OPERS Health Care

2021 Open Enrollment Guide

Your plan details are inside.

Look for changes that may apply to you.

2021 MEDICAL PLAN COVERAGE – WHAT YOU NEED TO KNOW

Open enrollment runs Oct. 15 - Dec. 7, 2020. Changes take effect Jan. 1, 2021

Pre-Medicare plan participants

2021 is the last year for the OPERS pre-Medicare group plan. Instead, OPERS will switch to an HRA model in which participants will receive a monthly allowance that can be used for reimbursement of plan premiums and other qualified medical expenses. Beginning early next year, watch for information on the transition process. **OPERS is here for you during this transition. We will provide plenty of information and educational opportunities.** Please watch your mailbox and inbox for information and instructions.

Premiums will not increase for 2021. Your monthly cost to participate in the OPERS pre-Medicare group plan will remain the same as it was in 2020.

Additional changes for 2021

The prescription drug out-of-pocket maximum is increasing by $400 from $2,400 to $2,800. The increase aligns us with the ACA guideline for overall maximum allowable out-of-pocket which is $8,550 for 2021.

The medical out-of-pocket maximum is staying the same as in 2020.

In 2021, there will be additional preventive drugs covered at 100 percent. These include medications used to prevent breast cancer and HIV in high risk patients. In addition, the three-day hospital stay requirement before being admitted to a skilled nursing facility is being removed.

Action Required

- Review 2021 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, 2020. 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 2021.

2021 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 2020:

- The Health Reimbursement Arrangement (HRA) base allowance amount remains at $450. Your monthly HRA deposit will remain the same as it was in 2020.
- 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.

Action Required

- Review 2021 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, 2020. Selecting a Medigap plan may require medical underwriting.

No changes? No problem. Your current plan(s) will automatically continue in 2021.

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.

Preventive care coverage can change

Preventive care coverage under the OPERS pre-Medicare plan is based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and can change from year to year.

The coverage for preventive mammograms is an example of how preventive care coverage can change. Since January 2016, the USPSTF provided some discretion on the screening frequency with support for screenings every one to two years. Last year the USPSTF changed its guidance for preventive mammograms to every two years for women between the ages of 50 and 74.

The information in this booklet is a reasonable guide for what is covered under your plan. However, because coverage for preventive services can change at any time, we highly recommend that either you or your provider contact Medical Mutual Customer Care at the number listed on your ID card to confirm any age requirements or frequency limitations for preventive care services prior to the procedure.

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.

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.

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

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

2021 Plan Coverage

All limits and maximums are per covered individual

UCR	In-Network	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%***
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.

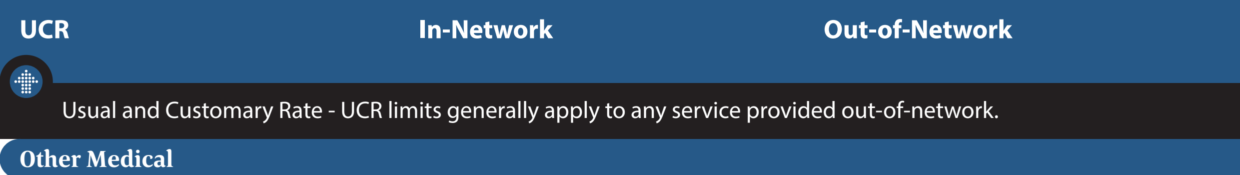
† Subject to age, gender and frequency limitations. For details, refer to your Plan documents or call your plan administrator.

Prescription drug coverage information is listed on page 4.

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

2021 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.*

OPERS Prescription Drug Plan

Express Scripts administers the OPERS Prescription Drug Plan. Please review the information carefully. For further plan descriptions, please refer to the Summary Plan Description document available on opers.org.

2021 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 $4 min/$12 max retail $10 min/$30 max mail	30% co-insurance $7 min/$20 max
Formulary brand	35% co-insurance $30 min/$80 max retail $75 min/$200 max mail	40% co-insurance $35 min/$100 max
Non-formulary brand	NOT COVERED	NOT COVERED
Specialty drugs - Brand , Biosimilar/Generic	$300 max	$300 max
Out-of-Pocket Maximum	$2,800	$2,800

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.

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) account 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 allowance amount remains at $450. Your monthly HRA deposit will remain the same as it was in 2020.
- Review 2021 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.
- 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 monthly HRA deposit (retirees only), you must be enrolled in a medical plan through Via Benefits.
- Enrolling, making changes or canceling coverage? Contact Via Benefits between Oct 15. and Dec. 7, 2020. 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

Introducing the Via Benefits Accounts mobile app

Access your HRA account anytime, anywhere, with the Via Benefits Accounts mobile app. Check your balance, submit a reimbursement request and get support right at your fingertips!

Download the Via Benefits Accounts mobile app on the Apple App Store or Google Play. Use your existing Via Benefits online account username and password to log in. Questions? Please call Via Benefits, Monday through Friday 8 a.m. to 9 p.m. Eastern Time.

Submitting for reimbursement

- **NEW!** In 2021, premiums for the OPERS vision and dental plans will be automatically reimbursed monthly from your HRA account with no additional forms to complete or receipts to provide. If you do not wish to have these premiums automatically reimbursed monthly from your HRA account, you can opt out by using the enclosed form.
- Recurring premium claim forms for 2021 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.

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.

2021 Medical Mutual Secondary Plan coverage is the same as 2020 coverage. This plan also includes prescription drug coverage as described on page 4. Prescription drug out-of-pocket maximum will increase from $2,400 to $2,800 in 2021.

2021 Medical Mutual Medicare Secondary Plan

Deductible per calendar year	$1,000
Co-insurance Amount	$2,500 (excluding deductible)
Out-of-pocket limit	$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%
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

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

***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.

Plan Feature Highlights

- **A comprehensive eye exam**
- **Savings of approximately 40 percent** on eye exams and eyewear.
- **Your choice of leading optical retailers** and private practitioners include LensCrafters, Target Optical and Pearle Vision locations.
- **Freedom to use any provider**
- **Digital tools.** You can search for providers, manage your benefits and view your ID card on Aetna's mobile app or by visiting aetnavision.com.
- **Shop online** for contacts or glasses online with retailers in Aetna's network. Your vision benefits will automatically apply when you check out.

Discounts and savings

You can find discounts on products and services through in-network providers. These discounts include:

- 20 percent off any balance over your frame allowance
- 15 percent off any balance over your conventional contact lens allowance
- Up to 40 percent off extra pairs of prescription eyeglasses and sunglasses
- Up to 20 percent off noncovered items, including nonprescription sunglasses and lens extras/add-ons like antireflective coatings
- Up to 15 percent off the retail price or 5 percent off the promotional price for LASIK laser eye surgery or photorefractive keratectomy from U.S. Laser Network
- Discounts on LASIK surgery through QualSight
- 40 percent off hearing exams and special pricing on hearing aids

2021 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 coverage 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.

2021 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

Spouse and child(ren) eligibility

Eligible plan participants 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.

How to enroll after waiting

To enroll after delaying enrollment, you must submit a Health Care Coverage Application during an enrollment period:

1. Annual open enrollment period (Oct. 15 – Dec. 7), with a Jan. 1 effective date of the following year.

2. Within 60 days of the involuntary cancellation of your health care coverage by another health care plan. You will need to include proof of involuntary loss of coverage from your employer or plan administrator with your application. Coverage will begin on the first day of the following month following OPERS' receipt of all required documents

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 due to a disability 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.

General Information

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*.

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 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 send you a Notice of Award 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. Your coverage will be terminated based on your Medicare Part A eligibility date if you fail to notify OPERS and enroll in Medicare within thirty days of becoming Medicare eligible.*

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 2019.
- Your household income* must have been at or below the following levels based on your 2019 federal income tax return:

Income Guidelines	
Single person	$24,980
Single with one dependent	$33,820
Single with two or more dependents	$42,660
Married	$33,820
Married with one or more dependents	$42,660

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) 2019 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 monthly HRA deposit. 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 account?
Yes, you can submit her plan premiums and you will be reimbursed up to the available balance in your HRA account. 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 Health Reimbursement Arrangement Claim Form (available through your Via Benefits online account) along with your OPERS Health Care Premium Receipt (available through your OPERS online account). In 2021, premiums for the OPERS vision and dental plans will be automatically reimbursed monthly from your HRA account with no additional forms to complete or receipts to provide. If you do not wish to have these premiums automatically reimbursed monthly from your HRA account, you can opt out during open enrollment.

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 monthly HRA deposit, you must be enrolled in a medical plan through the OPERS Medicare Connector administered by Via Benefits. Your existing group coverage will terminate. You can submit reimbursement claims for expenses incurred during the months you were not re-employed.

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 account 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 2020 plan through the Connector, you will remain enrolled in that plan until coverage is canceled.

General Information

Making changes to your coverage for 2021

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, 2020. Selecting a Medigap plan may require medical underwriting.

No changes? No problem. Your current plan(s) will automatically continue in 2021.

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, 2020. 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 2021.

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 2021 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.

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