OPERS Health Care

2020 Open Enrollment Guide

Your plan details are inside.

Look for changes
that may apply to you.

OPERS

2020 MEDICAL PLAN COVERAGE – WHAT YOU NEED TO KNOW

Open enrollment runs Oct. 15 - Dec. 7. Changes take effect Jan. 1, 2020.

Pre-Medicare plan participants

The full premium amount for the OPERS Retiree Health Plan administered by Medical Mutual will increase in 2020

The full premium amount was raised to keep pace with increased costs associated with:

- health care cost inflation,
- the prevalence of chronic conditions,
- significant use of the emergency room,
- high specialty drug prices, and
- the need to better align with insurance marketplace plan options

Pre-Medicare spouses can enroll for the full monthly premium. While our plan offers comprehensive coverage, should you find the cost is more than you can comfortably afford, other options may be available to you outside of OPERS. Resources for identifying these options include healthcare.gov, the Ohio Department of Insurance, and the Ohio Department of Medicaid.

Additional changes for 2020

Increased plan use contributed to the need to increase deductible, copay and co-insurance amounts. Please carefully review specific plan coverage details on page 2. Also, in previous years, a $49 premium reduction was automatically applied to qualifying accounts in preparation for the Cadillac Tax. Since the tax is expected to be repealed, the premium reduction will not apply for 2020 and going forward.

The OPERS Pre-Medicare plan continues to protect you financially by capping your annual in-network medical and prescription drug out-of-pocket costs at the ACA limit of $8,150. Please note, there is no out-of-pocket limit if you receive care from out-of-network providers.

Action Required

- Review 2020 premium and plan details provided within this booklet.

- Enrolling, making changes or canceling coverage? You must complete and return your open enrollment form or contact OPERS between Oct. 15 and Dec. 7, 2019.

  Canceling medical coverage or adjusting dental and/or vision coverage can be done by calling us at 1-800-222-7377.

No changes? No problem. Your coverage will automatically continue in 2020.

2020 OPERS Medicare Connector

Connector-eligible Medicare beneficiaries

If you are a retiree and/or eligible dependent who is enrolled in Medicare Parts A and B and selected a plan through Via Benefits for 2019:

- The Health Reimbursement Arrangement (HRA) base monthly allowance remains at $450. Your allowance amount will remain the same as it was in 2019.

- Beyond open enrollment, continue to rely on Via Benefits for help to resolve concerns with your current insurance provider and set up your online account. They can also help you access and understand insurance plans and the HRA plan.

Action Required

- Review 2020 plan details provided by your plan administrator. Look for changes in premiums, plan design and prescription drug formulary.

- Enrolled in a vision and/or dental plan with OPERS *and* Via Benefits? Review your coverage and determine if both plans are needed.

- Enrolling, making changes or canceling coverage? Contact Via Benefits between Oct 15. and Dec. 7, 2019. Selecting a Medigap plan may require medical underwriting.

No changes? No problem. Your current plan(s) will automatically continue in 2020.

Pre-Medicare plan participants

OPERS Retiree Health Plan administered by Medical Mutual

The OPERS Retiree Health Plan for eligible participants is a network/PPO plan that provides access to an extensive list of doctors, hospitals and other health care professionals. Call Medical Mutual customer service at 1-877-520-6728 or go online at Medmutual.com to find network providers in your area. Prescription drug coverage administered by Express Scripts is included. The OPERS Retiree Health Plan includes the Pre-Medicare Re-employed Retiree Plan.

Medical Mutual Pre-Medicare Re-employed Retiree Plan

The Medical Mutual Pre-Medicare Re-employed Retiree Plan is offered to re-employed retirees who are not yet eligible for Medicare. The coverage features for this plan are the same as the Pre-Medicare Medical Mutual Network/PPO Plan. If you are thinking about becoming re-employed, please contact OPERS first to be sure you understand how re-employment may impact OPERS health care coverage.

Re-employed retirees are defined as an OPERS retiree receiving his or her pension while at the same time being employed by an OPERS-covered employer. This also includes a surviving spouse who is employed in an OPERS-covered position and receiving a survivor benefit payment from OPERS.

Changes to 2020 medical plan coverage include increases to the annual deductible and co-insurance amount as well as inpatient copay, emergency room (emergency and non-emergency) copay, urgent care copay, specialist office copay and physical/speech/occupational therapy services copay amounts.

What is a deductible?
An annual amount you pay for covered health care services before your plan begins to pay.

What is a copay?
A fixed amount you pay for a covered health care service, usually when you receive the service.

What is co-insurance?
Your share of the cost of a covered service calculated as a percentage of the allowed amount for the service.

MEDICAL MUTUAL™

Website: www.medmutual.com
Phone: 1-877-520-6728

Medical Mutual PPO and Pre-Medicare Re-employed Plan Features

2020 Plan Coverage

All limits and maximums are per covered individual

UCR	In-Network	Out-of-Network
Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.		
Deductible per calendar year	$2,500	$5,000
Co-insurance Amount	$3,250 (excluding deductible)	No limit
Out-of-Pocket Limit∞	$5,750	No limit
Medical Services		
Outpatient Hospice	75%	60%
Mental Health	75%	60%
Substance Abuse (including alcohol)	75%	60%
Surgery	75%	60%
Office Visit - Medical Home	$15 copay	60%
Office Visit - Specialist	$50 copay	60%
Office Visit - Primary Care	$25 copay	60%
Emergency Services		
Emergency Room	$250* copay (emergency) $550 copay (non-emergency) 75% facility 75% all other charges	$250* copay (emergency) $550 copay (non-emergency) 75% facility 75% all other charges
Urgent Care	$60 copay	60%
Preventive services †		
Annual routine physical	100%**	60%***
Annual PAP, Mammography	100%**	60%***
Colonoscopy, Sigmoidoscopy, Bone Density Testing	100%**	60%***
Flu and Pneumonia Vaccines	100%**	60%***

All services are subject to medical necessity.

After a participant meets the annual deductible and the out-of-pocket limit in a calendar year, all medically necessary services are covered at 100% with the exception of lab services subject to coverage maximums.

** Waived if admitted*

∞ Out-of-pocket limit includes deductibles, copays and co-insurance amounts.

***Not subject to co-insurance or deductible*

****Subject to annual deductible*

Plan Features are general descriptions of coverage.

† Subject to age, gender and frequency limitations. For details, refer to your Plan documents or call your plan administrator.

Prescription drug coverage information is listed on page 4.

Medical Mutual PPO and Pre-Medicare Re-employed Plan Features

2020 Plan Coverage

All limits and maximums are per covered individual

UCR	In-Network	Out-of-Network
Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.		
Other Medical		
Lab and Diagnostic*	75%	60%
Chiropractors (10 visit limit)	75%	60%
Therapy Services	$40 copay, then 75%	60%
Ambulance	75%	60%
Home Health Care	75%	60%
Durable Medical Equipment	75%	60%
All Other	75%	60%
Inpatient		
Inpatient copay (per admission)	$300	$400
Semi-Private Room	75%	60%
Pre-Admission Testing	75%	60%
Skilled Nursing Facility**	75%	60%
Hospice	75%	60%

All services are subject to medical necessity.

After a participant meets the annual deductible and the out-of-pocket limit in a calendar year, all medically necessary services are covered at 100% with the exception of lab services subject to coverage maximums.

Plan Features are general descriptions of coverage. For details, refer to your Plan documents or call your plan administrator.

Prescription drug coverage information is listed on page 4.

**Does not include charges in excess of coverage maximum.*

***90-day benefit period, requiring three-day hospital stay.*

OPERS Prescription Drug Plan

Express Scripts administers the OPERS Prescription Drug Plan. **Changes to 2020 plan coverage include increases in the generic and brand deductibles as well as generic, formulary and specialty drug cost-sharing amounts.** Please review the information carefully. For further plan descriptions, please refer to the Summary Plan Description document available on opers.org.

2020 Prescription Drug Plan	Retail Preferred Network/ Home Delivery	Retail Non-Preferred Network
Annual deductible(s)	$200 (generics)$400 (brands)	$200 (generics)$400 (brands)
Generic	25% co-insurance $12 max retail $30 max mail	30% co-insurance $20 max
Formulary brand	35% co-insurance $80 max retail $200 max mail	40% co-insurance $100 max
Non-formulary brand	NOT COVERED	NOT COVERED
Specialty drugs - Brand , Biosimilar/Generic	$300 max	$300 max
Out-of-Pocket Limit	$2,400	$2,400

EXPRESS SCRIPTS®

Website: www.Express-Scripts.com

Phone: 1-866-727-5873

Health and Wellness Programs

If you are a pre-Medicare plan participant, you have access to a variety of health and wellness programs that cater towards differing lifestyles to help you reach your personal health goals. These comprehensive programs are available at no cost to you.

NEW Nurse Line

If it's not an emergency and you don't want to wait for your doctor's office to return your call, use the Medical Mutual Nurse Line, available 24 hours a day, seven days a week. Registered nurses can provide advice on when to seek urgent care, home treatments, understanding your medicine and how it works, how to make decisions about tests, medication and procedures as well as when to call a doctor and how to effectively communicate with them. Call the Medical Mutual Nurse Line at 1-888-912-0636.

Case Management

The goal of case management is to help you achieve wellness, stability, and independence by taking an active role in improving your health. Medical Mutual works with you, your doctors and other healthcare providers to create a care plan tailored to your needs.

QuitLine

A telephone-based program that offers a whole support system to help you quit using tobacco products. You'll partner with a tobacco cessation specialist who will provide one-on-one coaching and support, special tools, a customized quit plan and up to 8-weeks of free nicotine replacement therapy.

Lifestyle Coaching

Transform your physical and mental health with the help of a certified lifestyle coach. Receive one-on-one coaching to help you achieve and maintain your wellness goals.

Other benefits

- Medical Nutritional Counseling provided by a licensed registered dietician or a PCP for overweight or obese adults focusing on a healthy diet and physical activity to prevent cardiovascular disease (when identified as a preventive service).

- Access to cost saving resources such as coverage maximums and Medical Mutual's My Care Compare tool. The online tool is designed to help you find the best rates in your area for services such as lab work, X-rays and MRI's. Visit medmutual.com to learn more.

Participants eligible for the OPERS Medicare Connector

When you select an individual Medicare plan through Via Benefits, you can use Via Benefits' ongoing support for Health Reimbursement Arrangement (HRA) management, carrier claim resolution and Medicare plan questions. You may call Via Benefits at 1-844-287-9945 with any questions.

Important Message Reminders

- The base monthly HRA allowance amount remains at $450. Your allowance amount will remain the same as it was in 2019.
- Review 2020 plan details provided by your plan administrator. Look for changes in premiums, plan coverage and prescription drug formulary.
- Spouses continue to have access to individual Medicare plans through Via Benefits and will remain enrolled in their selected plan unless coverage is canceled.
- Via Benefits is now handling HRA processing in place of PayFlex. As a result, you may need to reset your communication preferences to opt-in to text messages and/or email notifications.
- Enrolled in a vision and/or dental plan with OPERS and Via Benefits? Review your coverage and determine if both plans are needed.
- Watch out for scams. You may receive calls and mail from other insurance agents and/or brokers offering medical/pharmacy plans. To remain eligible to receive your HRA allowance (retirees only), you must enroll in a medical plan through Via Benefits.
- Enrolling, making changes or canceling coverage? Contact Via Benefits between Oct 15. and Dec. 7, 2019. Selecting a Medigap plan may require medical underwriting.

No changes? No problem. Your coverage will automatically continue, and no action is needed from you.

Health Reimbursement Arrangement

Via Benefits is now handling health reimbursement arrangement processing in place of PayFlex. As a result, you may need to reset your communication preferences such as opting-in to text messages and/or email notifications.

Submitting for reimbursement

- Recurring premium claim forms for 2020 OPERS vision and dental premiums (if applicable) must be resubmitted each year with your OPERS Health Care Premium Receipt, which arrives in-homes late December.
- Recurring premium claim forms for 2020 Medicare Part B premiums (if applicable) must be resubmitted each year.
- If previously set up (and plans do not change), automatic reimbursement will continue.
- If you change medical plan carriers, automatic reimbursement will not automatically carry over. Talk with Via Benefits about whether automatic reimbursement is an option for the new plan that you are considering.

VIA BENEFITS™

Website: https://my.viabenefits.com/OPERS

Phone: 1-844-287-9945

Medical Mutual Medicare Secondary Plan

The Medical Mutual Medicare Secondary Plan is the plan OPERS provides Medicare-eligible re-employed retirees who are not eligible to participate in the OPERS Medicare Connector. Once OPERS determines you are eligible you may enroll in this plan if you are:

- Enrolled in Medicare Parts A and B and are
- a Medicare-eligible re-employed retiree or eligible dependent, or
- a Medicare-eligible retiree under age 65 with end-stage renal disease and out of your coordination period.

Changes to 2020 medical plan coverage include increases to the annual deductible and co-insurance amount and emergency room copay.

2020 Medical Mutual Medicare Secondary Plan

Deductible per calendar year	$1,000
Co-insurance Amount	$2,500
Out-of-pocket limit per calendar year	$3,500
Medical Services	
Outpatient Hospice	80%, Covered by Medicare at a certified hospice agency
Mental Health/Substance Abuse	80%
Surgery	80%
Office Visit (Primary Care Physician)	80%
Emergency Services	
Emergency Room	$150 copay (waived if admitted)
Urgent Care	$50 copay
Preventive*	(must be billed as routine)
Routine Physical Exam	100%
Annual PAP, Mammography	100%
Colorectal Cancer Screening	100%
Bone Density Testing	100%
Flu, Pneumonia, Hepatitis B vaccines	100%
Other Medical	
Diabetic testing supplies	100%
Diagnostic lab and X-ray	80%
Chiropractors	80%
Physical Therapy	80%
Ambulance	80%
Home Health Care	80%
Durable Medical Equipment	80%
Inpatient	
Inpatient Deductible	80%
Semi-Private Room	80%
Pre-Admission Testing	80%
Skilled Nursing Facility	80%
Hospice (Respite Care)	80%, Covered by Medicare at a certified hospice agency

**This is just a representative list of the preventive services covered. All charges subject to medical necessity.*

After a participant meets the annual deductible and the out-of-pocket maximum in a calendar year, all medically necessary services are covered at 100%. Plan Features are general descriptions of coverage. For details, refer to your Plan documents or call your Plan administrator.

The Medical Mutual Medicare Secondary Plan is a plan that pays the coverage shown after Original Medicare pays primary.

For further plan descriptions, please refer to the *Medical Plan Description* document at opers.org or call Medical Mutual for a copy to be mailed to you.

Aetna Vision Plan

Aetna Vision Preferred, administered by EyeMed, is available to you and your eligible dependents. If you choose to enroll in the vision plan, you'll be responsible for paying the entire premium for this coverage and you will remain enrolled for the full year. Once enrolled, changes can only be made during the next open enrollment period. With a recent change to procedures impacting European nations, OPERS has decided to cancel vision coverage at the end of 2019 for our participants residing in European Union countries. OPERS will reach out to retirees affected directly.

Plan Feature Highlights

- A comprehensive eye exam. Not only can eye exams detect serious vision conditions such as cataracts and glaucoma, but also the early signs of diabetes, high blood pressure and other health conditions.
- Savings of approximately 40 percent on eye exams and eyewear.
- Your choice of leading optical retailers and private practitioners include, LensCrafters, Target Optical, most Sears Optical and Pearle Vision locations.
- Laser Vision Correction. Save 15 percent off the retail price or 5 percent off the promotional price for LASIK or PRK procedures.
- Replacement Contact Lens Purchases. Visit contactsdirect.com to order replacement contact lenses for shipment to your home at less than retail price.

Plan Options

You have two vision coverage options to choose from: High or Low. If you use an Aetna vision provider, you'll have fewer out-of-pocket expenses; if you don't use an Aetna vision provider, you'll need to submit a claim form for reimbursement. For more details please visit aetnavision.com or call 1-866-591-1913.

2020 Vision Coverage

	High Option		Low Option	
Coverage type	**In-Network** Retiree Pays	**Out-of-Network Reimbursement** to retiree	**In-Network** Retiree Pays	**Out-of-Network Reimbursement** to retiree
Comprehensive eye exam	$0 copay	$65	$0 copay	$50
Contact lens fit & follow-up				
• Standard	$17 copay	$23	$32 copay	$8
• Premium	$62 copay	$23	$77 copay	$8
Frames	$0 copay up to $140 retail value, 80% of balance over $140	$78	$0 copay up to $50 retail value, 80% of balance over $50	$44
Lenses				
• Single Vision	$0 copay	$45	$5 copay	$35
• Bifocals	$0 copay	$60	$5 copay	$55
• Trifocals	$0 copay	$80	$5 copay	$75
• Most premium progressives	$85 - $110 copay	$60	$90 - $115 copay	$55
Contact lenses	$0 copay up to $240 retail value	$228	$10 copay up to $200 retail value	$180
Coverage period for exams	Once per calendar year	Once per calendar year	Once per calendar year	Once per calendar year
Coverage period for frames and lenses	Once per calendar year	Once per calendar year	Once every two calendar years	Once every two calendar years

Note: Coverage is available for lenses and frames - OR - contact lenses, but not both.

MetLife Dental Plan

Dental coverage administered by MetLife is optional for you and your dependents. If you choose to enroll in a dental plan, you'll be responsible for paying the entire premium for this coverage and will be enrolled for the full year. Once enrolled, changes can only be made during the next open enrollment period.

Choosing a dentist within the MetLife network can help reduce your costs. You can also choose an out-of-network dentist, but your out-of-pocket costs may be higher. There are more than 410,000 participating Preferred Dentist Program dentist locations nationwide, including over 96,000 specialist locations.

Plan Options

You have two dental coverage options to choose from: High or Low. Once enrolled you can view your Certificate of Coverage for additional details. Please visit the website below for coverage details. These certificates explain the dental options available in the High or Low option dental plans.

Claim Details

Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, call MetLife at 1-888-262-4874. For questions or a list of preferred dentists, visit metlife.com/mybenefits.

For more detailed coverage information about covered services and limitations, refer to opers.org or call MetLife.

2020 Dental Summary

	High Option		Low Option	
Coverage type	**In-Network:** Preferred Dentist Program	**Out-of-Network:**	**In-Network:** Preferred Dentist Program	**Out-of-Network:**
Diagnostic and Preventive Care Type A: Cleanings, emergency care, fluoride treatment, bitewing X-rays, and oral examinations	100% of Negotiated Fee*	100% of R&C Fee**	100% of Negotiated Fee*	80% of R&C Fee**
Oral Surgery and Minor Restoration Type B: Fillings, simple extractions and surgical removal of erupted teeth.	80% of Negotiated Fee*	65% of R&C Fee**	60% of Negotiated Fee*	50% of R&C Fee**
Major Services and Restoration Type C: Prosthodontics, inlays, onlays, crowns, dentures, pontics, implants and surgical removal of impacted teeth.	50% of Negotiated Fee*	35% of R&C Fee**	25% of Negotiated Fee*	25% of R&C Fee**
Deductible†:				
Individual	$0	$50	$50	$50
Family	$0	$100	$100	$100
Annual Maximum Benefit:				
Per Person	$2,000	$1,250	$2,000	$1,250

Like most group insurance policies, MetLife group policies contain certain exclusions, limitations, exceptions, reductions, waiting periods and terms for keeping them in force. Please contact MetLife for details about costs and coverage. Dental plan underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

** Negotiated Fee refers to the fees that participating Preferred Dentist Program dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and plan maximums.*

*** R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.*

† Applies to Type B and C Services

General Information

OPERS vision and dental coverage

If you receive a pension benefit, you qualify for OPERS vision and dental coverage, even if you don't qualify for medical and prescription drug coverage. Eligible plan participants also include:

A spouse — must have a valid marriage certificate.

Child(ren) — must be a participant's biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, unemancipated minor child and you are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19. The child must be under the age of 26 regardless of enrollment as a full-time student or marital status. Coverage may be extended beyond the age of 26 if the child is permanently and totally disabled prior to age 22.

If you are in the OPERS retiree health care plan and receive a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member, you may only enroll those dependents who would have been eligible dependents of the deceased retiree or member. Eligible dependents of surviving spouses are only eligible for enrollment if the surviving spouse is enrolled in a group plan.

It is your responsibility to notify OPERS, in writing, within 30 days of the date your dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid health care claims or reimbursement for which you'll be responsible to repay.

Multiple OPERS accounts

If you are eligible for health care coverage from more than one OPERS benefit, you will be placed under the primary OPERS account holder.

Other Ohio retirement systems

You may only receive primary health care coverage from one of five Ohio retirement systems (OPERS, STRS, SERS, OP&F and OHPRS). If you or your spouse qualify for retirement under another Ohio retirement system, you cannot waive coverage under that system to make OPERS your primary health care coverage. You must continue coverage under the other retirement system but may elect OPERS as secondary.

Disability benefit recipients

If you started to receive a disability benefit on or after Jan. 1, 2014, OPERS health care coverage is only available during the first five years of receiving a disability benefit. If you wish to continue health care coverage through OPERS beyond this time, you are required to enroll in Medicare due to a disability or meet the minimum age and service requirements of 10 years, or age 60 with 20 years of qualifying service credit if you receive a disability benefit on or after Jan. 1, 2015.

Because Medicare enrollment can take up to two years, OPERS strongly suggests you check with Medicare regarding your eligibility for coverage. You may qualify for health care coverage through Medicare even if you do not qualify for Social Security Disability Insurance.

You may be eligible for Medicare if you are age 65 or older, under age 65 with certain disabilities or have end-stage renal disease*.

General Information

Medicare includes the following: Medicare Part A (hospital) and Medicare Part B (medical).

- Medicare Part A: OPERS requires that you sign up as soon as you are eligible to enroll.

- Medicare Part B: OPERS requires you to sign up as soon as you are eligible.

**** Proof of enrollment in Medicare Parts A and B is required if you are eligible to enroll in the Medicare group plan. Proof of enrollment includes a copy of your Medicare card along or a letter from Social Security stating your coverage effective dates.***

If you are eligible for Medicare prior to turning age 65, the Social Security Administration will notify with a letter. You must forward a copy of this letter to OPERS within 30 days of receiving it. Additionally, you must enroll in Medicare upon receipt of this letter and provide OPERS a copy of your Medicare card or a letter from Social Security stating your coverage effective dates.

Income-Based Discount Program

The OPERS Income Based Discount Program provides a 30 percent reduction to the monthly OPERS group medical/ pharmacy coverage premium amount. Vision and dental premiums, as well as spouse and dependent medical premiums, are not included in this program. Program participants are required to re-apply each year and will receive a renewal application each October.

To qualify,

- You must have 20 years of qualifying health care service credit with a household income equal to or less than 200 percent of the federal poverty level in 2018.

- Your household income* must have been at or below the following levels based on your 2018 federal income tax return:

Income Guidelines	
Single person	$24,280
Single with one dependent	$32,920
Single with two or more dependents	$41,560
Married	$32,920
Married with one or more dependents	$41,560

Applications will only be accepted during the following times:

- When you first receive your monthly benefit and qualify for health care (application and all supplemental documents must be received within 30 days of release of the initial benefit payment).

- During the annual open enrollment period (application must be received by OPERS on or before Dec. 7) with a program effective date of the following January.

To apply for the Income-Based Discount Program, complete the Income-Based Discount Program application (HC-IBD) located at opers.org, or you may call OPERS to request one by mail. Send the completed and signed application along with a copy of your (and your dependent's if filing separately) 2018 filed federal tax return to OPERS.

****Household income is based on IRS guidelines and includes wages, pension, Social Security, welfare, workers compensation, child/spousal support, investment income and all reportable income as defined by the Internal Revenue Code.***

General Information

Frequently asked questions

What can I do to lower my out-of-pocket costs?
There are several ways to save on your out-of-pocket medical and prescription drug costs.

- Using a primary care physician who is classified as a medical home cannot only save you money on your copays, but they can help you coordinate your care.
- Use in-network medical providers and network retail pharmacies or home delivery.
- Choosing generic medications or brand medications that are on the formulary may help you save as well. Talk to your doctor about what prescription is most appropriate for you and if a formulary brand or generic would work.
- Many preventive services like an annual routine physical and flu vaccines are covered at 100 percent. These services are designed to help identify or even avoid longer term health issues and may help you save on your overall health expenses.
- In general, making good health choices like eating properly and exercising daily may help keep you healthier and may help you avoid some of the costs of continued care.

How do I terminate my coverage or coverage for my dependent(s)?
You can complete the open enrollment change form or call OPERS to terminate medical/pharmacy, vision or dental coverage. The most efficient way to make these changes may be to call OPERS at 1-800-222-7377. You may consider coverage outside OPERS as a more affordable option, such as the Health Care Marketplace plans available at healthcare.gov or by calling 1-800-318-2596.

I enrolled in a medical plan through Via Benefits and receive a health reimbursement arrangement allowance. My spouse is under age 65 and enrolled in the Medical Mutual plan. Can I reimburse her Medical Mutual plan premiums from my health reimbursement arrangement?
Yes, you can submit her plan premiums and you will be reimbursed up to the available balance in your health reimbursement arrangement. You can receive reimbursement for her Medical Mutual plan premium and for both of your OPERS vision and dental plan premiums, if enrolled. Please submit a Recurring Health Reimbursement Arrangement Claim Form (available through your Via Benefits online account) along with your OPERS Health Care Premium Receipt (mailing in mid-December and available through your OPERS online account).

What happens if I stop being re-employed in an OPERS-covered position?
OPERS must receive notification from your employer before we can officially change your status from re employed to not re-employed.

Pre-Medicare – Coverage for those re-employed in an OPERS–covered position is identical to the Medical Mutual plan for those who are not re-employed, so no action is necessary.

Medicare-eligible – In order to receive your health reimbursement arrangement allowance, you must be enrolled in a medical plan through the OPERS Medicare Connector administered by Via Benefits. Your existing group coverage will terminate.

As a spouse, can I enroll in a new Medicare plan outside of Via Benefits?
When you enroll in a plan through Via Benefits, they provide ongoing support for HRA management, carrier claim resolution and Medicare plan questions. Should you choose to enroll in a plan outside of Via Benefits, you will not have access to these services. Please note that if you enrolled in a 2019 plan through the Connector, you will remain enrolled in that plan until coverage is canceled.

General Information

Making changes to your coverage for 2020

Before making any decisions, please ensure you have carefully reviewed the plan details within this guide.

- If you have specific questions about how much the plans pay for certain services or facilities, such as hospitals, please call the plan administrators directly.

- If you are dually enrolled in a vision and/or dental plan with OPERS and Via Benefits, take some time to review your coverage and needs to determine if both plans are needed.

OPERS Medicare Connector, administered by Via Benefits

Enrolling, making changes or canceling coverage? Contact Via Benefits between Oct. 15 and Dec. 7, 2019. Selecting a Medigap plan may require medical underwriting.

No changes? No problem. Your current plan(s) will automatically continue in 2020.

OPERS plan coverage

Enrolling or adding dependents to your coverage? Fill out the enclosed form. Cancelling coverage or making changes to your coverage? Fill out the enclosed form or call OPERS between Oct. 15 and Dec. 7, 2019. If you choose to discontinue coverage, you may do so over the phone.

No changes? No problem. No action is needed by you. You do not need to complete the Health Care Open Enrollment Change Form or contact OPERS by phone as your current plan will automatically continue in 2020.

General Information

Health Care Open Enrollment Change Form: Things to Know

After OPERS receives the forms, they are electronically processed. Forms must be received by Dec. 7. To ensure your changes are communicated correctly, please follow these instructions:

1. Complete the form using blue or black ink.

2. Do not attempt to correct your address using this form.

3. Do not use the boxes provided to make coverage selections. Do not hand-write your selections or make other notes on the form.

4. Because of limited space, all covered dependents may not be pre-printed on the form. Please refer to page 1 of the statement to see a full list of currently covered dependents. If you wish to make coverage changes for dependents not listed on the form, please indicate these changes on a separate sheet of paper.

5. Use Section 4 on this form to enroll a spouse or child who is not currently enrolled. Dependents may only be enrolled in programs in which you are enrolled. Please provide all the required documentation listed on the form.

OPERS Board of Trustees

The 11-member OPERS Board of Trustees is responsible for the administration and management of OPERS. Seven of the 11 members are elected by the groups that they represent (i.e., college and university non-teaching employees, state, county, municipal, miscellaneous employees and retired members); the Director of the Department of Administrative Services for the state of Ohio is a statutory member, and three members are investment experts appointed by the Governor, the Treasurer of State, and jointly by the Speaker of the Ohio House of Representatives and the President of the Ohio Senate. For a current listing of the OPERS Board of Trustees, please visit opers.org.

The plan features within this document are valid only for the 2020 plan year.

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. This document is written in plain language for use by members of the Ohio Public Employees Retirement System. It is not intended as a substitute for federal or state law, nor will its interpretation prevail should a conflict arise between it and the Ohio Revised Code, Ohio Administrative Code or Internal Revenue Code. If you have questions about this material, please contact our office or seek legal advice from your attorney.

OPERS

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