Inpatient Board and Room, Including Ancillary Charges	80%
Inpatient Physician Visits and Surgical Procedures, Including Anesthesiologist	80%
Hospital Charges for Outpatient Surgery and Preadmission Testing	80%
Other Hospital Outpatient Services	80%
Private Duty Nurse	80%
Skilled Nursing Facility	80%; 90 days per Confinement Period
Inpatient Hospice Services	80%
Inpatient Alcohol, Drug Abuse Treatment	80%
Inpatient Mental Health	80%
MEDICAL SERVICES	
Primary Care Physician Office Visit	<p><b>HCAP:</b> 80%</p> <p><b>Basic:</b> First two visits per year \$20 Copayment All other visits: 80% after Deductible</p>

<b>PLAN FEATURES</b>	<b>Indemnity Plan (3)</b>
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted.</b>	
Consultation and Treatment by Specialist	80%
Preventive Care Services <ul style="list-style-type: none"> <li>Physical Exam</li> <li>Immunizations and Inoculations</li> <li>Colorectal Cancer Screening</li> <li>Mammogram</li> <li>Prostate Specific Antigen (PSA)</li> <li>Pap Smear</li> <li>Bone Density Screening</li> <li>Womens Preventive Services</li> </ul>	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply
Allergy Testing and Treatment	80%
Diagnostic X-Ray, Lab Testing and Medical Tests	80%
Urgent Care Facility	\$40 Copayment, subject to the Deductible, then 80%
<b>ADDITIONAL SERVICES</b>	
Autism Spectrum Disorder Services (to age 21) <ul style="list-style-type: none"> <li>Applied Behavioral Analysis - 20 hours per week limit per Benefit Period</li> <li>Occupational Therapy - 20 visits per Benefit Period</li> <li>Speech and Language Therapy - 20 visits per Benefit Period</li> </ul>	Benefits paid upon corresponding medical benefits
Outpatient Physical, Speech and Occupational Therapy Services	80% (Maintenance Care not covered)
Durable Medical Equipment	80%
Ambulance <ul style="list-style-type: none"> <li>Nonurgent</li> <li>Urgent/Emergency</li> </ul>	80% 80%
Home Health Care Visits	80%
Outpatient Hospice Services	80%
Outpatient Alcoholism Treatment	80%
Outpatient Drug Abuse Treatment	80%
Outpatient Mental Health Care	80%
Medically Necessary Endoscopic Services - First procedure every two Benefit Periods	100%
Chiropractic Visits/Spinal Manipulation Services	80% (Maintenance Care not covered)
Experimental Treatment (4) Experimental Treatment Lifetime Maximum	80% \$10,000
Wig/Toupee Benefit	80% (One wig every three years)
All Other Covered Medical Expenses	80%

**Notes:**

1. Annual Deductible must be met before any benefits are payable.
2. Includes annual Deductible, Coinsurance and primary care Physician Copayments.

3. Payments are based on the Allowed Amount or Noncontracting Amount for medically Necessary services as established by Medical Mutual. If Out-of-Network Providers charge in excess of these payments, you are responsible for the excess charges.
4. This coverage does not include any charges for services covered under any other part of the Plan.

## Enrollee With Medicare Part B Only

*Benefits are payable after Medicare Part B payment. Unless otherwise noted, the coverage listed below applies to Persons enrolled in the Basic Plan and HCAP administered by Medical Mutual.*

PLAN FEATURES	Preferred Provider Organization (PPO)		
	In-Network	Out-of-Network (4)	Indemnity Plan (4)
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted."</b>			
Benefit Period	Calendar Year	Calendar Year	Calendar Year
Annual Deductible per Enrollee (1)(3)	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$2,500</li> <li>• <b>HCAP:</b> \$300</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$5,000</li> <li>• <b>HCAP:</b> \$300</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$2,500</li> <li>• <b>HCAP:</b> \$300</li> </ul>
Annual Out-of-Pocket Maximum per Enrollee (2)(3)	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$6,500/single</li> <li>• <b>HCAP:</b> \$1,100/single</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$13,000/single</li> <li>• <b>HCAP:</b> \$3,300/single</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$6,500/single</li> <li>• <b>HCAP:</b> \$1,100/single</li> </ul>
Lifetime Benefit per Individual	Unlimited	Unlimited	Unlimited
Health Provider Access	Use any In-Network Provider	Use any Provider	Use any Provider
<b>EMERGENCY SERVICES</b>			
Hospital Charges for the Emergency Room	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment Copayment waived if admitted, subject to the Deductible, then 80%</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment Copayment waived if admitted, subject to the Deductible, then 80%</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Basic Plan:</b> \$150 Copayment</li> <li>• <b>HCAP:</b> \$150 Copayment Copayment waived if admitted, subject to the Deductible, then 80%</li> </ul>
<b>HOSPITAL, SKILLED NURSING AND HOSPICE SERVICES</b>			
Hospital Inpatient Certification Penalty	None	\$200	\$200
Hospital Inpatient Board and Room, Including Ancillary Charges	80%	50%	80%
Inpatient Physician Visits and Surgical Procedures, Including Anesthesiologist	80%	80%	80%
Hospital Charges for Outpatient Surgery and Preadmission Testing	80%	80%	80%
Other Hospital Outpatient Services	80%	80%	80%
Private Duty Nurse	80%	80%	80%
Skilled Nursing Facility	80% 90 days per Confinement Period	50% 90 days per Confinement Period	80% 90 days per Confinement Period
Inpatient Hospice Services	80%	50%	80%
Inpatient Alcohol, Drug Abuse Treatment	80%	50%	80%

PLAN FEATURES	Preferred Provider Organization (PPO)		
	In-Network	Out-of-Network (4)	Indemnity Plan (4)
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted.</b>			
Inpatient Mental Health	80%	50%	80%
<b>MEDICAL SERVICES</b>			
Primary Care Physician Office Visit	<b>HCAP:</b> 80% <b>Basic:</b> First two visits per year \$20 Copayment All other visits: 80% after Deductible	80%	<b>HCAP:</b> 80% <b>Basic:</b> First two visits per year \$20 Copayment All other visits: 80% after Deductible
Consultation and Treatment by Specialist	80%	80%	80%
Preventive Care Services <ul style="list-style-type: none"> <li>Physical Exam</li> <li>Immunizations and Inoculations</li> <li>Colorectal Cancer Screening</li> <li>Mammogram</li> <li>Prostate Specific Antigen (PSA)</li> <li>Pap Smear</li> <li>Bone Density Screening</li> <li>Womens Preventive Services</li> </ul>	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply	Enrollee pays 0%; (no Deductible); limited designated services; frequency/age/gender limitations apply
Allergy Testing and Treatment	80%	80%	80%
Diagnostic X-Ray, Lab Testing and Medical Tests	80%	80%	80%
Urgent Care Facility	\$40 Copayment, subject to the Deductible, then 80%	\$40 Copayment, subject to the Deductible, then 80%	\$40 Copayment, subject to the Deductible, then 80%
<b>ADDITIONAL SERVICES</b>			
Autism Spectrum Disorder Services (to age 21) <ul style="list-style-type: none"> <li>Applied Behavioral Analysis - 20 hours per week limit per Benefit Period</li> <li>Occupational Therapy - 20 visits per Benefit Period</li> <li>Speech and Language Therapy - 20 visits per Benefit Period</li> </ul>	Benefits paid upon corresponding medical benefits		
Outpatient Physical, Speech and Occupational Therapy Services	80% (Maintenance Care not covered)	80% (Maintenance Care not covered)	80% (Maintenance Care not covered)
Durable Medical Equipment	80%	80%	80%

PLAN FEATURES	Preferred Provider Organization (PPO)		Indemnity Plan (4)
	In-Network	Out-of-Network (4)	
<b>All covered services are subject to the Deductible, unless "not subject to the Deductible is specifically noted.</b>			
Ambulance			
• Nonurgent	80%	80%	80%
• Urgent/Emergency	80%	80%	80%
Home Health Care Visits	80%	80%	80%
Outpatient Hospice Services	80%	50%	80%
Outpatient Alcoholism Treatment	80%	80%	80%
Outpatient Drug Abuse Treatment	80%	80%	80%
Outpatient Mental Health Care	80%	80%	80%
Medically Necessary Endoscopic Services - First procedure every two Benefit Periods	100%	50%	100%
Chiropractic Visits/Spinal Manipulation Services	80% (Maintenance Care not covered)	80% (Maintenance Care not covered)	80% (Maintenance Care not covered)
Experimental Treatment (5) Experimental Treatment Lifetime Maximum	80% \$10,000	50% for Hospital Inpatient; 80% for other Outpatient charges \$10,000	80% \$10,000
Wig/Toupee Benefit	80% (One wig every three years)	80% (One wig every three years)	80% (One wig every three years)
All Other Covered Medical Expenses	80%	80%	80%

**Notes:**

1. Annual Deductible must be met before benefits are payable.
2. Includes annual Deductible, Coinsurance and primary care Physician Copayments.
3. In-Network and Out-of-Network accumulations are separate.
4. Payments are based on the Allowed Amount or Noncontracting Amount for medically Necessary services as established by Medical Mutual. If Out-of-Network Providers charge in excess of these payments, you are responsible for the excess charges.
5. This coverage does not include any charges for services covered under any other part of the Plan.

## DESCRIPTION OF COVERAGE

*Unless otherwise noted, the information in this section applies to Persons enrolled in the Basic Plans and HCAP Plans administered by Medical Mutual.*

Health expense coverage is expense-incurred coverage only and not coverage for the Condition itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated, even if the expenses were incurred as a result of an accident, injury or disease which occurred, commenced or existed while coverage was in force.

An expense for a service or supply is considered incurred on the date the service or supply is furnished. When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Medical Mutual. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Neither STRS Ohio nor Medical Mutual assumes any responsibility for the outcome of any covered services or supplies and makes no express or implied warranties concerning the outcome of any covered services or supplies.

### **Comprehensive Medical Expense Coverage**

Comprehensive medical expense coverage is merely a name for the benefits in this section. This term is not meant to imply that all medical expenses are covered. There are exclusions, Deductible features and stated maximum benefit amounts. These are all described in this booklet. All Covered Medical Expenses must be Necessary, unless otherwise specified.

The Schedule of Coverage section outlines the Payment Percentages that apply to the Covered Medical Expenses described on the following pages.

This Plan pays a benefit equal to the Payment Percentage of Covered Medical Expenses incurred in a calendar year, except for any different benefit level that may be provided for certain expenses outlined in this booklet.

After any applicable Deductible, health benefits are paid at the Coinsurance level that applies to the Covered Medical Expenses incurred.

If you are eligible for Medicare, all medical expenses covered under this Plan will be reduced by any Medicare benefits for those expenses, regardless of whether you elect to enroll in Medicare.

STRS Ohio will advise you of any changes to your coverage.

The following are Covered Medical Expenses:

### **Alcoholism and Drug Abuse**

#### **Inpatient Treatment**

If a Person is confined in a Hospital or Alcoholism or Drug Abuse Treatment Facility, the expenses incurred for detoxification are covered, but only if the detoxification is for the effective treatment of the underlying causes leading to rehabilitation from the addiction. Inpatient care must be approved by Medical Mutual before admission.

Effective treatment of alcoholism and drug abuse is considered a program of alcoholism and drug abuse therapy that is prescribed and supervised by a Physician and either:

- Has a follow-up therapy program, directed by a Physician, on at least a monthly basis; or
- Includes attendance at meetings at least twice a month with organizations devoted to the treatment of alcoholism and drug abuse.



## **Outpatient Treatment**

If a Person is not an Inpatient in either a Hospital or in an Alcoholism or Drug Abuse Treatment Facility, expenses for the effective treatment of alcoholism or drug abuse are covered. The benefits will be paid at the Payment Percentage shown in the Schedule of Coverage.

In addition, the following services are covered for the treatment of alcoholism and drug abuse:

- Individual and group psychotherapy;
- Psychological testing; and
- Family counseling: counseling with Enrollees to assist with diagnosis and treatment. This coverage will provide payment for Covered Medical Expenses for Enrollees under this Medical Plan Description. Charges will be applied to the Enrollee who is receiving family counseling services, not necessarily to the patient receiving treatment for alcoholism or drug abuse.

## **Allergy Tests and Treatment**

Allergy tests that are performed and related to a specific diagnosis are Covered Medical Expenses. Allergy shots are also covered.

## **Ambulance Services**

Covered Medical Expenses for professional ambulance services include local emergency ground transportation by a vehicle equipped and used only to transport the sick and injured:

- From your home or from the scene of an accident or medical emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to your home; or
- From your home to a Physician's office and then to a Hospital.

Trips must be to the closest facility that is medically equipped to provide the Covered Medical Expenses that are appropriate for your Condition.

Transportation will also be covered when provided by a professional ambulance service for other than local ground transportation only when special treatment is required and the transportation is to the nearest Hospital qualified and able to provide the special treatment.

## **Autism Services**

**Autism Spectrum Disorder Treatment** - coverage is provided for the services described below.

- Outpatient physical rehabilitation services that include:
  - Speech/language therapy and occupational therapy performed by licensed therapists;
  - Clinical therapeutic intervention, including, but not limited to, applied behavioral analysis. The analysis must be provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency to perform the services in accordance with a treatment plan; and
- Mental/behavioral health Outpatient services performed by a licensed psychologist, psychiatrist or Physician to provide consultation, assessment, development and oversight of treatment plans.

## **Case Management**

The Case Management Program provides personalized advice from dedicated Nurse Case Managers, who specialize in over 50 conditions like cancer, transplants and renal failure. Case Managers work with enrollees that may have chronic

or complex medical conditions along with their healthcare team to create a care plan. Through Case Management, alternative treatment options not listed in this Medical Plan Description may be considered for coverage when Medical Mutual determines such options will be cost effective and will promote optimal outcomes and are agreed to by the attending Physician and the patient.

## **Certification for Hospital Admissions**

This section applies to Persons without Medicare Part A covered under all Plans.

Hospital admissions require certification for Covered Medical Expenses to be payable as described below. See the Schedule of Coverage section for the inpatient certification penalty. If you are eligible for Medicare Part A, please be aware that Medicare may have its own certification requirements.

If you receive services from an In-Network Provider, the In-Network Provider is responsible for certification. If you receive services from an Out-of-Network Provider, you are responsible for certification. Certification of days of confinement can be obtained as follows:

- If the admission is a Nonurgent Admission, the Person or the Person's Physician must obtain certification by calling the number shown on your medical identification card. This must be done at least 14 days before the date the Person is scheduled to be confined as a full-time Inpatient;
- If the admission is an Emergency or Urgent Admission, you, the Person's Physician or the Hospital must obtain certification by calling the number shown on your medical identification card. This must be done:
  - Before the start of a confinement as a full-time Inpatient that requires an Urgent Admission; or
  - Not later than 48 hours following the start of a confinement as a full-time Inpatient that requires an Emergency Admission, unless it is not possible for the Physician to request certification within that time. In that case, it must be done as soon as reasonably possible; or
  - In the event the confinement starts on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.

If a Person becomes confined in a Hospital as a full-time Inpatient and Medical Mutual has not certified that such confinement (or any day of such confinement) is Necessary, and the confinement has not been ordered and prescribed by a Physician who is an In-Network Provider, then Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- If certification has been requested and denied or certification has not been requested and the confinement is not Necessary, no benefits will be paid for Hospital expenses incurred for Board and Room during the confinement;
- If certification has not been requested and the confinement is Necessary, a penalty equal to the Inpatient Certification Penalty shown in the Schedule of Coverage will be assessed for Board and Room, after any applicable Deductible. Thereafter, benefits for Board and Room will be paid at the applicable Payment Percentage; or
- Benefits for other Covered Medical Expenses will be paid at the Payment Percentage after any Deductible.

Whether or not a day of confinement is certified, no benefit will be paid for medical expenses incurred on any day of confinement as a full-time Inpatient if the expenses are excluded by any other terms of this Plan. No benefits will be paid for services determined by Medical Mutual to not be Necessary. If certification has been given for a day of confinement, the exclusion of services and supplies because they are not Necessary will not be applied to expenses for Hospital Board and Room.

If, in the opinion of the Person's Physician, it is Necessary for the Person to be confined for a longer time than already certified, the Person, the Physician or the Hospital may request that more days be certified by calling the number shown on your medical identification card. This must be done no later than the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the Hospital. A copy will be sent to you and your Physician.

## **Christian Science Practitioners, Nurses or Sanatoria**

The following are considered other Covered Medical Expenses:

- Charges of a Christian Science practitioner, but only if the practitioner is listed as such in the Christian Science Journal current at the time service is provided. Medical Mutual may, at any time and from time to time, require of any Person claiming benefits under this Plan, an examination by a Physician, and at the Physician's discretion, diagnostic examinations in a Hospital; and
- Charges for a Christian Science nurse who is listed in the Christian Science Journal current at the time service is provided and has:
  - Completed nurses' training at a Christian Science Benevolent Association Sanatorium; or
  - Graduated from another nurses' training course; or
  - Had three consecutive years of Christian Science nursing, including two years of training.

The following are considered covered Inpatient Hospital expenses:

- Charges of Christian Science Sanitoria operated or listed and certified by the commission for Accreditation of Christian Science Nursing Organizations/Facilities Inc., if incurred for healing and while under the care of a Christian Science practitioner. In general, supportive care, sheltered care, and rest and study services are not covered by the Plan. The Sanitoria Utilization Review Committee must verify that the services are required and must show evidence thereafter of having reviewed and verified periodically the need for continued services.

## Diagnostic Services

A diagnostic service is a test or procedure performed when you have specific symptoms to detect or monitor your Condition. It must be ordered by a Physician or Covered Provider and must be Necessary. Covered diagnostic services are limited to the following:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

## Emergency Services

You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week. If you are experiencing an Emergency Medical Condition, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. **Care and treatment once you are Stabilized are not Emergency Services.** Continuation of care beyond that needed to evaluate or Stabilize your Emergency Medical Condition will be covered according to your Schedule of Coverage. Please refer to your Schedule of Coverage for a detailed coverage explanation.

## Experimental Treatment

Covered Medical Expenses include expenses for:

- Investigational new drugs (IND) or Group C Treatment IND that have conditional approval by the Food and Drug Administration (FDA); or
- Other services and supplies that are not generally used for treatment of the particular disease, but the treatment generally used is no longer determined to be adequate and the other services and supplies have recognized value for treatment of the disease.

Experimental treatment expenses will be considered Covered Medical Expenses provided that:

- FDA approval has been given to the entity to charge for the IND; or
- Medical Mutual certifies, prior to the date that the charges are incurred, that the IND or other services and supplies are justified and appropriate given the clinical circumstances involved. The Eligible Beneficiary can request certification by calling Medical Mutual at the toll-free number listed on the medical identification card.

Experimental treatment benefits are subject to an experimental treatment lifetime maximum per Person and Payment Percentages as shown in the Schedule of Coverage.

## Gender Dysphoria Treatment

The Plan will cover Medically Necessary services for the treatment of gender dysphoria, subject to accepted medical clinical guidelines and corporate medical policies.

## Home Health Care

Charges made by an R.N., an L.P.N. or by a nursing agency for Skilled Nursing Care. Skilled Nursing Care is considered part or all of any nursing care that requires the education, training or technical skills of an R.N. or L.P.N.

Home health care expenses are also covered if the charge is made by a Home Health Care Agency, the care is given under a Home Health Care Plan and the care is given to a Person in his or her home.

Covered Medical Expenses for home health care include:

- Visiting nurse care by an R.N. or by an L.P.N. if an R.N. is not available. Visiting nurse care means a visit of not more than four hours for the purpose of performing specific skilled nursing tasks;
- Care provided solely for skilled observation for up to one, four-hour period per day for a period of no more than 10 consecutive days following:
  - Change in patient medication;
  - Need for treatment of an emergency Condition by a Physician or the onset of symptoms indicating the likely need for such treatment;
  - Surgery; or
  - Release from Inpatient confinement.
- Part-time or intermittent home health aide services for patient care when provided in conjunction with skilled services;
- Physical, occupational and speech therapy;
- Services of a licensed medical social worker provided in conjunction with covered nursing or therapy services; and
- The following to the extent they would have been covered under this Plan if the Person had been confined in a Hospital or Skilled Nursing Facility:
  - Medical supplies, drugs and medicines prescribed by a Physician;
  - Lab services provided by or for a Home Health Care Agency; and
  - Oxygen and its administration.

Each visit by a nurse or therapist is one visit. Each visit of up to four hours by a home health aide is one visit.

**Please note the Plan does not cover:**

- Custodial care, rest care or care that is only for someone's convenience;
- Homemaker services; and
- Food or home-delivered meals.

## Hospice Care

Charges made for the following services furnished to a Person for Hospice Care when given as a part of a Hospice Care Program. Services are subject to review for Medical Necessity:

### Facility Expenses

The charges made on its own behalf by a Hospice Facility, Hospital or Skilled Nursing Facility for:

- Board and Room and other services and supplies furnished to a Person while a full-time Inpatient for:
  - Pain control;
  - Other acute and chronic symptom management; and

- Respite Care when the Person's family or usual caretaker cannot, or will not, attend to the Person's physical and occupational therapy.
- Part-time or intermittent home health aide services for up to eight hours in any one day;
- Medical supplies, drugs and medicines prescribed by a Physician;
- Oxygen and its administration; and
- Bereavement counseling for Immediate Family.

### **Charges Made by Providers**

Charges made by the Providers below are considered Covered Medical Expenses only if the Provider is not an employee of a Hospice Care Agency and such agency retains responsibility for the care of the Person:

- A Physician for consultant or case-management services; or
- A physical or occupational therapist.

### **Home Health Care Agency**

The following charges made by a Home Health Care Agency are considered Covered Medical Expenses:

- Physical or occupational therapy;
- Part-time or intermittent home health aide services for up to eight hours in any one day;
- Medical supplies, drugs and medicines prescribed by a Physician; and
- Psychological and dietary counseling needs.

### **Other Expenses**

The following charges made by a Hospice Care Agency are considered Covered Medical Expenses:

- Bereavement counseling for Immediate Family;
- Consultation or case management services by a Physician;
- Medical social services under the direction of a Physician, including:
  - Assessment of the Person's social, emotional and medical needs, and the home and family situation;
  - Identification of community resources available to the Person; and
  - Assisting the Person to obtain those resources needed to meet the Person's assessed needs.
- Oxygen and its administration;
- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day; and
- Psychological and dietary counseling.

## **Hospital Expenses**

### **Inpatient Expenses**

Inpatient expenses include charges made by a Hospital, on its own behalf, for Board and Room and other Hospital services and supplies that are furnished to a Person who is confined as a full-time Inpatient. There is no limit on the number of days of confinement. Covered Medical Expenses include:

### **Ancillary Services**

- Operating, delivery and treatment rooms and equipment;
- Prescription drugs;
- Whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
- Anesthesia and anesthesia supplies and services;
- Oxygen and other gases;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services;
- Therapy services; and
- Surgically inserted prosthetics such as pacemakers and artificial joints.

## **Concurrent Care**

Care by two or more Physicians during one Hospital stay. While you are in the hospital for Surgery, you are covered for care by a Physician who is not your surgeon for an unrelated medical Condition.

## **Inpatient Medical Care Visits**

The examinations given to you by your Physician or Covered Provider while you are in the Hospital.

## **Inpatient Consultation**

A bedside examination by another Physician or Covered Provider when requested by your attending Physician.

## **Intensive Medical Care**

Constant medical attendance and treatment when your Condition requires it.

## **Newborn Exam**

Inpatient medical care visits to examine a newborn if the newborn has been enrolled in the health care Plan. Contact STRS Ohio for enrollment information.

## **Private Room**

When Necessary as a result of third-degree burns or a communicable disease requiring isolation for medical reasons. If you request a private room and it is not determined to be Necessary, Medical Mutual will provide benefits only for the Hospital's average semiprivate room rate.

## **Outpatient Expenses**

Outpatient expenses include charges made by a Hospital or Surgery Center, on its own behalf, for Outpatient services that are furnished to a Person while not admitted as an Inpatient.

## **Preadmission Testing Expenses**

Preadmission testing expenses include charges made by a Hospital or Surgery Center, on its own behalf, to test a Person while an Outpatient before scheduled Surgery if the:

- Tests are related to the scheduled Surgery;
- Tests are done within 10 days before the scheduled Surgery;
- Person undergoes the scheduled Surgery in a Hospital or Surgery Center. This does not apply if the tests show that Surgery should not be done because of the Person's physical Condition;
- Charge for the Surgery is a Covered Medical Expense under this Plan;
- Tests are done while the Person is not confined as an Inpatient in a Hospital. The charges for the tests would have been covered if the Person was confined as an Inpatient in a Hospital;
- Test results appear in the Person's medical record kept by the Hospital or Surgery Center where the Surgery is to be performed; and
- Tests are not repeated in or by the Hospital or Surgery Center where the Surgery is done.

If the Person cancels the scheduled Surgery, benefits are paid at the Payment Percentage that would have applied in the absence of this benefit.

## **Outpatient Surgical Expenses**

Charges made by a Hospital or Surgery Center for Outpatient services and supplies furnished in connection with a surgical procedure performed in the center. The procedure must meet these tests:

- It is not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity or involve any major blood vessels; and
- It can safely and adequately be performed only in a Surgery Center and it is not normally performed in the office of a Physician or a Dentist.

## **Outpatient Services and Supplies**

Outpatient services and supplies are services and supplies furnished by the Hospital or Surgery Center on the day of the procedure.

## **Maternity Services - Coverage Related to the Newborn's and Mother's Health Protection Act**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification or benefits related to the Newborn's and Mother's Health Protection Act, contact Medical Mutual.

## **Mental Disorders and Mental Illness**

Covered Medical Expenses for the Effective Treatment of a Mental Disorder or Mental Illness are as follows:

- If a Person is a full-time Inpatient either in a Hospital or Residential Treatment Facility, then expenses are covered in the same way as those for any other disease.
- If a Person is not an Inpatient in a Hospital or Residential Treatment Facility, then benefits will be paid at the Payment Percentage shown in the Schedule of Coverage.

Other Covered Medical Expenses include:

- Board and Room. Any charge exceeding the semiprivate room limit as set by Medical Mutual is not covered.
- Other Necessary services and supplies.

Your Physician or other Covered Provider must certify that there is a reasonable likelihood that your treatment will be of substantial benefit and that improvement is likely. The course of treatment your Physician or other Covered Provider recommends must be acceptable to Medical Mutual. Inpatient care must be approved by Medical Mutual before admission.

This Plan pays for covered expenses made by a Hospital or Residential Treatment Facility for Effective Treatment of a Mental Disorder or Mental Illness and given through a partial confinement treatment program for the intermediate short-term or medically-directed intensive treatment of a Mental Disorder or Mental Illness. These charges will be deemed Covered Medical Expenses to the same extent as Board and Room charges. A treatment session starts when the Person enters the place of treatment, and it ends when the Person leaves it after one partial confinement treatment. It includes all medically Necessary services and supplies furnished.

No benefits are paid for:

- Services of a Physician who is not on the staff of the place where the treatment is given;
- Psychiatric nursing and social work services if not ordered by a staff psychiatric Physician;
- Diagnostic psychological tests if not given by personnel licensed or certified to do so;
- Missed appointments, telephone consultations or personal comfort items;
- Services and supplies that are not part of care by an institution on a regular basis; and
- Services at a residential treatment facility that does not meet this Medical Plan Description's definition of a Residential Treatment Facility.

## **Mouth, Jaws and Teeth**

Covered Medical Expenses related to treatment of the mouth, jaws and teeth include:

Surgery needed to:

- Treat a fracture, dislocation or wound;
- Cut out:
  - Teeth partly or completely impacted in the bone of the jaw;

- Teeth that will not erupt through the gum;
  - Other teeth that cannot be removed without cutting into bone;
  - The roots of a tooth without removing the entire tooth; or
  - Cysts, tumors or other diseased tissues.
- Cut into gums and tissues of the mouth when not done in connection with the removal, replacement or repair of teeth; or
  - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Covered Medical Expenses also include nonsurgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, Surgery and orthodontic treatment are Covered Medical Expenses if such treatment is needed to remove, repair, replace, restore or reposition (1) natural teeth that have been damaged, lost or removed while the Person is covered under this Plan; or (2) other body tissues of the mouth that have been fractured or cut due to injury. Any such teeth must have been free from decay or in good repair and firmly attached to the jawbone at the time of injury.

The treatment must be done in the calendar year of the accident or the next calendar year.

If crowns (caps), dentures (false teeth), bridgework or in-mouth appliances are installed due to such injury, Covered Medical Expenses include only charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

The following charges are Covered Medical Expenses, only if provided in association with injury:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations or any related fitting or adjustment services whether or not the purpose of such services or supplies is to relieve pain;
- Root canal therapy; and
- Tooth removal (not needing cutting of bone).

## **Other Covered Medical Expenses**

Other Covered Medical Expenses include:

- Acupuncture services given to a Person by:
  - A Physician; and
  - When rendered:
    - As a form of anesthesia in connection with Surgery that is covered under this Plan;
    - To alleviate postoperative dental pain, fibromyalgia or myofascial pain;
    - To alleviate nausea and vomiting associated with chemotherapy, postoperative pain or pregnancy; or
    - To treat temporomandibular disorders (TMD).
- Charges made by a Hospital for Outpatient services and supplies.
- Charges made by a Physician, including second opinions.
- Charges made by an R.N. or L.P.N. or a nursing agency for private duty nursing if the Person's Condition requires continuous skilled nursing services and visiting nursing care is not adequate. This includes Inpatient private duty nursing services when ordered by a Physician and determined to be medically Necessary as determined by Medical Mutual. When private duty nursing services must be received in your home, nurse's notes must be sent in with your claim.
- Injectable prescription drugs approved by the Food and Drug Administration (FDA) for administration by a Covered Provider. In certain circumstances, not all Covered Providers may be able to administer injectable medications.

Medical Mutual, along with your Physician, will determine which setting is most appropriate for these drugs and biologicals to be administered to you.



- Charges made for diagnostic X-ray and laboratory tests that reveal need for treatment or are made because of definite symptoms of a Condition and X-ray therapy. A diagnostic service is a test or procedure performed when you have specific symptoms to detect or monitor your Condition. It must be ordered by a Physician or Covered Provider and must be Necessary. Covered diagnostic services are limited to the following:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and pathology services;
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

This includes X-ray and laboratory charges for mammograms, prostatic specific antigen (PSA) tests and Pap smears.

- Charges for the rental, purchase, repair or replacement of Durable Medical Equipment, anesthetics and oxygen. The initial purchase of such equipment and accessories needed to operate it is covered only if Medical Mutual is shown that:

- Long-term use is planned; and
- The equipment cannot be rented; or
- It is likely to cost less to purchase it than to rent it.

Repair or replacement of such purchased equipment and accessories will be covered only if Medical Mutual is shown that it is:

- Needed due to a change in the Person's physical Condition; or
- Likely to cost less to purchase a replacement than to repair the existing equipment or to rent similar equipment.

- Even though not incurred for treatment of a Condition, charges for:

- Contraceptive devices (intrauterine devices and diaphragms), implants and contraceptive injections;
- Physician office visits for insertion and removal of the devices, implants and administration of injections.

- Orthotic devices - Rigid or semirigid supportive devices that limit or stop the motion of a weak or diseased body part are covered. These devices include:

- Back and special surgical corsets;
- Braces for the leg, arm, neck or back;
- Therapeutic shoes for select Conditions as determined by Medical Mutual; and
- Trusses.

- Contact lenses or eyeglasses required because of, and prescribed and purchased within one year after, cataract Surgery or Surgery for retinal detachment. Coverage will be provided for one pair of contact lenses and one pair of eyeglasses, if both must be worn at the same time.

- Prosthetic limbs and eyes.

- Diabetic education that is designed to educate a Person about the Condition and lifestyle changes Necessary as a result of diabetes. To be considered Covered Medical Expenses, the services must be prescribed by a Physician and furnished by a Covered Provider.

- Office Visits and consultations to examine, diagnose and treat a Condition are Covered Services.

- Services not performed in-person (telehealth). When performed by a Provider with whom Medical Mutual has an agreement to perform these services, your coverage will include Providers' charges for consulting with Persons by telephone, facsimile machine, electronic mail systems or online visit services. Online Covered Medical Expenses include a medical consultation using the internet via a webcam, chat or voice. Non covered services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician-to-Physician consultation

- Nutritional counseling for gestational diabetes, chronic diseases and weight loss. The nutritional counseling must have a therapeutic role, be prescribed by a Physician and furnished by a Covered Provider.

- Disposable medical and surgical supplies that serve a specific therapeutic purpose. These include surgical dressings and other similar items.
- Surgery Necessary due to morbid obesity as defined by Medical Mutual.
- Wigs or hairpieces up to the limit specified in the Schedule of Coverage when prescribed by a Physician for hair loss due to injury, disease or treatment of a disease such as:
  - Alopecia areata with near complete or complete cranial hair loss;
  - Alopecia totalis and alopecia universalis;
  - Burns resulting in permanent alopecia;
  - Chemotherapy;
  - Fungal infections not responsive to an appropriate course (typically six weeks) of antifungal treatment resulting in near complete or complete hair loss;
  - Lupus; and
  - Radiation therapy.

### **Women's Health and Cancer Rights Act of 1998**

In accordance with the Women's Health and Cancer Rights Act of 1998, this Plan will provide benefits to include the following mastectomy-related procedures:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of a mastectomy, including lymphedemas (swelling of the hand and arm on the operated side).

This coverage will be provided in consultation with the attending Physician and the patient, and will be subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy. If you have any questions about coverage for mastectomies and reconstructive Surgery, please contact Medical Mutual.

### **Outpatient Rehabilitative and Habilitative Services**

Outpatient therapy services must be used to promote recovery from a Condition and ordered by a Physician or other Covered Provider to be covered. Covered Medical Expenses are limited to Necessary therapy services listed below:

- **Cardiac rehabilitation services** - Benefits are provided for cardiac rehabilitation services that are Necessary as the result of a cardiac event. The therapy must be reasonably expected to result in a significant improvement in the level of cardiac functioning. Some phases of cardiac rehabilitation services may not be covered.
- **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
- **Chiropractic Visits/Spinal Manipulation Services** - The treatment given by a chiropractor to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include, but are not limited to, office visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. Braces and molds are not covered under this benefit.
- **Dialysis treatments** - The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis that may include the supportive use of an artificial kidney machine.
- **Occupational therapy** - Occupational therapy services are covered if it is expected that therapy will result in a significant improvement in the level of functioning and that improvement will occur. All occupational therapy services must be performed by a certified or licensed occupational therapist.
- **Physical therapy** - The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Covered Medical Expenses include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. Braces and molds are not covered under this benefit. Services must be provided by a Physician or certified licensed physical therapist.
- **Pulmonary rehabilitation services** - Benefits are provided for Physician-supervised outpatient pulmonary therapy provided by a Hospital or other licensed health care facility that is Necessary and expected to result in significant improvement of body function.

- **Radiation therapy** - Treatment of disease by X-ray, radium or radioactive isotopes.
- **Respiratory therapy** - Treatment by the introduction of dry or moist gases into the lungs.
- **Speech therapy** - To be considered a Covered Medical Expense this therapy must be performed by a certified, licensed speech therapist and be expected to restore speech for a Person who has lost existing speech function.

## Plastic, Reconstructive or Cosmetic Surgery

Charges for plastic, reconstructive or cosmetic Surgery or other services and supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons, are Covered Medical Expenses provided that the Surgery, services or supplies:

- Improve the function of a part of the body (excluding a tooth or structure that supports the teeth) that is malformed as a result of a severe birth defect. This includes cleft lip or webbed fingers or toes. This also includes body parts malformed as a direct result of a Condition or Surgery performed to treat a Condition.
- Repair an injury. Surgery must be performed in the calendar year of the accident that caused the injury or in the next calendar year.

## Precertification

This section applies to Persons without Medicare Parts A and/or B covered under all Plans.

In-Network Providers are responsible for securing precertification (authorization) before care is provided. If you receive services from an Out-of-Network Provider, you are responsible for precertification by calling the phone number listed on the back of your medical identification card.

You must obtain precertification from Medical Mutual to receive the full benefits specified in the Schedule of Coverage for the following:

- Acute rehabilitation admissions;
- Skilled Nursing Facility admissions;
- Inpatient behavioral health services;
- Home Health Care services;
- PET scans;
- MRI of the cervical, lumbar and thoracic spine, and lower extremity joints; and
- MRA for lower extremity.

The list of services requiring precertification is subject to change.

## Preventive Health Care Services

Note that a routine physical exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Condition. Included under this benefit are a medical history, physical exam, immunizations and laboratory and radiology services listed below.

The Provider must use a wellness diagnosis code or procedure code to be covered as a preventive service. If a wellness diagnosis code or procedure code is not used, the preventive service will be subject to the Plan's Deductible and Coinsurance. For example, if a diagnosis of a medical Condition is made during the screening, the procedure is no longer considered routine and may be considered a diagnostic procedure under Surgical Services.

Even though not incurred in connection with a Condition, Covered Medical Expenses include:

### Evaluation and management

- Physician office visit for annual physical exam;
  - limited to one examination per year for males; and

- three per year (including visit with Pap Test and Examination) for females

### **Cancer screenings**

- Colon/prostate digital rectal exam (DRE);
- Cervical Pap smear;
- Annual gynecological exam;
- Clinical breast exam;
- Colonoscopy\*; and
- Sigmoidoscopy.

\*Note: Any associated pathology lab charges are covered as diagnostic and not preventive health care services

### **Radiology**

- Annual Mammogram;
- Osteoporosis screening; and
- Barium enema (screening).

### **Laboratory**

- Prostatic specific antigen (PSA);
- Fecal occult blood;
- Complete blood count (CBC);
- Metabolic panel;
- Thyroid studies;
- Rubella serology (for pregnancy);
- Cholesterol lipid panel;
- Hepatitis B surface antigen;
- HIV;
- Urinalysis;
- Venipuncture;
- Lead (for children); and
- HPV (for female teenagers).

### **EKG**

### **PPD tuberculosis skin test**

### **Immunizations**

- Influenza Type B;
- Poliovirus;
- Tetanus;
- Diphtheria;
- Rotavirus;
- Rubella;
- Hepatitis A & B;
- Herpes Zoster (Zostavax and Shingrix, vaccines to prevent shingles);
- Varicella;
- Pneumococcal;
- Influenza;
- FluMist (to be determined annually); and
- Meningococcal.

**Well Child Care Services** - Coverage for well child care services will be provided to Enrollees under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21.

Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests and appropriate immunizations.

**Women's preventive services** - These services will be provided in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

Coverage is provided for FDA-approved contraceptive methods and counseling. Prescribed contraceptive medication will be paid in accordance with any applicable Prescription Drug benefit.

### **Additional Preventive Services**

If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration;

Please refer to the phone number on the back of your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

### **Prescription Drug Expenses**

Prescription drugs not otherwise listed as covered are available to Plan Enrollees under a separate plan administered by Express Scripts. For more information, call Express Scripts at 866-685-2792 (Enrollees without Medicare); 888-416-3326 (Enrollees with Medicare).

### **Private Duty Nursing Services**

The services of an R.N., licensed vocational nurse or L.P.N. when ordered by a Physician and certified by Medical Mutual as Necessary are covered. These services include hourly skilled nursing intervention received in a patient's home or as an Inpatient.

Inpatient private duty nursing services include services that Medical Mutual certifies as Necessary because the degree of complexity is beyond what the Providers' regular nursing staff can provide. When private duty nursing services must be received in your home, nurse's notes must be submitted with your claim.

Additionally, all private duty nursing services must be certified as Necessary by your Physician initially and every 30 days thereafter.

Private duty nursing services do not include care that is primarily nonmedical or Custodial in nature such as bathing, exercising or feeding. Also, Medical Mutual does not cover services provided by a nurse living in your home or who is a member of your immediate family.

## Skilled Nursing Facility Expenses

Charges made by a Skilled Nursing Facility for the following services and supplies are covered, but only if furnished to a Person who requires Skilled Nursing Care in connection with a Condition and only if the services or supplies are Necessary to allow the patient to achieve independence in activities of daily living and to facilitate discharge from the facility:

- Semiprivate Board and Room (this includes charges for services, such as general nursing care, made in connection with room occupancy); if the Enrollee is in a private room, the Enrollee is responsible for paying the difference between the charges for a semiprivate room and a private room;
- Use of special treatment rooms;
- X-ray and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Skilled Nursing Care by an R.N., or by an L.P.N. directed by a full-time R.N., which requires the education, training and technical skills of an R.N. or L.P.N.;
- Other medical services usually given by a Skilled Nursing Facility (except Physician services); and
- Medical supplies not listed above.

Your Physician must order and Medical Mutual must certify that you are receiving Skilled Nursing Care and not Custodial Care.

If you are eligible for Medicare Part A, you must have been an Inpatient in a Hospital at least three consecutive days before your admission to a Skilled Nursing Facility. The admission to the Skilled Nursing Facility must be for a Condition for which you were treated in the Hospital and must occur within 30 days of discharge from the Hospital.

## Surgical Services

Coverage is provided for Necessary Surgery. In addition, coverage is provided for sterilization and the following Surgery-related procedures and services.

### Diagnostic Surgical Procedures

Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital.

### Multiple Surgical Procedures

When two or more Surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. The other procedures are considered incidental and not covered. However, if each Surgery is mutually exclusive of the other or is the result of multiple traumas, you will be covered for each Surgery.

When two or more Surgeries are performed through different body openings at the same time, the primary procedure will be covered at the Allowed Amount or Noncontracting Amount. Subsequent procedures will be covered at a portion of the Allowed Amount or Noncontracting Amount. No coverage will be provided for procedures considered by Medical Mutual to be incidental.

If the Surgery is performed by an In-Network Provider, you will not be responsible for the reduced amount not paid by the Plan. If Surgery is performed by an Out-of-Network Provider, you may be responsible for the amount not covered by the Plan.

If two or more foot Surgeries are performed, the most complex procedure will be covered at the Allowed Amount or Noncontracting Amount. The next two most complex procedures will be covered at half of the Allowed Amount or Noncontracting Amount. Subsequent procedures will be covered at one-fourth of the Allowed Amount or Noncontracting Amount. Whether a procedure is covered at the Allowed Amount or Noncontracting Amount depends on the contracting status of the Provider.

### Bilateral Surgical Procedures

When the same surgical procedure is performed bilaterally (i.e., on two sides) during one operative setting, the professional expenses for one side will be covered at the Allowed Amount or Noncontracting Amount and the subsequent side will be covered at half of the Allowed Amount or Noncontracting Amount for the particular procedure. The Hospital or Other Facility expenses will be covered at the Allowed Amount, Negotiated Amount or the Noncontracting Amount and will also be reduced for the second procedure. If Surgery is performed by an In-Network Provider, you will not be responsible for the reduced amount not paid by the Plan. If the Surgery is performed by an Out-of-Network Provider, you will likely be responsible for the amount not covered by the Plan. Whether a procedure is covered at the Allowed Amount, Negotiated Amount or Noncontracting Amount depends on the contracting status of the Provider.

### **Anesthesia**

Your coverage includes the administration of anesthesia performed in connection with a Covered Medical Expense by a Physician, Covered Provider, Certified Registered Nurse Anesthetist who is not the surgeon or the assistant at Surgery, or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration of anesthesia.

## **Transplant Services**

Your coverage includes benefits for the following human transplants:

- Bone marrow transplant;
- Cornea;
- Heart;
- Heart and lung;
- Kidney;
- Liver;
- Lung;
- Pancreas; and
- Pancreas/Kidney.

Other human transplants may be considered if determined to be Necessary.

### **Transplant precertification**

All transplant services must be precertified and approved by Medical Mutual.

After your Physician has examined you, the Physician must provide to Medical Mutual:

- Proposed course of treatment for the transplant;
- Name and location of the proposed Transplant Center; and
- Copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that have been specifically tailored to each organ. You may also be required to undergo an examination by a Physician chosen by Medical Mutual. You and your Physician will then be notified of Medical Mutual's decision.

### **Obtaining Donor Organs or Tissue**

The following services will be Covered Medical Expenses when they are Necessary to acquire a legally obtained human organ or tissue:

- Evaluation of the organ or tissue;
- Removal of the organ or tissue from the donor; and
- Transportation of the organ or tissue to the Transplant Center.

### **Donor Benefits**

Benefits necessary for obtaining an organ or tissue from a living donor or cadaver are provided. Donor benefits are provided and processed only under the transplant recipient's coverage and are subject to any applicable limitations and exclusions.

**Transportation Benefits** - Your coverage includes benefits for related travel expenses, including meals and lodging. Limits may apply.



## EXCLUSIONS

Any exclusion below will not apply to the extent that coverage is specifically named in this booklet or coverage of the charges is required under any law that applies to the coverage. The excluded charges will not be used when figuring benefits. The law of the jurisdiction where a Person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Coverage is not provided for the following services and supplies:

1. A resident Physician's help to your surgeon in performing covered Surgery when a Hospital staff member or intern is not available.
2. Acupuncture, except as provided for elsewhere in this document.
3. Allergy drops dispensed for self-administration or administration outside a Physician's office.
4. Arch supports and other foot care or foot support devices used only to improve comfort or appearance. These include, but are not limited to, devices to care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses and toenails.
5. Artificial insemination, in vitro fertilization or embryo transfer procedures.
6. Blood that is available without charge.
7. Care furnished mainly to provide a surrounding free from exposure that can worsen the Person's Condition.
8. Charges for care provided by a resident Physician or care provided by a Covered Provider who specializes in the mental health field and receives treatment as part of their training in that field.
9. Care, treatment, services or supplies that are not prescribed, recommended and approved by the Person's attending Physician or Dentist.
10. Charges for:
  - Care provided to help a Person in the activities of daily life such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
  - Care that does not require the education, training and technical skills of an R.N. or L.P.N.; or
  - Any service provided solely to administer oral medicines except where applicable law requires that such medicines be administered by an R.N. or L.P.N.
11. For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability or similar laws, even when the covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.
12. Condition that occurs as a result of any act of war.
13. Custodial care, as determined by Medical Mutual, rest care or care that is only for someone's convenience.
14. Detoxification, without a specified follow-up therapy program.
15. Dietary supplements, vitamins and any care that is primarily dieting or exercise for weight loss.
16. Drugs, medicines, pharmaceutical supplies and diabetic supplies that are covered under the STRS Ohio Prescription Drug Program.
17. Drugs or supplies for sexual performance, athletic performance or lifestyle enhancement, except to the extent that coverage for such drugs or supplies is specifically provided in this document.
18. Durable Medical Equipment as follows, unless otherwise noted in this document:
  - Rental costs if you are in a facility that provides such equipment;
  - Total rental costs that exceed the purchase price for the equipment;
  - Repair costs that are more than the rental price of another unit for the estimated period of use or are more than the purchase price of a new unit;
  - Physician's equipment such as a blood pressure cuff or stethoscope; and
  - Deluxe equipment, such as specially designed wheelchairs.

19. Education, special education, vocational or job training purposes whether or not given in a facility that also provides medical or psychiatric treatment.
20. Experimental or Investigational Services, except as otherwise described as covered in this document.
21. Eye Surgery mainly to correct refractive errors.
22. Eyeglasses, special coatings for eyeglass lenses, contact lenses or examinations for prescribing or fitting them, except those for patients with aphakia, soft lenses or sclera shells for use as corneal bandages or as prescribed and purchased within one year after cataract Surgery or retinal detachment Surgery.
23. Family, child, career, social adjustment, marital, pastoral and financial counseling services.
24. Fraudulent or misrepresented claims.
25. General health or lifestyle programs that are not related to a Person's Condition.
26. Hearing aids or examinations for prescribing or fitting them.
27. Home Health Care Services that are:
  - Dietetic services, food or home-delivered meals;
  - Financial or legal counseling, including estate planning or will preparation;
  - Funeral arrangements;
  - Homemaker services;
  - Provided solely to administer oral medicines except where applicable law requires that such medicines be administered by an R.N. or L.P.N.;
  - Transportation;
  - Provided by a Person who usually lives with you or is Immediate Family;
  - Respite Care that is not provided while a Person is confined as a full-time Inpatient, except as provided for elsewhere in this document; or
  - Not listed elsewhere in this document.
28. Hospice-related services including:
  - Volunteer services;
  - Spiritual counseling;
  - Homemaker services;
  - Food or home-delivered meals; and
  - Chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition.
29. Hospital ancillary items including:
  - Gowns, slippers, shampoo, toothpaste, body lotions and hygiene packs;
  - Telephone and television; and
  - Guest meals or gourmet menus.
30. Hypnosis.
31. Immunizations, except as specified.
32. Immunizations and vaccines, including the administration of these services, that are billed by a Pharmacy.
33. Incurred after you are no longer an Enrollee except as specified in the Benefits After Termination of Coverage section.
34. Inpatient care that:
  - Could have been performed on an Outpatient basis and when it was not Necessary for you to be an Inpatient to receive it; and
  - The primary purpose of which is diagnostic services, physical therapy or to provide an environmental change.
35. Maintenance Care.
36. Maintenance Care associated with providing a Person an environment free of alcohol or drugs.
37. Male Contraceptives and over-the-counter birth control for women without a prescription.
38. Medical supplies and equipment including:
  - Those that are for comfort and convenience or not primarily medical in nature such as exercycles, treadmills, bidet toilet seats, sauna baths, elevators and chair lifts;

- Those that are usually stocked in the home for general use such as elastic bandages, thermometers and corn and bunion pads;
  - Those that are disposable and for hygienic purposes;
  - Self-help devices, such as bed boards, bathtubs, overbed tables, adjustable beds and telephone arms;
  - Garter belts and corsets;
  - Corrective shoes that are not accompanying orthopedic braces;
  - Dentures that are not a Necessary part of a covered prosthesis;
  - Dental appliances;
  - Wigs and hairpieces for male pattern baldness (androgenetic alopecia) and other Conditions not specified as covered in this document.
39. Medical services and supplies including therapy and counseling services for the treatment of sexual problems, sexual inadequacies and dysfunctions including erectile dysfunction or impotence that do not have a physiological or organic basis. If there is a physiological or organic basis for treatment, the recommended course of treatment should be medically Necessary and follow evidence-based rationale.
40. Missed appointments, completion of claim forms or copies of medical records.
41. Noncovered services or services specifically excluded in the text of this document.
42. Nursing care that can be provided by, but does not require the education and training of, an R.N. or L.P.N.
43. Nutritional counseling for Conditions that have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.
44. Occupational therapy services when a Person suffers a temporary loss or reduction of function that is expected to improve on its own with increased normal activities.
45. Personal hygiene and convenience items.
46. Primal therapy, Rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, aquatherapy, vision perception training or carbon dioxide therapy.
47. Private duty nursing services that are provided by a nurse who usually lives in a Person's home or is a member of the Person's Immediate Family:
- Provided while a Person is confined in a facility other than a Hospital; and
  - To help a Person in the activities of daily living.
48. Reverse sterilization.
49. Routine physical exams, vision exams, dental exams, hearing exams or other preventive services and supplies except as provided for elsewhere in this document.
50. Services and supplies covered to any extent under any other part of this Plan or any other health care Plan of STRS Ohio.
51. Services and supplies not covered as routine physical examination are Charges:
- Covered to any extent under any other part of this Plan or under any other plan of STRS Ohio;
  - Required by a school, school system, camp or sporting entity;
  - Required by an insurance company to obtain insurance;
  - Required by a governmental agency, such as the FAA or DOT;
  - Given while a Person is confined in a Hospital or Other Facility Provider for Medical Care;
  - Not given by a Physician or under a Physician's direct supervision;
  - For medicines, drugs, appliances, equipment or supplies;
  - Related to psychiatric, psychological, personality or emotional testing or exams;
  - Related to employment; and
  - For premarital, vision, hearing or dental exams.
52. Services and supplies not performed within the scope of the Provider's license.
53. Services and supplies not prescribed by or performed by or under the direction of a Physician or Covered Provider.
54. Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
55. Services and supplies received from someone other than a Provider.

56. Services and supplies received in a military facility for a Condition related to military service.
57. Services and supplies that any school system is required to provide under any law.
58. Services and supplies that are not Necessary, as determined by Medical Mutual, for the diagnosis, care or treatment of the physical or mental Condition involved, even if they are prescribed, recommended or approved by the attending Physician or Dentist.
59. Services and supplies that, in the opinion of Medical Mutual or its authorized representative, are associated with injuries, illness or Conditions suffered due to the acts or omissions of a third party.
60. Services and treatment related to educational testing or training related to learning disabilities or developmental delays.
61. Service for which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except, as specified elsewhere in this Medical Plan Description or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled.
62. Services for which you have no legal obligation to pay in the absence of this or like coverage.
63. Skilled Nursing Facility Charges:
  - Once a Person is not expected to significantly improve from treatment for the current Condition unless Medical Mutual determines the services are Necessary;
  - For Maintenance Care that is not provided as part of Skilled Nursing Care or rehabilitation services; or
  - For the treatment of substance abuse, chronic brain syndrome, senility, intellectual disability or any other Mental Disorder.
64. Speech therapy except when prescribed therapy is expected to restore speech to a Person who has lost existing speech function as a result of a Condition or as provided elsewhere in this document.
65. Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form.
66. Telephone consultations or consultations via electronic mail, facsimile or internet/website, except as required by law, authorized by Medical Mutual, or as otherwise described in this Benefit Book.
67. To the extent that governmental units or their agencies make available or provide services or supplies that are:
  - Available, furnished, paid for, provided or required because of past or present service in the armed forces of a government; or
  - Available, furnished, paid for, provided or required under any law of a government, except a plan established by a government for its own employees or their dependents or Medicaid.
68. Transplant-related Charges:
  - Not furnished through a course of treatment that has been approved by Medical Mutual;
  - For other than a legally obtained human organ or tissue; or
  - For travel time and travel-related expenses of a Provider.
69. Transportation services except as provided for elsewhere in this document.
70. Treatment associated with teeth, dental X-rays, dentistry or any other dental processes, including:
  - Dental cleaning, in-mouth scaling, planing or scraping;
  - Filling, crown, denture or bridgework repair, replacement or restoration;
  - Myofunctional therapy;
  - Orthognathic (jaw) surgery; and
  - Tooth removal, repair, replacement, restoration or reposition when teeth are damaged or lost by biting or chewing except as specified.
71. Treatment of Conditions related to developmental delays, hyperkinetic syndromes, behavioral problems or intellectual disability, except as specified.
72. Treatment of mental illness that cannot be treated and services to treat a mental deficiency or retardation.
73. Treatment of the vertebral column unless related to a specific neuromusculoskeletal-related diagnosis.
74. Treatment with intraoral prosthetic devices, or by any other method, to alter vertical dimension.

## IMPORTANT PLAN PROVISIONS

*Unless otherwise noted, the information in this section applies to Persons enrolled in the Basic Plans and HCAP Plans administered by Medical Mutual.*

### Adjustment Rule

STRS Ohio has the right at any time to adjust the coverage available under the Plan. Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the Plan provisions, as adjusted. An enrollee does not have vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

### Non-Assignment

Medical Mutual will pay benefits directly to the In-Network Provider rendering services unless Benefit payments for In-Network Providers are paid directly to the Provider rendering service. You cannot assign your right to payment to any other person or to any Nonparticipating or Noncontracting Provider.

### Benefit Payment

Benefits will be paid promptly after the necessary written proof to support the claim is received. Most Providers will submit a claim for you. If you submit a claim yourself, use a claim form. In most cases, you can obtain a claim form from Medical Mutual or a Provider. Medical Mutual must receive a completed claim form with the correct information. If you need assistance completing your claim form, contact Medical Mutual. Medical Mutual may require nurse's notes or other medical records to determine whether benefits are available and in what amounts.

The Plan is not legally obligated to reimburse for Covered Medical Expenses unless written or electronically submitted proof that Covered Medical Expenses have been given to you is received.

Also, the Plan may pay up to \$1,000 of any benefit to any of your relatives who Medical Mutual believes are fairly entitled to the benefit. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

To have a payment or denial related to a claim reviewed, you must send a written request to Medical Mutual within six months of the claim determination.

### Your Financial Responsibilities

The Schedule of Coverage shows your and the Plan's financial responsibility for Covered Medical Expenses. You are responsible for paying the applicable monthly premium for your health care coverage. You are also responsible for paying the Deductible and Out-of-Pocket Maximums. The Deductible and Out-of-Pocket Maximums renew at the beginning of each calendar year. Some Providers can obtain a reasonable estimate of your Deductible and Coinsurance responsibilities from Medical Mutual and may require payment from you when providing their services.

If Medical Mutual has made payments up to the amounts of the benefit maximums indicated in the Schedule of Coverage, you are responsible for any charges (including Noncovered Charges, Excess Charges and Billed Charges), fees or costs for services, goods, supplies and related expenses that are in excess of the benefit maximums. Amounts paid by other parties do not accumulate toward benefit maximums. You are also financially responsible for all claims paid during any period of ineligibility.

For all Covered Medical Expenses, Medical Mutual will calculate your Deductible(s), Coinsurance and benefit maximum accumulation based on the Allowed Amount or Noncontracting Amount depending on the status of your Provider. Any charges exceeding the Allowed Amount will not apply toward the Deductible(s), Out-of-Pocket Maximum or benefit maximum accumulation.

Medical Mutual pays benefits for Covered Medical Expenses through agreements with In-Network, Contracting and Participating Providers based upon preset reimbursement amounts (the Negotiated Amount). When Covered Medical Expenses are rendered, the above Providers have agreed not to bill for any amount of Covered Medical Expenses above the Negotiated Amount, except for services and supplies for which the Plan has no financial responsibility because of a benefit maximum.

For Covered Medical Expenses rendered by Noncontracting and Nonparticipating Providers, you will be responsible for Excess Charges. You will also be responsible for the Out-of-Network Coinsurance for Covered Medical Expenses received from Out-of-Network Providers. The Out-of-Network Coinsurance continues until your Out-of-Network Out-of-Pocket Maximum is reached. Your Out-of-Pocket Maximum does not apply to Excess Charges. In other words, if you receive services from a Noncontracting or Nonparticipating Provider and you are balance billed, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

### **Annual Deductible**

Every calendar year, you must pay the dollar amount specified as the Deductible in the Schedule of Coverage before the Plan will provide benefits. The Deductible is the amount each Enrollee must pay before the Plan will provide benefits for Covered Medical Expenses. If a benefit is subject to a Deductible, only Covered Medical Expenses under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan records must show that you have incurred covered claims totaling the specified dollar amount. For this reason, it is important for you to submit copies of all your bills for Covered Medical Expenses. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which Medical Mutual receives and processes your claims. Also, if you are enrolled in a PPO plan, your Deductible accumulations for In-Network and Out-of-Network Care are not integrated. You cannot apply dollars accrued under your In-Network Deductible toward your Out-of-Network Deductible, or vice versa.

### **Out-of-Pocket Maximum for Medical Plans**

The amounts you pay toward your annual Deductible and the primary care office visits Copayments under the Basic Plan count toward the Out-of-Pocket Maximum. Deductibles, Copayments and Out-of-Pocket Maximums, as well as amounts paid by other parties, do not accumulate toward benefit maximums. Also, if you are enrolled in a PPO plan, your Out-of-Pocket Maximum accumulations for In-Network and Out-of-Network Care are not integrated. You cannot apply dollars accrued under your In-Network Out-of-Pocket Maximum toward your Out-of-Network Out-of-Pocket Maximum, or vice versa.

### **Basic Plans**

#### **Out-of-Pocket Maximum for an Enrollee**

##### **Indemnity Plan and PPO In-Network Care:**

When the amount a Person must pay in the Deductible, Coinsurance and primary care Physician Copayments for Covered Medical Expenses reaches \$6,500 in a calendar year, benefits will be payable at 100% of the Allowed Amount or Noncontracting Amount, as applicable, for all Covered Medical Expenses to which this limit applies for the rest of that calendar year.

##### **PPO Out-of-Network Care:**

When the amount a Person must pay in the Deductible and Coinsurance for Covered Medical Expenses reaches \$13,000 in a calendar year, benefits will be payable at 100% of the Allowed Amount or Noncontracting Amount, as applicable, for all Covered Medical Expenses to which this limit applies for the rest of that calendar year.

### **Health Care Assistance Program Plan (HCAP Plans)**

#### **Out-of-Pocket Maximum for an Enrollee**

##### **Indemnity Plan and PPO In-Network Care:**

When the amount a Person must pay in the Deductible and Coinsurance for Covered Medical Expenses reaches \$1,100 in a calendar year, benefits will be payable at 100% of the Allowed Amount or Noncontracting Amount, as applicable, for all Covered Medical Expenses to which this limit applies for the rest of that calendar year.

**PPO Out-of-Network Care:**

When the amount a Person must pay in the Deductible and Coinsurance for Covered Medical Expenses reaches \$3,300 in a calendar year, benefits will be payable at 100% of the Allowed Amount or Noncontracting Amount, as applicable, for all Covered Medical Expenses to which this limit applies for the rest of that calendar year.

**Lifetime Benefit**

This is the highest amount that will be paid under this Plan for any Person during his or her lifetime. The Lifetime Benefit is unlimited.

**Changes in Benefits or Provisions**

From time to time Medical Mutual may revise its coverage guidelines and those revisions may alter the nature of Covered Medical Expenses. If you or an Eligible Dependent are undergoing a course of treatment considered covered under previous guidelines, Medical Mutual will apply the guidelines that were in effect when the course of treatment began to ensure there is no decrease in your benefits.

**Foreign Travel**

When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered.

To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. Medical Mutual cannot process a claim unless the Provider lists separately the type and cost of each service you received. Medical Mutual will obtain the exchange rate for the date of service and reimburse you accordingly. Your benefit plan is in effect whether your treatment is received in a foreign country or in the United States. Only Covered Medical Expenses will be covered when received outside the United States.

If you are enrolled in a PPO and you travel to a foreign country and you receive treatment for an Emergency Condition, this Plan will pay benefits at the In-Network level. If the care rendered is not for an Emergency Condition, benefits will be paid at the Out-of-Network level. If you are enrolled for Medicare Parts A & B and you require medical treatment, this Plan will pay benefits as if you had no Medicare coverage.

**Monthly Premiums**

You are responsible for paying part or all of the cost of health care coverage through a monthly premium. Monthly premiums differ depending on your years of STRS Ohio service credit, your Medicare status, whether you have enrolled Eligible Dependents in the Plan and the Medicare status of these dependents. The State Teachers Retirement Board determines monthly premiums and may change the premiums periodically. For more information about monthly premiums, contact STRS Ohio.

**Coordination of Benefits**

Coordination of benefits is a process used to determine liability for the payment of health care expenses when an Eligible Beneficiary is covered by more than one health care plan. Medical Mutual follows coordination of benefit rules established by Ohio law that allow the plans providing coverage to decide which health care plan pays first and how much it must pay. The rules also determine if the other health care plan is required to pay and the amount that must be paid.

When you or your Eligible Dependents are covered by another group health care plan in addition to this one, you may not be able to collect benefits from both plans. Medical Mutual will follow Ohio coordination of benefits rules to determine which health care plan is primary and which is secondary. You must submit all bills first to the primary health care plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary health care plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary health care plan.

This Plan pays for health care only when you follow Medical Mutual's rules and procedures. If Medical Mutual's rules conflict with those of another health care plan, it may be impossible to receive benefits from both health care plans. You will be required to choose which health care plan to use.

If you or your Eligible Dependent is covered by a Medicare-contracted HMO on either an individual or group basis and elects to receive services that are not authorized by the HMO or that are Out-of-Network services, STRS Ohio benefits for such will be computed after estimated Medicare payments are taken into consideration.

### **Provision Enforcement**

Medical Mutual will coordinate benefits to the extent that Medical Mutual is informed by you or some other person or organization of your coverage under any other health care plan. Medical Mutual is not required to determine if and to what extent you are covered under any other health care plan.

To apply and enforce this provision or any similar provision of another health care plan, it is agreed that:

- Any Person claiming benefits described in this Medical Plan Description will furnish Medical Mutual with any information they may need; and
- Medical Mutual may, without the consent of or notice to any Person, release to or obtain from any source any necessary information.

### **Facility of Payment**

If payment is made under any other health care plan that Medical Mutual should have made under this provision, then Medical Mutual has the right to pay whomever is paid under the other health care plan. Medical Mutual will determine the necessary amount under this provision. Amounts paid are benefits covered under this Plan and Medical Mutual is discharged from liability to the extent of such amounts paid for Covered Medical Expenses.

### **Right of Recovery**

If the Plan pays more for Covered Medical Expenses than the applicable coordination of benefits rules require, Medical Mutual has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure Medical Mutual's right to recover the excess payment.

### **Plans That Do Not Coordinate Benefits**

This Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid;
- Group Hospital indemnity coverages which pay less than \$100 per day;
- School accident coverage; and
- Some supplemental sickness and accident policies.

### **How the Plan Pays as Primary**

When this Plan is primary, the Plan will pay the full benefit described in this Medical Plan Description as if you had no other coverage.

### **How the Plan Pays as Secondary**

When the Plan is secondary, its payments will be based on the balance left after the primary health care plan has paid. The Plan will pay no more than that balance. In no event will the Plan pay more than it would have paid had the benefit Plan been primary.

The Plan will pay only for health care services that are covered under this Medical Plan Description. The Plan will pay only if you have followed all of Medical Mutual's procedural requirements, including precertification.

The Plan will pay no more than Medical Mutual's Allowed Amount for the health care expenses involved. That amount may be less than the actual billed amount. Whether you will be responsible for the difference between the billed amount and Medical Mutual's Allowed Amount depends upon the contracting status of the Provider and the extent by which the



primary health care plan's payment covers your out-of-pocket expenses (i.e., your Deductible, Coinsurance and Copayment amounts).

If an In-Network Participating or Contracting Provider rendered services, the Provider will consider the primary payment plus Medical Mutual's secondary payment as "payment in full." You will not be responsible for the difference between Medical Mutual's Allowed Amount and the amount billed by the Provider.

If you obtain care from a Provider who does not have a contract with Medical Mutual, the Provider can bill you the difference between Medical Mutual's secondary payment and the amount billed.

Dollars paid by the primary health care plan are taken into consideration when calculating your out-of-pocket expenses. If the primary health care plan's payment exceeds the out-of-pocket expenses you would have incurred for a given claim (i.e., your Deductible, Coinsurance and Copayment amounts), the dollars paid by the primary health care plan offset the out-of-pocket expenses for which you would have otherwise been responsible. If the primary plan's payment is less than your out-of-pocket expenses calculated by Medical Mutual for the given claim, you will be responsible for the difference between the primary health care plan's payment and your out-of-pocket expenses.

### Which Health Care Plan Is Primary?

To decide which health care plan is primary, Medical Mutual has to consider both the coordination of benefits provision of the other health care plan and determine which member of your family is involved in a claim. The primary health care plan will be determined by the first of the following that applies:

- **Noncoordinating Plan** - If you have another group plan that does not coordinate benefits, it will always be primary.
- **Employee** - The plan that covers you as an active employee (neither laid off nor retired) is always primary.
- **Children (Parents Divorced or Separated)** - If a court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, Medical Mutual follows the birthday rule as explained under "Children and the Birthday Rule" below. If neither of those rules apply, the order will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.
- **Children and the Birthday Rule** - When your children's health care expenses are involved, Medical Mutual follows the "birthday rule." The health care plan of the parent with the first birthday in a calendar year is always primary for the children. For example: If your birthday is in January and your spouse's birthday is in March, your health care plan will be primary for all of your children. However, if your spouse's health care plan has a different coordination of benefits rule (for example, a "gender rule" that says the father's health care plan is always primary), Medical Mutual will follow the rules of that health care plan.
- **Longer or Shorter Length of Coverage** - The plan that covered you as an employee or retiree longer is the primary plan, and the plan that covered you the shorter period of time is the secondary plan.
- **Other Situations** - For situations not described above, the order of benefits will be determined in accordance with the Ohio Department of Insurance rule on coordination of benefits.

### Effect of Medicare

This section describes how medical expense coverage under this Plan varies depending on whether the Person is a Medicare beneficiary. For more information regarding how Medicare may affect coverage, see the Schedule of Coverage section for Enrollee With Medicare Parts A & B and Enrollee With Medicare Part B Only. Medical expense coverage under this Plan will be changed for any Person while eligible for Medicare.

A Person is considered a Medicare beneficiary when he or she is eligible for Medicare, regardless of whether he or she is covered under it, refused it, dropped it or failed to make proper request for it.

Enrollees with Medicare Parts A & B may use any Medicare-approved Covered Provider of services. Enrollees with Medicare Part B only (medical benefits) also may use any Medicare-approved Covered Provider. However, Enrollees who qualify for Medicare Part B only and who live in an In-Network Area must use In-Network Hospitals, Skilled Nursing or Hospice Facilities to receive maximum benefits. Enrollees who qualify for Medicare Part B only and who live outside an In-Network Area are not required to use In-Network Hospitals, Skilled Nursing or Hospice Facilities.

If you are currently enrolled in a Medical Mutual PPO plan, after you enroll in Medicare the deductible and out-of-pocket accumulations will carry forward if you remain enrolled with a Medical Mutual plan or change to the Aetna Medicare Plan (PPO).

## **Medicare Part A (hospitalization)**

Medicare Part A, known as hospital insurance, helps cover Inpatient care in Hospitals and Skilled Nursing Facilities. It also covers Hospice Care and some home health care. A Person is automatically eligible for coverage under Medicare Part A at age 65 if he or she is eligible to receive Social Security or Railroad Retirement benefits. In addition, there are other circumstances in which a Person can become eligible for Medicare Part A either before or after age 65. For example, a Person may be eligible for Part A through a spouse at age 62. If premium-free Medicare Part A is available and you do not enroll, you will no longer be eligible for STRS Ohio medical coverage. If you are eligible for Medicare before age 65, you are responsible for notifying STRS Ohio.

## **Medicare Part B (medical)**

Medicare Part B, also known as medical insurance, helps cover medically necessary physicians' services, outpatient hospital care and some other medical services that Medicare Part A does not cover, such as some of the services of physical and occupational therapists and some home health care. A Person must enroll in Medicare Part B to be eligible for STRS Ohio medical coverage. Whether or not he or she actually enrolls in Medicare Part B, claims for Covered Medical Expenses under this Plan will be processed as if he or she has Medicare Part B coverage. If you are eligible for Medicare before age 65, you are responsible for notifying STRS Ohio.

## **Plan Changes Relating to Medicare Parts A & B**

The following are changes in medical expense coverage when Medicare is involved:

- All medical expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the medical benefits of this Plan are figured;
- Charges used to satisfy a Person's Part B deductible under Medicare will be applied under this Plan in the order received by Medical Mutual. Two or more charges received at the same time will be applied starting with the largest first; and
- Any rule for coordinating other plan benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable expenses will be reduced by any Medicare benefits available for those expenses, regardless of whether you elect to enroll in Medicare.

### **Effect of Prior Coverage**

If the coverage of any Enrollee under any part of this Plan replaces any prior coverage in effect for the Enrollee, the rules apply to that part.

Prior coverage is any plan of group accident and health insurance that has been replaced by coverage under part or all of this Plan. It must have been sponsored by an employer that makes contributions to STRS Ohio. The replacement can be complete or in part for the eligible class to which you belong. Any such plan is considered prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any similar prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

### **Subrogation and Right of Recovery Provision**

#### **Definitions**

As used throughout this provision, the term "responsible party" means any party actually, possibly or potentially responsible for making any payment to a covered Person due to a covered Person's injury, illness or Condition. The term "responsible party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "insurance coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, any first-party insurance coverage and malpractice insurance.

For purposes of this provision, a "covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the Eligible Dependent of any Eligible Beneficiary or Person entitled to receive any benefits from the Plan and the estate of any Eligible Beneficiary or Person entitled to receive any benefits from the Plan.

### **Subrogation**

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a covered Person has against any responsible party with respect to any payment made by the responsible party to a covered Person due to a covered Person's injury, illness or Condition to the full extent of benefits provided or to be provided by the Plan.

### **Reimbursement**

In addition, if a covered Person receives any payment from any responsible party or insurance coverage as a result of an injury, illness or Condition, the Plan has the right to recover from, and be reimbursed by, the covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness or Condition, up to and including the full amount the covered Person receives from any responsible party.

### **Constructive Trust**

By accepting benefits (whether the payment of such benefits is made to the covered Person or made on behalf of the covered Person to any Provider) from the Plan, the covered Person agrees that if he or she receives any payment from any responsible party as a result of an injury, illness or Condition, he or she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the covered Person's fiduciary duty to the Plan.

### **Lien Rights**

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or Condition for which the responsible party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury or Condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the covered Person; the covered Person's representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

### **First Priority Claim**

By accepting benefits (whether the payment of such benefits is made to the covered Person or made on behalf of the covered Person to any Provider) from the Plan, the covered Person acknowledges that this Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered Person which is insufficient to make the covered Person whole or to compensate the covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered Person to pursue the covered Person's damage claim.

### **Applicability to All Settlements and Judgments**

The terms of this entire Subrogation and Right of Recovery Provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan shall recover the full amount of benefits paid hereunder without regard to any claim of fault on the part of the covered Person, whether under comparative negligence or otherwise. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages and/or general damages only.

### **Cooperation**

The covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered Person to notify the Plan within 30 calendar days of the date when any notice is given to any party, including an insurance company or attorney, of the covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or Condition sustained by the covered Person. The covered Person and his or her agents shall provide all information requested by the Plan, Medical Mutual or its representative including, but not limited

to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the covered Person or the institution of court proceedings against the covered Person.

The covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or Condition to identify any responsible party. The Plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

### **Severability**

If any one or more of the clauses contained in this Subrogation and Right of Recovery Provision is held to be invalid, illegal or unenforceable by any court of competent jurisdiction in any respect under any applicable law, the validity, legality and enforceability of the remaining provisions contained in this Subrogation and Right of Recovery Provision shall not in any way be affected or impaired. In the case of any determination of illegality, invalidity or unenforceability, the invalid, illegal or unenforceable clause shall be deemed enforceable to the fullest extent permitted by law and the parties shall use their best efforts to substitute a valid clause for the invalid clause.

### **Interpretation**

In the event that any claim is made that any part of this Subrogation and Right of Recovery Provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, Medical Mutual for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

### **Jurisdiction**

By accepting benefits (whether the payment of such benefits is made to the covered Person or made on behalf of the covered Person to any Provider) from the Plan, the covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

The Subrogation and Right of Recovery Provision shall be governed by and construed in accordance with the laws of the state of Ohio, without reference to its conflicts of laws provisions, and applicable federal law (including case law from state and federal courts with appropriate jurisdiction in Ohio).

### **Exclusion**

This Plan does not cover services and supplies, in the opinion of Medical Mutual or its authorized representative, that are associated with injuries, illness or Conditions suffered due to the acts or omissions of a third party.

## **Recovery of Overpayment**

If a benefit payment is made by Medical Mutual, to or on behalf of any Person, which exceeds the benefit amount such Person is entitled to receive in accordance with the terms of the Plan, this Plan has the right to:

- Require the return of the overpayment on request; or
- Reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that Person or another Person in his or her family.

STRS Ohio shall be entitled to recover the costs of any claims paid to an Enrollee if it is determined that the individual was not eligible for benefits at the time the claims were incurred, regardless of when the discovery is made.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

## Reporting Claims

A Person may submit any claim for Covered Medical Expenses to Medical Mutual if the Provider fails to do so. The claim must be submitted to Medical Mutual in writing and give proof of the nature and extent of the Medical Care involved. Please contact Medical Mutual for the required forms.

All claims should be reported promptly. No claim can be submitted later than two years after services have been received. The two-year period will not apply if Medical Mutual receives a coordinated claim for secondary coverage outside the two-year period, if the claim was submitted to the primary carrier within two years of the date of service.

Unless you are legally incapacitated, late claims will not be covered if they are filed more than two years after the deadline.

## Automatic Claims-Filing by Medicare (Medicare Crossover)

Automatic claims-filing, or Medicare crossover, is a process whereby Medicare Part B-covered claims are automatically filed by Medicare with Medical Mutual. Medicare crossover is available in all 50 states for Medical Mutual Enrollees.

Under the Medicare crossover process:

- Your Physician or supplier of services will file your claim with Medicare.
- Medicare will mail you a Medicare Summary Notice. Look carefully on this form for a message indicating that unpaid charges have been submitted to Medical Mutual.
- If the above message does not appear, you must submit to Medical Mutual a claim form, the original Medicare Summary Notice and a copy of itemized bills. (Keep copies of all these items for your records.) Please note that the first few claims your Provider files may not cross over until Medicare establishes your information in its system.

## Keeping Records of Expenses

Keep complete records of the expenses of each Person. They are required when a claim is made.

The names of Physicians and others who furnish services, dates expenses are incurred, and copies of all bills and receipts are very important.

## Explanation of Benefits

After Medical Mutual processes your claim, an explanation of benefits (EOB) will be provided to you. EOBs can also be viewed on Medical Mutual's website at [www.MedMutual.com](http://www.MedMutual.com). The EOB lists Covered Medical Expenses and Noncovered services along with explanations about why services are not covered. The EOB contains important information and a telephone number if you have any questions.

## Claim Review

### Consent to Release Medical Information - Denial of Coverage

You consent to the release of medical information to Medical Mutual and the Plan when you enroll and/or sign an Enrollment Form.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to Medical Mutual. Medical Mutual has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

## Right to Review Claims

When a claim is submitted, Medical Mutual will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. The fact that a Provider may recommend or prescribe treatment does not mean that it is automatically a Covered Service.

## Physical Examination

The Plan may require that you have one or more physical examinations at its expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services you have previously received and for which you have submitted claims. These examinations will not have any effect on your status as a Covered Person or your eligibility.

## Benefit Determination for Claims

### Urgent Care Claims

An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of **urgent** can be made by (a) an individual acting on behalf of the plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine or (b) any Physician with a knowledge of the claimant's medical Condition can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after Medical Mutual's receipt of the claim.

If you do not follow Medical Mutual's procedures or we do not receive all of the information necessary to make a benefit determination, Medical Mutual will notify you within 24 hours of receipt of the Urgent Care Claim and explain the applicable procedural deficiencies, or the specific deficiencies related to information necessary to make a benefit determination. You will have 48 hours to correct the procedural deficiencies and/or provide the requested information. Once Medical Mutual receives the requested information, we will notify you of the benefit determination as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the information.

Medical Mutual may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

### Concurrent Care Claims

A Concurrent Care Claim is any claim for ongoing treatment to be provided over a period of time or for a number of treatments, subject to Medical Mutual's approval. The decision is adverse if Medical Mutual decides to reduce or terminate benefits for the ongoing treatment (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with Medical Mutual's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Medical Mutual will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If Medical Mutual reduces or terminates a course of treatment before the end of the course previously approved, then the reduction or termination is considered an adverse benefit determination. Medical Mutual will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

### Pre-Service Claims

A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by Medical Mutual as a condition for payment of a benefit (either in whole or in part).

If you file a Pre-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 15 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

### **Post-Service Claims**

A Post-Service Claim is any claim that is not a Pre-Service Claim or an Urgent Care Claim. If you file a Post-Service Claim in accordance with Medical Mutual's claim procedures and all of the required information is received, Medical Mutual will notify you of its benefit determination within 30 days after receipt of the claim. Medical Mutual may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual. Medical Mutual will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

### **Benefit Determination Notices**

You will receive notice of a benefit determination, orally as allowed, or in writing, in a culturally and linguistically appropriate manner. All notices of a denial of a benefit will include the following:

- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount, if applicable;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of Medical Mutual's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under PHS Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the claim was denied based on Medical Necessity, Experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

## **Filing a Complaint**

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, you should have the following information available:

- name of patient
- identification number
- claim number(s) (if applicable)

- date(s) of service

If your complaint is regarding a claim, a Medical Mutual Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Group Contract, the Customer Service representative will telephone you with the response. If attempts to telephone you are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, you will receive a check, Explanation of Benefits or letter explaining the revised decision.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

## Filing an Appeal

**\* Please note: The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.**

If you are not satisfied with any of the following:

- a benefit determination;
- a Medical Necessity determination;
- a determination of your eligibility to participate in the plan or health insurance coverage; or
- a decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums)

then you may file an appeal.

To submit an appeal electronically, go to Medical Mutual's Web site, [www.MedMutual.com](http://www.MedMutual.com), under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card. You may also write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

Medical Mutual of Ohio  
Member Appeals Unit  
MZ: 01-4B-4809  
P.O. Box 94580  
Cleveland, Ohio 44101-4580  
FAX: (216) 687-7990

The request for review must come directly from the patient unless he/she is a minor or has appointed an authorized representative. You can choose another person to represent you during the appeal process, as long as Medical Mutual has a signed and dated statement from you authorizing the person to act on your behalf.

### **Mandatory Internal Appeal**

The Plan offers you a mandatory internal appeal. You must complete this mandatory internal appeal before any additional action is taken.

Mandatory internal appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described in the Filing an Appeal section above.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this plan. The internal appeal process is a review of your appeal by an appeals specialist, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment,



are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the medical condition and the treatment or service for which coverage is requested. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, Medical Mutual will provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, Medical Mutual considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of denial is issued. You will have an opportunity to respond before our time frame for issuing a notice of denial expires. Additionally, if Medical Mutual decides to issue a final denial based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires.

You will receive continued coverage pending the outcome of the appeals process. This means that Medical Mutual may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review.

The appeal procedures are as follows:

#### **Urgent Care Appeal**

- You, your authorized representative or your Provider may request an appeal for urgent care. The appeal does not need to be submitted in writing. You, your authorized representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment (1) could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided within 72 hours of the request. The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action. When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external review as described below.

#### **Pre-Service Claim Appeal**

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

#### **Post Service Claim Appeal**

- You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

All appeal denial notices will be culturally and linguistically appropriate and will include the following:

- the specific reason(s) for the denial;
- reference to the specific plan provision(s) on which the denial is based;
- sufficient information to identify the claim involved, including the date of services, the health care provider, and the claim amount (if applicable);
- statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits;

- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- notice of the availability of, and contact information for, an applicable office of consumer assistance established under PHS Act section 2793, if one is available;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity, Experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and
- a description of applicable appeal procedures.

If your claim is denied at the internal mandatory appeal level, then depending on the type of plan you have and the type of claim, there are two different voluntary review options available. You will be eligible for EITHER the External Review Process OR the Voluntary Internal Review Process. These two processes, and the eligibility requirements, are described below.

### **External Review Process**

Medical Mutual has established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within four months from your receipt of the notice of denial from the internal mandatory appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process;
3. You are or were covered under the plan at the time the service was requested or, in the case of retrospective review, were covered under the plan when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO). You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

Medical Mutual is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review.

### **External Review for Non-Urgent Care Claim Appeals**

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to Medical Mutual's Member Appeals Unit at the address listed above.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you ten business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either Plan or you. If the IRO reverses the adverse benefit determination, your Plan will provide coverage or payment for the claim.

### **Expedited External Review for Urgent Care Claim Appeals**

A request for an external review for Urgent or Expedited claims may be requested orally or electronically or in writing and should be addressed to Medical Mutual's Member Appeals Unit. You may request an external review for Urgent or Expedited claims at the same time you request an expedited internal appeal of your claim.

An expedited review may be requested if your Condition, without immediate medical attention, could result in any of the following:

1. seriously jeopardize your life or health or your ability to regain maximum function; or
2. in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within seventy-two hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either Plan or you. If the IRO reverses the adverse benefit determination, your Plan will provide coverage or payment for the claim.

### **Voluntary Internal Review Process**

Unless your Plan requires you to use an alternative dispute resolution procedure, if your internal mandatory appeal is denied, and your claim does not qualify for an external review, you have the option of a voluntary internal review by Medical Mutual. All requests for review may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the internal mandatory appeal.

The voluntary internal review may be requested at the conclusion of the internal mandatory appeal. The request for the voluntary internal review must be received by Medical Mutual within 60 days from the receipt of the internal mandatory appeal decision. Medical Mutual will complete its review of the voluntary internal review within 30 days from receipt of the request.

The voluntary internal review provides a full and fair review of the claim. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the internal mandatory appeal.

## **Termination of Coverage**

Coverage under this Plan terminates at the earliest occurrence of one of the following:

1. When coverage under the Plan of benefits discontinues.
2. When you cease to be an Eligible Beneficiary.
3. When you fail to pay a monthly premium within 30 days of the due date.

If your coverage ceases for any reason, contact STRS Ohio immediately to find out what rights you may have under this Plan.

You may terminate coverage under any STRS Ohio health care Plan referenced in this document at any time by calling STRS Ohio toll-free at 1-888-227-7877. Please note that if you terminate coverage there are limited opportunities to reenroll in a STRS Ohio health care Plan. Contact STRS Ohio to find out the opportunities to reenroll.

### **Dependent Coverage Only**

A dependent's coverage, including your spouse's, will terminate at the earliest occurrence of one of the following:

1. Discontinuance of all dependent coverage under the Plan of benefits.
2. When a dependent becomes covered as an Eligible Beneficiary.
3. When such Person ceases to meet this Plan's definition of an Eligible Dependent.
4. When Eligible Beneficiary coverage terminates.
5. When you fail to pay a monthly premium within 30 days of the due date.
6. Within 31 days from the day you notify STRS Ohio that coverage of a dependent is to terminate.

## **Continuation of Medical Expense Benefits After Termination**

If at the time this Plan discontinues, a Person is confined in a Hospital, nursing home, Skilled Nursing Facility, or institution devoted exclusively to the treatment of alcoholism or drug abuse, coverage will be available for Covered Medical Expenses directly related to such confinement during the first 31 consecutive days following termination of this Plan.

If this Plan discontinues during a pregnancy of a Person, any benefits provided in connection with such pregnancy will continue to be available, but only during the first 31 consecutive days following termination of this Plan.

## **Continuing Dependent Coverage Upon the Death of Eligible Beneficiary**

If you die while covered under any part of this Plan, any medical expense coverage then in force for your dependents may be continued subject to determination of continuing eligibility by STRS Ohio and subject to the ongoing offering of the Plan's continuation of coverage options, which are described in the next section of this booklet.

Any dependent's coverage, including your spouse's, will cease at the end of the month when any one of the following events occurs:

- Your spouse dies or remarries;
- A dependent ceases to meet the qualification of an Eligible Dependent;
- A dependent becomes an Eligible Beneficiary under this Plan;
- The Plan terminates coverage for the category under which the dependent qualified as an Eligible Dependent;
- Any required contributions stop.

If medical expense coverage is being continued for your dependents, your child born after your death will also be covered.

## **COBRA Continuation of Coverage Options**

In the event a covered spouse or covered dependent child loses coverage, they may be eligible for COBRA continuation coverage. For more information on your options, contact STRS Ohio.

## **Other General Provisions**

The following additional provisions apply to your coverage:

- If you or your Eligible Dependent is covered by a Medicare HMO on either an individual or group basis and elects to receive services that are not authorized by the HMO or that are Out-of-Network services, STRS Ohio benefits for such services will be computed after estimated Medicare payments are taken into consideration.
- If you are eligible for and enrolled in Medicare (Parts A & B or Part B only) and you obtain services from a non-Medicare Approved Physician, Hospital or Covered Provider, STRS Ohio benefits for such services will be computed after estimated Medicare payments are taken into consideration. You will be responsible for the difference between benefits paid by STRS Ohio and the Provider's billed charges.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.
- In the event Medical Mutual changes its clinical policy with respect to health care services and supplies, you and any enrolled dependents will not be denied coverage for those services or supplies given in connection with care or treatment that started before the change in Medical Mutual's clinical policy, if such change would result in a decrease in benefits with respect to that care or treatment.
- Your eligibility in the Plan or entitlement to receive certain benefits covered under the Plan will not be adversely affected by an administrative error or omission on the part of Medical Mutual or STRS Ohio.

- Medical Mutual will have the right and opportunity to have a Physician or Dentist of its choice examine any Person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.
- This document describes the main features of the Plan. If you have any questions about the terms of the Plan or about the proper payment of benefits, you may obtain more information from Medical Mutual.

# NOTICE OF PRIVACY PRACTICES

The following notice describes how medical information about you can be used and disclosed and how you can obtain access to this information. Please read it carefully. This privacy notice applies to Enrollees in STRS Ohio's self-funded health care plans and the self-funded prescription drug program (the "STRS Ohio Health Care Plan"). The STRS Ohio Health Care Plan (the "Plan") is required by law to maintain the privacy of protected health information and to provide individuals with notice of the Plan's legal duties and privacy practices with respect to protected health information and to abide by the terms of such notice currently in effect.

## **STRS Ohio's Philosophy on Member Privacy**

The State Teachers Retirement Board is committed to member service and privacy. As part of your participation in the STRS Ohio Health Care Plan, STRS Ohio and its business partners, whom we use to administer and deliver health care coverage, receive enrollee-protected health information through the operation and administration of the Plan. Protected health information means any information, transmitted or maintained in any form or medium, which the Plan creates or receives that relates to your physical or mental health, the delivery of health care services to you or payment for health care services and that identifies you or could be used to identify you. All protected health information and other Plan records are maintained in compliance with state and federal laws, as well as our own privacy policies. If you have questions or want further information about this notice, please mail them to the Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. The policies and procedures outlined in this notice became effective April 14, 2003.

## **How the STRS Ohio Health Care Plan Uses and Discloses Your Protected Health Information**

To provide your health coverage and administer the STRS Ohio Health Care Plan, the Plan needs some of your protected health information. In administering your health care and prescription drug coverage, the Plan may use and disclose your protected health information in the various ways described below. Not every possible use or disclosure in a category is listed; however, all of the ways the Plan is permitted to use and disclose information fall into one of these categories.

### **1. Uses and Disclosures of Your Protected Health Information for Payment, Health Care Operations and Administrative Matters**

The law permits the STRS Ohio Health Care Plan to use and disclose your protected health information without your authorization as follows:

- a. Treatment - To health care Providers who are involved in your care, for purposes such as verifying eligibility, Medicare status and Effective Date of coverage, in order to facilitate treatment and care. For example, the Plan may make disclosures to Physicians, nurses and other health care professionals involved in your care.
- b. To Obtain Payment - To STRS Ohio business partners that administer the STRS Ohio Health Care Plan, a governmental payer or other responsible third party for the purpose of billing or collecting payment for the medical treatment or prescription drugs you have received or to provide your health care Provider with necessary eligibility information. For example, the Plan may need to share your health information with a Provider to verify the delivery of services or items that you received so that the Plan's Claims Administrator can pay the Provider or reimburse you for the cost of the services or items.
- c. Health Care Operations - The STRS Ohio Health Care Plan may use and disclose protected health information for health care operations, which include, but are not limited to, use and disclosures: (1) by Plan health care representatives who disclose the minimum amount of protected health information to STRS Ohio personnel who need to know that information to administer the plan; (2) by Plan health care representatives who act as a liaison between the enrollee and various health plan administrators; (3) for quality assessment of the Plan through distribution and analysis of Enrollee satisfaction surveys; (4) in connection with the performance of disease management functions; and (5) for general administrative activities, including customer service, cost-management functions, data management, communications, claims and operational audits, and legal services. In addition, the Plan may send you information based on your own health information to tell you about possible treatment options or alternatives or other health-related benefits or services that may be of interest to you. The Plan may also combine your health information with that of other Enrollees in the Plan to evaluate the coverage provided by the Plan and to evaluate the quality of care the Plan Enrollees receive as a whole.

## 2. **Other Uses and Disclosures of Your Protected Health Information for Which Your Authorization Is Not Necessary**

In limited instances, the law allows the STRS Ohio Health Care Plan to use and disclose your protected health information without your authorization in the following situations:

- a. **Family** - The STRS Ohio Health Care Plan may disclose your protected health information to a family member who is directly involved with your medical care or with the payment related to your care. The Plan may request that your family members verify their own identity and otherwise demonstrate that they are acting on your behalf.
- b. **Disaster Relief Purposes** - For the limited circumstances of disaster relief efforts to a public or private disaster relief entity and for purposes of notifying your family of your Condition and location.
- c. **Required by Law** - For compliance with federal, state or local law, which disclosures will be limited to the minimum amount of information necessary to comply with applicable legal requirements.
- d. **Public Health Activities** - The STRS Ohio Health Care Plan may disclose protected health information about you for public health activities including activities related to preventing or controlling disease, or, when required by law, to notify public authorities concerning cases of abuse or neglect.
- e. **Victims of Abuse, Neglect or Domestic Violence** - To a government authority, including a social service or protective agency, if the STRS Ohio Health Care Plan reasonably believes you to be a victim of abuse, neglect or domestic violence.
- f. **Health Oversight Activities** - To a health oversight agency for oversight activities authorized by law, including claims and operational audits; civil, administrative or criminal investigations; inspections; or licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
- g. **Judicial and Administrative Proceedings** - If you are involved in a lawsuit or dispute, the STRS Ohio Health Care Plan may disclose protected health information about you in response to a court or administrative order. The STRS Ohio Health Care Plan may also disclose protected health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- h. **Law Enforcement Purposes** - If requested by a law enforcement official for limited law enforcement purposes. For instance, to identify or locate a suspect, fugitive, material witness or missing person.
- i. **Uses and Disclosures About Decedents** - To a coroner or medical examiner for the purpose of identifying a deceased Person, determining the cause of death or other duties as authorized by law. The STRS Ohio Health Care Plan may also release medical information to funeral directors as necessary to carry out their duties.
- j. **Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes** - To organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.
- k. **Uses and Disclosures to Avert a Serious Threat to Health or Safety** - The STRS Ohio Health Care Plan may use or disclose medical information about you if it reasonably believes, in good faith, that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person.
- l. **Specialized Government Functions** - For specialized government functions allowed by law, such as for national security and intelligence purposes.
- m. **Workers' Compensation** - For compliance with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries.
- n. **Business Associates** - The STRS Ohio Health Care Plan contracts with parties who provide services necessary for operation of the Plan. For example, the Plan is assisted in its operations by third-party administrators. These persons who assist the Plan are called business associates. At times, the Plan may disclose protected health information to its business associates so they can provide services to the Plan. The Plan will require that any business associates who receive protected health information safeguard the privacy of that information.
- o. **Military and Veterans** - If you are a member of the armed forces, the STRS Ohio Health Care Plan may release protected health information about you as required by military command authorities.

## 3. **Other Uses and Disclosures of Your Protected Health Information Requiring Your Written Authorization**

In all situations **other than those described previously**, we will ask for your written authorization before using or disclosing your protected health information. If you have given us authorization, you may revoke it in writing at any time, unless the STRS Ohio Health Care Plan has already disclosed the information.

#### 4. More Stringent Ohio Laws

Certain provisions of Ohio law may now, or in the future, impose greater restrictions on uses and/or disclosures of protected health information or otherwise be more stringent than federal rules protecting the privacy of protected health information. If such provisions of Ohio law apply to a use or disclosure of protected health information or under other circumstances described in this notice, the STRS Ohio Health Care Plan must comply with those provisions.

#### Your Legal Rights

Federal privacy regulations give Enrollees the right to make certain requests regarding their health information. You may ask the STRS Ohio Health Care Plan to:

- **Restrict the uses or disclosures of your protected health information to carry out payment, health care operations and administrative matters.** You also have the right to request a limit on your protected health information that the STRS Ohio Health Care Plan discloses about you to someone who is involved in your care, such as a family member or friend. For example, you could ask that the Plan not disclose or use information about a certain medical treatment you received. **IMPORTANT NOTE: The Plan is not required to agree to your request.** To request restrictions on the use or disclosure of your protected health information, mail your request to: Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. In your request, please provide: (1) what protected health information you want to limit; (2) whether you want to limit the STRS Ohio Health Care Plan's use, disclosure or both; and (3) to whom you want the disclosure limits to apply (for example, your spouse).
- **Communicate with you about your protected health information in a certain way or at a certain location.** For example, you can ask that the STRS Ohio Health Care Plan contact you only at a certain phone number or mailing address. To request confidential communications, mail your request to: Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. The Plan will accommodate all reasonable requests. Your request must specify how or where you would like to be contacted. After STRS Ohio receives your request, the information may be forwarded to third-party administrators of the Plan. As a result, additional reasonable information may be required from you by the third-party administrator to process your request.
- **Inspect and copy your protected health information that may be used to make decisions about payment and your care.** To inspect and copy your protected health information, mail your request to: Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. If you request a copy of the information, STRS Ohio may charge a reasonable fee for the costs of preparing a summary or explanation of your protected health information or for the costs of copying, mailing or other supplies associated with your request. If you agree in advance, the STRS Ohio Health Care Plan may instead provide you with a summary or explanation of your protected health information. Under Ohio and federal law, STRS Ohio may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your protected health information, in many instances you may request that the denial be reviewed.
- **Request an amendment to your protected health information if you think the information is incomplete or incorrect for as long as the information is maintained by the STRS Ohio Health Care Plan.** To request an amendment, mail your request to: Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. If the Plan rejects your amendment for any reason allowable under state or federal law, STRS Ohio will permit you to submit a written statement of disagreement to be kept with your protected health information. The Plan may reasonably limit the length of such statement of disagreement.
- **Provide a listing of any disclosures of your protected health information in the six years prior to the date on which the listing is requested.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures of protected health information the STRS Ohio Health Care Plan has made about you. The Plan is not required to account for certain disclosures such as those made for the purposes of treatment, payment or health care operations, pursuant to a prior authorization by you or for certain law enforcement purposes. You may obtain a list or accounting of disclosures of protected health information by submitting a written request to the STRS Ohio Health Care Plan's Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. Your request must state the time period for which you desire the accounting, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should also specify the format of response you prefer (i.e., on paper or electronically). The first list of disclosures you request within a 12-month period is free. For additional lists within the same 12-month period, the Plan may charge you for the costs of providing the list. The Plan will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.



### **This Notice Is Subject to Change**

The STRS Ohio Health Care Plan may change the terms of this notice and its privacy practices at any time. If such a change is made, the new terms and policies will be effective for all of the information that the Plan already has about you as well as any information that it may receive or hold in the future. STRS Ohio will post a copy of the current notice on its website at [www.strsoh.org](http://www.strsoh.org) and at the office located at 275 E. Broad St., Columbus, OH 43215-3771. You may request a paper copy of this notice by calling the STRS Ohio Member Services Center toll-free at 1-888-227-7877. Please note that STRS Ohio does not destroy your protected health information when you terminate coverage with the STRS Ohio Health Care Plan. It may be necessary to use and disclose this information for the purposes described in this document even after your coverage terminates, although policies and procedures will remain in place to protect you against inappropriate use or disclosure.

### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the STRS Ohio Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the STRS Ohio Health Care Plan, mail your comments to: Privacy Officer, STRS Ohio, 275 E. Broad St., Columbus, OH 43215-3771. To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact the Office of Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601; (312) 886-2359; [www.hhs.gov/ocr](http://www.hhs.gov/ocr). **You will not be penalized in any way for filing a complaint.**

# 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 أذكر 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 nínizín: Díí saad bee yánílti' go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kojí' 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).

**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](mailto: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](http://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:  
(800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:  
[hhs.gov/ocr/office/file/index.html](http://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 Consumers Life Insurance Company.

