Ohio Public Employees Retirement System
277 East Town Street • Columbus, Ohio 43215-4642 • 1-800-222-7377 • www.opers.org

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JOHN DOE T4 P1
277 EAST TOWN STREET
COLUMBUS OH 43215-4642
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2019 Open Enrollment Statement

Below are your 2018 health care selections, options and costs for 2019.

2018 Coverage Summary

Name	Medical Plan	Medical	Vision	Dental	Total Premium
JOHN DOE	HRA	See below	$5.62	$33.54	$39.16
JANE DOE	Medical Mutual	$1,159.61	$5.62	$33.54	$1,198.77
2018 Monthly Premium					$1,237.93

2019 Coverage Summary

Name	Medical Plan	Medical	Vision	Dental	Total Premium
JOHN DOE	HRA	See below	$6.02	$34.32	$40.34
JANE DOE	Medical Mutual	$1,305.95	$6.02	$34.32	$1,346.29
2019 Monthly Premium					$1,386.63

Health Reimbursement Arrangement (HRA)

HRA allowance amounts for participants enrolled in a medical plan through Via Benefits are listed below for 2018 and 2019.

Name	2018	2019
JOHN DOE	$373.50	$373.50
Monthly HRA Deposit	**$373.50**	**$373.50**

***IMPORTANT* - Please see the back of this statement for more information specific to your account.**

The chart below provides pricing for yourself and eligible dependents you may want to cover in 2019.

Enrolling in medical coverage

Participants not-yet-eligible for Medicare will be enrolled in the OPERS Retiree Health Plan administered by Medical Mutual. Retirees enrolled in Medicare Parts A and B, excluding OPERS re-employed retirees, will receive a monthly deposit into an HRA. Enrollment in a medical plan through Via Benefits is required to receive an HRA allowance.

Optional vision and dental coverage

OPERS offers two levels of optional vision and dental coverage. Monthly premiums are shown below. The same level of coverage will apply to each family member. Enrollment is for the entire calendar year.

Eligible Participants	HRA Deposit	Medical Mutual	Aetna Vision High	Aetna Vision Low	Metlife Dental High	Metlife Dental Low
Recipient	$373.50	N/A	$6.02	$2.41	$34.32	$20.37
Spouse	N/A	$1,305.95	$6.02	$2.41	$34.32	$20.37
Per Child	N/A	$263.70	$4.66	$1.68	$20.39	$12.36

Note:

- Any retiree or child eligible for Medicare must be enrolled in Medicare Parts A and B and enrolled in a medical plan through Via Benefits in order to receive an HRA allowance. They will not be eligible for the OPERS group medical/pharmacy plan.
- The benefit recipient must enroll in coverage for dependents to be eligible for coverage.
- If you become employed in an OPERS-covered position or your OPERS employment status changes, please contact us at 1-800-222-7377.

If not currently enrolled and you wish to enroll yourself or your eligible dependents in OPERS coverage, please complete the enclosed form.

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Health Care Open Enrollment Change Form

If you wish to enroll, make changes to or cancel your OPERS health care coverage, if applicable, please complete this Form. Fill in the circle next to your choices (IN BLUE OR BLACK INK), SIGN AND DATE SECTION 5 (REVERSE SIDE) and return it to OPERS by Dec. 7, 2018. Any health care changes will take effect Jan. 1, 2019.

Section 1 - Recipient Personal Information

JOHN DOE
277 EAST TOWN STREET
COLUMBUS OH 43215-4642

Section 2 - Recipient Enrollment, Change or Cancellation of Current Coverage - *Use this Section to enroll in, change or cancel your medical/pharmacy coverage and/or your current vision and/or dental coverage.* ***By cancelling any coverage in this Section, you will also be cancelling that coverage for any enrolled dependents.***

2019 Medical/Pharmacy Coverage:	**AETNA VISION**	**METLIFE DENTAL**
Please see your 2019 Open Enrollment Statement	**ENROLL in:**	**ENROLL in:**
	O Low	O Low
OR	**OR**	**OR**
	CANCEL	CANCEL
	O Vision	O Dental

Section 3 - Existing Dependent Enrollment/Change/Cancel - *Use this Section to enroll an existing spouse or dependent(s) (if applicable) in plans in which they are not already enrolled, or change or cancel their coverage. If you want to make a change in coverage for a covered child not listed here, please attach a separate sheet of paper that indicates the child's name, their date of birth and the coverage change requested.*

JANE DOE

Enroll in: O Medical O Vision O Dental

Cancel: O Medical O Vision O Dental

*If you elect to enroll yourself or your eligible dependent in vision and/or dental coverage, the enrollment will be for the 2019 calendar year and cannot be cancelled.

PLEASE DO NOT MAIL THIS FORM UNTIL YOU SIGN AND DATE SECTION 5 (REVERSE SIDE)

Section 4 - Additional Dependent Enrollment - *Use this Section to enroll a spouse or dependent(s) who are not currently enrolled and to identify a Medicare-eligible dependent not currently enrolled. These dependents may only be enrolled in the coverage and plans in which you are enrolled. If you would like to add more than two children, please attach another sheet for any additional children and provide all of the information requested for each child.*

SPOUSE INFORMATION - *To verify your spouse's eligibility, you must provide copies of your marriage certificate and your spouse's birth certificate. A social security number is required for enrollment.*

First Name **MI** **Last Name**

Date of Birth

Month **Day** **Year** **Male** **Female** **Social Security Number**

Enroll in: ☐ **Medical** ☐ **Dental** ☐ **Vision**

A. Does your spouse receive a benefit from OPERS or any other Ohio retirement system(s)? *(Please mark all that apply)*

☐ **OPERS** ☐ **STRS** ☐ **SERS** ☐ **OP&F** ☐ **HPRS** If so, please provide the account number

If your spouse receives a benefit from another Ohio retirement system, that coverage must be maintained as primary.

B. Is your spouse eligible for Medicare? ☐ **Yes** ☐ **No** *If "Yes", provide a copy of his/her Medicare card or a statement issued by Social Security confirming the Medicare effective date.*

Dependent Information - *To verify your dependent's eligibility, you must provide a copy of each child's birth certificate or adoption decree. A social security number is required for enrollment.*

1. Child First Name **MI** **Last Name**

Date of Birth

Month **Day** **Year** **Male** **Female** **Social Security Number** **Is this child Incapacitated?** ☐ **Yes** ☐ **No**

Enroll in: ☐ **Medical** ☐ **Dental** ☐ **Vision**

Is this child eligible for Medicare? ☐ **Yes** ☐ **No** *If "Yes", provide a copy of his/her Medicare card or a statement issued by Social Security confirming the Medicare effective date.*

2. Child First Name **MI** **Last Name**

Date of Birth

Month **Day** **Year** **Male** **Female** **Social Security Number** **Is this child Incapacitated?** ☐ **Yes** ☐ **No**

Enroll in: ☐ **Medical** ☐ **Dental** ☐ **Vision**

Is this child eligible for Medicare? ☐ **Yes** ☐ **No** *If "Yes", provide a copy of his/her Medicare card or a statement issued by Social Security confirming the Medicare effective date.*

Section 5 - Acknowledgment and Authorization - *Please read the following acknowledgment carefully.*

SIGN AND DATE THIS FORM BEFORE RETURNING IT TO OPERS.

I authorize the changes to my health care coverage that I have indicated on this Form. If I am enrolling dependents, I acknowledge that the information provided on this Form is true and accurate and the enrolled dependents are eligible for coverages, as defined by Ohio Administrative Code 145-4-09 and the applicable federal laws regarding dependent coverage. I acknowledge that it is my responsibility to notify OPERS within 30 days of a dependent becoming ineligible for coverage. I authorize the appropriate premium (if applicable) for the coverage I am requesting, including dependent coverage (if applicable), to be deducted from my OPERS benefit check.

Today's Date

Month **Day** **Year**

Recipient Signature _____

Do not print or type name