EFFECTIVE JAN. 1, 2024

STRS OHIO HEALTH CARE
Program Guide

STRS OHIO HealthCare PROGRAM

Who to Contact

WEBSITE	MAILING ADDRESS	CUSTOMER SERVICE (EASTERN TIME)
Aetna Basic Plan		
www.aetnaresource.com/p/strs-commercial-plan-microsite	Claims Address: Aetna P.O. Box 981106 El Paso, Texas 79998-1106	800-645-5677 (toll-free) Hours: Weekdays, 8 a.m.–6 p.m.
Aetna Medicare Plan		
strs.aetnamedicare.com	Claims Address: Aetna P.O. Box 981106 El Paso, TX 79998-1106	833-383-4612 (toll-free) Hours: Weekdays, 8 a.m.–9 p.m.
CVS Caremark (CVS)		
www.caremark.com	Claims Address: CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136	800-756-6841 (toll-free) Hours: 7 days a week, 24 hours a day
Medicare		
www.medicare.gov		800-633-4227 (toll-free) Hours: 7 days a week, 24 hours a day
SilverScript *CVS affiliate for Medicare Part D plan enrollees*		
www.caremark.com	Claims Address: Claims Processing P.O. Box 52066 Phoenix, AZ 85072-2066	800-756-6859 (toll-free) Hours: 7 days a week, 24 hours a day
Social Security Administration		
www.ssa.gov		800-772-1213 (toll-free) Hours: Weekdays, 7 a.m.–7 p.m.
STRS Ohio		
www.strsoh.org	Mailing Address: Health Care Services Department 275 E. Broad St. Columbus, OH 43215-3771	888-227-7877 (toll-free) Hours: Weekdays, 8 a.m.–5 p.m.

Welcome

Thank you for your interest in the STRS Ohio Health Care Program. We recognize access to quality health insurance in retirement is important. This is why STRS Ohio's medical plans include hospital, medical and prescription coverage. Separate dental and vision insurance is also available.

Coverage is currently offered to eligible benefit recipients who participate in the Defined Benefit Plan or Combined Plan. Members who retire on or after Aug. 1, 2023, need at least 20 years of total service to participate in the STRS Ohio Health Care Program. At least 15 or more years of total service is required for members who retired before Aug. 1, 2023. Eligible dependents may enroll in a plan if the benefit recipient is enrolled.

STRS Ohio currently makes medical plan premiums less expensive for eligible service retirement and disability benefit recipients by subsidizing a portion of the monthly premium costs. Once you enroll in a plan, monthly premiums will be deducted from your STRS Ohio benefit payment.

The plans available to you depend on your Medicare status on file with STRS Ohio and Medicare. STRS Ohio requires all medical plan participants to be enrolled in Medicare Parts A & B at age 65 or when eligible. Medicare Part B is required for all enrollees. Medicare Part A is also required if it is available to you at no cost (premium free).

To find out the plans available to you, review the personalized list of plan options you may have received with this guide. If you do not have a personalized list, please register for an STRS Ohio Online Personal Account or call STRS Ohio.

If you have questions after reviewing this guide, please contact STRS Ohio. To stay up to date on health care program news throughout the year, sign up for STRS Ohio's email news service by sending us an email (go to www.strsoh.org and select "Contact" from the top menu).

STRS Ohio Member Services Center.....888-227-7877
STRS Ohio website..... www.strsoh.org
STRS Ohio email.....Go to www.strsoh.org and select "Contact" from top menu

The STRS Ohio Health Care Program is authorized by Chapter 3307 of the Revised Code, which may be amended at any time by the Ohio General Assembly. Furthermore, coverage under the program may be modified or eliminated at any time by the State Teachers Retirement Board. Health care coverage is not guaranteed. STRS Ohio may change or discontinue all or part of the program 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 at any time.

This guide is an overview of the STRS Ohio Health Care Program. It is not a legal document. Your plan will send you a comprehensive description of your coverage after enrollment is confirmed.

What's Inside

Section 1: Eligibility and Enrollment

Eligibility Requirements

MEDICARE COVERAGE

Individuals who are eligible for Medicare must have Medicare coverage to qualify for an STRS Ohio plan. STRS Ohio requires all medical plan participants to be enrolled in Medicare Parts A & B at age 65 or when eligible. Medicare Part B is required for all enrollees. Medicare Part A is also required if it is available to you at no cost (premium free). If you decline Medicare Part B or premium-free Part A, you will no longer be eligible for STRS Ohio medical coverage. See Section 4 for details.

U.S. RESIDENCY

To be eligible and remain eligible for coverage, the individual must reside physically in the United States with a permanent residence in one of the U.S. 50 states or U.S. territories.

BENEFIT RECIPIENTS

Service Retirement

A Defined Benefit Plan or Combined Plan member is eligible for coverage based on years of total service credit. A member who retires:

- **On or after Aug. 1, 2023,** must have 20 or more years of total service credit.
- **Jan. 1, 2004, through July 1, 2023,** must have 15 or more years of total service credit.
- **Before Jan. 1, 2004,** does not have a minimum service credit requirement.

Disability

A disability recipient is eligible for coverage.

A recipient who later applies for service retirement:

- **On or after Aug. 1, 2023,** must have 20 or more years of total service credit.
- **Jan. 1, 2004, through July 1, 2023,** must have 15 or more years of total service credit.
- **Before Jan. 1, 2004,** a recipient with no break in benefits between the disability benefit and service retirement benefit has no minimum service credit requirement.

EMPLOYED NON-MEDICARE ENROLLEES

STRS Ohio medical coverage for employed individuals not eligible for Medicare is limited to secondary coverage under STRS Ohio's Aetna Basic Plan when they: (1) are eligible for medical and prescription coverage through their employer, or (2) hold a position for which other similarly situated employees are eligible for medical and prescription coverage.

STRS Ohio requires non-Medicare enrollees to verify their employment status and access to employer health coverage. If you are employed and not eligible for Medicare, it is your responsibility to provide verification through your STRS Ohio Online Personal Account. If you prefer to opt out of secondary coverage by canceling your STRS Ohio plan enrollment, contact STRS Ohio.

ELIGIBLE DEPENDENTS

Once the benefit recipient enrolls, a spouse, child and/or disabled adult child may be eligible for coverage. You must notify STRS Ohio when a dependent no longer meets eligibility requirements and indicate the day, month and year your dependent is no longer eligible. Premium deductions from your monthly STRS Ohio benefit payment do not guarantee coverage if your dependent no longer meets eligibility requirements.

Spouse

A person who is married to a service retirement/disability benefit recipient; or a person who was married to a member or service retirement/disability benefit recipient at the time of the member's or benefit recipient's death.

Child

A child of a service retirement/disability benefit recipient or member who is under age 26 and is a biological child, legally adopted child/stepchild or child for whom the benefit recipient or member has been legally appointed as guardian.

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
- Continuously 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 continuously physically or mentally incompetent and continuously unable to earn a living where both conditions occurred prior to age 22.

BENEFICIARIES AND SURVIVORS

Beneficiaries of Service Retirement Benefit Recipients (Survivor Annuitants)

A spouse, child or disabled adult child receiving benefits under a Joint and Survivor Annuity or Annuity Certain plan of payment who was an eligible dependent of the service retirement benefit recipient at the time of the benefit recipient's death. The service retirement benefit recipient must have been eligible for coverage at the time of death for a beneficiary to qualify for coverage. (See "Benefit Recipients" on Page 3 for eligibility criteria.)

Survivors of Active Members or Disability Benefit Recipients (Survivor Benefit Recipients)

A spouse, child or disabled adult child who is granted survivor benefits under division (C)(2) of Section 3307.66, Revised Code, and who was an eligible dependent at the time of the active member's or disability benefit recipient's death. Based on the type of survivor benefit selected, the following minimum years of total service credit may be required: 20 years if the effective date of survivor benefits is on or after Aug. 1, 2023, or 15 years if the effective date of survivor benefits was Jan. 1, 2004, through July 1, 2023.

Premium Subsidy and Financial Assistance

PREMIUM SUBSIDY FOR BENEFIT RECIPIENTS

STRS Ohio currently makes medical plan premiums less expensive for eligible service retirement and disability benefit recipients by subsidizing a portion of the monthly premium costs. Covered dependents do not receive a premium subsidy.

Benefit recipients who participate in the Defined Benefit Plan or Combined Plan are eligible for a premium subsidy based on years of total service credit. To qualify for a premium subsidy:

- Benefit recipients who retire **on or after Aug. 1, 2023,** must have 20 or more years of total service credit.
- Benefit recipients who retired **before Aug. 1, 2023,** must have 15 or more years of total service credit.

HEALTH CARE ASSISTANCE PROGRAM

The Health Care Assistance Program (HCAP) is designed to provide qualified benefit recipients with financial assistance to help 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 years of total service credit, and
- Disability benefit recipients receiving STRS Ohio benefits.

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 Aetna Basic Health Care Assistance Plan or the Aetna Medicare Plan. Medicare-eligible participants must maintain their Medicare 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 175% of the current year's federal poverty level for a family of two; **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 175% of the current year's federal poverty level for a family of two. (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 your 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.

How STRS Ohio Health Care Is Funded

The laws that govern STRS Ohio do not guarantee nor fund health care. In 1983, the State Teachers Retirement Board established the Health Care Fund to help support the health care program. Funding comes from: premiums paid by enrollees in the health care program, annually determined employer contributions (currently 0%), investment earnings on the Health Care Fund, federal subsidies and pharmaceutical reimbursements for prescription drugs.

Enrolling as a New Benefit Recipient

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 indicate you want to enroll, health care information will be mailed to you after your benefit application has been processed.

Review the coverage available to you and the monthly premiums charged for coverage. If you did not previously select a plan on your application, you must call STRS Ohio to select your plan. If you do not specify a plan or submit required Medicare information, you will be enrolled in the Aetna Basic Plan.

The date health care coverage begins for you and your eligible dependents will be determined as follows:

- **Service retirement recipients** — For recipients electing 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 electing 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.
- **Beneficiaries of service retirement benefit recipients (survivor annuitants)** — For recipients who were 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.
- **Survivors of active members or disability benefit recipients (survivor benefit 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.

Determining your effective date of coverage

Be sure to verify the date your employer-sponsored coverage will end. Knowing this information will help you determine an accurate start date of STRS Ohio coverage. Keep in mind:

- The effective date of STRS Ohio coverage cannot be changed after premium deductions and coverage have begun.
- The health care coverage you had through your employer is separate from your STRS Ohio coverage. Any amounts you have accumulated toward an annual deductible or out-of-pocket maximum do not transfer to your STRS Ohio plan from your employer plan.

Paying your monthly premium

Your monthly premium for coverage will be deducted from your STRS Ohio benefit payment. If your monthly premium exceeds your benefit payment, the remainder of your premium must be paid in full through the establishment of a direct debit account with your financial institution and STRS Ohio. (A direct debit account allows premium payments to be automatically withdrawn from your checking or savings account.) If payment is not received by the first business day of the month the premium is due, your coverage may be canceled.

Enrolling After Monthly Benefits Begin

Qualifying Events

Eligible benefit recipients and their eligible dependents may request enrollment if they believe they have experienced a qualifying event. An enrollment application is required and must be received within 31 days of the qualifying event.

Each individual requesting enrollment must meet the requirements of a qualifying event listed below. Eligible dependents experiencing a qualifying event may request enrollment when the benefit recipient is already enrolled or is also requesting enrollment.

- **Medicare enrollment** — An eligible individual may enroll upon initial eligibility for and enrollment in Medicare Parts A & B or Part B-only (when you are not eligible for premium-free Part A). Coverage will be effective the first of the month Medicare coverage begins. Proof of Medicare enrollment is required.
- **Loss of other coverage** — An eligible individual may enroll upon loss of other creditable coverage. This includes an individual moving to a permanent U.S. residence from a foreign country. Coverage becomes effective the first of the month in which other coverage is lost. A letter is required from your employer or plan administrator listing the types of coverage lost (medical, dental and/or vision), names of each individual losing coverage and dates of termination.
- **Marriage** — Service retirement or disability recipients may enroll a spouse upon marriage. Coverage will be effective the first of the month following the date of marriage. If the marriage occurs on the first of the month, coverage is effective on that date. A copy of the marriage certificate is required.

- **Birth, legal adoption or legal guardianship** — Benefit recipients may enroll an eligible child for coverage beginning the first of the month of the date of birth, legal adoption or legal guardianship. A copy of the birth certificate or adoption or guardianship papers is required.

Open Enrollment

An eligible individual may enroll during open enrollment without a qualifying event. Open enrollment is offered in November each year for medical plans and once every two years for dental and vision plans. Online enrollment applications are accepted Nov. 1 through the Tuesday before Thanksgiving. Coverage will begin Jan. 1 following open enrollment.

Coverage Considerations

CHANGES IN ELIGIBILITY

Eligible dependents

Notify STRS Ohio by phone or in writing before the end of the month when an enrolled dependent no longer meets eligibility requirements. Please indicate the date your dependent is no longer eligible. **Note:** If your dependent is enrolled in the Aetna Medicare Plan and you notify us at the end of the month, your cancellation request may not be fulfilled until the end of the following month due to insufficient time to relay the request to Aetna and Medicare under their termination requirements. STRS Ohio must receive all cancellation requests by the **15th of the month** to stop the next month's premium deduction from your STRS Ohio benefit payment. Premium deductions from your monthly benefit payment do not guarantee coverage if your dependent no longer meets eligibility requirements.

Employed non-Medicare enrollees

You must notify STRS Ohio if you are employed in a public or private position. Coverage under the STRS Ohio Health Care Program is limited for employed enrollees who are ***not*** eligible for Medicare. See Page 4 for additional information.

Moving to a new residence

If you are moving, call STRS Ohio as soon as you know your new address. STRS Ohio will inform you if your medical plan options will change as a result of your new address. Keep in mind, coverage is not available if you move outside of the United States or its territories.

FOREIGN TRAVEL

Coverage outside the United States is limited. Before traveling to a foreign country, check with Aetna and CVS to learn how your coverage will be affected while you are abroad.

COVERAGE UNDER MORE THAN ONE STRS OHIO ACCOUNT OR RETIREMENT SYSTEM

If you are eligible for health care coverage under more than one STRS Ohio account, you are limited to coverage under only one account. Additionally, if you are eligible for health care coverage through more than one Ohio public retirement system, guidelines determine which system is responsible for your coverage. Contact STRS Ohio for details.

CHANGING PLANS AFTER ENROLLMENT

Once you enroll in an STRS Ohio medical plan, you will remain in the plan you select for the calendar year, unless you experience one of the following events.

The events listed below allow enrollees to change plans during the calendar year. This means enrollees can switch to another STRS Ohio medical plan for which they are eligible. Plan changes may apply to both the benefit recipient and any covered dependents.

- Enrollee experiences one of the following events and requests to change plans within 31 days of the event: (1) marriage, divorce, dissolution or legal separation; (2) birth, adoption or legal guardianship of a child; (3) death; or (4) full loss of premium subsidy.
- Enrollee becomes eligible for and enrolls in Medicare Parts A & B or Part B-only (when you are not eligible for premium-free Part A). Enrollee must request to change plans within three months following the effective date of Medicare. **Note:** After Medicare enrollment is confirmed, Aetna Basic Plan participants will be enrolled in the Aetna Medicare Plan. If you do not want the Aetna Medicare Plan, you must notify STRS Ohio.
- Enrollee is a new retiree. The new enrollee must request to change plans within 31 days of receiving the first monthly benefit payment.
- An enrollee permanently moves to another service area, which results in different plan options being available.
- An Aetna Medicare Plan enrollee may cancel coverage at the end of any month and select the Aetna Basic Plan. The request must be received by the 15th of the month to take effect the first of the following month.

Note: *If you experience one of the events listed above during the calendar year and choose to change plans, your medical annual deductible and out-of-pocket maximums will transfer to the new plan.*

CANCELING COVERAGE

Canceling coverage at any time

You may cancel your or your dependent's STRS Ohio medical coverage at any time through your STRS Ohio Online Personal Account. All cancellation requests must be received by the 15th of the month to stop the next month's premium deduction from your STRS Ohio benefit payment. Please note, there are limited opportunities to reenroll in an STRS Ohio plan after you cancel coverage. See Page 6 for details.

Canceling your dependent's coverage due to loss of eligibility

- **Spouse** — In the event of a divorce, your spouse's coverage ends the first of the month following finalization of the divorce. The cancellation request must be received by the 15th of the month to stop the next month's premium deduction from your STRS Ohio benefit payment. Retroactive cancellations are not permitted. It is the benefit recipient's responsibility to notify STRS Ohio when a divorce is finalized. Your spouse may be eligible for COBRA continuation coverage. Contact STRS Ohio for more information.
- **Child** — In the event a covered child loses access to STRS Ohio coverage because a parent dies, parents become divorced or the child stops being eligible for coverage, the child may be eligible for COBRA continuation coverage. Contact STRS Ohio for more information.
- **After death of benefit recipient (Single Life Annuity)** — If you selected a Single Life Annuity at the time of retirement and have dependents enrolled in an STRS Ohio plan at the time of your death, dependent coverage may be discontinued at the end of the month in which your death occurred. Your dependents may be eligible for COBRA continuation coverage. Contact STRS Ohio for more information.

Section 2: Understanding Your Plan Options

STRS Ohio's medical plans include hospital, medical and prescription coverage. Separate dental and vision insurance is also available. Please contact STRS Ohio if you are interested in supplemental dental and vision coverage.

Which Plans Are Available to You?

To find out the plans available to you, review the personalized letter you may have received with this guide. You can also view your plan options in your STRS Ohio Online Personal Account. If you do not have an account, visit www.strsoh.org and click "Register" at the top of the home page.

Your plan options are determined by your Medicare status on file with STRS Ohio. If your most recent eligibility is not on file, your plan options may differ from those listed in your letter or your Online Personal Account.

- Plan options for Medicare enrollees are the Aetna Medicare Plan and Aetna Basic Plan. The Aetna Medicare Plan has lower premiums and out-of-pocket costs than the Aetna Basic Plan.
- The only plan option for non-Medicare enrollees is the Aetna Basic Plan.

Keep in mind, prescription coverage is included in STRS Ohio's medical plans. This means you do not need to purchase additional prescription coverage.

Plan Features to Consider

Features to consider when selecting your plan include:

- **Services** — Look at the services offered by each plan. Are any services limited or not covered? Is there a good match between what is provided and what you think you will need?
- **Choice** — Which doctors, hospitals and other medical providers can you use? Do you need approval from the plan before going into the hospital or getting specialty care?
- **Location** — Where will you go for care? Are these places conveniently located? How does the plan cover services when you're away from home?
- **Costs** — How much will you pay for your monthly premiums, including Medicare Part B (if applicable) and other out-of-pocket expenses? If a plan does not cover certain services, how much will you have to pay? Although you may not know in advance what your health care needs will be for the coming year, you can think about the services you or your family might need. This will help you estimate what your total costs might be for services under each plan.

Prescription Coverage

Prescription coverage administered by CVS Caremark (CVS) is included with STRS Ohio's medical plans. Enrollees with Medicare are covered by SilverScript, a Medicare Part D plan. SilverScript is an affiliate of CVS. Non-Medicare enrollees are covered by CVS Caremark.

The deductible, copayments/coinsurance and maximum annual expense are the same for both plans. Other coverage features may vary. See Page 12 for more information.

You can purchase covered prescription medications for a copayment/coinsurance through CVS network retail pharmacies or the CVS Mail Service Pharmacy. CVS offers a broad retail network of chain and independent pharmacies including CVS pharmacies. You can use any network pharmacy; you are not limited to CVS store locations.

Key Terms to Understand

When reviewing plans, it's important to understand the following terms:

- **Allowed/noncontracting provider amounts** — The predetermined amount a plan will pay a provider for covered medically necessary services as established by the plan administrator. This amount may also be referred to as eligible expense, payment allowance or negotiated rate. If your provider is noncontracted and charges more than the plan's allowed amount, you may be responsible for paying the difference.
- **Annual deductible** — For medical plans, this is the amount you must pay before the plan pays a portion of your hospital/medical costs. **There is a separate annual deductible for prescription drugs.** For prescription coverage, this is the amount you must pay for covered brand-name drugs before the plan begins paying a portion of the costs for these drugs. Generic drug costs are not subject to nor applied to the deductible.
- **Coinsurance** — The percentage of covered charges you must pay after you have met your annual deductible, such as 20% for a specialist physician office visit.
- **Copayment** — The amount you pay for a specific service, such as $20 for a primary care physician office visit or $10 for generic drugs at retail.
- **Indemnity** — "Traditional" health care coverage in which reimbursement is made either to you or directly to your provider, up to an allowed dollar amount or coverage limit determined by the plan administrator. You are responsible for any charges exceeding this amount or limit. As an enrollee, you can use any health care provider.
- **Mail Service Pharmacy** — The CVS Caremark mail-order pharmacy that fills prescriptions for a copayment/coinsurance.
- **Maximum out-of-pocket limit** — This is the maximum annual amount you will pay for prescription drugs. Once the maximum out-of-pocket limit is met, you pay nothing for covered drugs for the remainder of the year.
- **Medicare Advantage** — A health care plan approved by Medicare in which the federal government reimburses a private company to provide the enrollee with basic Medicare coverage and other services. These plans are sometimes referred to as "Medicare Part C plans" or "MA plans." A Medicare Advantage plan covers all the services that Medicare Parts A & B cover and may provide additional coverage for services not typically covered by Medicare, such as preventive services, and vision and hearing services. When you enroll in a Medicare Advantage plan, your Medicare Parts A & B benefits are assumed by the Medicare Advantage plan. STRS Ohio's Aetna Medicare Plan is a Medicare Advantage plan. You must remain enrolled in Medicare Part B and pay your monthly Part B premium to Medicare when enrolled in this plan.
- **Monthly premium** — The amount you pay monthly for coverage under the plan. This amount must be paid even if you don't use any of the services.
- **Out-of-pocket maximum** — The amount you must pay in a calendar year before the medical plan pays 100% of remaining expenses for covered hospital/medical services that year. This amount does not include prescription coverage costs and any charges exceeding allowed/noncontracting provider amounts set by the plan administrator, unless otherwise noted.

- **Preferred Provider Organization (PPO)** — A group of selected health care providers who have agreed to offer comprehensive services at contractually determined reimbursement levels. These providers — including physicians, hospitals and other health care providers — are referred to as "in-network" providers. As an enrollee, you can use out-of-network providers, but your out-of-pocket expenses will be higher.
- **Telemedicine** — The remote diagnosis and treatment of patients by means of telecommunications technology.
- **Tier 1: Generic** — Generic medications available for the lowest copayment and not subject to the deductible.
- **Tier 2: Preferred Brand** — Brand-name medications available for a copayment after the deductible is met.
- **Tier 3: Non-Preferred Drug** — Medications available for a copayment after the deductible is met. These medications have a higher copayment than Tier 2 drugs.
- **Tier 4: Specialty (High Cost)** — Specialty medications available for the lesser of 8% of the cost or the maximum cost based on days' supply after the deductible is met. These high-cost medications typically include infused, injectable and oral drugs that are used to treat chronic and life-threatening diseases; are often difficult to administer; may cause adverse reactions; may require temperature control or other special handling; and/or may have restrictions as determined by the Food and Drug Administration.
- **U.S. Preventive Services Task Force** — An independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

Section 3: Plans and Premiums

Please review this section for the coverage features and premiums of the plans for Medicare and non-Medicare enrollees. Plan options and premiums are based on Medicare status.

Prescription Plan Features for 2024	SilverScript (Medicare) CVS Caremark (Non-Medicare)	
Annual Brand-Name Deductible per Enrollee (Generic drug costs are not subject to nor applied to the deductible.)	$275 for covered brand-name drugs	
Network Retail/Long-Term Care Pharmacy 31-day Supply (If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)	**Tier 1: Generic** — $10 **Tier 2: Preferred Brand** — $30 (after deductible) **Tier 3: Non-Preferred Drug** — $75 (after deductible for brand-name drugs) **Tier 4: Specialty (High Cost)** — After deductible, lesser of 8% of the cost **or** $450 for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days*	You can receive a 90-day supply at any CVS Pharmacy, Longs Drugs or Navarro Discount Pharmacy for the same price as mail service. Low-Cost Generic Drug Program medications are included.
Maximum Day Supply	**Retail:** 90 days (Medicare); 31 days (non-Medicare) **Mail Service:** 90 days (Medicare and non-Medicare)	
Mail Service Pharmacy Copayments/Coinsurance (If the cost of the drug is less than the copayment, the enrollee pays the cost of the drug.)	**Low-Cost Generic Drug Program medications:** $9 **Tier 1: Generic** — $25 **Tier 2: Preferred Brand** — $75 (after deductible) **Tier 3: Non-Preferred Drug** — $187.50 (after deductible for brand-name drugs) **Tier 4: Specialty (High Cost)** — After deductible, lesser of 8% of the cost **or** $450 for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days*	
Maximum Out-of-Pocket Limit	If an enrollee pays a total of **$4,000** out of pocket in copayments/coinsurance/deductible for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.	

*Non-Medicare enrollees must use CVS Specialty pharmacy; Medicare enrollees may use any specialty pharmacy.

MEDICAL PLAN FEATURES FOR 2024

	Medicare				Non-Medicare	
	Aetna Medicare Plan (Medicare Advantage PPO)		**Aetna Basic Plan** (PPO or Indemnity)		**Aetna Basic Plan** (PPO or Indemnity)	
	In-Network (PPO) or Extended Service Area (ESA PPO)[1]	**Out-of-Network (PPO)[1]**	**In-Network and Indemnity[2,4]**	**Out-of-Network[2,4]**	**In-Network and Indemnity[2]**	**Out-of-Network[2]**
PLAN FEATURES						
Annual Deductible per Enrollee[3]	$0	$500	$2,500	$5,000	$2,500	$5,000
Out-of-Pocket Maximum[3] (Includes deductible, copayments and coinsurance. Excludes prescription costs.)	$1,500 per enrollee	$2,500 per enrollee	$6,500 per enrollee	$13,000 per enrollee	$6,500 per enrollee	$13,000 per enrollee
Lifetime Benefits Maximum per Enrollee	Unlimited		Unlimited		Unlimited	
Health Provider Access	Use network provider (PPO); use any provider that accepts Medicare and the Aetna plan (ESA PPO)	Use any provider that accepts Medicare	Use network provider (PPO); use any covered provider (indemnity)	Use any covered provider	Use network provider (PPO); use any covered provider (indemnity)	Use any covered provider
PHYSICIAN, HOSPITAL, SKILLED NURSING AND HOME HEALTH CARE						
Primary Care Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays $0 (no deductible)	Enrollee pays $40 after deductible	Enrollee pays $20 (no deductible)	Enrollee pays 50% after deductible	Enrollee pays $20 (no deductible)	Enrollee pays 50% after deductible
Specialist Physician Office Visit (Includes in-person, phone and video visits.)	Enrollee pays $25 (no deductible)	Enrollee pays $55 after deductible	Enrollee pays 20%		Enrollee pays 20%	Enrollee pays 50%
Urgent Care	Enrollee pays $40 (no deductible)		Enrollee pays $40, then 20% after deductible		Enrollee pays $40, then 20% after deductible	
Hospital Services (Inpatient/Outpatient)	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20%[5]	Enrollee pays 50%[5]	Enrollee pays 20%	Enrollee pays 50%
Hospital Charges for Outpatient Surgery/Preadmission Testing	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20%		Enrollee pays 20%	Enrollee pays 50%
Emergency Room Care	Enrollee pays $75 (no deductible); copayment waived if admitted		Enrollee pays $150, then 20% after deductible; copayment waived if admitted		Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Skilled Nursing Facility (Benefit period varies by plan.)	Enrollee pays 0% after deductible; no day limit	Enrollee pays 8% after deductible; no day limit	Enrollee pays 20% (90 days per benefit period); after 90 days, enrollee pays 100%	Enrollee pays 50% (90 days per benefit period); after 90 days, enrollee pays 100%	Enrollee pays 20% (90 days per benefit period); after 90 days, enrollee pays 100%	Enrollee pays 50% (90 days per benefit period); after 90 days, enrollee pays 100%
Inpatient Mental Health	Enrollee pays 4%	Enrollee pays 8%	Enrollee pays 20%; no limit on days	Enrollee pays 50%; no limit on days	Enrollee pays 20%; no limit on days	Enrollee pays 50%; no limit on days
Home Health Care	Enrollee pays 0% after deductible; no visit limit	Enrollee pays 8% after deductible; no visit limit	Enrollee pays 20%; no visit limit		Enrollee pays 20%; no visit limit	

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

[2] For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

[3] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate, except for the Aetna Medicare Plan.

[4] Benefits are payable after Medicare payments.

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

MEDICAL PLAN FEATURES FOR 2024

	Medicare				Non-Medicare	
	Aetna Medicare Plan (Medicare Advantage PPO)		**Aetna Basic Plan** (PPO or Indemnity)		**Aetna Basic Plan** (PPO or Indemnity)	
	In-Network (PPO) or Extended Service Area (ESA PPO)[1]	**Out-of-Network (PPO)[1]**	**In-Network and Indemnity[2,3]**	**Out-of-Network[2,3]**	**In-Network and Indemnity[2]**	**Out-of-Network[2]**
PREVENTIVE SERVICES (If you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, any applicable copayment/coinsurance/deductible will apply for care received for the existing medical condition.)						
Limited designated services such as routine physical, bone density screening, mammogram, colorectal screening, Pap smear and immunizations/inoculations; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations or Medicare guidelines when applicable. Contact the plan for details.	Enrollee pays 0% (no deductible)		Enrollee pays 0% (no deductible)		Enrollee pays 0% (no deductible)	
OUTPATIENT SERVICES						
Diagnostic X-ray/Lab Testing	Enrollee pays 4% for diagnostic X-ray after deductible; 0% for lab testing (no deductible)	Enrollee pays 8% for diagnostic X-ray after deductible; 0% for lab testing after deductible	Enrollee pays 20%		Enrollee pays 20%	
Outpatient Mental Health (Includes in-person, phone and video visits.)	Enrollee pays $25 (no deductible); no visit limit	Enrollee pays $55 after deductible; no visit limit	Enrollee pays 20%; no visit limit		Enrollee pays 20%; no visit limit	Enrollee pays 50%; no visit limit
ADDITIONAL SERVICES (Contact the plan for details.)						
Fitness/Weight Management	SilverSneakers membership; discounts on weight management services		Discount membership to gyms in the GlobalFit network; discounts on weight management services		Discount membership to gyms in the GlobalFit network; discounts on weight management services	
Vision Care	Enrollee pays 0% for annual routine eye exam; eyewear discounts available at participating providers		Discounts on eye exams and eyewear		Discounts on eye exams and eyewear	
Hearing	Up to $1,000 reimbursement for hearing aids per 36 months; discount programs may also be available		Discount programs may be available		Discount programs may be available	
Telemedicine (Virtual provider visits; provider varies by plan.)	Enrollee pays $0 for Teladoc visit (no deductible)	Teladoc visit covered at same level as in-network primary care physician or specialist physician office visit	Teladoc visit covered at same level as in-network primary care physician or specialist physician office visit		Teladoc visit covered at same level as in-network primary care physician or specialist physician office visit	
Non-Emergency Transportation (Transportation for non-emergency medical appointments.)	Enrollee pays 0%; trip and mileage allowances may apply; unlimited transportation for dialysis patients		No coverage		No coverage	

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

[2]For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

[3]Benefits are payable after Medicare payments.

MONTHLY PREMIUMS FOR 2024

ELIGIBILITY GROUP* (See requirements below)		Medicare		Non-Medicare
		Aetna Medicare Plan (Medicare Advantage PPO)	**Aetna Basic Plan** (PPO or Indemnity)	**Aetna Basic Plan** (PPO or Indemnity)
BENEFIT RECIPIENT ELIGIBLE FOR SUBSIDY YEARS OF SERVICE		**MONTHLY PREMIUM**	**MONTHLY PREMIUM**	**MONTHLY PREMIUM**
Retired before 8/1/2023	**Retire on or after 8/1/2023**	Premiums shown below are reduced by a $30 Medicare Part B credit for benefit recipients enrolled in an STRS Ohio Medicare plan. Enrollment in Medicare Part B is mandatory.		Medicare Part B credit does not apply.
30+	35+	25	137	279
29	34	28	140	307
28	33	32	144	335
27	32	35	147	363
26	31	39	151	391
25	30	42	154	419
24	29	46	158	447
23	28	50	162	475
22	27	53	165	503
21	26	57	169	531
20	25	60	172	558
19	24	64	176	586
18	23	67	179	614
17	22	71	183	642
16	21	74	186	670
15	20	78	190	698
Benefit Recipient Not Eligible for Subsidy		131	243	1,117
Benefit recipients enrolled in the Health Care Assistance Program pay a $0 monthly premium. Eligible dependents pay premiums shown below.				
Spouse		161	273	1,117
Per Child		161	273	296
Disabled Adult Child		161	273	1,117

***Eligibility Requirements**

- **Retire on or after Aug. 1, 2023:** At least 20 years of service credit is required to qualify for coverage and a subsidy.
- **Retired Jan. 1, 2004–July 1, 2023:** At least 15 years of service credit is required to qualify for coverage and a subsidy.
- **Retired before Jan. 1, 2004:** No minimum years of service credit is required to qualify for coverage; however, at least 15 years of service credit is required to qualify for a subsidy.

Section 4: Medicare Enrollment Is Required

STRS Ohio requires all medical plan participants to be enrolled in Medicare Parts A & B at age 65 or when eligible. Medicare Part B is required for all enrollees. Medicare Part A is also required if it is available to you at no cost (premium free). If you decline Medicare Part B or premium-free Part A, you will no longer be eligible for STRS Ohio medical coverage.

Understanding Medicare

WHAT IS MEDICARE?

Medicare is a federal health insurance program for people age 65 and older, some people with disabilities under age 65 and people with end-stage renal disease or amyotrophic lateral sclerosis (ALS). A common misconception is that Ohio educators do not qualify for Medicare because they did not contribute to Social Security. However, you are eligible for Medicare when you turn age 65 even if you are not eligible for Social Security retirement benefits.

MEDICARE "PARTS"

Part A (hospital insurance)

STRS Ohio requires you to enroll in Medicare Part A if coverage is premium-free. Most U.S. citizens or permanent residents age 65 or older qualify for premium-free Medicare Part A (hospital insurance) based on their own employment history. You are eligible for premium-free Part A at age 65 if:

- You paid Medicare taxes for at least 40 quarters. This includes working in a federal, state or local government job (including public education) and any jobs in which you contributed to Social Security.
- You receive Social Security or Railroad Retirement benefits or you are eligible to receive these benefits but haven't filed for them yet.

If you do not qualify for premium-free Medicare Part A based on your own employment history, you may qualify based on your current or former spouse's work history if:

- You are currently married for at least one year and your spouse is age 62 or older.
- You are divorced and currently single, and you were married to your former spouse for at least 10 years.
- You are widowed and currently single, and you were married for at least nine months before your spouse died.

Please note, your spouse does not need to apply for Social Security benefits for you to be eligible for premium-free Medicare Part A based on his or her employment history.

Important: If you are not eligible for premium-free Medicare Part A at age 65 but you later become eligible through your spouse, you must contact Social Security to sign up for Medicare Part A at no cost.

Prior to age 65, you may qualify for Medicare Part A if you have a qualifying disability, end-stage renal disease or ALS.

If you believe you are not eligible for premium-free Medicare Part A, STRS Ohio may require proof of your ineligibility.

Part B (medical insurance)

STRS Ohio requires you to enroll in Medicare Part B for a monthly premium. Almost every U.S. citizen or legal resident in the United States for at least five years who is age 65 or older (or under age 65 but eligible for Medicare Part A) can enroll in Medicare Part B. If you believe you are not eligible for Medicare Part B, STRS Ohio will require proof of ineligibility.

Part C (Medicare Advantage plans)

In addition to Parts A & B, Medicare offers Part C (Medicare Advantage plans). Medicare Advantage plans are approved by Medicare and administered by private companies. You do not need to enroll in Part C — enrollment in Parts A & B or Part B-only (when you are not eligible for premium-free Part A) qualifies you for coverage under our group Medicare Advantage plans.

Part D (prescription insurance)

Medicare also offers Part D (prescription drug plans). If you want to remain enrolled in an STRS Ohio plan, you cannot enroll in any other Part D plan — all of the medical plans we offer for enrollees with Medicare Parts A & B or Part B-only already include Medicare Part D prescription coverage. Enrollment in any other Part D plan will cancel your STRS Ohio plan enrollment.

Medicare Enrollment Requirements

You qualify for Medicare at age 65 even if you did not contribute to Social Security.

Coverage type	Am I required to enroll?	What happens if I do not fulfill the requirement?
Part A (hospital)	**Yes** — You must enroll if coverage is premium free. **No** — Do not enroll if you must pay a premium to Medicare.	If premium-free Part A is available and you do not enroll, you will no longer be eligible for STRS Ohio health care coverage. If you must pay a Part A premium to Medicare, you do not need to enroll. However, if you later become eligible for premium-free Medicare Part A through your current or former spouse, you must sign up for Part A at no cost.
Part B (medical)	**Yes** — You must enroll and pay a monthly premium to Medicare.	If you do not enroll in Part B or you stop paying your monthly Part B premium to Medicare, you will no longer be eligible for STRS Ohio health care coverage.
↑	Proof of Medicare enrollment is required. Submit your Medicare information through your STRS Ohio Online Personal Account.	↑
Part C (Medicare Advantage)	**No** — Enrollment in Parts A & B or Part B-only (when you are not eligible for premium-free Part A) qualifies you for coverage under STRS Ohio's Aetna Medicare Plan.	You must not enroll in any other Medicare Advantage plan if you want to keep your coverage under the Aetna Medicare Plan.
Part D (prescription)	**No** — Part D prescription coverage is included in your STRS Ohio medical plan.	You must not enroll in any other Part D plan. If you do, your STRS Ohio medical and prescription coverage will be canceled.

HOW MEDICARE WORKS WITH YOUR STRS OHIO COVERAGE

Medicare Parts A & B do not replace your STRS Ohio coverage. Instead, Medicare works with your STRS Ohio plan to provide maximum hospital and medical coverage. In general, when you enroll in Medicare Parts A & B, Medicare becomes the primary payer of your hospital and medical expenses; STRS Ohio becomes the secondary payer. If you enroll in the Aetna Medicare Plan, the plan assumes responsibility for paying for covered services and receives payment from Medicare.

After you enroll in Medicare, you must pay **two separate monthly premiums:** a premium for STRS Ohio coverage (paid to STRS Ohio) and a premium for Medicare Part B coverage (paid to Medicare).

CAN YOU DELAY MEDICARE ENROLLMENT IF YOU ARE STILL EMPLOYED?

If you or your spouse is still employed and covered by a group health plan through the employer, you may choose to delay your enrollment in Medicare. However, if you delay your enrollment, you should be aware of the following:

- You will have an eight-month special enrollment period in which to sign up for Medicare after the employer health coverage ends or employment ends (whichever comes first). See Page 19 for details. You will not be subject to a late enrollment penalty if you sign up during this special enrollment period.
- If the employer has more than 20 employees, your employer health plan will be the primary payer of covered hospital and medical expenses. Your STRS Ohio plan will be the secondary payer.
- If you discontinue the employer health coverage and fail to enroll in Medicare, you will not be eligible for an STRS Ohio medical plan.

MEDICARE PRIOR TO AGE 65

Some people under age 65 qualify for Medicare due to a qualifying disability benefit through the Social Security Administration, end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant) or ALS (a progressive neurodegenerative disease often referred to as Lou Gehrig's disease). If you enroll in Medicare prior to age 65, you must send STRS Ohio proof of Medicare Parts A & B enrollment.

Note: If you are under age 65 and qualify for Medicare because of end-stage renal disease, there is a 30-month coordination period during which the Centers for Medicare & Medicaid Services requires the STRS Ohio plan to be the primary payer of your hospital and medical expenses and Medicare to be the secondary payer. During this 30-month coordination period, you will be charged the monthly premium for enrollees without Medicare.

Enrolling in Medicare

WHEN TO ENROLL IN MEDICARE

Initial enrollment period

You have a seven-month initial enrollment period in which to sign up for Medicare. This period begins three months before you turn age 65, includes the month you turn age 65 and ends three months after the month of your birthday.

For coverage to be effective the month you turn age 65, you must sign up during the first three months of the initial enrollment period (one to three months before the month of your birthday). If you wait to sign up during the last four months of the period, your effective date of Medicare will be delayed.

General enrollment period

If you miss the initial enrollment period, you can enroll during a general enrollment period from Jan. 1 through March 31 each year. Coverage begins the month after you enroll. A late enrollment penalty will apply if you don't qualify for a special enrollment period. See Page 20 for more information on extra fees for late enrollments.

Initial Enrollment Period for Medicare

Begins three months before and ends three months after the month you turn age 65

You will have NO DELAY in coverage if you enroll:

Three months before you turn 65 ↓ Two months before you turn 65 ↓ One month before you turn 65

Coverage begins the month you turn 65
(If your birthday is the first of the month, coverage begins the first day of the previous month.)

You will have a DELAY in coverage if you enroll:

The month you turn 65	One month after you turn 65	Two months after you turn 65	Three months after you turn 65
↓	↓	↓	↓

Coverage begins one month after the month you enroll

Special enrollment period

If you delay enrollment at age 65 because you or your spouse is still employed and covered by a group health plan through the employer, you can enroll in Medicare during a special enrollment period. Special enrollment allows you to enroll without paying a late enrollment penalty during either of the following time frames:

- At any time while you have employer group health coverage (your own or through your spouse); or
- During the eight-month period that begins the month employer health coverage ends or the month employment ends (whichever comes first). If you do not enroll by the end of the eighth month, general enrollment guidelines apply.

See Page 18 for additional information about delaying Medicare enrollment while employed.

HOW TO ENROLL IN MEDICARE

Enrolling in Medicare is an easy two-step process. However, it may take more than one month for the entire application process to be completed. **For best results, we recommend applying for Medicare three months before your 65th birthday.**

Step 1 — Sign up for Medicare.

Apply for Medicare three months before your 65th birthday so there is no delay in Medicare coverage.

If you are enrolling in both Medicare Parts A & B, you can complete your Medicare application online at www.ssa.gov. If you are not eligible for premium-free Part A and are enrolling in Part B-only, you must visit your local Social Security Administration office or call Social Security toll-free at 800-772-1213 to enroll.

If you visit your local office, find out which documents to bring with you to your appointment.

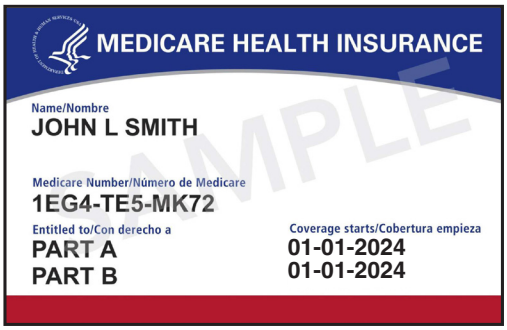
Step 2 — Send proof of Medicare enrollment to STRS Ohio.

Once you enroll in Medicare, you must provide proof of Medicare enrollment by submitting your Medicare information through your STRS Ohio Online Personal Account. (Your Medicare information can be found on your Medicare card.) To submit your information:

- Log in to your Online Personal Account at www.strsoh.org.
- Click "Health Care."
- Click "Submit Medicare Information" under Useful Links.

If you do not have an Online Personal Account, first register at www.strsoh.org by clicking "Register" at the top of the home page. Once you create your account, follow the instructions above to submit your Medicare information.

Important: If you do not submit proof of Medicare enrollment, you will not be eligible for STRS Ohio health care coverage.



Note: *Please check all information on your Medicare card for accuracy. If it is incorrect, contact Medicare to request a new card with the correct information.*

New Plan Options and Premiums

YOUR PLAN OPTIONS AND PREMIUMS WILL CHANGE

After you submit proof of Medicare enrollment to STRS Ohio, you will be eligible for the Aetna Medicare Plan in addition to the Aetna Basic Plan. The Aetna Medicare Plan has lower premiums and out-of-pocket costs than the Aetna Basic Plan.

Premiums for benefit recipients with Medicare are lower than non-Medicare premiums. Also, premiums for benefit recipients with Medicare are reduced by a $30 Medicare Part B premium credit.

You can review your new plan options and premiums in your STRS Ohio Online Personal Account or contact STRS Ohio for this information.

Note: *If you are not currently enrolled in an STRS Ohio plan, initial eligibility for and enrollment in Medicare is a qualifying event that allows you to add STRS Ohio coverage outside of open enrollment. You can enroll in a plan through your STRS Ohio Online Personal Account.*

YOUR PLAN ENROLLMENT

Aetna Basic Plan participants will be enrolled in the Aetna Medicare Plan after STRS Ohio receives proof of Medicare enrollment and Medicare approves your enrollment request. If you do not want the Aetna Medicare Plan, you may opt out and select the Aetna Basic Plan. To opt out of the Aetna Medicare Plan, select "AMA Opt Out" when you submit your Medicare information through your STRS Ohio Online Personal Account.

You may select a new plan up to three months after your 65th birthday. The effective date of coverage will be the first of the month following notification to STRS Ohio, **if received by the 15th of the month.** There will be no interruption in your STRS Ohio coverage.

Be aware, your plan selection cannot be processed until STRS Ohio receives proof of Medicare enrollment. Any delay in submitting this proof will delay your enrollment in the plan you select.

If you are selecting the Aetna Medicare Plan, you will not be officially enrolled in the plan until Medicare approves your enrollment request. Additionally, once enrolled, you must not subsequently sign up for another Medicare Advantage plan. If you do, your STRS Ohio coverage will be canceled by Medicare.

In addition, the prescription coverage included with your STRS Ohio medical plan will be provided by SilverScript, a Medicare Part D plan. Enrollment in any other Part D plan will cancel your STRS Ohio medical and prescription coverage.

Note: *If you select the Aetna Medicare Plan, your out-of-network annual deductible and out-of-pocket maximums will transfer to your new plan from the Aetna Basic Plan.*

After You Enroll in Medicare

PAYING YOUR MEDICARE PART B PREMIUMS

Your Medicare Part B premium is **not included** in your monthly STRS Ohio medical plan premium. It is a separate premium that must be paid to Medicare, not to STRS Ohio.

If you receive a monthly Social Security, Railroad Retirement or Civil Service Retirement payment, your Medicare Part B premium will be deducted automatically from this payment. Otherwise, Medicare will send you a bill for your Part B premium.

Another payment option, which STRS Ohio recommends if you will be billed by Medicare, is to have your Part B premium automatically deducted through Medicare Easy Pay. This is a free, electronic payment option offered by Medicare. Through Medicare Easy Pay, Medicare automatically deducts the premium payment from your savings or checking account. To sign up for Medicare Easy Pay, call Medicare toll-free at 800-633-4227.

Pay your monthly Medicare Part B premium before the due date to avoid cancellation of your Medicare Part B coverage. If your Part B coverage is canceled, you will no longer be eligible for STRS Ohio health care coverage.

EXTRA FEES FOR LATE ENROLLMENTS AND HIGHER INCOMES

Medicare charges late enrollment penalties if you delay enrollment in Medicare Part B or go 63 days or more without Medicare Part D or creditable prescription coverage. This additional cost will be charged as long as you have Medicare coverage. Also, Medicare Part B and Part D enrollees with higher annual incomes are subject to monthly Medicare surcharges. Surcharges vary by income levels set by Medicare. Failure to pay surcharges will result in cancellation of your STRS Ohio medical coverage by Medicare. Visit www.medicare.gov for more information.

MEDICARE PART B PREMIUM CREDIT

Benefit recipients enrolled in an STRS Ohio Medicare plan receive partial reimbursement for paying their monthly Part B premium to Medicare. The reimbursement is provided through lower premiums, which are reduced by a $30 Medicare Part B credit.

MEDICARE PART B-COVERED DRUGS AND SUPPLIES

Medicare Part B covers a limited number of drugs/supplies as determined by the Centers for Medicare & Medicaid Services. Following are examples of drugs/supplies covered by Medicare Part B:

- Diabetic supplies such as blood sugar testing monitors, test strips, lancets and lancet devices, and blood sugar control solutions.
- Injections administered in a doctor's office.
- Certain oral cancer drugs.
- Drugs used with some types of durable medical equipment, such as a nebulizer or external infusion pump.
- Under limited circumstances, certain drugs administered in a hospital outpatient setting.

Please contact Aetna for additional information on Medicare Part B-covered drugs and supplies.

QUALIFYING FOR EXTRA HELP WITH PRESCRIPTION COSTS

Medicare offers a low-income subsidy program to qualified participants in a Medicare Part D prescription plan. Under the program (also called Extra Help), participants may pay a lower deductible and lower copayment amounts for covered prescription drugs. Medicare, *not STRS Ohio*, determines if participants qualify for the subsidy program.

Medicare works directly with SilverScript to determine if you qualify for assistance. If you qualify, SilverScript will send you a letter informing you about the program. If you receive a letter from SilverScript, you will be enrolled automatically in the subsidy program offered by Medicare. If you do not receive a letter and believe you may qualify for assistance, you can call Medicare directly for more information or to request an application.

Confused About Medicare? We Can Help

Understanding Medicare and its requirements can sometimes be confusing. That's why we offer the webinar, *Medicare Enrollment and STRS Ohio*. We'll guide you through the Medicare enrollment process, provide information specific to new Medicare enrollees and address any questions you submit during the live presentation. To register for this free webinar, go to the Receiving Benefits section of our website at www.strsoh.org and select "Seminars & Webinars."

Section 5: Legally Required Notices

Quality Standards

To be offered as an STRS Ohio health care plan option, a plan must meet the following quality standards:

1. Adhere to performance standards related to enrollees' access to medical providers, claims payment accuracy, processing time and the quality of service provided by the plan's customer service department.
2. Allow medical providers to talk with plan enrollees about reasonable care options, including those not covered by the plan or can be provided at a lower cost, and about how services are reimbursed.
3. Support surveys of enrollees to assess satisfaction with the plan. Use survey results to improve customer service and the quality of health care provided.
4. Provide a coverage-appeal process for enrollees that includes, as a final level of appeal, deliberation by an independent health care professional(s).
5. Show a commitment to improving the health of the plan's older adult enrollees.
6. Have business associate agreements that require safeguarding protected health information and are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

In addition, HMO and PPO plans are encouraged to have or be pursuing accreditation by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC), or have programs in place to ensure the delivery of quality care to enrollees. NCQA and URAC use nationally recognized standards to measure plan performance in the areas of quality of care, access to care, utilization management and consumer satisfaction.

Release of Information and Confidentiality Statement

By accepting coverage under an STRS Ohio health care plan, all enrollees, including any enrolled dependents, shall:

1. Furnish STRS Ohio or its designees any and all information STRS Ohio may reasonably require pertaining to health care coverage and the operations of its health care plan.
2. Enroll in Medicare Part B for a monthly premium at age 65 or whenever eligible, enroll in Medicare Part A if coverage is premium-free and submit proof of Medicare enrollment to STRS Ohio.
3. Authorize and direct any physician or other health care provider, health plan, pharmacy, pharmacy benefits manager or program administrator to furnish STRS Ohio or its designees any and all information and records (or copies of records) relating to care or services provided directly to the enrollee or services provided indirectly to the enrollee related to the administration of the health care program.

Any and all records pertaining to health care services that STRS Ohio in its sole discretion determines are necessary to implement and administer the terms of health care coverage and/or are necessary for the appropriate review and management of its health care plans may be used by and released to STRS Ohio and its designees, or used by and released among STRS Ohio designees.

All individually identifiable information and records pertaining to health care coverage and services are considered by STRS Ohio to be confidential and will not be given, sold or transferred to any person or organization not designated by STRS Ohio.

STRS Ohio designees include but are not limited to disease management and wellness program plan administrators, data warehouses, and actuarial and consulting firms that STRS Ohio has contracted with and holds business associates agreements.

Affordable Care Act and Your STRS Ohio Medical Plan

The federal Affordable Care Act requires nearly all Americans to have health insurance. All STRS Ohio medical plans meet the Affordable Care Act's minimum essential requirement, so you are considered covered as an enrollee.

If you do not want coverage through STRS Ohio, other options may be available. Some options may include coverage through an employer, COBRA, other retirement plan, private health policy or public program such as Medicare, Medicaid or the Veterans Health Administration.

Individuals who are not eligible for Medicare can also purchase coverage through the Health Insurance Marketplace. The Marketplace offers a convenient way to find and compare private health policies. A tax credit lowering your monthly premium may also be available. For information about enrollment options through the Health Insurance Marketplace, visit www.healthcare.gov.

Notice of Privacy Practices

This notice describes how medical information about you can be used and disclosed and how you can obtain access to this information.

This privacy notice applies to enrollees in the State Teachers Retirement System of Ohio ("STRS Ohio") self-funded health care plans and the self-funded prescription drug plans (the "Program"). The Program is required by law to maintain the privacy of protected health information (as defined below, the "PHI") and to provide individuals with notice of the Program's legal duties and privacy practices with respect to PHI and to abide by the terms of such privacy notice currently in effect and to notify individuals following a breach of unsecured PHI. The Program includes several types of plans: indemnity plans, preferred provider organization (PPO) plans, Medicare Advantage plans, commercial health maintenance organization (HMO) plans, Medicare HMO plans and prescription drug plans. These plans have agreed to participate as an organized health care arrangement as defined in 45 C.F.R. §160.103 ("OHCA"), and have agreed to abide by the terms of this privacy notice with respect to PHI created or received by the plans as part of their participation in the OHCA.

STRS Ohio's philosophy on enrollee privacy

STRS Ohio is committed to enrollee service and privacy. As part of your participation in the Program, STRS Ohio and its business partners used to administer and deliver health care coverage receive enrollee PHI through the operation and administration of the Program. PHI means any information, transmitted or maintained in any form or medium, which the Program 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 PHI and other Program 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 privacy notice, please submit a written request to the attention of the Program's Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771. The policies and procedures outlined in this privacy notice originally became effective April 14, 2003, and were amended Oct. 1, 2019.

How the Program uses and discloses your PHI

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

A. Uses and Disclosures of Your PHI for Treatment, Payment and Health Care Operations

The law permits the Program to use and disclose your PHI without your authorization as follows:

(i) **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 Program may make disclosures to physicians, nurses and other health care professionals involved in your care.

(ii) **To Obtain Payment** — To STRS Ohio business partners that administer the Program, 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 Program may need to share your health information (1) with providers to verify the delivery of services or items you received so the Program's claims administrator can pay the provider or reimburse you for the cost of the services or items; (2) to determine if a treatment you received was medically necessary or covered under the Program; (3) with a third-party service provider to perform utilization review; (4) with another health plan to coordinate benefit payments; or (5) for adjudication or subrogation of health claims.

(iii) **Health Care Operations** — The Program may use and disclose PHI for health care operations, which include, but are not limited to, use and disclosures: (1) by Program health care representatives who disclose the minimum amount of PHI to STRS Ohio associates who need to know that information to administer the Program; (2) by Program health care representatives who act as a liaison between the enrollee and various health plan administrators; (3) for quality assessment of the Program 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, fraud detection, data management, communications, claims and operational audits and legal services. In addition, the Program 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 Program may also combine your health information with that of other enrollees in the Program to evaluate the coverage provided by the Program and to evaluate the quality of care the Program enrollees receive as a whole.

B. Other Uses and Disclosures of Your PHI for Which Your Authorization Is Not Necessary

In limited instances, the law allows the Program to use and disclose your PHI without your authorization in the following situations:

(i) **Family** — The Program may disclose your PHI to a family member who is directly involved with your medical care or with the payment related to your care. The Program may request that your family members verify their own identity and otherwise demonstrate that they are acting on your behalf.

(ii) **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.

(iii) **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.

(iv) **Public Health Activities** — The Program may disclose PHI 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.

(v) **Victims of Abuse, Neglect or Domestic Violence** — To a government authority, including a social service or protective agency, if the Program reasonably believes you to be a victim of abuse, neglect or domestic violence.

(vi) **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.

(vii) **Judicial and Administrative Proceedings** — If you are involved in a lawsuit or dispute, the Program may disclose PHI about you in response to a court or administrative order. The Program may also disclose PHI 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.

(viii) **Law Enforcement Purposes** — If requested by a law enforcement official for limited law enforcement purposes. For instance, pursuant to laws that require the reporting of wounds or other physical injuries; pursuant to a court order, court-ordered warrant, subpoena or summons; in response to a law enforcement official's request for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; in response to a law enforcement official's request for information about an individual who is suspected to be a victim of a crime; to a law enforcement official about an individual who has died if the Program has a suspicion the death may have resulted from criminal conduct; or to law enforcement officials if the Program believes in good faith criminal conduct occurred on its premises.

(ix) **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 Program may also release medical information to funeral directors as necessary to carry out their duties.

(x) **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.

(xi) **Uses and Disclosures to Avert a Serious Threat to Health or Safety** — The Program 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.

(xii) **Specialized Government Functions** — For specialized government functions allowed by law, such as for national security and intelligence purposes; disclosure to authorized federal officials for the provision of protective services to the President or other authorized persons; disclosure of health information about an inmate or other individual to a correctional institution or a law enforcement official.

(xiii) **Workers' Compensation** — For compliance with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

(xiv) **Business Associates** — The Program contracts with parties who provide services necessary for operation of the Program. For example, the Program is assisted in its operations by third-party administrators. These persons who assist the Program are called business associates. At times, the Program may disclose PHI to its business associates so they can provide services to the Program. The Program will require that any business associates who receive PHI safeguard the privacy of that information.

(xv) **Military and Veterans** — If you are a member of the armed forces, the Program may release PHI about you as required by military command authorities.

(xvi) **Underwriting** — The Program may use or disclose your PHI for underwriting purposes, but the Program is prohibited from using or disclosing PHI that is genetic information for underwriting purposes. Underwriting purposes include, for example, the computation of premium or contribution amounts under the Program and the application of any preexisting condition exclusion under the Program, but do not include determinations of medical appropriateness where an individual seeks a benefit under the Program.

(xvii) **Notifying the sponsor of the Program** — The Program may disclose your PHI to STRS Ohio, the sponsor of the Program.

(xviii) **Disclosures to the Secretary of the U.S. Department of Health and Human Services** — The Program is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Program's compliance with the Privacy Rule.

C. Other Uses and Disclosures of Your PHI Requiring Your Written Authorization

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

D. More Stringent Ohio Laws

Certain provisions of Ohio law may now, or in the future, impose greater restrictions on uses and/or disclosures of PHI or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI or under other circumstances described in this privacy notice, the Program 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 Program to:

- **Restrict the uses or disclosures of your PHI to carry out treatment, payment and health care operations.** You also have the right to request a limit on your PHI that the Program 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 Program not disclose or use information about a certain medical treatment you received. **IMPORTANT NOTE: The Program is not required to agree to your request, unless the health information pertains solely to a health care item or service for which you, and not the Program, have paid in full.**

  To request restrictions on the use or disclosure of your PHI, mail your request to: Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771. In your request, please provide:

  — What PHI you want to limit;

  — Whether you want to limit the Program's use, disclosure or both; and

  — To whom you want the disclosure limits to apply (for example, a family member).

- **Communicate with you about your PHI in a certain way or at a certain location.** For example, you can ask that the Program contact you only at a certain phone number or mailing address. To request confidential communications, mail your request to: Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771. The Program will accommodate all reasonable requests. Your request must specify how or where you would like to be contacted. After the Program receives your request, the information may be forwarded to third-party administrators of the Program. As a result, additional reasonable information may be required from you by the third-party administrator to process your request.

- **Inspect and copy your PHI that may be used to make decisions about payment and your care.** To inspect and copy your PHI, mail your request to: Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771. If you request a copy of the information, the Program may charge a reasonable fee for the costs of preparing a summary or explanation of your PHI or for the costs of copying, mailing or other supplies associated with your request.

  If you agree in advance, the Program may instead provide you with a summary or explanation of your PHI.

  Under Ohio and federal law, the Program may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your PHI, in many instances you may request that the denial be reviewed.

- **Request an amendment to your PHI if you think the information is incomplete or incorrect for as long as the information is maintained by the Program.** To request an amendment, mail your request to: Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771. If the Program rejects your amendment for any reason allowable under state or federal law, the STRS Ohio Health Care Program will permit you to submit a written statement of disagreement to be kept with your PHI. The Program may reasonably limit the length of such statement of disagreement.

- **Provide a listing of any disclosures of your PHI in the six (6) 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 PHI the Program has made about you. The Program 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 PHI by submitting a written request to the attention of the Program's Privacy Officer, STRS Ohio Health Care Program, 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. 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 Program may charge you for the costs of providing the list. The Program 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.

- **Obtain a paper copy of this privacy notice.** Even if you have agreed to receive this privacy notice electronically, you may nonetheless obtain a paper copy of this privacy notice by submitting a written request to the attention of the Program's Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771.

This privacy notice is subject to change

The Program may change the terms of this privacy 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 Program already has about you, as well as any information that it may receive or hold in the future. The Program will post a copy of the current privacy notice on its website at 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 privacy notice by submitting a written request to Privacy Officer, STRS Ohio Health Care Program, 275 E. Broad St., Columbus, OH 43215-3771 or by calling STRS Ohio's Member Services Center toll-free at 888-227-7877.

Please note that the Program does not destroy your PHI when you terminate coverage with the Program. It may be necessary to use and disclose this information for the purposes described in this privacy notice 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 Health Care Program Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services.

To file a complaint with the Program, mail your comments to: Privacy Officer, STRS Ohio Health Care Program, 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.

You will not be penalized in any way for filing a complaint.

General Notice of COBRA Continuation Coverage Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under an STRS Ohio health plan (the Plan). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. COBRA continuation coverage can become available to qualified beneficiaries (spouses and children) who lose health coverage under the Plan due to certain events. For additional information about your rights and obligations under the Plan and under federal law, please contact your COBRA Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A covered spouse or dependent child of a member could become a qualified beneficiary if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for the coverage.

- If you are a covered spouse, you may become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events: (1) your spouse dies; or (2) you become divorced or legally separated from your spouse.

- If you are a covered child (biological or adopted), you may become a qualified beneficiary if you lose coverage under the Plan because of the following qualifying events: (1) your parent dies; (2) your parents become divorced or legally separated; or (3) you are no longer eligible for coverage under the Plan as a dependent child.

Notifying STRS Ohio of COBRA qualifying event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after STRS Ohio has been notified that a qualifying event has occurred. It is the beneficiary's responsibility to notify STRS Ohio within 60 days of the occurrence of the qualifying event. The 60-day notification period begins the date the qualifying event occurs. After the beneficiary notifies STRS Ohio, the COBRA Administrator will be informed that a qualifying event has occurred. The COBRA Administrator will then send the beneficiary an informational packet within 30 days after receiving notification from STRS Ohio.

How is COBRA coverage provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered members may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the member, divorce or legal separation, or a child losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

COBRA continuation coverage begins on the date that Plan coverage would otherwise have been lost by reason of a qualifying event and stops at the end of the maximum period. It may stop earlier if: (1) premiums are not paid on a timely basis; (2) after the COBRA election, coverage is obtained with another group health plan (e.g., through an employer) that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary; or (3) after the COBRA election, a beneficiary becomes entitled to Medicare coverage.

Other coverage options

Other coverage options may be available for you and your family. You may be able to enroll in another group health plan for which you are eligible, such as a spouse's plan, if you request enrollment within 30 days of loss of coverage. Additionally, you may be eligible to enroll in an individual plan through Medicaid or the Health Insurance Marketplace. By enrolling through the Marketplace, you may qualify for lower monthly premiums and lower out-of-pocket costs. Being eligible for COBRA coverage does not limit your eligibility for coverage or a tax credit through the Marketplace. You can learn more about these options at www.healthcare.gov.

For more information

For more information about your COBRA rights under the Public Health Services Act, contact the Centers for Medicare & Medicaid Services (CMS) toll-free at 800-633-4227 or visit www.cms.gov.

Specific questions about your COBRA continuation coverage rights as an STRS Ohio enrollee should be addressed to your COBRA Administrator: PayFlex Systems USA, Inc., Benefits Billing Department, P.O. Box 953374, St. Louis, MO 63195-3374. Phone: 888-678-7835 (toll-free); email: COBRAmail@payflex.com; fax: 402-231-4302.

Notify your COBRA Administrator of address changes

To protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Notice of Medicare Part D Creditable Coverage

This notice provides important information about prescription coverage through STRS Ohio's medical plans and Medicare Part D. Please read this notice carefully and keep a copy for your records.

As an enrollee in an STRS Ohio medical plan, you should not enroll in more than one Medicare Part D plan. STRS Ohio has received an actuarial determination that the prescription coverage included in the STRS Ohio medical plans is creditable, meaning it is as good as or better than the standard Medicare Part D prescription coverage.

Required information from the Centers for Medicare & Medicaid Services

If you are eligible for Medicare Parts A & B, Part A-only or Part B-only, you have an opportunity to enroll in Medicare Part D each year from Oct. 15 through Dec. 7. If you are not currently eligible for Medicare, you can enroll in Medicare Part D when you turn age 65. Keep in mind, however, that creditable prescription coverage is included in your STRS Ohio medical plan. This means you should not enroll in more than one Medicare Part D plan.

If you are not currently enrolled in Medicare Parts A & B, Part A-only or Part B-only, the initial enrollment period is the seven-month period that begins three months before you first meet eligibility requirements and ends three months after the month of first eligibility. You will pay a higher Medicare Part D premium if you go without creditable prescription coverage for 63 consecutive days or longer after your initial enrollment period ends.

Information for enrollees with Medicare Parts A & B, Part A-only or Part B-only

You will be enrolled automatically in SilverScript, a Medicare Part D plan, for no additional monthly premium as part of your STRS Ohio medical plan's coverage. SilverScript is an affiliate of CVS Caremark.

Because Medicare Part D coverage is already included in your STRS Ohio medical plan, you should not enroll in any other Medicare Part D plan. If you enroll in another Medicare Part D plan, your STRS Ohio medical and prescription coverage will be canceled. Medicare does not allow enrollment in more than one Medicare Part D plan. In addition, if you decline coverage under the Medicare Part D plan included with your STRS Ohio medical plan, your STRS Ohio medical coverage will be canceled.

Before making any changes to your Medicare Part D plan coverage, call STRS Ohio to find out how your STRS Ohio coverage will be affected. If you have specific questions about your prescription coverage, contact SilverScript.

Please note that if you cancel your STRS Ohio medical coverage, you will lose medical and prescription coverage provided by STRS Ohio. In addition, you will have only the coverage you qualify for under Medicare Parts A & B, Part A-only or Part B-only unless you purchase a separate supplemental plan. Keep in mind that Medicare Parts A & B cover only a few prescription drugs.

Keep this notice for your records. If you decide to enroll in Medicare Part D in the future, you may need to present a copy of this notice to avoid paying a higher monthly premium amount under Medicare. You may request a copy of this document from STRS Ohio at any time or visit www.strsoh.org.

For more information

1. Call STRS Ohio's Member Services Center toll-free at 888-227-7877 for information about this notice or to request additional copies.
2. Contact SilverScript toll-free at 800-756-6859 for information about your prescription coverage.
3. Call Medicare toll-free at 800-MEDICARE (800-633-4227) or visit www.medicare.gov for information about your options under Medicare Part D.
4. Call the Social Security Administration toll-free at 800-772-1213 or visit www.ssa.gov to find out if you qualify for extra assistance to help pay for Medicare prescription drug plan costs.

Notice for the Women's Health and Cancer Rights Act of 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, STRS Ohio's Aetna Basic Plan will provide coverage to include the following mastectomy-related procedures:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses 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 deductible and coinsurance provisions that apply for the mastectomy. If you have questions about coverage of mastectomies and reconstructive surgery, please call Aetna toll-free at 800-645-5677.

Section 1557 Notice of Nondiscrimination

The State Teachers Retirement System of Ohio (STRS Ohio) Health Care Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The STRS Ohio Health Care Program does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The STRS Ohio Health Care Program:

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

If you need these services, contact STRS Ohio's Section 1557 Coordinator. If you believe the STRS Ohio Health Care Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: STRS Ohio's Section 1557 Coordinator, 275 E. Broad St., Columbus, OH 43215; phone: 614-227-4097; fax: 614-744-3343; email: legal@strsoh.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

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

Limited English Proficiency of Language Assistance Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 614-227-4097.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 614-227-4097.

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 614-227-4097

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 614-227-4097.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 614-227-4097

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 614-227-4097.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 614-227-4097.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 614-227-4097.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 614-227-4097.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 614-227-4097.

주의: 한국어를 _사용하시는 _경우, 언어 _지원 _서비스를 _무료로 _이용하실 _수 _있습니다. 614-227-4097.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 614-227-4097.

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. 614-227-4097.

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 614-227-4097.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 614-227-4097.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 614-227-4097.

STRS OHIO HealthCare PROGRAM

275 E. Broad St., Columbus, OH 43215-3771 • 888-227-7877 • www.strsoh.org

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