



Ohio Public Employees Retirement System

2021 Summary Plan Description
Prescription Drug Coverage

Administered by Express Scripts



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This publication is written in plain language for use by members of the Ohio Public Employees Retirement System. It is not intended as a substitute for the Federal or state law, namely the Ohio Revised Code, the Ohio Administrative Code, or the Internal Revenue Code, nor will its interpretation prevail should a conflict arise between it and the Ohio Revised Code, Ohio Administrative Code, or Internal Revenue Code. Rules governing the retirement system are subject to change periodically either by statute of the Ohio General Assembly, regulation of the Ohio Public Employees Retirement Board, or regulation of the Internal Revenue Code. If you have questions about this material, please contact our office or seek legal advice from your attorney.

This document reflects information as of the date listed herein. There is no promise, guarantee, contract or vested right to access to health care coverage or a premium allowance. The board has the discretion to review, rescind, modify or change the health care plan at any time.

OPERS PRESCRIPTION DRUG COVERAGE

As a Participant in the OPERS' Retiree Health Plan (the "Plan") administered by Medical Mutual, you are eligible for the prescription drug coverage described on the following pages, provided you are in compliance with plan requirements. This coverage is provided by OPERS and administered by Express Scripts. With your prescription drug coverage, you may purchase Prescription Drugs through a network retail pharmacy, Express Scripts' Home Delivery Pharmacy and Accredo Specialty Pharmacy.

COVERAGE STATEMENT

The OPERS prescription drug coverage described in this booklet is effective Jan. 1, 2021 and is administered by Express Scripts. The coverage information applies to Participants in the Plan. The Plan is authorized by Chapter 145 of the Ohio Revised Code, which may be amended at any time by the Ohio General Assembly. Furthermore, coverage under the Plan may be modified or eliminated at any time by the OPERS Board. Like all other health coverage sponsored by OPERS, prescription drug coverage is not guaranteed. OPERS hopes to continue the Plan but reserves the right to change or discontinue all or part of these plans at any time. Premiums, copayments/co-insurance, deductibles and all other charges or fees paid by a participant may change from year to year.

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

The Plan's prescription drug coverage is not insured by Express Scripts; it is paid from OPERS' funds. Express Scripts provides certain administrative services to the Plan. The Plan is not an ERISA-covered plan.

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

Proceeds received by OPERS as a result of offering prescription drug coverage are used to offset the cost of prescription drug claims, and the administration and operation of the Plan to the benefit of participants.

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

DEFINITIONS

Accredo Specialty Pharmacy Services: A pharmacy that dispenses specialty medications (e.g., injectables and supplies) and provides care management services to assist with therapy.

Benefit Recipient: An individual who is receiving a monthly pension benefit payment from OPERS and is properly enrolled in the Plan, as determined by OPERS. The term “you” or “your” refers to the Benefit Recipient.

Biosimilar Drug: A generic version of biologics, or specialty drugs, used to treat illnesses such as rheumatoid arthritis, Crohn’s disease, multiple sclerosis and a variety of cancers.

Brand-Name Drug: A Prescription Drug that is protected by a patent, supplied by a single company and marketed under the manufacturer’s brand name.

Co-insurance: The specified percentage of charges a Participant is required to pay for Formulary Brand-Name and Generic Drugs after the annual Deductible is met.

Copayment (Copay): The specified fee a participant in a health plan is required to pay for prescription drugs. The Plan’s prescription drug coverage doesn’t require copayments.

Covered Drug: Prescription Drugs and certain supplies that are covered.

Deductible: The dollar amount a Participant is required to pay annually for Formulary Brand-Name and Generic Drugs before the Plan pays a portion of the Participant’s cost for these Covered Drugs.

Eligible Dependent: The Benefit Recipient’s spouse and/or biological or legally adopted child(ren) as described in the Plan eligibility guidelines, who meets the terms and conditions for coverage under the Plan and who is properly enrolled in the Plan as determined by OPERS.

Formulary: A list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee. This list reflects the current clinical judgment of practicing health care practitioners—based on a review of current data, medical journals, and research information. The Plan’s Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Formulary are not covered by the Plan.

Formulary Drug: A Brand-Name or Generic Drug that is listed on your Formulary. It is also referred to as a “preferred drug.”

Generic Drug: A Prescription Drug that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and is approved by the FDA.

Home Delivery Pharmacy: An Express Scripts’ mail-order pharmacy that fills prescriptions by mail for Participants under this Plan.

Maintenance Drug: A medication that is used for chronic health conditions on an ongoing or long-term basis (e.g., antihypertensive medication taken daily to control high blood pressure).

Non-Formulary Drug: A Brand-Name Drug that is not included on the Formulary and the Participant is responsible for paying 100% of the drug cost.

Non-preferred Retail Pharmacy: An out-of-network retail pharmacy that is under contract with Express Scripts but features higher co-insurance.

Out-of-Pocket Limit (Out-of-Pocket Maximum): The maximum amount a Participant pays for covered prescription drug expenses per calendar year. This maximum amount includes your Co-insurance amounts and your Deductible. Once the maximum expense limit is met, the Participant pays nothing for Covered Drugs for the remainder of the year.

Over-the-Counter Drug (OTC): Any medical substance that can be purchased without a prescription.

Participant: A Benefit Recipient or Eligible Dependent, as determined by OPERS, who has met all conditions of eligibility and has successfully enrolled under the Plan.

Plan (or “OPERS Retiree Health Plan”): The health plan that OPERS sponsors for eligible Benefit Recipients and Eligible Dependents.

Preferred Retail Pharmacy: An in-network retail pharmacy that is under contract with Express Scripts that provides lower copays and/or co-insurance.

Prescription Drug: Any medication, which by federal or state law, may not be dispensed without a prescription from a licensed health care professional authorized to prescribe drugs.

Prior Authorization: Verification that must be obtained before a medication is dispensed to ensure it is being used for a medically-approved indication.

Quantity Level Limit (QLL): Specific maximum quantity per dispensing, allowed for a drug.

Specialty Drug: High-cost drugs used to treat complex, chronic medical conditions that are often injected or infused and require special storage and monitoring. These medications must be obtained through Accredo, Express Scripts’ specialty pharmacy.

Step Therapy: The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails.

ENROLLMENT PROVISIONS

The effective date of enrollment will be determined by OPERS. When you enroll, there may be a waiting period before coverage can become effective. Contact OPERS for complete enrollment guidelines.

No person may be covered both as a Benefit Recipient and as an Eligible Dependent or as an Eligible Dependent of more than one Benefit Recipient. OPERS will not be the responsible system for prescription coverage for Benefit Recipients or Eligible Dependents who defer coverage, or who become eligible for coverage under another Ohio Retirement System (State Teachers Retirement System, Ohio Police and Fire Pension Fund, School Employees Retirement System of Ohio or State Highway Patrol Retirement System) after Jan. 1, 2007. OPERS coverage can be chosen as secondary coverage, however, as long as eligibility requirements are met.

If you will be residing at a different location on a permanent or seasonal basis, you will need to contact OPERS with your updated address information.

The Plan's prescription drug coverage is combined with its medical coverage. To be enrolled in OPERS prescription drug coverage, you must be enrolled in the OPERS Health Plan. Enrollment eligibility is defined in accordance with the Ohio Administrative Code Section 145-4-06, 145-4-08 and 145-4-09. Provisions to change your prescription drug coverage are outlined in the OPERS 2021 Coverage Guide available at opers.org.

Monthly Premiums

You are responsible for paying a portion of the cost of your medical/prescription drug coverage through a monthly premium. Monthly premiums may differ depending on your years of qualifying service credit, age at which you elected to participate in the Plan, and whether you have enrolled Eligible Dependents in the coverage. The OPERS Board determines monthly premiums and may change the premiums periodically. For more information about monthly premiums, contact OPERS.

Termination of Coverage

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

- When OPERS discontinues the Plan;
- When you cease to be a Benefit Recipient. All coverage stops at the end of the month in which the Benefit Recipient becomes ineligible;
- When you are no longer eligible for participation in the Plan due to Medicare eligibility or other eligibility requirements established by OPERS; or
- When you fail to make your premium payment.

If your coverage ceases for any reason, contact OPERS immediately to find out what rights you have under this coverage. You may terminate coverage under any OPERS-sponsored plan at any time. For instructions, please call OPERS toll-free at 1-800-222-7377. Please note that if you terminate coverage, you may re-enroll, if eligible, during the annual open enrollment period or within 60 days after your health care coverage is cancelled by another group plan. At termination of coverage, you may be eligible for a continuation of coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

COVERED DRUGS AND SUPPLIES

The following Covered Drugs and Supplies are available at Network Retail Pharmacies and through Express Scripts' Home Delivery Pharmacy and Accredo Specialty Pharmacy:

- **FDA-approved pharmaceuticals requiring a written prescription**, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a licensed pharmacist.
- **Insulin and diabetic testing supplies including:**
 - Insulin
 - Blood test strips
 - Alcohol prep pads
 - Lancets
 - Dextrose chew tabs
 - Insulin needles and syringes
 - Insulin injectors
 - Glucagon emergency kits
 - Blood glucose meter testing solutions

To obtain coverage for the items listed above, a written prescription from your doctor indicating that the medication or supply item is prescribed for the diagnosis or treatment of your diabetes is required.

- **Prescription contraceptives**, excluding contraceptive devices, appliances, implants and injectables.
- **All over-the-counter (OTC) Aspirin, Oral Fluoride, Folic Acid and tobacco cessation.** A prescription from your doctor is required for these OTC products to be covered.
- **Vaccines:**
 - Hepatitis A and B, Human Papillomavirus(HPV)
 - Measles, Mumps, Rubella
 - Zoster
 - Varicella
 - Tetanus
 - Diphtheria
 - Influenza
 - Pneumonia
 - Pertussis

A prescription from your doctor is required for these vaccines to be covered; some of these vaccines are subject to restrictions (e.g., pneumonia).

COVERAGE FEATURES AND FINANCIAL RESPONSIBILITIES

Deductible

There is a \$200 annual Deductible per Participant for Generic Drugs and a \$400 Deductible for Brand-Name Drugs under the Plan. This means a Participant pays the full cost of these Generic Drugs and Brand-Name Drugs until the Deductible is reached. After the Deductible is reached, the Participant begins paying the applicable Co-insurance for these Covered Drugs. *There is only one Deductible for each Participant regardless of whether you obtain the medication at a retail pharmacy, through Home Delivery or the specialty pharmacy.*

Co-insurance

Co-insurance must be paid at the time the prescription order is submitted. Note: If the cost of the drug is less than the Co-insurance, you will pay the lower amount. Co-insurance amounts are based on the type of medication. Generic and Brand-Name medication types are established and updated periodically by a nationally recognized drug pricing and classification source.

Medication Formulary status may change without advance notice. You will be required to pay the applicable Co-insurance for the Covered Drug after you meet the Deductible until your Out-of-Pocket Limit is met. To confirm a Co-insurance amount before you have a prescription filled, sign in at [express-scripts.com](https://www.express-scripts.com) or call Express Scripts toll-free at 1-866-727-5873.

The Patient Protection and Affordable Care Act (PPACA) requires certain health plans to provide certain medications and devices received at Preferred Retail Pharmacies and prescribed for preventive services at a \$0 Copayment/Co-insurance to a participant. The preventive medications, as identified and recommended by the United States Preventive Services Task Force, are the following: aspirin, bowel preps, breast cancer preventive medications, HIV pre-exposure prevention medications, immunizations, oral fluoride, folic acid, tobacco cessation drugs and contraceptives.

Retail Pharmacies

With the appropriate prescription, you can obtain up to a maximum 30-day supply of brand medication. Up to a 90-day supply of generic medications are available at a retail pharmacy at three times the retail Co-insurance.

Preferred Retail Pharmacy

The preferred network includes more than 59,000 independent and chain pharmacies nationwide. The network currently includes, but is not limited to, large chain pharmacies like CVS, Target, RiteAid, Giant Eagle, Wal-Mart and Kroger. The network is subject to change.

For a list of network pharmacies, call Express Scripts toll-free at 1-866-727-5873 or visit [express-scripts.com](https://www.express-scripts.com).

When you have your prescriptions filled at a Preferred Retail Pharmacy, your Co-insurance amounts are as follows:

2021 Retail Pharmacy Coverage (30 day supply)	Retail Preferred Pharmacy	Retail Non-Preferred Pharmacy
Deductible (Calendar year)	\$200 Generic \$400 Brand	\$200 Generic \$400 Brand
Generic	25% Retail co-insurance (\$4 min / \$12 max retail)	30% co-insurance (\$7 min / \$20 max)

Formulary Brand	35% Retail co-insurance (\$30 min / \$80 max)	40% co-insurance (\$35 min / \$100 max)
Non-Formulary Brand	Not covered	Not covered
Out-of-Pocket Limit (100% coverage after you have spent \$2,800 in Deductible and Co-insurance)	\$2,800 per participant	\$2,800 per participant

Out-of-Network U.S. Retail Pharmacy

If you obtain your prescriptions from an out-of-network Retail Pharmacy, you will pay the full price of the medication at the time of purchase. To receive reimbursement, you will need to complete and submit a claim form along with the prescription receipts to Express Scripts. Out-of-network Retail Pharmacies have not agreed to discount pricing, so your costs will usually be higher. You must submit claims to Express Scripts within 365 days of the dispensing date to be eligible for reimbursement less the applicable Co-insurance.

Foreign Pharmacies

If you obtain your prescriptions from a pharmacy outside of the United States or Puerto Rico, you will pay the full price of the medication at the time of purchase (The drug dispensed at a foreign pharmacy *must* be an FDA-approved pharmaceutical and you must submit claims to Express Scripts within 365 days of the dispensing date to be eligible for reimbursement). After completing and submitting a claim form to Express Scripts, along with the prescription receipts, you will be reimbursed up to 60 percent of the amount OPERS would have been charged for an FDA-approved pharmaceutical had you used a Preferred Retail Pharmacy. If you are visiting for an extended period of time, you can fill your prescription using Express Scripts Home Delivery Pharmacy before you go. You can request a vacation override to receive up to six-month supply of medication in this situation.

Home Delivery Pharmacy

With the appropriate prescription, you can obtain up to a maximum 90-day supply of medication through Express Scripts’ Home Delivery Pharmacy. Co-insurance must be paid at the time the order is submitted. Medications will generally be delivered to your home within two weeks from the date Express Scripts receives your prescription order. You are responsible for any applicable postage when mailing prescriptions to Express Scripts.

When you have your prescriptions filled through the Home Delivery Pharmacy, your Co-insurance amounts are as follows:

2021 Home Delivery Pharmacy Coverage (90 day supply)	
Deductible (Calendar year)	\$200 Generic \$400 Brand
Generic	25% co-insurance (\$10 min / \$30 max)

Formulary Brand	35% co-insurance (\$75 min / \$200 max)
Non-Formulary Brand	Not covered
Out-of-Pocket Limit (100% coverage after you have spent \$2,800 in Deductible and Co-insurance)	\$2,800 per participant

Note: Home Delivery Pharmacy Co-insurance is based on the date the claim is approved for processing, not the date the prescription order is mailed or submitted. If you have reached your Out-of-Pocket Limit and you place an order in December, your claim must be approved for processing by Dec. 31 to ensure zero out-of-pocket cost.

Specialty Pharmacy

Specialty Drugs must be obtained through Accredo, Express Scripts' specialty pharmacy. Some exceptions apply. With the appropriate prescription, you can obtain up to a maximum 30-day supply of medication. Specialty Drugs largely fall into the formulary brand category but could also fall into the biosimilar or generic Specialty Drug category. These medications are subject to the appropriate Co-insurance as listed below. Accredo Specialty Pharmacy also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

Medications will be shipped to your home within 24–72 hours of receiving your order. If you obtain a prescription for a specialty medication from a retail pharmacy, beginning with your second fill, you will be required to fill the specialty medication through Accredo Specialty Pharmacy. Starting Jan. 1, 2018, copayments for certain specialty medications may be set to the maximum available from the manufacturer funded copay assistance. Only the actual amount you pay out of pocket will be applied to the Out-of-Pocket Limit. Prescriptions filled through Accredo Specialty Pharmacy provider are subject to the following Co-insurance for up to a 30-day supply:

2021 Specialty Pharmacy Coverage – Generic and Brand (30 day supply)	
Generic/Biosimilar	\$300 max
Brand Formulary	\$300 max
Non-Formulary	Not covered
Out-of-Pocket Limit	You will be covered for your prescription drug costs at 100% after an annual Out-of-Pocket Limit of \$2,800 has been met.

PLAN LIMITATIONS

- Up to a maximum 30-day supply of brand medication per original prescription or refill, as prescribed by your doctor, may be obtained at one time from a Preferred Retail Pharmacy. May not be filled more than once in a 30-day period.
- Up to a maximum 90-day supply of medication per original prescription or refill, as prescribed by your doctor, may be obtained through Express Scripts' Home Delivery Pharmacy.
- Prescribed medications, especially certain controlled substances, may be subject by law to dispensing limitations and to the professional judgment of the pharmacist.
- Through Express Scripts' Home Delivery Pharmacy or specialty pharmacy, if your doctor prescribes a drug that is available as both a Generic Drug and a Brand-Name Drug, the Generic Drug will be dispensed if allowed by state law unless you or your doctor specifically indicates otherwise.
- Drug manufacturer coupons cannot be used toward Co-insurance costs when using Express Scripts' Home Delivery Pharmacy.

PLAN EXCLUSIONS

Coverage is not provided for:

- Over-the-Counter Drugs except those listed as covered herein;
- Charges you are not required to pay or charges made only because health care coverage exists (subject to the right, if any, of the U.S. government to recover reasonable and customary charges for care provided in a military or veterans' hospital);
- Medication for which coverage is payable under workers' compensation or any occupational disease or similar law, whether such coverage is insured or self-insured;
- Erectile dysfunction products;
- Drugs or supplies that are covered under the medical coverage of the Plan;
- Durable Medical Equipment (DME) and other therapeutic devices or appliances;
- Drugs whose FDA-approved indication is to promote or stimulate hair growth regardless of the prescriber's intended use;
- Drugs whose FDA-approved indication is for cosmetic purposes regardless of the prescriber's intended use;
- Drugs or medicines lawfully obtainable without a prescription order of a licensed authorized prescriber, except insulin;
- Immunization agents unless otherwise listed as covered;
- Any charge for the administration or injection of any drug;
- Any diagnostic or testing supply (e.g., contrast dyes);
- Any amount of brand-name medicine that is more than a 30-day supply filled at the Network Retail Pharmacy or more than a 90-day supply filled through Express Scripts' Home Delivery Pharmacy;

- Any covered Generic and/or Preferred Brand-Name Drug therapeutic alternatives that are available for Non-Formulary Drugs;
- Drugs that may be received by a Benefit Recipient or an Eligible Dependent at no charge under local, state or federal programs;
- Drugs to be taken by or given to a Benefit Recipient or an Eligible Dependent while he or she is confined in a hospital or other health care facility;
- Any prescription or refill in excess of the number specified by the licensed professional or applicable law or any refill dispensed after one year from the licensed professional's original order;
- Drugs prescribed for sickness or injury resulting from war or acts of war;
- Non-sedating antihistamines;
- Experimental, investigational or unproven drugs, or drugs used for a treatment not approved by the FDA, even though a charge is made to the covered person;
- Compounded preparations that: include components not approved by the FDA (e.g., bioidentical hormones); are not approved by the FDA (e.g., transdermal verapamil); or are deemed experimental, investigational or unproven by the FDA;
- Depigmentation Agents;
- Homeopathic Drugs;
- Legend Medical Foods;
- Allergens;
- Proton Pump Inhibitors (PPI's)

COMPOUND DRUGS

For compound drugs to be covered under the Plan, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. That list may be obtained from Express Scripts. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g. if the cost of any ingredient has increased more than 5% every other week or more than 10% annually), the cost will not be considered reasonable. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage.

PRIOR AUTHORIZATION

Certain Prescription Drugs are subject to Prior Authorization or need to be preapproved by Express Scripts before they will be a Covered Drug. Drugs subject to Prior Authorization may cause potentially serious side effects and/or have a high potential for inappropriate use. Physicians now have access to EPA (electronic prior authorization), which is a process that allows the prescriber to request and complete a Prior Authorization (PA) with Express Scripts electronically from the electronic medical record (EMR) used in their normal daily workflow.

Your doctor may initiate the Prior Authorization process by calling Express Scripts toll-free at 1-800-417-8164 or by fax at 1-800-357-9577. They can also initiate using the web-based portal at Express-PAth.com. If you plan to have your prescription for a Prior Authorization drug filled at a Preferred Retail Pharmacy, consider working with your provider and completing the Prior

Authorization process before you go to the Preferred Retail Pharmacy. A registered pharmacist working at the Preferred Retail Pharmacy may also initiate or assist in the process. If you pay out of pocket waiting for a Prior Authorization approval, be aware that reimbursement will only be for 90 days from the approval date.

If approved, your prescription will be filled within any stated plan limits. If the medication is not approved for coverage, you will be responsible for paying the full cost of the drug. However, rejection of coverage may be appealed. To appeal, you or your doctor must follow the procedure outlined in the Appeals section on page 14.

COVERED DRUG LIMITATIONS

Certain Prescription Drugs are covered up to preset limits. These limits are based upon standard FDA approved dosing for the medications. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, Prior Authorization is required. In such cases your doctor may initiate Prior Authorization by calling Express Scripts' Prior Authorization Department toll-free at 1-800-753-2851. Several hundred drugs are subject to quantity limitations for patient safety based on FDA guidelines. **The following are the top ten drug categories based on OPERS Participant utilization that reach Quantity Level Limits (QLL):**

- Sleep
- Nausea/Vomiting
- Infection
- Migraine Headache
- Fungal Infection
- Osteoporosis Medications
- Pain Medications
- Cholesterol Medications
- Pain and Inflammation Medications
- Viral Infection Medications

For more information about specific drugs subject to coverage limitations, please call Express Scripts.

STEP THERAPY

Certain Prescription Drugs are subject to Step Therapy review. Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails. If Step Therapy criteria are not met, Prior Authorization will be required. Your doctor may initiate the Prior Authorization process by calling Express Scripts' Prior Authorization Department toll-free at 1-800-753-2851. If you pay out-of-pocket waiting for a prior authorization to be approved, please be aware that reimbursement will only be for 90 days from the approval date.

If approved, your prescription will be filled within any stated plan limits. If the medication is not approved for coverage, you will be responsible for paying the full cost of the drug.

However, rejection of coverage may be appealed. To appeal, you or your doctor must follow the procedure outlined in the Appeals section on page 14.

COORDINATION OF BENEFITS

If you have prescription drug coverage under another plan (e.g., an employer plan, Medicare Part B or Part D), you will be subject to the Coordination of Benefits (COB) provision under this Plan. The COB provision will determine which plan is responsible for your prescription drug expenses. For example, a Medicare Part D plan or another medical insurer may be obligated to pay expenses before the Plan. To be eligible for coverage, you are required to follow the COB procedures including, but not limited to, those relating to Prior Authorization. The Deductible must be met before COB provisions apply to Formulary and Non-Formulary medications.

Under COB, you will be reimbursed the lesser of the amount OPERS would have paid as primary payer on submitted charges, less the applicable Deductible/ Co-insurance. Submitted charges are defined as the remainder not paid by the primary payer on the prescription. For more information about COB under this Plan, call Express Scripts toll-free at 1-866-727-5873.

MAKING A COMPLAINT

This section explains how to use the process for filing a complaint with Express Scripts. The complaint process is used for problems related to quality of care, waiting times, and the customer service you receive from Express Scripts. Here are examples of the kinds of problems handled by the complaint process. If you have any of these problems you can file a complaint:

- Disrespect, poor customer service, or other negative behaviors
- Unhappy about how Customer Service has dealt with you
- Kept waiting too long by a pharmacist or Customer Service
- Believe the written information Express Scripts has given you is too hard to understand
- Believe Express Scripts has not given you the notice they are required to give
- Right to privacy was not respected

Reasons for possible complaints may also be related to the timeliness of Express Scripts' actions in respect to the coverage decisions and appeals process. If you have already asked for a coverage decision or made an appeal, and you think Express Scripts is not responding quickly enough, you can also make a complaint about their response time:

- You asked Express Scripts to give you a 'fast response' and they have said they will not.
- You believe Express Scripts is not meeting the deadlines for giving you a coverage decision or answer to an appeal.
- You believe Express Scripts is not meeting the deadlines for covering or reimbursing you for an approved coverage decision or appeal.
- Express Scripts does not give you a decision on time and fails to forward your case to the Independent Review Entity within the required time limit.

Who Can File a Complaint?

You can file a grievance yourself, or you can have someone act for you. If you want a friend, relative, your doctor, or other person to be your representative, call Express Scripts Customer

Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give Express Scripts a copy of the signed form.

Contact Express Scripts to File a Complaint

Call Express Scripts at the number on the back of your prescription ID card for filing a grievance. If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to Express Scripts. The complaint must be made within 60 calendar days after you had the problem you want to complain about.

If you are making a complaint because Express Scripts denied your request for a fast response to a coverage decision or appeal, Express Scripts will automatically give you a fast complaint. If you have a “fast” complaint, it means Express Scripts will give you an answer within 24 hours.

Express Scripts Reviews Your Complaint and Gives you an Answer

If possible, Express Scripts will answer you right away. If you call Express Scripts with a complaint, they may be able to give you an answer on the same phone call. If your health condition requires Express Scripts to answer quickly, Express Scripts will do that.

Most complaints are answered in 30 calendar days. If Express Scripts needs more information and the delay is in your best interest or if you ask for more time, they can take up to 14 more days to answer your complaint. In some cases, you can get a fast grievance, and they will respond within 24 hours.

If Express Scripts does not agree with some or all of your complaint or doesn't take responsibility for the problem you are complaining about, they will let you know. Express Scripts' response will include reasons for this answer. Express Scripts must respond whether they agree with the complaint or not.

APPEALS

Internal Review

When a claim for a Covered Drug is rejected, you may request that Express Scripts reconsider the rejection by requesting an appeal within 45 days after the date you first request coverage. Appeals for coverage of drugs that are not covered under the Plan (see Plan Exclusions on Page 9) will not be considered. In addition, certain Covered Drugs that are subject to quantity limitations (see Covered Drug Limitations on Page 11) cannot be appealed.

To request an appeal, call Express Scripts toll-free at 1-800-344-3405 ext. 373022. Upon receipt of your request for appeal, Express Scripts will send you a Prescription Claim Appeals Form. You and/or your physician should complete the form and mail or fax it to Express Scripts. Express Scripts' mailing address and fax number are noted below.

Express Scripts, Inc.
Attn: Pharmacy Appeals — A8XA Mail Route
BL0390 6625 W. 78th St.
Bloomington, MN 55439
Fax: 1-877-852-4070

Upon receipt of your completed Prescription Claim Appeals Form, Express Scripts will conduct an internal review of your appeal request. You will receive written notification of the outcome of Express Scripts' internal review within 30 days of the date Express Scripts received your completed Prescription Claim Appeals Form. If the original rejection is overturned on appeal and coverage is granted, coverage will be authorized by Express Scripts. If the appeal is rejected for coverage, coverage will not be provided; however, you may obtain the drug on your own at your own expense. A second request for internal review will be honored only if your condition changes and you supply new clinical information that was not available at the time of the original request.

External Review

If your appeal under the internal review process is rejected for coverage based on medical necessity grounds and you do not agree with that decision, you or your doctor (on your behalf) may submit a second request for medical necessity review within 45 days of the internal review denial. Medical necessity reviews are conducted by an external review organization not affiliated with Express Scripts. All available clinical information must be submitted when a request for an external review for medical necessity is made. You should receive written notification of the outcome of the external review within 30 days of the date Express Scripts receives your request for medical necessity review.

If the external review organization overturns the original rejection and coverage is granted, coverage will be authorized by Express Scripts. If the appeal is rejected for coverage, coverage will not be provided; however, you may obtain the drug on your own at your own expense. A second request for external review will be honored only if your condition changes and you supply new clinical information that was not available to your doctor at the time of the original request.

Urgent Appeal Requests

If you or your doctor believes an appeal request is urgent, write "urgent" on the written appeal request.

Urgent appeals will be reviewed and a determination should be made within 72 hours of Express Scripts' receipt of the appeal request. Your appeal request can be faxed to Express Scripts' Pharmacy Appeals Department at 1-877-852-4070.

IMPORTANT PHONE NUMBERS AND RESOURCES

Express Scripts

Claims and General Administrative

1-866-727-5873 within the U.S.
1-925-820-0700 (ext. 37-8710) outside the U.S.
1-800-899-2114 TDD
express-scripts.com

Express Scripts

Coverage Decisions and Appeal

1-800-344-3405 (ext. 373022)
1-800-899-2114 TTY
1-877-852-4070 Fax
Pharmacy Appeals-A8XA Mail Route BL0390
6625 W 78th Street
Bloomington, MN 55439

Express Scripts

Prior Authorization Department

1-800-753-2851 Phone
1-800-357-9577 Fax

Accredo Specialty Pharmacy

1-800-803-2523
accredo.com
1640 Century City Parkway
Memphis, TN 38134

OPERS Member Services Center

1-800-222-7377
opers.org
277 E. Town Street
Columbus, OH 43215

AUTHORIZATION TO RELEASE INFORMATION

By accepting coverage under the Plan, all Participants, including any enrolled Dependents, agree that they shall: (1) furnish OPERS or its designees any and all information and proof OPERS may reasonably require pertaining to health care coverage and the operations of its Plan; and (2) authorize and direct any person or organization that has provided services to the Participant to furnish OPERS or its designees any and all information and records (or copies of records) relating to care or services provided directly or indirectly to the Participant or relating to the administration of the Plan. Such information and records may be requested by OPERS or its designees at or within any reasonable time.

OPERS will protect, use and disclose information pertaining to your “protected health information” in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to the extent that HIPAA applies to the Plan. HIPAA permits the Plan to use and disclose your protected health information (1) in connection with medical treatment you receive; (2) for payment purposes, which include uses and/or disclosures related to payment for services you receive, payments of premiums to the Plan, determining eligibility for coverage, claims management and/or utilization review; and (3) to conduct health care operations. Health care operations of the Plan include quality assessment and health improvement activities including case management and care coordination. The Plan may also disclose protected health information for other purposes permitted under HIPAA, which are more fully described in the document, OPERS Notice of Privacy Practices. Your rights regarding your protected health information are also addressed in the OPERS Notice of Privacy Practices, which may be obtained by contacting the OPERS Member Services Center at 1-800-222-7377 or by visiting the OPERS website at opers.org.

FRAUD

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

RECOVERY OF COSTS

OPERS is entitled to recover the costs of any claims paid on behalf of a Participant if it is determined that the individual was not eligible for coverage at the time the claims were incurred, regardless of the amount of time that has passed.

Issue Date: January 2021

MEDICARE PART B COVERED DRUGS AND SUPPLIES

This section applies only to Participants with Medicare Part B.

Under certain conditions, a limited number of drugs/supplies can be coordinated with Medicare Part B. When a pharmacy claim is coordinated with Medicare Part B, the claim is submitted to Medicare first for primary payment and then to Express Scripts for secondary payment. This process is known as Medicare coordination of benefits (COB). Under this COB process, the Plan will pay the Participant's portion of prescription costs for specific Medicare Part B-covered drugs and supplies that are coordinated with Medicare, after Medicare Part B pays, leaving the Participant with a minimal Co-insurance obligation.

Select medications in the following therapeutic classes are eligible for coordination under Medicare Part B: diabetic testing supplies; respiratory medications and nebulizers; and immunosuppressive, oral anticancer and oral antiemetic medications. Note: The drugs/supplies eligible for coordination may differ at retail and mail. Contact Express Scripts for a list of eligible drugs/supplies. Coverage for any Medicare Part B drug or supply is subject to qualifications and regulations set by Medicare.

Participating Medicare Retail Pharmacy

Participants must use a participating Medicare Retail Pharmacy that is licensed to submit claims to Medicare Part B to have a claim for a Medicare Part B drug/supply coordinated with Medicare. Participants are advised to call their retail pharmacy to find out if it is licensed to submit claims to Medicare Part B on their behalf. If a Participant does not use a participating Medicare Retail Pharmacy, the claim cannot be coordinated with Medicare, and the Participant will pay the full cost of the prescription at the time of purchase and will not be able to recover the costs. Medicare regulations permit only licensed providers to submit claims to Medicare. If a claim for a Medicare Part B drug/supply is not submitted to Medicare first, Express Scripts cannot accept the claim as secondary payer.

Note that some specialty medications dispensed by Accredo Specialty Pharmacy, may also be eligible for coordination with Medicare Part B. Contact Accredo at 1-866-654-2174 for more information.

NOTICE OF MEDICARE PART D CREDITABLE COVERAGE

This notice is being provided to you by OPERS as required by Medicare. It requires no immediate action on your part. It provides certain protection to you should you wish to enroll in a Medicare prescription plan in the future in place of this coverage. You should keep this with your other important health insurance papers.

Important Notice about our prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Express Scripts and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. **There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. OPERS has determined that the prescription drug coverage offered by OPERS through Express Scripts is, on average for all Plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Express Scripts coverage will be affected. If you decide to join a Medicare drug plan and drop your current Express Scripts coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with OPERS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage:

Contact OPERS for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Express Scripts changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program

(See your copy of the Medicare & You handbook for their telephone number)

- For personalized help, call 1-800-MEDICARE (1-800 633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at [socialsecurity.gov](https://www.socialsecurity.gov), or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.