Medical Mutual of Ohio

www.MedMutual.com/PSHB

Customer Service 800-315-3144

MEDICAL MUTUAL®

2025

A Health Maintenance Organization (Standard and Basic Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

Serving: The Northern Ohio Counties of Allen, Ashland, Ashtabula, Auglaize, Columbiana, Cuyahoga, Defiance, Erie, Fulton, Geauga, Henry, Huron, Lake, Lorain, Lucas, Mahoning, Medina, Mercer, Ottawa, Portage, Putnam, Richland, Sandusky, Seneca, Stark, Summit, Trumbull, Wayne, Williams and Wood.

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 16
- Summary of Benefits: Page 104

Enrollment codes for this Plan:

D3A Basic Option - Self Only

D3C Basic Option - Self Plus One

D3B Basic Option - Self and Family

D3D Standard Option - Self Only

D3F Standard Option - Self Plus One

D3E Standard Option - Self and Family

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-928

Important Notice

Important Notice for Medicare eligible Active Employees from Medical Mutual
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the PSHB Plan's prescription drug coverage for active employees is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D plan, you can keep your PSHB coverage and your PSHB plan will coordinate benefits with Medicare.

Please be advised

If you lose or drop your PSHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov , or call the SSA at 800-772-1213 TTY 800-325-0778.

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your PSHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about open market Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Medical Mutual of Ohio under contract (CS 1182 PS) between Medical Mutual of Ohio (Medical Mutual) and the United States Office of Personnel Management, as authorized by Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. Customer service may be reached at 800-315-3144 TTY: 711 or through our website: www.MedMutual.com/PSHB. The address for Medical Mutual's administrative offices is:

Medical Mutual of Ohio
100 American Road
Cleveland, OH 44144

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). You do not have a right to benefits that were available before January 1, 2025, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

All brochures are written in plain language to make them easy to understand. Here are some examples: All (PSHB) brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Medical Mutal.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium. Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-315-3144 (TTY 711) and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

Do not maintain family members on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain PSHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you take notes, ask questions and understand answers.
2. **Keep and bring a list of all the medications you take.**
   - Bring the actual medication or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
   - Read the label and patient package insert when you get your medication, including all warnings and instructions
   - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.
   - Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
   - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital or clinic is best for your health needs.**
   - Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     - "Exactly what will you be doing?"
     - "About how long will it take?"

- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- https://psnet.ahrq.gov/issue/national-patient-safety-foundation The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your PSHB plan will incur costs to correct the medical error.

PSHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the PSHB Program**

  See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as:

  - Information on the PSHB Program and plans available to you
  - A health plan comparison tool

  Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System.

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your PSHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov/PSHB/. For assistance with the PSHB System, call the PSHBP Helpline at (844) 451-1261. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one PSHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another PSHB or FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the PSHB Program, change your enrollment, or cancel coverage using the PSHB System. For a complete list of QLEs, visit the PSHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the PSHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no PSHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the PSHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for PSHB coverage, you must continue your PSHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

- **Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)**

  Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible and their covered Medicare Part D-eligible family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please, contact CMS for assistance or contact us at 800-315-3144 (TYY: 711) or at our website at www.MedMutual.com/PSHB.

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

  If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

  When you retire, you can usually stay in the PSHB Program. Generally, you must have been enrolled in the FEHB and/or PSHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When PSHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

  If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

  If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

  If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are not eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

- **Medicare PDP EGWP**

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this plan. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 800-315-3144 (TTY: 711).

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance . It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-PSHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the PSHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-315-3144 (TTY: 711) or visit our website at www.MedMutual.com/PSHB.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that PSHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Medical Mutual holds the following accreditation: National Committee for Quality Assurance (www.ncqa.org). To learn more about this plan's accreditation(s), please visit the following websites: www.MedMutual.com/PSHB.

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a Standard Option or Basic Option Plan.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Standard and Basic Options

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Preventive care services

Preventive care services are generally covered with no cost sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health education resources and accounts management tools

Your rights and responsibilities

OPM requires that all PSHB plans provide certain information to their PSHB members. You may get information about us, our networks, and our providers. OPM's PSHB website www.opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below:

- Your Medical Mutual plan is underwritten and insured by Medical Mutual of Ohio. A trusted insurer for more than 80 years, Medical Mutual is the oldest and largest health insurance company headquartered in the state of Ohio. We are a mutual health insurance company, owned by its policyholders and directed by a Board of Trustees and corporate officers.
- Medical Mutual of Ohio is a not-for-profit company.
- This medical benefit Plan is provided by Medical Mutual of Ohio. Medical and hospital services are provided by the Medical Mutual MedFlex Network of providers

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Medical Mutual of Ohio at www.MedMutual.com/PSHB. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-315-3144 (TTY 711) or write to Medical Mutual of Ohio, Customer Care, PO Box 6018, Cleveland, OH 44101-1018. You may also visit our website at www.MedMutual.com/PSHB.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.MedMutual.com/PSHB to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is: Allen, Ashland, Ashtabula, Auglaize, Columbiana, Cuyahoga, Defiance, Erie, Fulton, Geauga, Henry, Huron, Lake, Lorain, Lucas, Mahoning, Medina, Mercer, Ottawa, Portage, Putnam, Richland, Sandusky, Seneca, Stark, Summit, Trumbull, Wayne, Williams and Wood Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. New for 2025

This is the first year for the Postal Service Health Benefits Program (PSHBP). This Section is not an official statement of benefits. For that, go to Section 5. Benefits.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation.

Note: If you are enrolled in our Medicare Part D PDP EGWP, you will receive a second ID card for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-315-3144 (TTY: 711) or write to us at Medical Mutual of Ohio, Customer Care, PO Box 6018, Cleveland, OH 44101-1018. You may also request replacement cards through our website: www.MedMutual.com/PSHB.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay cost-sharing as defined in Section 10, *Definitions of terms we use in this* brochure.

Balance Billing Protection

PSHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-315-3144 (TTY: 711) for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care.

- **Primary care**

Your primary care provider can be a Physician or group of Physicians, advanced nurse practitioners trained in family or general practice, geriatrics, internal medicine, obstetrics/gynecology or neonatology/pediatric medicine. Your primary care provider will provide most of your healthcare or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Here are some other things you should know about specialty care:

Specialty care is care you receive from providers other than a primary care provider. You may pay different cost-sharing for your specialty care. A referral is not required to see a specialist that is participating in your network. You may make appointments directly with these providers.

You generally must receive your care from a participating Network provider. However, if your Network provider determines that covered services are not available from participating In Network providers, they will need to obtain authorization in advance for a referral, you may seek the initial consultation from the specialist to whom you are referred. You must then return to your Network provider after the consultation, unless your referral authorizes a certain number of additional visits without the need to obtain another referral. In order to receive covered follow up care from an Out of Network specialist, the provider must first obtain authorization from us. Do not go to an Out of Network provider for return visits until you have received written authorization from us for additional services. Services, drugs and supplies related to a covered abortion (see Section 6. General exclusions- services, drugs and supplies we do not cover), are covered. Please contact Medical Mutual for information on how to access this coverage including claims related issues at 800-315-3144.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will work with you to identify another specialist for you to see.
- If you have a chronic and disabling condition and
  - lose access to your specialist because your coverage changed from the FEHB to the PSHB and your health plan does not participate in the PSHB; or
  - lose access to your specialist because we drop out of the Postal Service Employees Health Benefits (PSHB) Program and you enroll in another PSHB program plan; or:
  - lose access to your specialist because we terminate our contract with your specialist for other than cause; or
  - lose access to your specialist because we reduce our service area and you enroll in another PSHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-315-3144 (TTY: 711). If you are new to the PSHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to this PSHB plan, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the PSHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

For certain services, your Plan provider must obtain approval from us. Before giving approval, we may consider if the service or item is medically necessary and meets other coverage requirements. We call this review and approval process precertification.

Your Plan provider must obtain precertification for:

- Inpatient hospital care services, surgery and procedures
- Certain Outpatient surgeries, call customer service for information
- Non-emergency Ambulance transport, including air ambulance
- Bariatric surgery and related services
- Chemotherapy
- Clinical trials
- Cosmetic, reconstructive and plastic surgery
- Durable medical equipment (DME) and orthopedic and prosthetic devices
- Inpatient services for behavioral health and alcohol and chemical dependency
- Injections/infusions
- Organ/tissue transplants and related services
- Skilled Nursing Facility
- Hyperbaric oxygen
- Dental Related Procedures due to accident or injury
- Genetic Testing (including but not limited to BRCA1 and BRCA2)
- Services or items from a non-Plan Provider or at non-Plan facilities
- Gender Reassignment surgery and related services

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-315-3144 (TTY: 711) before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-315-3144 (TTY: 711). You may also call OPM's Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-315-3144 (TTY: 711). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

• **Concurrent care claims**	A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.
• **Emergency inpatient admission**	If you have an cause emergency admission due to a condition that you reasonably believe puts your life in danger or could serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
• **Maternity care**	You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby. Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.
• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-315-3144 (TTY: 711). If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent care claim**	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
3. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Cost for Covered Services

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care provider, you pay a copayment of $10 per office visit, and when you go in the hospital, you pay $100 per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The Standard Option has no calendar year deductible.
- The calendar year deductible is $750 per person under the Basic Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $750 under the Basic Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,500 under the Basic Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,500 under the Basic Option.

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $6,000 for Self Only or $12,000 per person for Self Plus One, or $12,000 per Self and Family enrollment (for the Standard Option) or $6,500 for Self Only or $13,000 per person for Self Plus One, or $13,000 per Self and Family enrollment (for the Basic option) in any calendar year, you do not have to pay any more for covered services.

However, copayments for the following services do not count toward your catastrophic protection out-of-pocke maximum, and you must continue to pay copayments for these services.

For members enrolled in our Plan's associated MA-PD or PDP EGWP, we are required to accumulate all members' actual out-of-pocket costs for Medicare-covered drugs, services and supplies toward the PSHB catastrophic maximum(s).

If you are enrolled in our Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP), the prescription drug out-of-pocket maximum is $1,000. After this maximum is met, we pay 100% of all eligible covered prescription drug benefits.

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit, the effective date of the change is January 1, and covered expenses that apply to this plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB plans during Open Season, the effective date of your new PSHB plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

In-network services are services provided by a MedFlex provider.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of Ohio.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to

https://www.medmutual.com/Employers/No-Surprises-Act-Transparency-Under-the-Consolidated-Appropriations-Act-2021.aspx

or contact the health plan at 800-315-3144 (TTY: 711).

Section 5. Standard and Basic Option Benefits

Page 104 and page 106 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Standard and Basic Option Benefits Overview

Page 94 and page 96 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Basic and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 800-315-3144 (TTY: 711) or on our website at www.MedMutual.com/PSHB.

This Plan offers two options: the Standard and Basic Options. Both Options are designed to include preventive and acute care services provided by our Plan providers, but offer different levels of benefits and services for you to choose from to best fit your health care needs.

Each option offers unique features.

Standard Option

Specific benefits of our PSHB Standard Option include:

- $25 per visit to your primary care provider (PCP) or $45 per visit to a specialist for diagnostic services
- $650 per inpatient admission
- $325 per visit for emergency services
- $15 per prescription or refill for covered retail generic drugs up to a 30-day supply
- $75 per prescription or refill for covered retail preferred brand name drugs up to a 30-day supply
- $180 per prescription or refill for covered retail non-preferred brand name drugs up to a 30-day supply.
- 25% up to $500 per prescription or refill for covered Specialty Drugs up to a 30-day supply through a contracted specialty pharmacy.

Basic Option

Specific benefits of our PSHB Basic Option include:

- $30 per visit to your primary care provider (PCP) or $60 per visit to a specialist for diagnostic services
- 20% coinsurance after deductible per inpatient admission
- $325 per visit for emergency services
- $10 per prescription or refill for covered retail generic drugs up to a 30-day supply
- 40% up to $250 per prescription or refill for covered retail preferred brand name drugs up to a 30-day supply
- 60% up to $350 per prescription or refill for covered retail non-preferred brand name drugs up to a 30-day supply.
- 30% up to $500 per prescription or refill for covered retail Specialty Drugs up to a 30 day supply through a contracted specialty pharmacy .

Please review this brochure carefully to learn which of our Medical PSHB options is best for you. If you would like more information about our benefits please contact us at 800-315-3144 (TTY: 711) or visit our Website: www.MedMutual.com/PSHB.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The Standard Option has no calendar year deductible. The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). We added "after deductible" when the deductible applies.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**Standard Option**	**Basic Option**
Professional services of physicians and other health care professionals • In a physician's office • Office medical consultations • Second surgical opinions • Advance care planning	$25 per primary care office visit $45 per specialty care office visit	$30 per primary care office visit $60 per specialty care
Professional services of physicians • In an urgent care center	$35 per visit	$45 per visit
Professional services of physicians and other health care professionals • In ambulatory surgical centers • At home by a physician • During a hospital stay • In a skilled nursing facility	Nothing	20% of the Plan allowance (deductible applies)
Telehealth services	**Standard Option**	**Basic Option**
Services not performed in-person When performed by a Provider with whom Medical Mutual has an agreement to perform these services, your coverage will include: • Providers' charges for consulting by telephone, facsimile machine, electronic mail systems or online services.	$25 per primary care office visit $45 per specialty care office visit	$30 per primary care office visit $60 per specialty care

Telehealth services - continued on next page

Benefit Description	You pay	
Telehealth services (cont.)	**Standard Option**	**Basic Option**
• Online covered services include a medical consultation using the internet via a webcam, chat or voice.	$25 per primary care office visit $45 per specialty care office visit	$30 per primary care office visit $60 per specialty care
Not covered *Non covered services include, but are not limited to, communications used for:* • *Reporting normal lab or other test results* • *Office appointment requests* • *Billing, insurance coverage or payment questions* • *Requests for referrals to doctors outside the online care panel* • *Benefit precertification* • *Physician-to-Physician consultation*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**Standard Option**	**Basic Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-ray • Non-routine mammogram • CT Scans/MRI • Ultrasound • Electrocardiogram and EEG • Nuclear medicine • PET scans Note: Tests related to infertility are covered under the infertility services benefit. See Section 5(a), Infertility services.	Nothing	20% of the Plan allowance (deductible applies)
Preventive care, adult	**Standard Option**	**Basic Option**
Routine physical every year: **The following preventive services are covered at the time interval recommended at each of the links below:**	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines. • To build your personalized list of preventive services go to https://www.health.gov/myhealthfinder • Routine mammogram - including 3D mammograms • Adult Immunizations-endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible. • Routine exams limited to - One routine eye exam every 12 months	Nothing	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows:	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• Intensive nutrition and behavioral weight-loss counseling therapy • Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases. • Family centered programs when medically identified to support obesity Note: Also see Section 5(h) • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) or 5(f)(a), if applicable for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	Nothing	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**Standard Option**	**Basic Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://www.brightfutures.aap.org • Children's immunization's endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • To build your personalized list of preventive services go to https://www.health.gov/myhealthfinder	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**Standard Option**	**Basic Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, • Behavioral Counseling to Promote a Healthy Diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider.	Nothing	Nothing
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications.	Nothing	Nothing
• When Bariatric or Metabolic surgical treatment or intervention is for severe obesity. See Section 5(b) for surgery requirements and cost share.	Nothing	Nothing
Maternity care	**Standard Option**	**Basic Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing	Nothing
Breastfeeding and lactation support, supplies and counseling for each birth Note: Here are some things to keep in mind: You do not need to precertify your vaginal delivery; see page 21 for other circumstances, such as extended stays for you or your baby.	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**Standard Option**	**Basic Option**
• As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing	Nothing
Family planning	**Standard Option**	**Basic Option**
Contraceptive counseling on an annual basis	Nothing	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a), if applicable.	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**Standard Option**	**Basic Option**
Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. If the attending Physician determines a particular service or FDA-approved item is required for medical reasons, Medical Mutual will cover that Contraceptive service or item without cost sharing. **Surgical Contraceptive Assistance** If you need information regarding which contraceptives are covered on your plan including surgical contraceptive services, contact our Customer Care at 1-800-315-3144. You plan covers tubal ligations without a cost share. Pre-authorization is only required for surgeries that required an inpatient admission. We will respond to any inquires you have regarding contraceptive services within 24 hours. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing	Nothing
Voluntary male sterilization	$25 per office visit	$30 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All Charges*

Benefit Description	You pay	
Infertility services	**Standard Option**	**Basic Option**
Infertility is defined as not being able to conceive after 1 year of unprotected sex when the individual with female reproductive organs is under 35 years of age, 6 months of unprotected sex for an individual with female reproductive organs aged 35 years and older, or 12 months of attempts of artificial insemination (6 months for individuals 35 years of age and older). Infertility may also be defined by demonstration of a disease or condition of the reproductive tract such that unprotected sex or artificial insemination would be ineffective. There are many approaches to management of infertility, including traditional fertility treatments such as artificial insemination. Options for use of artificial insemination include intrauterine insemination (IUI), intracervical insemination (ICI), and intravaginal insemination (IVI). Treatment may be permitted based on medical history or diagnostic testing. Diagnosis and treatment of infertility specific to: • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) The plan will cover three cycles (annually) of artificial insemination procedures/services. The following infertility services are considered medically necessary and eligible for reimbursement when provided by in-network providers: • Artificial Insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Therapeutic injection of drugs or hormones • Sperm preparation/washing for artificial insemination	30% of the Plan Allowance Nothing for inpatient	50% of the Plan Allowance (deductible applies)
• Fertility drugs (See Section 5(f) or 5(f)(a), if applicable	30% of the Plan Allowance Nothing for inpatient	50% of the Plan Allowance (deductible applies)

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**Standard Option**	**Basic Option**
Not covered: *These exclusions apply to fertile as well as infertile individuals or couples:* • *Assisted reproductive technology (ART) procedures, including related services and supplies, such as:* - *in vitro fertilization (IVF)* - *embryo transfer and gamete infra-fallopian transfer (GIFT) and zygote infra-fallopian transfer (Z1FT)* • *Sperm and eggs (whether from a member or from a donor) and services and supplies related to their procurement and storage, including freezing* • *Ovum transplants for fertile members* • *Infertility services when either member of the family has been voluntarily surgically sterilized* • *Services to reverse voluntary, surgically induced infertility* • *Services for surrogate mothers who are not Plan members* • *Preimplantation Genetic Diagnosis (PGD)* • *Services that are not FDA supported or supported by evidence based guidelines* *Services provided by out-of-network providers*	*All charges*	*All charges*
Iatrogenic Infertility services Coverage is provided for standard fertility preservation procedures for men and women as recognized by the American Society for Reproductive Medicine (ASRM) and/or American Society of Clinical Oncology (ASCO) for anyone facing the possibility of "iatrogenic infertility," that is, infertility caused by a necessary medical intervention. This type of coverage does not include: • Elective fertility preservation, such as egg freezing sought due to natural aging • Infertility treatments such as in vitro fertilization that might be needed after the necessary medical intervention, such as a cancer treatment to achieve a pregnancy; or • Long-term storage costs Note: All the infertility service exclusions listed in the Not Covered section above also apply to the Iatrogenic Infertility services.	30% of the Plan allowance Nothing for inpatient	50% of the Plan allowance (deductible applies)

Benefit Description	You pay	
Allergy care	**Standard Option**	**Basic Option**
• Testing	$25 per primary care office visit $45 per specialty care office visit	20% of the Plan allowance (deductible applies)
• Treatment	Nothing	Nothing
• Allergy serum	Nothing	Nothing
Not covered: • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**Standard Option**	**Basic Option**
• Cardiac rehabilitation	$25 per outpatient office visit	20% of the Plan allowance (deductible applies)
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 47.	$25 per office visit	20% of the Plan allowance (deductible applies)
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Note: Intravenous (IV)/Infusion Therapy requires our prior approval. See Section 3, You need prior Plan approval for certain benefits.	$25 per office visit, except Nothing if received in the home	20% of the Plan allowance (deductible applies)
• Growth hormone therapy (GHT) • Note: Growth hormone requires our prior approval and is covered under the prescription drug benefit. See Section 3, *You need prior Plan approval for certain benefits* and Section 5(1), *Prescription drug benefits.*	$25 per office visit	20% of the Plan allowance (deductible applies)
• Respiration and inhalation therapy	Nothing	20% of the Plan allowance (deductible applies)
• Medical Nutrition Therapy - Behavioral Counseling for pregnant women to promote a healthy diet • Medical Nutrition Therapy - Behavioral Counseling for children with Phenylketonuria (PKU) • *Must meet specific medical criteria	First nine visits - Nothing After initial nine preventive visits - Nothing	First nine visits Nothing After initial nine preventive visits- 20% of the Plan allowance (deductible applies)
Applied Behavioral Analysis Therapy (ABA) - Autism Spectrum Disorder	$25 per outpatient office visit Nothing for inpatient	20% of the Plan allowance (deductible applies)

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**Standard Option**	**Basic Option**
• All ages and services are covered subject to the corresponding medical benefit, except the following limits that apply to the Outpatient therapies per calendar year: Occupational Therapy - 60 visits per calendar year; Speech Therapy - 60 visits per calendar year; Physical Therapy- unlimited	$25 per outpatient office visit Nothing for inpatient	20% of the Plan allowance (deductible applies)
Not covered: • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b), Organ/Tissue transplants.*	*All charges*	*All charges*
Physical and occupational therapies	**Standard Option**	**Basic Option**
60 visits per calendar year (combined benefit for Physical and Occupational Therapy): • Physical habilitative and rehabilitative therapy by qualified physical therapists to attain or restore bodily function when you have a total or partial loss of bodily function due to illness or injury • Occupational habilitative and rehabilitative therapy by occupational therapists to assist you in attaining or resuming self-care and improved functioning in other activities of daily life when you have a total or partial loss of bodily function due to illness or injury	$25 per outpatient office visit Nothing per visit during covered inpatient admission	20% of the Plan allowance (deductible applies)
Not covered: • *Long-term therapy* • *Exercise programs* • *Maintenance therapy* • *Cognitive rehabilitation programs* • *Therapies done primarily for educational purposes* • *Services provided by local, state and federal government agencies, including schools*	*All charges*	*All charges*
Speech therapy	**Standard Option**	**Basic Option**
Habilitative and rehabilitative services for 60 visits per calendar year.	$25 per outpatient office visit Nothing per visit during covered inpatient admission.	20% of the Plan allowance (deductible applies)
Not covered: • *Therapies done primarily for educational purposes* • *Therapy for tongue thrust in the absence of swallowing problems* • *Voice therapy for occupation or performing arts* • *Services provided by local, state, and federal government agencies including schools*	*All charges*	*All charges*

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
• Hearing aids for children through age 17, if the hearing aids are prescribed, fitted, and dispensed by a licensed Plan audiologist Notes: • A single hearing aid providing hearing to both ears (binaural hearing aid) is considered two hearing aids for purposes of this benefit. • For coverage of: - Hearing screenings, see Section 5(a), Preventive care, children and, for any other hearing testing, see Section 5(a), Diagnostic and treatment services. - Audible prescription reading and speech generating devices, see Section 5(a), Durable medical equipment	All charges in excess of $1,000 for each hearing impaired ear every 36 months	All charges in excess if $1,000 for each hearing impaired ear every 36 months
Not covered: • *All other hearing testing, except as may be covered in Section 5(a), Diagnostic and treatment services and Section 5(a), Preventive care, children* • *Hearing aids, including testing and examinations for them, for all persons age 18 and over.*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
• Diagnosis and treatment of diseases of the eye • Eye refractions to determine the need for vision correction and provide a prescription for eyeglasses or contact lenses	$25 per primary care office visit $45 per specialty care office visit	$30 per primary care office visit $60 per specialty care office visit
Not covered: • *Eyeglass lenses or frames* • *Contact lenses, examinations for contact lenses or the fitting of contact lenses* • *Eye surgery solely for the purpose of correcting refractive defects of the eye* • *Vision therapy, including orthoptics, visual training and eye exercises*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care	**Standard Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 per primary care office visit $45 per specialty care office visit	$30 per primary care office visit $60 per specialty care office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Standard Option**	**Basic Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% of the Plan allowance	20% of the Plan allowance (deductible applies)
Not covered: • *Corrective shoes* • *Foot orthotics and podiatric use devices, such as arch supports, heel pad and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Comfort, convenience, or luxury equipment or features* • *Prosthetic devices, equipment, and supplies related to the treatment of sexual dysfunction* • *Educational training in the use of the prosthetic devices and orthotic appliances* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**Standard Option**	**Basic Option**
We cover rental or purchase, at our option, of durable medical equipment. Covered items include: • Oxygen • Hospital beds • Wheelchairs • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Infant apnea monitors • Commodes • Apnea monitors • Bilirubin lights (for home photo therapy for infants) • Compression sleeves and gloves used in treatment of physical complications of mastectomy, including lymphedema Notes: • Durable medical equipment (DME) is equipment that is prescribed by a Plan physician; obtained through sources designated by the Plan; consistent with Medicare guidelines; intended for repeated use; primarily and customarily used to serve a medical or therapeutic purpose in the treatment of an illness or injury; designed for prolonged use and appropriate for use in the home. • We cover only those standard items that are adequate to meet the medical needs of the member. We may require you to return the equipment to us, or pay us the fair market price of the equipment, when it is no longer prescribed.	25% of the Plan allowance	30% of the Plan allowance (deductible applies)
Breastfeeding pump, including any equipment required for pump functionality Note: We cover a 12 month rental.	Nothing	Nothing
Not covered: • *Audible prescription reading devices* • *Comfort, convenience, or luxury equipment or features* • *Non medical items such as sauna baths or elevators* • *Exercise and hygiene equipment* • *Electronic monitors of the heart, lungs, or other bodily functions, except for infant apnea monitors*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• *Devices to perform medical testing of bodily fluids, excretions, or substances, except blood glucose monitors for insulin dependent diabetics* • *Devices, equipment, supplies, and prosthetics related to the treatment of sexual dysfunction disorders* • *Modifications to the home or vehicle* • *Repairs, adjustments, or replacements due to misuse or loss*	*All charges*	*All charges*
Home health services	**Standard Option**	**Basic Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Notes: • We only provide these services in the Plan's service areas. • The services are covered only if you are homebound and a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home.	Nothing	20% of the Plan allowance (deductible applies)
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Custodial care* • *Private duty nursing* • *Personal care and hygiene items* • *Care that a Plan provider determines may be appropriately provided in a Plan facility, hospital, skilled nursing facility or other facility we designate and we provide, or offer to provide, that care in one of these facilities*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic	**Standard Option**	**Basic Option**
Up to 20 chiropractic visits per calendar year. • Manipulation of the spine and extremities Note: Participating chiropractors are listed at http://www.medmutual.com/PSHB	$25 per office visit	$30 per office visit
Not covered: • *Chiropractic appliances*	*All charges*	*All charges*
Alternative treatments	**Standard Option**	**Basic Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**Standard Option**	**Basic Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. • Diabetes self management	Nothing	20% of the Plan allowance (deductible applies)

Section 5(b). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The Standard Option has no calendar year deductible. The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of severe obesity (bariatric surgery)	$25 per primary care office visit for outpatient services $45 per specialty care office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
Bariatric Metabolic Surgery Members must meet the following medical criteria to be eligible for coverage: Age =18 years or adolescent aged 13 to 17 years; and Severe, clinical obesity defined as *at least one* of the following: 1. BMI =40 kg/m^2 (=37.5 kg/$m^{2)}$ for Asian patients when ethnicity is confirmed by provider attestation, or	$25 per primary care office visit for outpatient services $45 per specialty care office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**Standard Option**	**Basic Option**
2. BMI =35 kg/m^2 (=32.5 kg/m^2 for Asian patients when ethnicity is confirmed by provider attestation) with medical record documentation of high-risk comorbid clinical conditions including *at least one* of the following (presence and extent of comorbidities will be determined based upon review of medical record documentation): and 1. Clinically significant cardiopulmonary problems (e.g., hypertension, sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy); 2. Diabetes mellitus; or 3. Physical problems severely interfering with function (e.g., joint disease that would be treatable except for the obesity or body size problems; employment or ambulation precluded by obesity); or 4. Evidence of fatty liver disease (e.g., nonalcoholic fatty liver disease [NAFLD], nonalcoholic steatohepatitis [NASH]); and 5. Unequivocal clearance for bariatric surgery by a licensed mental health provider that indicates the following: no behavioral health factors preclude a successful outcome of surgery, there is an absence of any major uncontrolled psychiatric disorders, and the individual is able to comply with the recommended medical/surgical preoperative and postoperative treatment plans (NOTE: The following will require clearance specifically by a licensed psychologist or psychiatrist: Members with a history of severe psychiatric disturbance; members currently under the care of a psychologist or psychiatrist; or members on psychotropic medications. Depression due to obesity is not normally considered a contraindication for obesity surgery); and 6. Medical clearance to proceed with surgery from appropriate specialties, such as cardiology, pulmonary medicine, or sleep medicine, related to existing comorbid disease states (providers that are board-certified in obesity medicine may meet these criteria); and 7. Information regarding probable and potential postoperative complications, dietary, and medical postoperative limitations, and potential cosmetic sequelae has been received by the individual; and 8. Medical record documentation or a documented clinical history by the provider of at least 12 months that supports *all* of the above criteria;	$25 per primary care office visit for outpatient services $45 per specialty care office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**Standard Option**	**Basic Option**
NOTE: If a patient, whose initial BMI is 40 kg/m^2 or greater, loses sufficient weight to fall just below the BMI cutoff due to participation in a preoperative weight-loss program, that patient may still be eligible for bariatric surgery based on their initial BMI determination. Metabolic surgery may be considered as an option to treat type 2 diabetes in adults with BMI 30.0-34.9 kg/m^2 (27.5-32.4 kg/m^2 in Asian Americans) who do not achieve durable weight loss and improvement in comorbidities (including hyperglycemia) with nonsurgical methods. Bariatric/Metabolic surgery will be provided according to guidelines set forth by the American Diabetes Association, the American Academy of Pediatrics (AAP), and the American Society for Metabolic and Bariatric Surgery. See Section 3, *You need prior Plan approval for certain services,* for more information. You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet additional criteria necessary for bariatric surgery, including but not limited to nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Medical Mutual of Ohio designated physician.	$25 per primary care office visit for outpatient services $45 per specialty care office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
• Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a)	$25 per primary care office visit for outpatient services $45 per specialty care office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
Not covered: • *Reversal of voluntary sterilization*	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**Standard Option**	**Basic Option**
• *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*	*All charges*
Reconstructive surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Gender Affirming Care and Services - Coverage for Gender Affirming Care and Services will be provided according to the World Professional Association for Transgender Health's (WPATH) Standards including facial feminization. - There are no exclusions for medically necessary gender affirming care surgeries. - Your Plan provider must obtain precertification from the plan prior to obtaining any gender reassignment surgery. Please see Section 3 for additional details regarding the "precertification" process.	$45 per office visit for outpatient services Benefits paid based on services rendered A $650 copayment applies for any inpatient hospitalizations	20% of the Plan allowance (deductible applies) for inpatient and outpatient services
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)*	*All charges*	*All charges*

Benefit Description	You pay	
Oral and maxillofacial surgery	**Standard Option**	**Basic Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures • Medical and surgical treatment of temporomandibular joint (TMJ) disorder (non-dental); • Other surgical procedures that do not involve the teeth or their supporting structures.	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for procedures related to accidental injury of teeth* • *Correction of any malocclusion not listed above* • *Any dental care involved in treatment of temp oromandibularjoint (TMJ) pain dysfunction syndrome* • *Dental services associated with medical treatment such as surgery and radiation treatment, except for services related to accidental injury of teeth (See Section 5(g))*	*All charges*	*All charges*
Organ/tissue transplants	**Standard Option**	**Basic Option**
These s**olid organ transplants** are covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis] • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Lung: single/bilateral/lobar • Pancreas	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Systemic sclerosis	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
• National Transplant Program (NTP) – *Note: We cover related medical and hospital expenses of the donor when we cover the recipient.* We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	$45 per office visit for outpatient services Nothing for inpatient services	20% of the Plan allowance (deductible applies)
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**Standard Option**	**Basic Option**
Professional services provided in – • Hospital (inpatient)	Nothing	20% of the Plan allowance (deductible applies)
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% of the Plan allowance (deductible applies)

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The Standard Option has no calendar year deductible. The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Notes: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$650 per admission	20% of the Plan allowance (deductible applies)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and x-rays • Blood and blood products • Dressings, splints, plaster casts, and sterile tray services • Medical supplies, appliances, and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing	20% of the Plan allowance (deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
• The collection and storage of autologous blood for elective surgery when authorized by a Plan physician. Note: You may receive covered hospital services for certain dental procedures if a Plan physician determines you need to be hospitalized for reasons unrelated to the dental procedure. The need for anesthesia, by itself, is not such a condition.	Nothing	20% of the Plan allowance (deductible applies)
Not covered: • *Custodial care and care in an intermediate care facility* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds* • *Private nursing care, except when medically necessary* • *Inpatient dental procedures* • *Cord blood procurement and storage for possible future need for a yet-to-be determined member recipient.*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**	**Basic Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Lab, x-ray, and other diagnostic tests • Blood and blood products • The collection and storage of autologous blood for elective surgery, when authorized by a Plan physician • Pre-surgical testing • Dressing, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service	$375 per outpatient surgery	20% of the plan allowance (deductible applies)
Not covered: • *Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient.*	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**	**Basic Option**
Up to 100 days per calendar year • When you need full-time skilled nursing care All necessary services are covered, including: • Room and board • General nursing care • Medical social services • Prescribed drugs, biologicals, supplies, and equipment, including oxygen, ordinarily provided or arranged by the skilled nursing facility	Nothing	20% of the Plan allowance (deductible applies)
Not covered: • *Custodial care and care in an intermediate care facility* • *Personal comfort items, such as telephone, television, barber services, and guest meals and beds.*	*All charges*	*All charges*
Hospice care/End of Life Care	**Standard Option**	**Basic Option**
Supportive and palliative care for a terminally ill member: • You must reside in the service area • Services are provide - in the home, when a Plan physician determines that it is feasible to maintain effective supervision and control of your care in your home, or - in a Plan-approved hospice facility, if approved by a Plan physician Services include inpatient care, outpatient care, and family counseling. A Plan physician must certify that you have a terminal illness, with a life expectancy of approximately six months or less. Note:	Nothing	Nothing

Hospice care/End of Life Care - continued on next page

Benefit Description	You pay	
Hospice care/End of Life Care (cont.)	**Standard Option**	**Basic Option**
Hospice is a program for caring for the terminally ill patient that emphasizes supportive services, such as home care and pain and symptom control, rather than curative care. A person who is terminally ill may elect to receive hospice benefits. These palliative and supportive services include nursing care, medical social services, therapy services for purposes of safety and symptom control, physician services, palliative drugs in accord with our drug formulary guidelines, medical supplies and equipment, and short-term inpatient care for pain control and acute and chronic symptom management. We also provide inpatient respite care, counseling, and bereavement services. If you make a hospice election, you are not entitled to receive other health care services that are related to the terminal illness. If you have made a hospice election, you may revoke that election at any time, and your standard health benefits will be covered.	Nothing	Nothing
Not covered: • *Independent nursing (private duty nursing)* • *Homemaker services*	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
• Local licensed ambulance service when medically necessary Note: See Section 5 (d) for emergency services	$350 per trip	20% of the plan allowance (deductible applies)
Not covered: • *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.*	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The Standard option has no calendar year deductible. The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In a life-threatening emergency, call 911 or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member must notify us within 24 hours unless it is not reasonable to do so. It is your responsibility to be sure we have been timely notified.

Emergency inpatient admission
If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

Emergencies within our service area

If you are unsure whether you are experiencing an emergency, call your Primary Care Provider at the number listed in the Provider Directory, or call our 24/7 Nurse Line 888-912-0636 (TTY: 711) for assistance. To better coordinate your emergency care, if you are inside the Service Area, you should go to a Plan facility if possible. You must return to us for follow-up care after emergency services are received within our service area.

Emergency care may be received by calling 911 or by going to the nearest emergency room.

If you need to be hospitalized at a non-Plan facility, we must be notified as soon as reasonably possible. You can call us toll-free from anywhere in the United States at 800-338-4114. If you are hospitalized in a non-Plan facility and our physicians believe care can be better provided in a Plan designated hospital, you will be transferred when medically feasible. If you do not notify us, we will not cover any services you receive after transfer would have been possible. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching us would result in death, disability, or significant jeopardy to your condition.

Emergencies outside our service area

Emergency care may be received by calling 911, by going to the nearest emergency room or seeking care at any urgent care or physician's office for medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, you must notify us as soon as is reasonably possible. You can call us toll-free from anywhere in the United States at 800-338-4114. If a Plan provider believes care can be better provided in a Plan hospital, we will transfer you when medically feasible. Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers to be covered by this Plan. With the MedFlex HMO, you will be responsible for the full cost of any services you receive from non-network providers. (excluding emergency services).

You may obtain emergency and urgent care from Med Flex medical facilities and providers when you are in the Medical Mutual service area. You may also call Customer Care at 800-315-3144 (TTY:711).

Benefit Description	You pay	
Emergencies within our service area	**Standard Option**	**Basic Option**
• Urgent care center	$35 per visit	$45 per visit
• Emergency care as an outpatient at an emergency facility, including physicians' services Notes: • We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient. Your inpatient admission copayment will still apply (see Section 5(c)). Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived.	$325 per visit	$325 per visit
Not covered: • *Elective care or non-emergency care* • *Urgent care at a non-Plan urgent care center*	*All charges*	*All charges*
Emergency outside our service area	**Standard Option**	**Basic Option**
• Urgent care center	$35 per visit	$45 per visit
• Emergency care as an outpatient in a hospital, including physicians' services Notes: • We waive your emergency room copayment if you are directly admitted to a hospital as an inpatient. Your inpatient admission copayment will still apply (See Section 5(c)). • Transfers to an observation bed or observation status do not qualify as an admission to a hospital and your emergency copayment will not be waived.	$325 per visit	$325 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*	*All charges*

Emergency outside our service area - continued on next page

Benefit Description	You pay	
Emergency outside our service area (cont.)	**Standard Option**	**Basic Option**
• *Follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The Standard Option has no calendar year deductible. The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- As an additional benefit, all Covered Persons under the plan may take advantage of the option of seeing a MedFlex provider free of charge for up to three sessions. The MedFlex provider may offer up to three (3) sessions at no charge to provide the Covered Person(s) with brief consultation and referral sources, if warranted. This additional benefit is provided as a service to Covered Persons to facilitate timely assessment and referral to a Participating Provider where delays might otherwise occur in getting timely, appropriate treatment.
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional services	**Standard Option**	**Basic Option**
We cover professional services recommended by a mental health or substance use disorder Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Notes: • We cover the services only when we determine that the care is clinically appropriate to treat your condition, and only when you receive the care as part of a treatment plan developed by a mental health or substance use disorder Plan provider. • OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment in favor of another.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Benefit Description	You pay	
Diagnostics	**Standard Option**	**Basic Option**
Diagnosis and treatment of mental illness. Services include: • Diagnostic evaluation • Treatment and counseling (including individual and group therapy visits) • Crisis intervention and stabilization for acute episodes	$25 per office visit for individual therapy $12 per office visit for group therapy	$30 per office visit for individual therapy $60 per office visit for group therapy
• Psychological testing necessary to determine the appropriate psychiatric treatment	$25 per office visit for individual therapy $12 per office visit for group therapy	$30 per office visit for individual therapy $60 per office visit for group therapy
Diagnosis and treatment of substance use disorders. Services include: • Detoxification (medical management of withdrawal from the substance) • Treatment and counseling (including individual and group therapy visits) Notes: • You may see an outpatient mental health or substance use disorder Plan provider for outpatient services without a referral from your primary care provider. See Section 3, *How you get care,* for information about services requiring our prior approval. • Your mental health or substance use disorder Plan provider will develop a treatment plan to assist you in improving or maintaining your condition and functional level, or to prevent relapse and will determine which diagnostic and treatment services are appropriate for you.	$25 per office visit for individual therapy $5 per office visit for group therapy (maximum $5 per day for substance abuse benefit)	$30 per office visit for individual therapy $60 per office visit for group therapy
• Medication evaluation and management	$25 per office visit	$30 per office visit
Inpatient hospital or other covered facility	**Standard Option**	**Basic Option**
• Inpatient psychiatric or substance use disorder care • Residential Treatment Note: All inpatient admissions require approval by a mental health or substance use disorder Plan physician.	$650 per admission limited to 100 days per calendar year	20% of the Plan allowance (deductible applies)

Benefit Description	You pay	
Outpatient hospital or other covered facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$25 per day	20% of the Plan allowance (deductible applies)
Not covered: • *Care that is not clinically appropriate for the treatment of your condition* • *Inpatient services we have not approved* • *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of psychiatric condition* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* • *Services that are custodial in nature* • *Services rendered or billed by a school or a member of its staff* • *Services provided under a federal, state, or local government program* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms* • *Inpatient services that are not part of a preauthorized approved treatment plan*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart in this section.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and we cover them only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The Standard Option has no calendar year deductible. The calendar year deductible for the BasicOption is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment). We added "deductible applies" when the deductible applies.
- Be sure to read Section 4, *Your Cost for Covered Services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including withMedicare.

There are important features you should be aware of. These include:

What if my doctor prescribes a medication that is not on the National Preferred Plus formulary?

Talk with your doctor or health provider to see if the formulary includes a medication to treat your condition. In most cases, your provider will find one that meets your needs.

In the rare instance that none of the covered medications is appropriate for you and a non-formulary medication is required, your provider can contact Express Scripts and ask for a formulary coverage review by:

If an exception is made based on medical necessity, you will only pay your plan's applicable cost share (e.g., generic, non-preferred brand, specialty). If your provider does not request a coverage review and you fill a prescription for a non-formulary medication, you will pay the full cost.

Exception requests for Contraceptive medications will be processed within 24 hours of receiving all necessary information from your provider.

Calling 1-800-753-2851. Your provider will receive a form to fill out and fax back to Express Scripts. Express Scripts will send you and your doctor a letter confirming if coverage is approved (usually within three business days of receiving the necessary information).

Accessing our online tool at https://www.Express-PAth.com. Your provider can initiate new requests, complete existing requests or check the status of previously submitted requests.

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. We cover prescriptions filled at a non-Plan pharmacy only for covered out-of-area emergencies and out-of-area urgent care services as specified in Section 5(d), Emergency services/accidents.
- **Where you can obtain them.** You may fill your prescriptions at any in-network retail pharmacy. To see what retail pharmacies are in the National Medicare Performance Network, log in to our secure member website, My Health Plan, at www.MedMutual.com/ member. Click Find a Provider then choose Pharmacy as the Provider Type. You may also use Express Scripts Home Delivery pharmacy. Plan members called to active military duty (or members in time of national emergency), should call a Plan pharmacy when they need to fill prescribed medications.
- **We have a formulary.** A group of physicians, pharmacists, and other healthcare professionals choose the medications included in our drug formulary. These providers meet regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. If you would like information about whether a particular drug is included on our formulary, please call Express Scripts at 800-417-1961 (TTY: 711 - for hearing impaired) or view the formulary on our secure member website, My Health Plan. Log in at www.MedMutual.com/ member and click on Benefits and Coverage, then Prescription Drug Benefit.

- **These are the dispensing limitations.** Prescription drugs will be provided for one copayment up to a 30-day supply or a 90-day supply sent to your home through our direct mail service. We provide up to a 30-day supply based on (a) the prescribed dosage, (b) the standard manufacturer's package size, and (c) specified dispensing limits. Drugs to treat sexual dysfunction have dispensing limitations; contact Express Scripts at 800-417-1961 (TTY: 711 - for hearing impaired) for details. Drugs that have a significant potential for waste or misuse and those we determine are in limited supply in the market will be provided for up to a 30-day supply in any 30-day period.
- **The Generic Incentive Program.** If members request a brand name drug when a generic equivalent is available they will pay the brand name drug copayment (preferred or non-preferred) PLUS the difference in cost between the generic and the brand name drug. Please note: For mail-order pharmacy maintenance, or long-term prescriptions (taken for three months or more), the generic equivalent will automatically be substituted unless you or your provider specifies the brand-name drug must be provided through a dispense-as-written (DAW) order.
- **Why use generic drugs?** Typically generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When do you have to file a claim?** You do not need to file a claim when you receive drugs from a Plan or affiliated pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for covered out-of-area emergency and out-of-area urgent care as specified in Section 5(d), Emergency services/accidents. For information about how to file a claim, see Section 7, Filing a claim for covered services.
- **Preventive Plus Generic Medication Program.** You pay nothing for drugs on the Standard Plus Medication List. The Prevention Plus Generic Medication Program medication list includes medication to treat asthma, diabetes, high blood pressure and high cholesterol.
- **The Active Choice Home Delivery Program** encourages you to utilize mail order and receive 90-day supplies for maintenance medications which promotes adherence and will reduce your member cost share for long-term medications and say money. If your Prescription Drug Order is for a Prescription Drug that is for a Prescription Drug that is available through the Home Delivery Drug Program and you choose not to use the Home Delivery Prescription Drug Program, you will be required to pay 100% of the Allowed Amount when your Prescription Order is filled beyond the third time within a 180 day period unless you call Express Scripts at 800-417-1961 (TTY: 711 — for hearing impaired) and make an active choice to continue filling at retail. If you inform Express Scripts of your decision to refill maintenance medications at an in-network retail pharmacy, you may continue to do so without penalty. Costs for maintenance medications will no longer count towards your Plan's calendar year deductible (Basic Option) or out-of-pocket maximum if you continue to refill maintenance medications through their retail pharmacy without notifying Express Scripts.

Benefit Description	You pay	
Covered medications and supplies	**Standard Option**	**Basic Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Certain over-the-counter medications prescribed by a provider and listed on the Plan's formulary • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Growth hormones Growth hormone requires our prior approval. See Section 3, Services requiring our prior approval. • Drugs for sexual dysfunction	**Retail Pharmacy** Tier 1 - $15 per prescription or refill for retail generic drugs for up to 30-day supply Tier 2 - $75 per prescription or refill for retail preferred brand-name drugs for up to 30-day supply Tier 3 - $180 per prescription or refill for retail non-preferred brand-name drugs for up to 30-day supply Tier 4 - 25% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs filled through a contracted specialty pharmacy	**Retail Pharmacy** Tier 1 - $10 per prescription or refill for retail generic drugs for up to 30-day supply Tier 2 - 40% up to $250 per prescription or refill for retail preferred brand-name drugs for up to 30-day supply Tier 3 - 60% up to $350 per prescription or refill for retail non-preferred brand-name drugs for up to 30-day supply Tier 4 - 30% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs filled through a contracted specialty pharmacy

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
• Compound drugs - For compound drugs you will be charged your applicable generic or brand name drug copayment depending on the compound drug's main ingredient, whether the main ingredient is a generic or brand name drug - A compound drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription. - The Carrier does not cover compounded prescriptions unless all the ingredients are FDA approved and determined to be medically necessary • Drugs to treat gender dysphoria - Drug treatment for gender dysphoria is individualized and varies. Examples of covered drugs are included below and may require prior authorization. Drug coverage is subject to change. Please consult the formulary for more information. - Feminizing hormone therapy: estradiol tablets or patches, estradiol valerate injection - Masculinizing hormone therapy: testosterone cypionate injection, testosterone enanthate injections Financial assistance programs also known as "Patient Assistance Programs," "Fee Forgiveness," "Nor Out-of-Pocket," 'Manufacturers Coupons," "Discount programs," for Specialty Drugs will not count toward your out-of-pocket maximum or deductible, if you have one.	**Retail Pharmacy** Tier 1 - $15 per prescription or refill for retail generic drugs for up to 30-day supply Tier 2 - $75 per prescription or refill for retail preferred brand-name drugs for up to 30-day supply Tier 3 - $180 per prescription or refill for retail non-preferred brand-name drugs for up to 30-day supply Tier 4 - 25% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs filled through a contracted specialty pharmacy **Mail Order** Tier 1 - $30 per prescription or refill for mail-order generic drugs for up to 90-day supply Tier 2 - $150 per prescription or refill for mail-order preferred brand-name drugs for up to 90-day supply Tier 3 - $360 per prescription or refill for mail-order non-preferred brand-name drugs for up to 90-day supply Tier 4 - Mail order not available for specialty medications **Note:** If there is no generic equivalent available, you will still have to pay the brand name copay.	**Retail Pharmacy** Tier 1 - $10 per prescription or refill for retail generic drugs for up to 30-day supply Tier 2 - 40% up to $250 per prescription or refill for retail preferred brand-name drugs for up to 30-day supply Tier 3 - 60% up to $350 per prescription or refill for retail non-preferred brand-name drugs for up to 30-day supply Tier 4 - 30% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs filled through a contracted specialty pharmacy **Mail Order** Tier 1 - $20 per prescription or refill for mail order generic drugs for up to a 90-day supply Tier 2 - 40% coinsurance up to $500 maximum for mail order preferred brand for up to a 90-day supply Tier 3 - 60% up to $700 maximum for mail order for non-preferred brand-name drugs for up to a 90-day supply Tier 4 - Mail order not available for specialty medications **Note:** If there is no generic equivalent available, you will still have to pay the brand name copay.
Anti-Obesity Drugs	50% of the Plan allowance	50% of the Plan allowance (deductible applies)
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines.	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Medical Mutual offers robust coverage of contraceptive options in all categories. If a contraceptive is not covered but medically necessary, we offer a simple exceptions process. Your provider can contact Express Scripts to request the exception by calling 1-800-753-2851. If your provider agrees that a non-covered contraceptive is medical necessary, the exception will be granted, and your request will be approved for $0 coverage. Exception requests for Contraceptive medications will be processed within 24 hours of receiving all necessary information from your provider. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Medical Mutual allows online adjudication of OTC contraceptives at the pharmacy, which prevents members from having to pay out of pocket and submit for reimbursement later. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and programs in Section 5(a)	Nothing	Nothing
Fertility and Sexual dysfunction drugs Note: Fertility drugs are limited to three cycles per year	50% of the Plan allowance	50% of the Plan allowance (deductible applies)
Prescription and over-the-counter tobacco cessation drugs approved by the FDA to treat tobacco dependence	Nothing	Nothing
Not covered • *Drugs and supplies for cosmetic purposes*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs to enhance athletic performance* • *Prescriptions filled at out-of-network pharmacies, except for out-of-area emergencies or out of area urgent care services* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription drugs, unless they are included in our drug formulary or listed as covered above* • *Medical supplies such as dressings and antiseptics, except as listed above* • *Drugs used to shorten the duration of the common cold* • *Any requested packaging of drugs other than the dispensing pharmacy's standard packaging Replacement of lost, stolen or damaged prescription drugs or accessories* • *Drugs related to non-covered services* • *Drugs for the promotion, prevention, or other treatment of hair loss or growth*	*All charges*	*All charges*
Opioid Rescue Agents Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/.	Nothing	Nothing
Preventive medications	**Standard Option**	**Basic Option**
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Important things you should keep in mind about these benefits:

- These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP).
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at (800-315-3144 TTY:711).

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have a pharmacy network that may include pharmacies that are out-of-network or excluded for those enrolled in our standard non-PDP EGWP Prescription Drug Program.

We cover prescription drugs and medications, as described in the chart in this section.

- Please remember that all benefits are subject to the definition, limitations, and exclusions in this brochure and as allowed under Medicare rules.
- Your prescribers must obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The Medicare Part D calendar year deductible is: $0 per person. This deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your Cost for Covered Services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage.
- If you choose to opt out of or disenroll from our PDF EQWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at the Benistar Admin. Services, Inc. Retiree Customer Service Center at 1-800-236-4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a **qualifying life event (QLE)** and receive PSHB Program Prescription Drug Coverage.

The PDP EGWP opt out process:

If you were automatically group enrolled into the Express Scripts Medicare PDP EGWP and choose to opt out you can request that you not be enrolled by notifying Benistar Admin. Services, Inc., which is administering and servicing various aspects of your Express Scripts Medicare PDP EGWP prescription drug coverage. You can notify Benistar Admin. Services, Inc. Retiree Customer Service Center at 1-800-236-4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

What happens if I opt out of Express Scripts Medicare PDP EGWP enrollment?

Important: Keep in mind that if you leave our plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

If you choose not to be enrolled in this plan, you can join a new Medicare prescription drug plan or Medicare health plan outside of your former employer's plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. You can, however, join or leave a plan at any time if Medicare decides that you need Extra Help with paying the plan costs. If Medicare decides that you no longer need Extra Help, you will have two months to make changes after Medicare notifies you of its decision. You can call 1.800.MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1-877-486-2048.

Whom should I contact if I have questions?

If you have questions about the Express Scripts Medicare PDP EGWP plan, please review your plan documents or contact Benistar Admin. Services, Inc. Retiree Customer Service Center at 1-800-236-4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

The PDP EGWP disenrollment process:

When you are enrolled in the Express Scripts Medicare PDP EGWP, you may choose to disenroll at any time.

Whom should I contact if I have questions?

If you would like to disenroll from the Express Scripts Medicare PDP EGWP plan, please contact the Benistar Admin. Services, Inc. Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

If you have already joined another Medicare prescription drug plan (or a Medicare Advantage Plan with prescription drug coverage), you should have received a confirmation letter. If you have **not** joined another Medicare plan, you should think about doing so. **If you do not enroll in a new plan at this time or you do not have or obtain creditable prescription drug coverage (as good as Medicare's) for 63 days or more, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.**

General Medicare enrollment/disenrollment guidelines Remember that you can generally enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. If you meet certain special exceptions, such as if you qualify for Extra Help in paying for your prescription drug costs (see below), you may enroll in a new plan at any time during the year. Otherwise, you can only enroll in a plan, disenroll from a plan or switch plans between **October 15 and December 7** of each year.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at the Benistar Admin. Services, Inc. Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p. m., Eastern Time. TTY users should call 711.

Each new enrollee will receive a description of our PDP EGWP Summary of Benefits, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.

There are important features you should be aware of. These include:

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. We cover prescriptions filled at a non-Plan pharmacy only for covered out-of-area emergencies and out-of-area urgent care services as specified in Section 5(d), Emergency services/accidents.
- **Where you can obtain them**. You may fill your prescriptions at a National Medicare Performance Network pharmacy. To see what retail pharmacies are in network, log in to our secure member website, My Health Plan, at www.MedMutual.com/member. Click Find a Provider then choose Pharmacy as the Provider Type. You may fill a prescription through home delivery from Express Scripts Pharmacy.
- **Plan members called to active military duty** (or members in time of national emergency), should call a Plan pharmacy when they need to fill prescribed medications.
- **We have a formulary**. A group of physicians, pharmacists, and other healthcare professionals choose the medications included in our drug formulary. These providers meet regularly to consider adding and removing prescription drugs on the drug formulary based on new information or drugs that become available. If you would like information about whether a particular drug is included on our formulary, please call Express Scripts at 800-417-1961 (TTY: 711 - for hearing impaired) or view the formulary on our secure member website, https://www.express-scripts.com. Under "Prescriptions", click "Price a Medication." You can also log in at www.MedMutual.com/member and click on Benefits and Coverage, then Prescription Drug Benefit. Or call Customer Service to find out if your drug is covered.
- **These are the dispensing limitations**. These are the dispensing limitations. Non-specialty prescription drugs may be provided for one copayment up to a 31-day supply or a 90- day supply. Specialty prescription drugs may be provided for one copayment up to a 31-day supply. Prescriptions may be provided up to a limited days supply on (a) the prescribed dosage, (b) the standard manufacturer's package size, and (c) specified dispensing limits. Drugs to treat sexual dysfunction have dispensing limitations. Drugs that have a significant potential for waste or misuse will be provided for up to a 31-day supply in any 31-day period.
- **Generic Prescription Drugs** The generic equivalent will automatically be substituted unless you or your provider specifies the brand-name drug must be provided through a dispense-as-written (DAW) order.
- **Why use generic drugs?** Typically, generic drugs cost you and us less money than a brand-name drug. Under federal law, generic and brand-name drugs must meet the same standards for safety, purity, strength, and effectiveness.
- **When do you have to file a claim?** You do not need to file a claim when you receive drugs from a Plan or affiliated pharmacy. You have to file a claim when you receive drugs from a non-Plan pharmacy for covered out-of-area emergency and out-of-area urgent care as specified in Section 5(d), Emergency services/accidents. For information about how to file a direct claim, contact:
  Benistar Retiree Customer Service: 1-800-236-4782
  ESI Patient Customer Service: 1-888-345-2560
  ESI TDD: 1-800-716-3231

- **Preventive Plus Generic Medication Program** You pay nothing for drugs on the Standard Plus Medication List. The Prevention Plus Generic Medication Program medication list includes medication to treat asthma, diabetes, high blood pressure and high cholesterol.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(deductible applies" when it does not apply.		
Covered medications and supplies	**Standard Option**	**Basic Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs to treat gender dysphoria Drug treatment for gender dysphoria is individualized and varies. Examples of covered drugs are included below and may require prior authorization. Drug coverage is subject to change. Please consult the formulary for more information: - Feminizing hormone therapy: estradiol tablets or patches, estradiol valerate injection - Masculinizing hormone therapy: testosterone cypionate injection, testosterone enanthate injection • Sexual dysfunction drugs	**Retail Pharmacy** Preventive Drugs: Nothing: when prescribed by a healthcare professional and filled by a network pharmacy. Generic Drugs: $10 per prescription or refill for retail generic drugs up to 30-day supply Preferred Brand Name Drugs: $75 per prescription or refill for retail preferred brand-name-drugs for up to 30-day supply Non-Preferred Brand Name Drugs: 60% up to $180 per prescription or refill for retail non-preferred brand-name drugs for up to 30-day supply Specialty Drugs: 25% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs **Mail Order** Generic Drugs: $20 per prescription or refill for mail order generic drugs up to 90-day supply Preferred Brand Name Drugs: $150 per prescription or refill for mail order preferred brand-name- drugs for up to 90-day supply Non-Preferred Brand Name Drugs: 60% up to $360 per prescription or refill for mail order non-preferred brand-name drugs for up to 90-day supply Specialty Drugs: 25% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs	**Retail Pharmacy** Preventive Drugs: Nothing: when prescribed by a healthcare professional and filled by a network pharmacy. Generic Drugs: $10 per prescription or refill for retail generic drugs up to 30-day supply Preferred Brand Name Drugs: $75 per prescription or refill for retail preferred brand-name-drugs for up to 30-day supply Non-Preferred Brand Name Drugs: 60% up to $180 per prescription or refill for retail non-preferred brand-name drugs for up to 30-day supply Specialty Drugs: 25% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs **Mail Order** Generic Drugs: $20 per prescription or refill for mail order generic drugs up to 90-day supply Preferred Brand Name Drugs: $150 per prescription or refill for mail order preferred brand-name- drugs for up to 90-day supply Non-Preferred Brand Name Drugs: 60% up to $360 per prescription or refill for mail order non-preferred brand-name drugs for up to 90 day supply Specialty Drugs: 25% up to $500 per prescription or refill for a 30-day supply of covered Specialty Drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Medical Mutual offers robust coverage of contraceptive options in all categories. If a contraceptive is not covered but medically necessary, we offer a simple exceptions process. Your provider can contact Express Scripts to request the exception by calling 1-800-753-2851. If your provider agrees that a non-covered contraceptive is medical necessary, the exception will be granted, and your request will be approved for $0 coverage. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a) Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications*	*All charges*	*All charges*
Preventive medications	**Standard Option**	**Basic Option**
The following are covered: • Preventive Medications with a USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.	Nothing: when prescribed by a healthcare professional and filled by a network pharmacy.

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The Standard Option has no calendar year deductible. The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One enrollment, or $1,500 per Self and Family enrollment).
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Accidental injury benefit	**Standard Option**	**Basic Option**
We cover services to promptly repair (but not replace) a sound, natural tooth, if: • damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • the tooth has not been restored previously, except in a proper manner, and • the tooth has not been weakened by decay, periodontal disease or other existing dental pathology. Note: Services will be covered only when provided within 72 hours following the accidental injury.	Nothing	Nothing
Not covered: • *Services for conditions caused by an accidental injury occurring before your eligibility date*	*All charges*	*All charges*
Dental benefits	**Standard Option**	**Basic Option**
We have no other dental benefits	*Not covered*	*Not covered*

Section 5(h). Wellness and Other Special Features

Maternity Support	If a new baby is on the way, download the MedMutual Maternity app. It features a variety of resources and tools to help families prepare for baby's arrival. Visit MedMutual.com/MaternityApp to learn more. For pregnancies that are considered high-risk, we offer access to a registered nurse who specializes in high-risk maternity care. Call our Case Management team at 1-800-258-3175 to learn more.
Wellness Program	Medical Mutual's wellness programs provide plan members with core initiatives designed to help them understand overall health, identify health risks and participate in a programs to improve your total well-being. The following programs and services are available to all Medical Mutual covered plan members: • Health Assessment • QuitLine Tobacco Cessation Program • Nurse Line • Weight Watchers discount • Fitness discounts • Hearing discounts • Wellness portal • Online educational tools • Online wellness challenges **The Health Assessment** Begin a focus on your health by completing the Health Assessment which allows you to assess you current health status. The Health Assessment is a confidential questionnaire that compiles information about your health status, current medical conditions and daily health habits to give you an overall picture of your health. The results show current health status, potential risk for chronic health conditions, and suggestions for improving health going forward. It offers the following advantages: • Helps you make more informed decisions about healthcare and lifestyle. • Helps you take control of your own health. • Prepares you for doctor's visits, including knowing what questions to ask. • Tailors educational materials to your health status and risks. The Health Assessment allows the Carrier to provide you with additional information on helpful programs Medical Mutual offers that can help you in the following areas: • Nutrition • Physical Activity • Seat belt usage • Stress • Tobacco use • Weight management

	QuitLine Tobacco Cessation Program - Program participants have access to professional telephone counseling, educational materials and a supply of nicotine replacement therapy (gum or patches) at no cost. **Weight Watchers Discount** - Plan members can participate in an online, at work or local meeting series and obtain a discount on the registration fees each calendar year. **Fitness Discounts** - We partner with local and national fitness clubs to offer discounts on club membership fees. **Wellness Portal** - Medical Mutual plan members will have access to a wellness portal providing health and wellness education, program enrollment information
24 hour nurse line	You may call 888-912-0636 (TTY:771) 24 hours a day, 7 days a week for any of your health concerns. You may talk with a registered nurse who can help assess medical symptoms and provide advice over the phone, when appropriate, including directing you to urgent care.
Services for deaf and hearing impaired	We provide a TTY/text telephone number at: 711. Sign language services are also available.
Disease and Maternity Management	Whether you live with a chronic condition or just found out you're pregnant, having a health coach to guide you can help improve your overall well-being. You can trust the Carrier's Chronic Condition Management and Maternity Programs to support you. Medical Mutual programs, available at no additional cost to qualified members, help members who are pregnant or diagnosed with one or more of the following conditions: • Asthma • Chronic Obstructive Pulmonary Disease (COPD) • Congestive Heart Failure • Coronary Artery Disease • Diabetes • MSK/Pain Management Our chronic condition management program includes several incentives for qualified members designed to enhance participation and improve clinical outcomes. • Active diabetes program participants receive essential diabetic testing supplies, if needed. • Diabetic participants receive an electronic tablet and glucometer to monitor and report symptoms and track blood sugar levels • Heart failure participants receive an electronic tablet, if needed, to monitor and report symptoms and weight. • COPD participants receive an electronic tablet and scale, if needed, to monitor and report symptoms • Coronary artery disease participants receive an electronic tablet and home blood pressure monitor to report symptoms and track daily readings. • The Sword program offers qualifying members with musculoskeletal conditions such as chronic low back pain, neck and shoulder pain, and pain from most type of arthritis, with access to digital/virtual physical therapy. Qualifying patients receive easy to use technology to utilize at home that connects participants virtually with a Sword physical therapist.

Centers of excellence	Medical Mutual's Care Management staff includes nurse care managers who work closely with the plan member and family members to help choose the most appropriate facility based on the individual's specific needs. For transplant needs, our dedicated transplant team of specialized registered nurses work proactively with plan members and their health care providers to direct them to the plan's network transplant center based on the member's health care needs. These Medicare Certified Transplant centers provide solid and tissue transplant procedures throughout the State of Ohio. If it is determined that the plan member requires services that are not available within the State of Ohio, the transplant team coordinates out of state transplants utilizing a Transplant network.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services*.**

We do not cover the following:

- When a service is not covered, all services, drugs, or supplies related to the non-covered service are excluded from coverage, except services we would otherwise cover to treat complications of the non-covered service
- Care by non-Plan providers, except for authorized referrals, emergencies, (see Emergency services/accidents and Special features)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program
- Services required for (a) obtaining or maintaining employment or participation in employee programs or (b) insurance or governmental licensing
- Services, drugs, or supplies you receive without charge while in active military service
- Services provided or arranged by criminal justice institutions for members confined therein
- Services or supplies we are prohibited from covering under the Federal Law.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 800-315-3144 (TYY: 711), or at our website at www.MedMutual.com/PSHB.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Claims Administration
Medical Mutual of Ohio
PO Box 6018
Cleveland, OH 44101-1018

Prescription drugs

Submit your claims to:

Claims Administration
Medical Mutual of Ohio
PO Box 6018
Cleveland, OH 44101-1018

Other supplies or services

Submit your claims to:

Claims Administration
Medical Mutual of Ohio
PO Box 6018
Cleveland, OH 44101-1018

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance) and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website. If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow Medicare's appeals process outlined in Section 8a. Medicare PDP EGWP Disputed Claims Process.

Please follow this Postal Service Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to Customer Care, PO Box 6018, Cleveland, OH 44101-1018 or calling 800-315-3144 (TTY: 711).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Member Appeals, Medical Mutual, PO Box 94580, Cleveland, OH 44101-4580; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or. c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, room 3443, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM’s review within 60 days. There are no other administrative appeals. If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-315-3144. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at 202-936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-315-3144 (TTY: 711). We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination through Medicare's appeals process. See Section 8(a).

Section 8(a). Medicare PDP EGWP Disputed Claims Process

When a claim is denied in whole or in part, you may appeal the denial.

Part D Prescription Drugs

How to ask for a coverage decision or make an appeal

This section tells you what to do if you have problems getting a Part D drug or you want Express Scripts Medicare to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication.

This section is about your Part D drugs only.

- If you do not know if a drug is covered or if you meet the rules, you can ask Express Scripts Medicare. Some drugs require that you get approval from Express Scripts Medicare before we will cover them.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact Express Scripts Medicare to ask for a coverage decision.
- For more information on asking for coverage decisions or appeals about your Part D prescription drugs, see **Express Scripts Medicare Evidence of Coverage, Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

How to contact us when you are asking for a coverage decision or appeal

A coverage decision is a decision we make about your coverage or about the amount we will pay for your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made.

Initial Coverage Reviews for Part D Prescription Drugs and Appeals for Part D Prescription Drugs - Contact Information

Call:
1-844-374-7377
Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.

TTY:
1-800-716-3231
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are free. Our business hours are 24 hours a day, 7 days a week.

Fax:
1-877-251-5896

Write:
For Medicare Reviews:
Express Scripts
Attn: Medicare Reviews
P.O. Box 66571
St. Louis, MO 63166-6571

For Medicare Appeals:
Express Scripts
Attn: Medicare Appeals
P.O. Box 66588
St. Louis, MO 63166-6588

Website:
www.express-scripts.com

Step-by-step: How to ask for a coverage decision, including an exception:

Legal Term: A "fast coverage decision" is called an **"expedited coverage determination."**

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

"Standard coverage decisions" are made within **72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask Express Scripts Medicare to give you a "fast coverage decision." **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received.* (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells Express Scripts Medicare that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you We will answer your complaint within 24 hours of receipt of the complaint.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

Start by calling, writing, or faxing our plan to make your request for Express Scripts Medicare to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website at https://www.**express-scripts.com**. To assist Express Scripts Medicare in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf.

If you are requesting an exception, provide the "supporting statement," which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to Express Scripts Medicare. Or your doctor or other prescriber can tell Express Scripts Medicare on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3:We consider your request and give you our answer.

Deadlines for a "fast coverage decision"

- We must generally give you our answer within **24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires Express Scripts Medicare to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires Express Scripts Medicare to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask Express Scripts Medicare to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

A "fast appeal" is also called an "**expedited redetermination**."

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal".

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision."

Step 2: You, your representative, doctor, or other prescriber must contact Express Scripts Medicare and make your Level 1 appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

- **For standard appeals, submit a written request or call Express Scripts Medicare.**
- **For fast appeals, either submit your appeal in writing or call Express Scripts Medicare.**
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist Express Scripts Medicare in processing your request.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your Examples of good cause may include a serious illness that prevented you from contacting Express Scripts Medicare or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires Express Scripts Medicare to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: **If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the "independent review organization" is the "**Independent Review Entity**." It is sometimes called the "IRE."

The **independent review organization is an independent organization hired by Medicare.** It is not connected with Express Scripts Medicare and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable time frame, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this This information is called your "case file." **You have the right to ask Express Scripts Medicare for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast appeal"

- If your health requires it, ask the independent review organization for a "fast "
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard appeal"

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your

Step 3: The independent review organization gives you their answer.

For "fast appeals":

- **If the independent review organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.**

For "standard appeals":

- **If the independent review organization says yes to part or all of your request for coverage,** we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back for a drug you already bought,** we are required to send payment to you within **30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal.") In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.

Taking your appeal to Level 3 and beyond

Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal
An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal
The **Medicare Appeals Council (Council)** will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal
A judge at the **Federal District Court** will review your appeal

- A judge will review all of the information and decide *yes* or *no* to your This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.MedMutual.com/PSHB.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Please see Section 4, *Your Costs for Covered Services*, for more information about how we pay claims.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended PSHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these programs, eliminating your PSHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your PSHB plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact 800-315-3144 (TTY: 711).

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.
When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-315-3144 (TTY: 711) or see our website at www.MedMutual.com/PSHB.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Compare for STANDARD and BASIC Option

Benefit: Out of Pocket Maximum

Member Cost **STANDARD Option without** Medicare: $6,000/$12,000
Member Cost **STANDARD Option with** Medicare parts A and B: $6,000/$12,000
Member Cost **BASIC Option without** Medicare: $6,500/$13,000
Member Cost **BASIC Option with** Medicare parts A and B: $6,500/$13,000

Benefit: Primary Care

Member Cost **STANDARD Option without** Medicare: $25
Member Cost **STANDARD Option with** Medicare parts A and B: $25
Member Cost **BASIC Option without** Medicare: $30
Member Cost **BASIC Option with** Medicare parts A and B: $30

Benefit: Specialist

Member Cost **STANDARD Option without** Medicare: $45
Member Cost **STANDARD Option with** Medicare parts A and B: $45
Member Cost **BASIC Option without** Medicare: $60
Member Cost **BASIC Option with** Medicare parts A and B: $60

Benefit: Inpatient Hospital

Member Cost **STANDARD Option without** Medicare: $650
Member Cost **STANDARD Option with** Medicare parts A and B: $650
Member Cost **BASIC Option without** Medicare: 20% after deductible
Member Cost **BASIC Option with** Medicare parts A and B: 20% after deductible

Benefit: Outpatient Surgery

Member Cost **STANDARD Option without** Medicare: $375
Member Cost **STANDARD Option with** Medicare parts A and B: $375
Member Cost **BASIC Option without** Medicare: 20% after deductible
Member Cost **BASIC Option with** Medicare parts A and B: 20% after deductible

You can find more information about how our plan coordinates benefits with Medicare at www.MedMutual.com/PSHB.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our PSHB Medicare Advantage plan:

You may enroll in our Medicare Advantage plan and remain enrolled in our PSHB plan. For more information regarding our PSHB Medicare Advantage Plan, please contact 1-800-801-4823 (TTY: 711). Customer Care specialists are available to answer your call from 8 a.m. to 8 p.m. EST, seven days a week from October 1 to March 31 (except Thanksgiving and Christmas) and 8 a.m. to 8 p.m. EST Monday through Friday from April 1 to September 30 (except holidays)

The PSHB Medicare Advantage Plan offers enhancements to your PSHB plan by waiving your cost shares for many services and adding extra benefits for no additional cost. Enrollment in our PHSB Medicare Advantage plan is voluntary.

Below is a Summary of the benefits available on the PSHB plans we offer, you will be able to compare the plan options by reviewing the highlights for each plan listed.

Compare PSHB Standard Option, Basic Option & PSHB Medicare Advantage Option.

Benefit: Out of Pocket Maximum

Member Cost STANDARD Option without Medicare: $6,000/$12,000
Member Cost STANDARD Option & PDP - Medicare parts A and B: $6,000/$ 12,000
Member Cost BASIC Option without Medicare: $6,500/$ 13,000
Member Cost BASIC Option & PDP -Medicare parts A and B: $6,500/$ 13,000
Member Cost PSHB Medicare Advantage Option – Medicare parts A and B: Not Applicable since we are waiving the medical cost shares on this plan option.

- **Medicare Advantage (Part C)**

Benefit: Primary Care

Member Cost STANDARD Option without Medicare: $25
Member Cost STANDARD Option with PDP - Medicare parts A and B: $25
Member Cost BASIC Option without Medicare: $30
Member Cost BASIC Option with PDP - Medicare parts A and B: $30
Member Cost PSHB Medicare Advantage Option – Medicare parts A and B: $0

Benefit: Specialist

Member Cost STANDARD Option without Medicare: $45
Member Cost STANDARD Option with PDP - Medicare parts A and B: $45
Member Cost BASIC Option without Medicare: $60
Member Cost BASIC Option with PDP - Medicare parts A and B: $60
Member Cost PSHB Medicare Advantage Option – Medicare parts A and B: $0

Benefit: Medicare Advantage Prescription Drugs

Member Cost STANDARD Option for Generic Drugs Retail: $10
Member Cost STANDARD Option for Preferred Brand Name Drugs Retail: $75
Member Cost STANDARD Option for Non-Preferred Brand Name Drugs Retail: 60% up to $180
Member Cost STANDARD Option for Specialty Drugs Retail: 25% up to $500
Member Cost STANDARD Option for Generic Drugs Mail Order: $20
Member Cost STANDARD Option for Preferred Brand Name Drugs Mail Order: $150
Member Cost STANDARD Option for Non-Preferred Brand Name Drugs Mail Order: 60% up to $360
Member Cost STANDARD Option for Specialty Drugs Mail Order: 25% up to $500

Member Cost BASIC Option for Generic Drugs Retail: $10
Member Cost BASIC Option for Preferred Brand Name Drugs Retail: $75
Member Cost BASIC Option for Non-Preferred Brand Name Drugs Retail: 60% up to $180
Member Cost BASIC Option for Specialty Drugs Retail: 25% up to $500
Member Cost BASIC Option for Generic Drugs Mail Order: $20
Member Cost BASIC Option for Preferred Brand Name Drugs Mail Order: $150
Member Cost BASIC Option for Non-Preferred Brand Name Drugs Mail Order: 60% up to $360
Member Cost BASIC Option for Specialty Drugs Mail Order: 25% up to $500

This Plan and another plan's Medicare Advantage plan: You may enroll in another non-PSHB plan's Medicare Advantage plan and also remain enrolled in our PSHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended PSHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant, you can suspend your PSHB coverage to enroll in a Medicare Advantage plan, eliminating your PSHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

- **Medicare Prescription Drug Plan (PDP) Drug Plan Employer Group Waiver Plan (EGWP)**

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in our Medicare Advantage Prescription Drug Plan (MAPD), you will be automatically group enrolled into our Medicare PDP EGWP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to receive benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: You have the choice to opt out of or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

Members with higher incomes may have a separate premium payment for their Medicare Part D Prescription Drug Plan (PDP) benefit. Please refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov , or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact 800-801-4823 (TTY: 711).

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage. However, you can enroll in our MAPD during Open Season or for a **qualifying life event (QLE)** and receive PSHB Program Prescription Drug Coverage.

The PDP EGWP opt out process:

If you were automatically group enrolled into the Express Scripts Medicare PDP EGWP and choose to opt out you can request that you not be enrolled by notifying Benistar Admin. Services, Inc., which is administering and servicing various aspects of your Express Scripts Medicare PDP EGWP prescription drug coverage. You can notify Benistar Admin. Services, Inc. Retiree Customer Service Center at 1-800-236-4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

What happens if I opt out of Express Scripts Medicare PDP EGWP enrollment?

Important: Keep in mind that if you leave our plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

If you choose not to be enrolled in this plan, you can join a new Medicare prescription drug plan or Medicare health plan outside of your former employer's plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. You can, however, join or leave a plan at any time if Medicare decides that you need Extra Help with paying the plan costs. If Medicare decides that you no longer need Extra Help, you will have two months to make changes after Medicare notifies you of its decision. You can call 1.800.MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for assistance. TTY users should call 1-877-486-2048.

Whom should I contact if I have questions?

If you have questions about the Express Scripts Medicare PDP EGWP plan, please review your plan documents or contact Benistar Admin. Services, Inc. Retiree Customer Service Center at 1-800-236-4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

The PDP EGWP disenrollment process:

When you are enrolled in the Express Scripts Medicare PDP EGWP, you may choose to disenroll at any time.

Whom should I contact if I have questions?

If you would like to disenroll from the Express Scripts Medicare PDP EGWP plan, please contact the Benistar Admin. Services, Inc. Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

If you have already joined another Medicare prescription drug plan (or a Medicare Advantage Plan with prescription drug coverage), you should have received a confirmation letter. If you have **not** joined another Medicare plan, you should think about doing so. **If you do not enroll in a new plan at this time or you do not have or obtain creditable prescription drug coverage (as good as Medicare's) for 63 days or more, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.**

General Medicare enrollment/disenrollment guidelines Remember that you can generally enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. If you meet certain special exceptions, such as if you qualify for Extra Help in paying for your prescription drug costs (see below), you may enroll in a new plan at any time during the year. Otherwise, you can only enroll in a plan, disenroll from a plan or switch plans between **October 15 and December 7** of each year.

Note: If you choose to opt out of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or for a QLE. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at the Benistar Admin. Services, Inc. Retiree Customer Service Center at 1.800.236.4782, Monday through Friday, 8:30 a.m. through 5:30 p.m., Eastern Time. TTY users should call 711.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have PSHB coverage on your own as an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have PSHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Postal Service and your position is excluded from the PSHB (your employing office will know if this is the case) and you are not covered under PSHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Postal Service and your position is not excluded from the PSHB (your employing office will know if this is the case) and...		
• You have PSHB coverage on your own or through your spouse who is also an active employee		✓
• You have PSHB coverage through your spouse who is an annuitant	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a Postal employee receiving Workers' Compensation		✓*
8) Are a Postal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30-month coordination period)**		✓
• Medicare based on ESRD **(after the 30-month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have PSHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have PSHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

(1) Assistance with activities of daily living, for example, walking, getting in and out of bed, dressing, feeding, toileting, and taking medicine. (2) Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates, or the presence of a supervising licensed nurse. Custodial care that last 90 days or more is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational services

We do not cover a service, supply, item, or drug that we consider experimental. We consider a service, supply, item, or drug to be experimental when the service, supply, item or drug:

1. has not been approved by the FDA; or
2. is the subject of a new drug or new device application on file with the FDA; or
3. is part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial; or is intended to evaluate the safety, toxicity, or efficacy of the service; or
4. is available as the result of a written protocol that evaluates the service's safety, toxicity, or efficacy; or
5. is subject to the approval or review of an Institutional Review Board; or
6. requires an informed consent that describes the service as experimental or investigational.

We carefully evaluate whether a particular therapy is safe and effective or offers a reasonable degree of promise with respect to improving health outcomes. The primary source of evidence about health outcomes of any intervention is peer-reviewed medical or dental literature.

Group health coverage

Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an employee organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, or coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also "group health coverage."

Healthcare professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medically Necessary

All benefits need to be medically necessary in order for them to be covered benefits. Generally, if your Plan physician provides the service in accord with the terms of this brochure, it will be considered medically necessary. However, some services are reviewed in advance of you receiving them to determine if they are medically necessary. When we review a service to determine if it is medically necessary, a Plan physician will evaluate what would happen to you if you do not receive the service. If not receiving the service would adversely affect your health, it will be considered medically necessary. The services must be a medically appropriate course of treatment for your condition. If they are not medically necessary, we will not cover the services. In case of emergency services, the services that you received will be evaluated to determine if they were medically necessary.

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B

Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C

Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D EQWP

A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Us/We

Us and We refer to Medical Mutual.

You

You refers to the enrollee and each covered family member.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800-315-3144 (TTY: 711). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the Standard Option - 2025

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.MedMutual.com/PSHB. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- The Standard Option does not have an annual deductible.

Standard Option Benefits	You pay	Page
Medical services provided by physicians and other health care professionals: Diagnostic and treatment services provided in the office	$25 per primary care office visit $45 per specialty care office visit	27
Services provided by a hospital: • Inpatient	$650 per admission	53
Services provided by a hospital: • Outpatient	$375 per outpatient surgery	54
Emergency benefits: • In-area	$325 per visit	58
Emergency benefits: • Out-of-area	$325 per visit	58
Mental health and substance use disorder treatment:	Regular cost-sharing.	60-62
Prescription drugs: **PDP RX MOOP**: $2000 **In-Network Retail:** 31-day supply **Mail Order:** 90-day supply **Specialty Drugs:** 30-day supply	**Retail Pharmacy** • Tier 1 - Generic Drugs: - $10 per prescription or refill • Tier 2 - Preferred Brand Name Drugs: $75 per prescription or refill • Tier 3 - Non-Preferred Brand Name Drugs: 60% with a maximum of a $180 copayment per prescription or refill • Tier 4 - Specialty Drugs (through a contracted specialty pharmacy): 25% with a maximum of a $500 copayment **Mail Order** • Tier 1 - Generic Drugs: $20 per prescription or refill • Tier 2- Preferred Brand Name Drugs: $150 per prescription or refill • Tier 3- Non-Preferred Brand Name Drugs: 60% with a maximum of a $360 copayment per prescription or refill	65-69

	• Tier 4 - Specialty Drugs: Not applicable or available	
Prescription drugs: • In-network Mail order 90-day supply	Tier 1 - $30 per prescription or refill for mail-order generic drugs for up to 90-day supply Tier 2- $150 per prescription or refill for mail-order preferred brand-name drugs for up to 90-day supply Tier 3- $360 per prescription or refill for mail-order non-preferred brand-name drugs for up to 90-day supply Tier 4- Mail order not available for Specialty medications	65-69
Dental care:	No benefit. Except for Accidental Injury to teeth	74
Vision care:	Refractions; $25 per primary care office visit $45 per specialty care office visit	38
Special features:	24/7 Nurse Line; Centers of Excellence; Services for the deaf, hard or hearing or speech impaired, Wellness, Disease and Maternity Management	75-77
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $6,000/Self Only or $12,000/per Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	22-23

Notes

Summary of Benefits for the Basic Option – 2025

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage at www.MedMutual.com/PSHB. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- The calendar year deductible for the Basic Option is $750 per person ($1,500 per Self Plus One, or $1,500 per Self and Family enrollment). We added "after deductible" when the deductible applies.

Basic Option Benefits	You pay	Page
Medical services provided by physicians and other health care professionals: Diagnostic and treatment services provided in the office	$30 per primary care office visit $60 per specialty care office visit	27
Services provided by a hospital: Inpatient **Services provided by a hospital**: Outpatient	20% after deductible 20% after deductible	53 54
Emergency benefits: In-area **Emergency benefits:** Out-of-area	$325 per visit $325 per visit	58
Mental health and substance use disorder treatment:	Regular cost-sharing	60-62
Prescription drugs: **PDP RX MOOP**: $2000 **In-Network Retail:** 31-day supply **Mail Order:** 90-day supply **Specialty Drugs:** 30-day supply	**Retail Pharmacy** • Tier 1 - Generic Drugs: - $10 per prescription or refill • Tier 2 - Preferred Brand Name Drugs: $75 per prescription or refill • Tier 3 - Non-Preferred Brand Name Drugs: 60% with a maximum of a $180 copayment per prescription or refill • Tier 4 - Specialty Drugs (through a contracted specialty pharmacy): 25% with a maximum of a $500 copayment **Mail Order** • Tier 1 - Generic Drugs: $20 per prescription or refill • Tier 2- Preferred Brand Name Drugs: $150 per prescription or refill • Tier 3- Non-Preferred Brand Name Drugs: 60% with a maximum of a $360 copayment per prescription or refill • Tier 4 - Specialty Drugs: Not applicable or available	65-69
Dental care:	No benefit. Except for Accidental Injury to teeth	74
Vision care:	Refractions;	38

	$30 per primary care office visit $60 per specialty care office visit	
Special features:	24/7 Nurse Line; Centers of Excellence; Services for the deaf, hard or hearing or speech impaired, Wellness, Disease and Maternity Management	75-77
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum): The deductible accumulates towards the out-of-pocket maximum.	Nothing after $6,500/Self Only or $13,000/per Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	22-23

Notes

2025 Rate Information for Medical Mutual of Ohio

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options please go to www.opm.gov/healthcare-insurance/pshb/premiums/

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Basic Option Self Only	D3A	$149.67	$49.89	$324.29	$108.09
Basic Option Self Plus One	D3C	$329.27	$109.76	$713.42	$237.81
Basic Option Self and Family	D3B	$59.21	$119.73	$778.28	$259.42
Standard Option Self Only	D3D	$286.09	$284.63	$619.86	$616.70
Standard Option Self Plue One	D3F	$618.40	$637.19	$1,339.87	$1,380.50
Standard Option Self and Family	D3E	$672.95	$696.79	$1,458.06	$1,509.71