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Visit opers.org for information about OPERS Retiree Education Seminars conducted around the state and to access your individual account.

Complete plan documents and Summary of Benefits and Coverage documents as required by the Affordable Care Act are available online at opers.org or your plan administrator website(s).
OPERS Health Care

While health care coverage is not required by law, the Ohio Public Employees Retirement System recognizes the important role it plays as part of a secure retirement for its members.

OPERS’ health care features medical plans, a prescription drug plan and optional vision and dental plans. Which medical plan you participate in is based on your Medicare status and whether or not you are re-employed in an OPERS-covered position.

Pre-Medicare participants

OPERS Pre-Medicare Retiree Coverage

OPERS pre-Medicare retiree coverage consists of two different medical plans: the Medical Mutual network/Preferred Provider Organization Plan (PPO) and the Medical Mutual Re-employed Plan. The Medical Mutual network/PPO Plan is for those not yet eligible for Medicare; the Medical Mutual Re-employed Plan is for those who are re-employed in an OPERS-covered position.

Medicare-eligible participants

The OPERS Medicare Connector and Health Reimbursement Arrangement

If you are Medicare-eligible, you are required to enroll in Medicare Parts A and B. After you enroll in Medicare, you may select a medical plan and prescription drug plan through the OPERS Medicare Connector administered by Via Benefits™. Upon enrolling into a medical plan, you will receive a monthly allowance deposited in a Health Reimbursement Arrangement, or HRA. These funds may be used to reimburse the cost of medical plan premiums and other qualified medical expenses incurred by you and eligible dependents. Spouses are not eligible to receive a separate HRA allowance.

Medical Mutual Medicare Secondary Plan

You can enroll in the Medical Mutual Medicare Secondary Plan if you are:

- enrolled in Medicare and not eligible to select a plan through the Connector,
- not qualified to receive the health reimbursement arrangement allowance due to re-employment or
- under age 65 with end stage renal disease.

Prescription Drug Plan

OPERS is partnered with Express Scripts and offers prescription drug coverage for participants enrolled in the OPERS retiree health care program. Coverage details are outlined within the following pages.

Optional Vision and Dental Plans

If you receive a pension benefit, you can choose to enroll in the optional Aetna vision plan or MetLife dental plan. You do not have to qualify for medical and prescription drug coverage. Eligibility and coverage options provided under these plans and enrollment information are outlined within the following pages. Enrollment is for the entire calendar year.
Health Care Coverage Eligibility

You can apply for health care if your OPERS benefit effective date is:

Jan. 1, 2015 or after
You retire with at least 20 years of qualifying OPERS service credit and have reached age 60 (or reached any age with 30-32 years of qualifying service credit, depending upon your OPERS retirement group).

Dec. 1, 2014 or prior
You retired with at least 10 years of qualifying OPERS service credit.

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 in order to make OPERS your primary health care coverage. You must continue coverage under the other retirement system, but may elect OPERS as secondary if the plan can coordinate coverage.

If you are eligible for health care coverage from more than one OPERS benefit, you will be enrolled in health care coverage under your own retirement account, not as a spouse or surviving spouse.

Years of employer contributions
The following types of service credit apply to OPERS health care eligibility: contributing service, certain qualifying Ohio retirement system transfers, interrupted military (USERRA), unreported time and restored (refunded) service. Any non-contributing service credit you have purchased will not apply to your health care eligibility nor will it apply in determining your health care allowance if your effective date for retirement is Jan. 1, 2014 or later.

Minimum earnings
Contributing service credit for health care coverage is accumulated only if your earnable salary is at least $1,000 per month. Partial health care credit will not be granted for months in which less than $1,000 is earned. Qualifying credit based on a salary less than $1,000 per month earned prior to Jan. 1, 2014 will continue to count toward health care eligibility.
Health Care Coverage Eligibility

Disability retirement
If you receive a disability benefit from OPERS, you are eligible to participate in the OPERS health care plan regardless of age and/or years of qualifying service credit. However, if you receive a disability benefit with an effective date on or after Jan. 1, 2014, you will have access to OPERS’ health care plan only during the first five years of the benefit.

You may continue to have access to OPERS health care beyond five years if you meet one of the following:

- Have a benefit effective date on or between Jan. 1, 2014 and Dec. 31, 2014 and have 10 years of qualified service credit or qualify for Medicare on the basis of disability before the age of 65 prior to the end of the five years. Once you reach age 65, you must have 10 years of qualified service credit to remain eligible.
- Have a benefit effective date on or after Jan. 1, 2015 and have 20 years of qualified service credit and reach age 60 or qualify for Medicare on the basis of disability before the age of 65 prior to the end of the five years. Once you reach age 65, you must have 20 years of qualified service credit to remain eligible.

A previous disability retirement based on a different condition will not qualify a new disability benefit application for an exception to the five-year rule.

OPERS requires that you apply for a disability benefit through the Social Security Administration and notify OPERS of the enrollment. Because Medicare disability 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*. For more information on Medicare go to page 19 or visit opers.org.

1. If you are eligible for Medicare due to end-stage renal disease, the initial enrollment period depends on the date the treatment began.
2. Recipients must provide proof of Medicare enrollment (a copy of the Medicare card) within 30 days of being notified.
3. If you are not approved or eligible to receive a disability benefit through Social Security, you must enroll in Medicare upon turning age 65.

* Proof of enrollment in Medicare Parts A and B is required if you are under age 65 with certain disabilities or have end-stage renal disease. Proof must be received within 30 days of notification that you are eligible for Medicare with your Medicare effective date. Your Notice of Award letter includes this information. You must notify OPERS of your enrollment in Medicare within 30 days of receipt of your notification of Medicare coverage; you will not be eligible for coverage in the pre-Medicare OPERS retiree plan four months after your Medicare enrollment, but may be eligible for one of the OPERS Medicare plans.
Health Care Coverage Eligibility

Revised Disability Recipient converting to Age and Service Retirement
The benefit recipient’s age on the effective date of disability will determine when a Revised Disability recipient may convert to an age and service retirement. Please see the chart below for the amount of health care qualifying service credit needed to be eligible for health care when converting to an age and service retirement.

<table>
<thead>
<tr>
<th>Effective Dates</th>
<th>Health Care Qualifying Service Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised Disability and Age and Service Retirement</td>
<td>Age and Service Retirement</td>
</tr>
<tr>
<td>Revised Disability effective date: Jan. 1, 2015 or after</td>
<td>20 years of qualifying health care service credit under the Traditional Pension Plan or Combined Plan (this does not include time spent on disability)</td>
</tr>
<tr>
<td>Age and service retirement: Jan. 1, 2015 or after</td>
<td></td>
</tr>
<tr>
<td>Revised Disability effective date: Dec. 1, 2014 or earlier</td>
<td>10 years of qualifying health care service credit under the Traditional Pension Plan or Combined Plan (this does not include time spent on disability)</td>
</tr>
<tr>
<td>Age and service retirement date: Jan. 1, 2014 or after</td>
<td></td>
</tr>
<tr>
<td>Revised Disability effective date: Dec. 1, 2013 or earlier</td>
<td>10 years of qualifying health care service credit under the Traditional Pension Plan or Combined Plan</td>
</tr>
<tr>
<td>Age and service retirement: Dec. 1, 2013 or earlier</td>
<td></td>
</tr>
</tbody>
</table>

Spouse and child(ren) eligibility
Eligible plan participants also include:

- **A legal spouse** — must have a valid marriage certificate.
- **Child(ren)** — must be a retiree’s or deceased member’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. Evidence of the incapacity is required and is subject to approval by OPERS.

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.

Pre-Medicare and Medicare spouses enrolled in either the OPERS pre-Medicare retiree coverage or Medical Mutual Medicare Secondary Plan will be responsible for the full cost of OPERS health care coverage. As a result, you may decide the premium to cover a spouse not yet eligible for Medicare is more than you can comfortably afford. In this case, there are a number of options available through the Health Care Marketplace, commonly referred to as Exchange plans. And, depending on income level, you may qualify for substantial help from the federal government to pay for a plan via the marketplace. Resources include the Ohio Department of Insurance Consumer Services, Ohio Department of Aging and Ohio Department of Medicaid.

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.
Health Care Coverage Eligibility

Survivor benefits
If you die while you are still working or while receiving a disability benefit, your dependents who are eligible for a monthly benefit may be able to enroll in OPERS health care. If the survivor has a benefit effective date on or after Jan. 1, 2015, you must have at least 20 years of qualifying OPERS service credit and have reached age 60 (or reached any age with 30-32 years of qualifying service credit, depending upon your OPERS retirement group) prior to your death for your dependents to be eligible to enroll.

Families with both Medicare and pre-Medicare participants
Participants covered under OPERS health care may be enrolled in different plans based on Medicare enrollment. If you are eligible to enroll in Medicare, please read and understand the section of this booklet describing coverage for Medicare participants. If you are pre-Medicare, please refer to the section describing the OPERS pre-Medicare health plan coverage.

Participant authorizations
State and federal law prohibit the release of OPERS retirement account or health care information to a third party without the retiree’s written authorization. To provide this authorization, you may contact OPERS at 1-800-222-7377 to request a copy of the Authorization: Release of Account Information or the OPERS HIPAA Authorization form. These authorization forms are also available on the OPERS website, opers.org.
OPERS Pre-Medicare Retiree Coverage

The OPERS pre-Medicare retiree plan coverage available for eligible participants is a network/Preferred Provider Organization (PPO) plan administered by Medical Mutual. This PPO network gives you access to an extensive list of doctors, hospitals and other health care professionals. Call Medical Mutual customer service at 1-877-520-6728 to find network providers in your area. OPERS pre-Medicare retiree coverage includes the pre-Medicare network/PPO and the pre-Medicare re-employed retiree plans. Features and coverage for both plans are the same. Prescription drug coverage administered by Express Scripts is also provided.

Medical Mutual pre-Medicare re-employed coverage

The Medical Mutual pre-Medicare re-employed retiree plan is offered to re-employed retirees who are not eligible for Medicare. 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.

Enrollment

If you are an age and service retiree or disability benefit recipient and choose to enroll in OPERS pre-Medicare retiree coverage, your coverage will begin on the first day of the month in which OPERS receives your retirement benefit application, or your benefit effective date, whichever is later.

If you are receiving a survivor benefit, your health care coverage will begin on your benefit effective date but not more than one year from the date OPERS receives your health care application.

During the 30-day period following the release of your first benefit payment, you may make one change to the application you filed. Any OPERS member applying for retirement and planning to enroll in the OPERS retiree health plan or the optional vision and dental plans must submit the Health Care Coverage Application during the retirement application process. Failure to provide the completed form within 30 days after your first monthly benefit payment is released will result in the deferral of health care coverage. The next available time to enroll in the OPERS Retiree Health Plan would be during the annual open enrollment period or within 60 days of involuntary loss of coverage from another source.

OPERS will not provide you or your eligible dependents health care coverage during a suspension or forfeiture of your retirement benefit.
OPERS Pre-Medicare Retiree Coverage

Waiting to enroll
If you are under age 65, waiting to enroll may have its perks. Each retiree has an allowance percent amount that applies to health care.

- If you are pre-Medicare, this percent determines how many dollars you pay toward your monthly premium.
- If you are enrolled in Medicare Parts A and B and enroll in an individual Medicare plan through the Connector, the percentage determines how much money is deposited into your HRA each month.
- Because your allowance amount is based on your age when you enroll, your allowance percentage will increase by three percent for each year you wait to enroll up to age 65.

Your decision to wait to enroll applies to medical and prescription coverage for yourself and for your dependents. You are not eligible for the Medicare Part A premium reimbursement when not enrolled in OPERS health care. You will still be permitted to enroll in the optional vision and/or dental plan.

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

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

Enrolling eligible dependents outside of open enrollment
If you are already enrolled in OPERS health care, you may only enroll your eligible dependents outside of open enrollment if you have experienced a life change (or a qualifying event). A qualifying event can be a new marriage or divorce, a new child because of birth or adoption, or an involuntary loss of coverage from another source. You must tell us of such an event, complete an enrollment application and provide supporting documentation of the qualifying event within 60 days. If OPERS does not receive the required supporting documents within 60 days, eligible dependents cannot be enrolled until the next open enrollment period.
OPERS Pre-Medicare Retiree Coverage

Cancelling your OPERS health care coverage

You can cancel your OPERS health care coverage, excluding vision and dental coverage, at any point during the year and re-enroll at another time. To cancel coverage, you must either call us at 1-800-222-7377 or complete and send us the Health Care Cancellation form, accessible at opers.org. Medical/pharmacy coverage will be terminated, effective the first day of the month following the date of the call or receipt of the completed cancellation form.

Re-enrolling in coverage

If you voluntarily choose to cancel OPERS health care coverage, you can re-enroll during open enrollment, or within 60 days of involuntary loss of your coverage by another health care plan.

Required documents for re-enrollment

- **Voluntary termination**: Proof of creditable coverage in another health care plan up through the month the application is received when re-applying during open enrollment.
- **Involuntary termination**: Proof of involuntary loss of coverage from your plan administrator or employer confirming involuntary loss of coverage when re-applying outside of open enrollment.

When re-applying outside of open enrollment, plan coverage begins the first day of the month following OPERS’ receipt of all required documents. Open enrollment coverage is effective Jan. 1.

Cancelling dependent coverage

You must notify OPERS immediately if your covered spouse and/or children become ineligible for coverage due to divorce/dissolution, death or if a child fails to meet eligibility requirements. OPERS will require that you provide a certified copy of your divorce/dissolution decree or your spouse’s or child’s death certificate. If a child fails to meet the eligibility requirements, OPERS requires notification from you indicating the child’s last date of eligibility. If you fail to notify OPERS that a family member is no longer eligible, overpayment of health care or prescription claims could occur and unnecessary premiums could be taken from your benefit check.

You may voluntarily terminate your spouse and/or children’s medical/pharmacy coverage either over the phone or by sending in a cancellation form at any time during the year.

Open Enrollment

Open enrollment is held Oct. 15 through Dec. 7. During this period, you may enroll in or cancel medical/pharmacy coverage and/or the optional vision and dental plans, make adjustments to your current coverage and enroll or cancel coverage for eligible dependents. Each year as open enrollment approaches, OPERS will provide retirees enrolled in the OPERS retiree health care program with information about health care choices and costs. Please be sure to read the material carefully, as premiums and plan features often change from year to year. Any changes you elect to make during open enrollment will be effective Jan. 1 of the following year.
OPERS Pre-Medicare Retiree Coverage

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:

<table>
<thead>
<tr>
<th>Income Guidelines</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single person</td>
<td>$24,280</td>
</tr>
<tr>
<td>Single with one dependent</td>
<td>$32,920</td>
</tr>
<tr>
<td>Single with two or more dependents</td>
<td>$41,560</td>
</tr>
<tr>
<td>Married</td>
<td>$32,920</td>
</tr>
<tr>
<td>Married with one or more dependents</td>
<td>$41,560</td>
</tr>
</tbody>
</table>

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/spouse support, investment income and all reportable income as defined by the Internal Revenue Code.
### 2020 Plan Coverage

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Usual and Customary Rate</strong> - UCR limits generally apply to any service provided out-of-network.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible per calendar year</td>
<td>$2,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Co-insurance amount</td>
<td>$3,250</td>
<td>No Limit</td>
</tr>
<tr>
<td>Co-insurance amount</td>
<td>(excluding deductible)</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Limit∞</td>
<td>$5,750</td>
<td>No Limit</td>
</tr>
</tbody>
</table>

### Medical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospice</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Substance Abuse (including alcohol)</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Surgery</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Office Visit - Medical Home</td>
<td>$15 copay</td>
<td>60%</td>
</tr>
<tr>
<td>Office Visit - Specialist</td>
<td>$50 copay</td>
<td>60%</td>
</tr>
<tr>
<td>Office Visit - Primary Care</td>
<td>$25 copay</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Emergency Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>$250* copay (emergency)</td>
<td>$250* copay (emergency)</td>
</tr>
<tr>
<td></td>
<td>$550 copay (non-emergency)</td>
<td>$550 copay (non-emergency)</td>
</tr>
<tr>
<td></td>
<td>75% facility</td>
<td>75% facility</td>
</tr>
<tr>
<td></td>
<td>75% all other charges</td>
<td>75% all other charges</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$60 copay</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Preventive Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual routine physical</td>
<td>100%**</td>
<td>60%***</td>
</tr>
<tr>
<td>PAP, Mammography†</td>
<td>100%**</td>
<td>60%***</td>
</tr>
<tr>
<td>Colonoscopy, Sigmoidoscopy, Bone Density Testing†</td>
<td>100%**</td>
<td>60%***</td>
</tr>
<tr>
<td>Flu and Pneumonia Vaccines</td>
<td>100%**</td>
<td>60%***</td>
</tr>
</tbody>
</table>

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 13.

∞ Out-of-pocket limit includes deductibles, copays and co-insurance amounts.
*Waived if admitted
**Not subject to co-insurance or deductible
***Subject to annual deductible
† Subject to age and frequency limitations
Pre-Medicare Medical Mutual Network/PPO and Pre-Medicare Re-employed Retiree Plan Features

2020 Plan Coverage

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

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 13.
Prescription Drug Plan

For pre-Medicare and Medicare OPERS retiree health care program participants

Pre-Medicare and Medicare retirees enrolled in the Medical Mutual network/PPO, Medical Mutual Re-employed Plan and Medical Mutual Medicare Secondary Plan utilize the prescription drug plan administered by Express Scripts. There are three programs that retirees can use to receive medications:

1. **Retail pharmacy program**
   Receive up to a 30-day supply of medication, plus refills, as prescribed by your physician. To use the retail pharmacy network, you must present your prescription drug ID card and prescription(s) to the pharmacist.

2. **Preferred retail pharmacy program**
   Pay the lowest copay and co-insurance amounts by using a preferred network of retail pharmacies. To find out if a pharmacy is preferred, call the number on the back of your Express Scripts ID card.

3. **Home delivery program**
   Receive up to a 90-day supply of medication, plus refills, as prescribed by your physician. To use the Home Delivery pharmacy, place an order using the Express Scripts website, by mailing the prescription(s) and the correct copay to Express Scripts, or by calling 1-866-727-5873. TTY users should call 1-800-716-3231.

**Specialty medications**
Specialty medications must be obtained through Accredo, Express Scripts’ specialty pharmacy (some exceptions apply) and are limited to a 30-day supply. These medications are high-cost drugs used to treat complex, chronic medical conditions, often injected or infused and require special storage and monitoring. Specialty medications largely fall into the formulary brand category, with some in the biosimilar or generic specialty drug category. These medications are subject to the appropriate co-insurance as listed.

<table>
<thead>
<tr>
<th>2020 Prescription Drug Plan</th>
<th>Retail Preferred Network/ Home Delivery</th>
<th>Retail Non-Preferred Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible(s)</td>
<td>$200 (generics) $400 (brands)</td>
<td>$200 (generics) $400 (brands)</td>
</tr>
<tr>
<td>Generic</td>
<td>25% co-insurance $4 minimum/$12 max retail $10 minimum/$30 max mail</td>
<td>30% co-insurance $7 minimum/$20 max</td>
</tr>
<tr>
<td>Formulary brand</td>
<td>35% co-insurance $30 minimum/$80 max retail $75 minimum/$200 max mail</td>
<td>40% co-insurance $35 minimum/$100 max</td>
</tr>
<tr>
<td>Non-formulary brand</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Specialty drugs - Brand, Biosimilar/Generic</td>
<td>$300 max</td>
<td>$300 max</td>
</tr>
<tr>
<td>Annual out-of-pocket maximum</td>
<td>$2,400 (per ACA limits)</td>
<td>$2,400 (per ACA limits)</td>
</tr>
</tbody>
</table>
**Value-Based Insurance Design for Pre-Medicare Plan Participants**

**OPERS pre-Medicare retiree coverage features several elements of value-based insurance design.**

A value-based insurance design has plan coverage features that encourage you to use high value health care services by lowering your out-of-pocket costs for those services. Lower copays for Medical Homes and coverage maximums for certain lab tests are examples of value-based design under OPERS pre-Medicare retiree coverage.

**Access to medical homes**

Led by a primary care provider, this team of health care professionals all work together to give you comprehensive and coordinated care covering all of your health and wellness needs.

- OPERS and Medical Mutual believe this model is so important that we offer a lower copay for care received from a SuperMed Network provider who is recognized as a Medical Home.
- Visit medmutual.com to find out if your primary care provider is part of a Medical Home, by searching ‘Medical Home’; you can also call Medical Mutual at 1-877-520-6728 to ask if your practitioner is listed.

**Coverage maximums for certain laboratory tests**

This is the maximum amount Medical Mutual will pay for certain lab tests done by SuperMed network providers. Not applicable are lab services provided during an emergency room visit, an inpatient hospital stay or during an outpatient procedure.

**How coverage maximums work:**

- **If a SuperMed provider’s contracted rate with Medical Mutual is at or below the coverage maximum** for specific lab services, you do not pay more than your normal out-of-pocket responsibility (such as network deductibles and coinsurance payments).
- **If a SuperMed provider’s contracted rate is above the coverage maximum,** you will pay your normal out-of-pocket responsibility plus the difference between the coverage maximum and the provider’s contractual reimbursement amount.

**For example,** a basic lipid panel coverage maximum is $10.39. Yet, some labs charge as much as $60.

- Under a provider that charges at or below the coverage maximum ($10.39), the most you would pay out-of-pocket is your co-insurance amount of $2.60.
- Under the higher-cost provider, you would pay $49.61 in addition to your co-insurance.

**To find a provider who charges at or below the coverage maximum for a specific lab test:**

1. Log into the Medical Mutual secure member web site, My Health Plan, at medmutual.com and go to the My Care Compare tool.
2. Enter the name of the lab test. Results will show if the lab test has a coverage maximum, what the coverage maximum is and which providers are charging that price or lower (and which are charging more).
OPERS Health and Wellness Programs for Pre-Medicare Plan Participants

As 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 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 the program is to help improve your overall health and get the most appropriate care in the most cost-efficient manner. Medical Mutual works with you, your doctors and other health care 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 lifestyle coach. Receive one-on-one coaching to help you achieve and maintain your wellness goals.

**Other resources**
- 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.
OPERS and Medicare Coverage for Medicare participants

Medicare coverage
Medicare is federal health insurance for those 65 and older, under age 65 with certain disabilities and any age with end-stage renal disease.

There are three parts of Medicare that apply to OPERS:

1. Medicare Part A is hospital coverage.
   You need at least 40 quarters of Social Security credit or have paid sufficient Medicare tax to be eligible for premium-free Medicare Part A. You may also qualify for Medicare Part A coverage through a spouse’s work record. If you do not have enough quarters to receive premium-free Medicare Part A, you will pay a monthly premium for Medicare Part A. OPERS provides reimbursement for Medicare Part A premiums to those who qualify.

2. Medicare Part B is outpatient medical coverage.
   Everyone is eligible to enroll in Medicare Part B once they have reached age 65 (or have a qualifying illness or disability, as discussed previously). In order to enroll, you must pay a monthly premium to Social Security.


Medicare enrollment at age 65
When you or your covered spouse becomes eligible for Medicare, you must enroll in Medicare Parts A and B. Once enrolled in Medicare, you will choose an individual Medicare plan (Medigap or Medicare Advantage) using the OPERS Medicare Connector administered by Via Benefits. A Medigap plan will pay after Original Medicare; a Medicare Advantage plan replaces Original Medicare. As an enrollee in either a Medigap or Medicare Advantage plan, you are responsible for paying your Medicare Part B premium.

It is important that you and your covered spouse apply for Medicare Part A and Part B three months (or 90 days) before you reach age 65. If you refuse Medicare coverage because of active employment or any other reason, you will not be eligible for OPERS health care. OPERS will send a reminder letter to enroll in Medicare coverage before your 65th birthday. Via Benefits will also contact you and your covered spouse prior to your 65th birthday to begin the plan selection and enrollment process.
OPERS and Medicare Coverage for Medicare participants

Medicare eligibility prior to age 65
If you or any of your covered dependents become eligible for Medicare before age 65, you must notify OPERS within 30 days of being notified by Social Security of your eligibility by sending us your Notice of Award letter issued by Social Security. OPERS requires you and any dependents enrolled in OPERS health care to enroll in Medicare Parts A and B when first eligible.

Medicare Part A reimbursement
Public employees hired prior to April 1986 were not required to pay Medicare tax through their public employer. If you did not pay this tax during your public employment career, you do not have access to Medicare Part A without paying a monthly premium. Ohio law now allows OPERS to provide premium reimbursement to those who are not eligible for premium-free Medicare Part A. As a Medicare-eligible OPERS retiree, you are required to enroll in and pay the monthly premium for Medicare Part A coverage through the Centers for Medicare and Medicaid Services.

Important information
- OPERS provides a monthly reimbursement for your Medicare Part A premium cost and also provides a 50 percent Medicare Part A premium reimbursement to eligible spouses. Please contact OPERS to obtain the Medicare Part A Reimbursement Form.
- With enrollment in both Medicare Parts A and B, retirees and eligible spouses will have the opportunity to make a plan selection through the OPERS Medicare Connector; retirees will receive a health reimbursement arrangement allowance upon enrolling into a medical plan.
- If you disenroll or fail to pay your Medicare Part A premium to the Centers for Medicare and Medicaid Services, you will be responsible for repaying OPERS the amount OPERS overpaid you.
- If the amount changes or you no longer have to pay a premium, notify OPERS immediately by submitting documentation from Social Security that states the new amount and date the new amount when into effect (other than a premium bill).

More information about Medicare and Medicare programs can be found within Understanding the Basics: Medicare and the OPERS Medicare Connector available at opers.org.
The OPERS Medicare Connector and Health Reimbursement Arrangement for Medicare-Eligible Plan Participants

The OPERS Medicare Connector, administered by Via Benefits™

With the help of a Via Benefits Licensed Benefit Advisor, retirees enrolled in both Medicare Parts A and B select a Medigap (Medicare Supplement) or Medicare Advantage plan as well as a Medicare Part D prescription drug plan on the individual Medicare market. Vision and dental coverage are still offered through OPERS. Upon enrolling and staying enrolled in a medical plan, retirees receive a Health Reimbursement Arrangement, or HRA.

When you select an individual Medicare plan through Via Benefits, you are able to use Via Benefits’ ongoing support for HRA management, carrier claim resolution, health reimbursement arrangement and Medicare plan questions. You may call Via Benefits at 1-844-287-9945 with any questions.

Health Reimbursement Arrangement allowance

The Health Reimbursement Arrangement, or HRA, allowance is provided to eligible retirees for reimbursement of qualified out-of-pocket medical expenses incurred by you or your qualified dependents. For example, you may seek reimbursement of premiums (e.g., individual Medicare Advantage or Medigap (Medicare Supplement) plan, Medicare Part B, dental and vision) and other out-of-pocket expenses as defined by the Internal Revenue Service including medical and prescription drug copays and co-insurance.

Once you have qualified medical expenses, you may file a reimbursement claim to receive funds from your account. Reimbursements of qualified medical expenses are not taxable income and are not reported on any tax form.

The monthly amount deposited into your account depends on your years of service and age when enrollment in the OPERS health care plan first takes place. Rolled into this amount will be an administrative fee of $2.33 that will be deducted monthly from each enrolled retiree’s account. You can check the amount in your health reimbursement account at any time by logging into your Via Benefit online account.

If you are new to selecting a plan through our vendor, be sure to carefully read the materials that OPERS and Via Benefits will mail to you. Materials offer step-by-step instructions for each phase. You may call Via Benefits at 1-844-287-9945 with any questions.

Questions? Call Via Benefits at 1-844-287-9945 to speak with a Licensed Benefit Advisor.
The OPERS Medicare Connector and Health Reimbursement Arrangement for Medicare-Eligible Plan Participants

**Spouses enrolled in Medicare Parts A and B**
Eligible spouses over age 65 can enroll in an individual Medicare plan with the help of Via Benefits. There are also resources for Medicare eligible participants to learn more about plans available outside of the Connector. Please visit opers.org for more information.

**Re-employed Retirees**
If you are a Medicare-eligible retiree or a retiree who is enrolled in Medicare and is re-employed in an OPERS-covered position, refer to page 25 to learn about health plan options available to you.

**Enrolling or terminating eligible dependents**

**Enrolling** — if you are enrolled in a Medicare plan with the help of the Connector, you may also enroll eligible dependents at the time of retirement, open enrollment or a qualifying event. A qualifying event can be a new marriage or divorce, the birth or adoption of a Medicare-eligible child or an involuntary loss of coverage from another source.

You must notify OPERS of the change, complete an enrollment application and provide supporting documentation (such as birth certificate, marriage certificate) of the qualifying event within 60 days. If OPERS does not receive the required supporting documents within 60 days, you will not be able to enroll the eligible dependents until the next open enrollment period.

**Terminating eligible dependents** — if you are enrolled in a Medicare plan you chose with the help of the Connector, you must notify OPERS immediately if your covered dependent becomes ineligible for coverage due to divorce/dissolution, death or if a child fails to meet eligibility requirements. OPERS will require that you provide a certified copy of your divorce/dissolution decree or your spouse’s or child’s death certificate. If a child fails to meet the eligibility requirements, OPERS requires notification from you indicating the child’s last date of eligibility.

VIA BENEFITS™
1-844-287-9945
my.viabenefits.com/opers
Medical Mutual Medicare Secondary Plan

The Medical Mutual Medicare Secondary Plan is a secondary plan OPERS will provide for Medicare-enrolled retirees who are not eligible to participate in the OPERS Medicare Connector.

Eligible participants

- Medicare-enrolled re-employed retirees and their Medicare-enrolled dependents
  A re-employed retiree is one receiving a pension while also being employed by an OPERS-covered employer.

- Medicare-enrolled retirees under age 65 with end-stage renal disease

Carrier identification cards are issued by Medical Mutual and prescription drug coverage is the same as the Pre-Medicare Prescription Drug Plan. For more information about OPERS health care and re-employment, see page 25.
Medical Mutual Medicare Secondary Plan

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

### 2020 Medical Mutual Medicare Plan

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per calendar year</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Co-insurance Amount (excluding deductible)</strong></td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>Out-of-pocket limit per calendar year</strong>*</td>
<td>$3,500</td>
</tr>
</tbody>
</table>

#### Medical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospice</td>
<td>80%, Covered by Medicare at a certified hospice agency</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td>80%</td>
</tr>
<tr>
<td>Surgery</td>
<td>80%</td>
</tr>
<tr>
<td>Office Visit (Primary Care Physician)</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Emergency Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>$150 copay (waived if admitted)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td>(must be billed as routine)</td>
</tr>
<tr>
<td>Routine Physical Exam</td>
<td>100%</td>
</tr>
<tr>
<td>PAP, Mammography</td>
<td>100%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>100%</td>
</tr>
<tr>
<td>Bone Density Testing</td>
<td>100%</td>
</tr>
<tr>
<td>Flu, Pneumonia, Hepatitis B vaccines</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### Other Medical

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic testing supplies</td>
<td>100%</td>
</tr>
<tr>
<td>Diagnostic lab and X-ray</td>
<td>80%</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>80%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>80%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Inpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Deductible</td>
<td>80%</td>
</tr>
<tr>
<td>Semi-Private Room</td>
<td>80%</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>80%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80%</td>
</tr>
<tr>
<td>Hospice (Respite Care)</td>
<td>80%, Covered by Medicare at a certified hospice agency</td>
</tr>
</tbody>
</table>

*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 limit 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 Medical Mutual.
Re-employment coverage options

Pre-Medicare — If you retire and then return to work in an OPERS-covered position, Ohio retirement law requires you to enroll in your employer’s health plan if the employer offers coverage to other employees in similar positions. You cannot waive your employer’s plan unless you have other health coverage allowing the OPERS health plan to be your secondary payor.

If your employer offers health coverage and you do not enroll, you are not eligible to participate in OPERS coverage. Proof of creditable coverage must be received within 60 days of your employment start date in order to have OPERS as secondary coverage. Once OPERS confirms your eligibility, you will be enrolled in the pre-Medicare re-employed retiree plan.

The features and coverage for the Medical Mutual Pre-Medicare Re-employed Plan are exactly the same as the Medical Mutual network/PPO Plan. Retirees should contact OPERS first to be sure they understand how re-employment may impact OPERS health care coverage. If you are enrolled in the Medical Mutual Pre-Medicare Re-employed Retiree Plan, a prescription drug plan is available to you.

Medicare — If you retire and then return to work in an OPERS-covered position, OPERS requires you to enroll in your employer’s health plan, provided the employer offers coverage to other employees in similar positions. You cannot waive your employer’s plan unless you have other health coverage, besides Medicare, allowing OPERS health care to be your secondary or tertiary payor. Proof of creditable coverage must be received within 60 days of your employment start date in order to have OPERS as secondary coverage. If your employer offers health coverage and you do not enroll, you are not eligible to participate in OPERS coverage.

When a Medicare-eligible OPERS retiree becomes re-employed in an OPERS-covered position, they are considered an active employee and cannot receive monthly health reimbursement arrangement allowance deposits while re-employed. Federal rules state that only retirees can access the health reimbursement arrangement, which OPERS uses to reimburse participants for premiums and out-of-pocket expenses.
General Information for All Plan Participants

Retirees enrolled in Medicare Parts A and B who are also employed in an OPERS-covered position have the following options:

1. **Enroll in the Medicare Secondary Plan**, administered by Medical Mutual. OPERS will provide an allowance toward the monthly premium.

2. **Choose an individual Medicare plan through the Connector**. This option does not allow for pre-Medicare dependents to be enrolled in an OPERS health care plan with an allowance. Deductibles and out-of-pocket limits may start over during a plan year when moving from one plan to another. Reimbursements from an active HRA account are limited to medical expenses incurred while not re-employed.

**Pre-Medicare and Medicare-eligible re-employed retirees**: Proof of coverage must be received within 60 days of the employment start date in order to have OPERS as secondary coverage. Federal law prohibits participants from being covered by the OPERS health care plan as secondary coverage if offered a high deductible health plan coupled with a health savings account. For more information, refer to the **Re-employment and Health Care Coverage Fact Sheet** found at opers.org.

**Member-Directed Retiree Medical Account**

We offer a retiree medical account to participants enrolled in the OPERS Member-Directed Plan. The vested amounts can be used to reimburse qualified medical expenses upon retirement or account refund. For more information, refer to the **Retiree Medical Account for Member-Directed Plan Participants Fact Sheet** found at opers.org.
Aetna Vision Plan for All Plan Participants

Aetna Vision Preferred, administered by EyeMed, is a vision coverage option available to you and your eligible dependents. If you choose to enroll in a vision plan, you’ll be responsible for paying the entire premium for this coverage. With a recent change to procedures impacting European nations, vision coverage is no longer available to our participants residing in European Union countries.

Plan Features

✓ A comprehensive eye exam. Not only can eye exams detect serious vision conditions such as cataracts and glaucoma, but they can also detect the early signs of diabetes, high blood pressure and many other health conditions.

✓ Savings of around 40 percent. There are two plan options to choose from both offering a significant savings on eye exams and eyewear.

✓ Your choice of leading optical retailers including LensCrafters, Target Optical, most Sears Optical and Pearle Vision locations, as well as thousands of private practitioners.

Added Benefits

✓ Eye Care Supplies. Receive 20 percent off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor’s services or contact lenses).

✓ 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.
Aetna Vision Plan for All Plan Participants

Plan Options
You have two options of vision coverage to choose from: High or Low. If you use an Aetna vision provider, you will have less out-of-pocket expenses; if you don’t use an Aetna vision provider, you’ll need to submit a claim form for reimbursement.

<table>
<thead>
<tr>
<th>2020 Monthly Premium for the OPERS Vision plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Coverage</td>
</tr>
<tr>
<td>High Option</td>
</tr>
<tr>
<td>Low Option</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2020 Vision Coverage</th>
<th>High Option</th>
<th>Low Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage type</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Retiree Pays</td>
<td>Reimbursement to retiree</td>
</tr>
</tbody>
</table>

Comprehensive eye exam
- $0 copay
- $65
- $0 copay
- $50

Contact lens fit & follow-up
- Standard: $17 copay, $23
- Premium: $62 copay, $23
- $32 copay, $8
- $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 for All Plan Participants

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

Plan Highlights

✔ Choose a dentist within the MetLife network to help reduce your costs. Negotiated fees apply to in-network services and may apply to services not covered by your plan and those provided after you’ve exceeded your annual plan maximum.

✔ 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 options of dental coverage to choose from: High or Low. Once enrolled you can view your Certificate of Coverage for additional details. These certificates explain the dental options available in the High or Low option dental plans.

Claims 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.

---

1. MetLife’s negotiated or preferred Dentist Program fees refer to the fees that dentists participating in MetLife’s Preferred Dentist Program have agreed to accept as payment in full, for services rendered by them. MetLife’s negotiated fees are subject to change.

2. Negotiated fees for non-covered services may not apply in all states. Plans in LA, MS, MT and TX vary. Please call MetLife for more details.
## 2020 Monthly Premium for the OPERS Dental plan

<table>
<thead>
<tr>
<th>Dental Coverage</th>
<th>Recipient</th>
<th>Spouse</th>
<th>1 Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Option</td>
<td>$36.59</td>
<td>$36.59</td>
<td>$21.74</td>
</tr>
<tr>
<td>Low Option</td>
<td>$21.71</td>
<td>$21.71</td>
<td>$13.18</td>
</tr>
</tbody>
</table>

## 2020 Dental Summary

<table>
<thead>
<tr>
<th>Coverage type</th>
<th></th>
<th>In-Network: Preferred Dentist Program</th>
<th>Out-of-Network: Preferred Dentist Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Care Type A: Cleanings, Emergency Care, Fluoride treatment, bitewing X-rays, and Oral examinations</td>
<td>100% of Negotiated Fee*</td>
<td>100% of R&amp;C Fee**</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery and Minor Restoration Type B: Fillings, Simple extractions and Surgical removal of erupted teeth.</td>
<td>80% of Negotiated Fee*</td>
<td>65% of R&amp;C Fee**</td>
<td></td>
</tr>
<tr>
<td>Major Services and Restoration Type C: Prosthodontics, inlays, onlays, crowns, dentures, pontics, implants and surgical removal of impacted teeth.</td>
<td>50% of Negotiated Fee*</td>
<td>35% of R&amp;C Fee**</td>
<td></td>
</tr>
</tbody>
</table>

### Deductible†:

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Annual Maximum Benefit: Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Option</td>
<td>$0</td>
<td>$0</td>
<td>$2,000</td>
</tr>
<tr>
<td>Low Option</td>
<td>$50</td>
<td>$100</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

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 Type C services.
The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

### High and Low Option

#### Diagnostic & Preventive Care - Type A

<table>
<thead>
<tr>
<th>Procedure</th>
<th>How Many/How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis (cleanings)</td>
<td>Two per calendar year</td>
</tr>
<tr>
<td>Oral Examinations</td>
<td>Two exams per calendar year</td>
</tr>
<tr>
<td>Topical Fluoride Applications</td>
<td>One fluoride treatment per calendar year for dependent children up to 16th Birthday</td>
</tr>
<tr>
<td>X-rays</td>
<td>Full mouth X-rays: one per 60 months; Bitewing X-rays: one set per calendar year</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>Space Maintainers for dependent children up to 14th birthday</td>
</tr>
<tr>
<td>Sealants</td>
<td>One application of sealant material every 60 months for each nonrestored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday</td>
</tr>
</tbody>
</table>

#### Oral Surgery & Minor Restorative – Type B

<table>
<thead>
<tr>
<th>Procedure</th>
<th>As needed or as needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings</td>
<td>As needed</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>As needed</td>
</tr>
<tr>
<td>Crown, Denture, and Bridge Repair/ Recementations</td>
<td>As needed</td>
</tr>
<tr>
<td>Endodontics</td>
<td>Root canal treatment as needed (excluding molar root canals)</td>
</tr>
<tr>
<td>Minor Oral Surgery - Simple Extractions and Surgical removal of erupted teeth</td>
<td>As needed</td>
</tr>
<tr>
<td>Periodontics</td>
<td>Periodontal scaling and root planing once per quadrant, every 2 years</td>
</tr>
<tr>
<td></td>
<td>Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year</td>
</tr>
</tbody>
</table>

#### Major Services and Restorative – Type C

<table>
<thead>
<tr>
<th>Procedure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridges and Dentures</td>
<td>Initial placement to replace one or more natural teeth, which are lost while covered by the Plan</td>
</tr>
<tr>
<td></td>
<td>Dentures and bridgework replacement: one every 10 years</td>
</tr>
<tr>
<td></td>
<td>Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed</td>
</tr>
<tr>
<td>Crowns/Inlays/Onlays</td>
<td>Replacement: once every 10 years</td>
</tr>
<tr>
<td>Endodontics</td>
<td>Molar root canal treatment as needed</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>When dentally necessary in connection with oral surgery, extractions or other covered dental services</td>
</tr>
<tr>
<td>Periodontal Surgery</td>
<td>Periodontal surgery once per quadrant, every 24 months</td>
</tr>
</tbody>
</table>

metlife.com/mybenefits
1-888-262-4874
The following actions require the completion of an OPERS form and may require supporting documentation to complete the process.

If filing for a pension and health care, OPERS strongly encourages you to apply online. Listed are the required forms and documents that allow for coverage and plan adjustment requests to be reviewed. There may be limitations on when these are completed and when the change takes effect. Most forms are printable and fillable and available at opers.org.

<table>
<thead>
<tr>
<th>What do you need to do?</th>
<th>What form does OPERS need you to complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enroll myself or myself and spouse/dependents in OPERS Health Care and the HRA</td>
<td>Health Care Coverage Application (HC-1G)</td>
</tr>
<tr>
<td>Enroll myself or myself and spouse/dependents in OPERS Health Care at the start of my re-employment</td>
<td>Health Care Coverage Application (HC-1G)</td>
</tr>
<tr>
<td>Defer my enrollment in OPERS health care</td>
<td>Health Care Coverage Application (HC-1G)</td>
</tr>
<tr>
<td>Add/change/cancel existing medical/prescription, vision or dental coverage for next plan year</td>
<td>Open Enrollment Change Form (HC-10)</td>
</tr>
<tr>
<td>Add/change coverage for my spouse and/or dependents</td>
<td>Health Care Coverage: Change of Coverage (HCCHG)</td>
</tr>
<tr>
<td>Cancel coverage for myself, my spouse and/or dependents</td>
<td>Health Care Coverage: Voluntary Termination of Medical/Pharmacy Coverage (HCCANC) or call OPERS to cancel</td>
</tr>
<tr>
<td>Enroll myself, my spouse and/or my dependents in vision and/or dental coverage only</td>
<td>Application for Vision and/or Dental Coverage (HC-10DV)</td>
</tr>
<tr>
<td>Apply for OPERS Income Based Discount Program</td>
<td>2020 Income Based Discount Program</td>
</tr>
<tr>
<td>Authorize release of health care information</td>
<td>HIPAA Authorization (HIPAA AUTH)</td>
</tr>
<tr>
<td>What additional documents does OPERS need to process your request?</td>
<td>Initial Enrollment</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>The following items are required for all enrolled participants, if applicable¹ PLUS (Health care only) • Proof of involuntary loss of coverage from the other health plan confirming the termination date for each individual you are enrolling</td>
<td>✘</td>
</tr>
<tr>
<td>The following items are required for all enrolled participants, if applicable¹ PLUS • Proof of creditable coverage</td>
<td>✘</td>
</tr>
<tr>
<td>None</td>
<td>✘</td>
</tr>
<tr>
<td>None, unless enrolling a new dependent¹</td>
<td>✘</td>
</tr>
<tr>
<td>The following items are required for all enrolled participants, if applicable¹ PLUS • Proof of involuntary loss of coverage from the other health plan confirming the termination date for each individual you are enrolling</td>
<td>✘</td>
</tr>
<tr>
<td>The following items, if applicable to your dependents • Divorce Decree • Death Certificate</td>
<td>✘</td>
</tr>
<tr>
<td>The following items are required for all enrolled participants, if applicable¹ PLUS • Proof of involuntary loss of coverage from the other health plan confirming the termination date for each individual you are enrolling</td>
<td>✘</td>
</tr>
<tr>
<td>Copy of your 2018 filed federal tax return</td>
<td>✘</td>
</tr>
<tr>
<td>None</td>
<td>✘</td>
</tr>
</tbody>
</table>

¹Primary documents include: birth certificate, marriage certificate, Medicare card, adoption decree, court order - if applicable.
### Resources

<table>
<thead>
<tr>
<th>Health Insurance Marketplace</th>
<th>1-800-318-2596</th>
<th>healthcare.gov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>1-800-MEDICARE (1-800-633-4227)</td>
<td>medicare.gov</td>
</tr>
<tr>
<td>Medicare Fraud Reporting Pro-Seniors (also legal services)</td>
<td>1-800-488-6070</td>
<td>proseniors.org</td>
</tr>
<tr>
<td>Ohio Department of Aging</td>
<td>1-800-266-4346</td>
<td>aging.ohio.gov</td>
</tr>
<tr>
<td>Ohio Department of Insurance Consumer Services</td>
<td>1-800-686-1526</td>
<td>insurance.ohio.gov</td>
</tr>
<tr>
<td>Ohio Department of Medicaid</td>
<td>1-800-324-8680</td>
<td>jfs.ohio.gov/ohp medicaid.ohio.gov</td>
</tr>
<tr>
<td>Ohio Senior Health Insurance Information Program (OSHIIP)</td>
<td>1-800-686-1578</td>
<td>insurance.ohio.gov</td>
</tr>
<tr>
<td>Social Security Administration</td>
<td>1-800-772-1213</td>
<td>ssa.gov</td>
</tr>
<tr>
<td>U.S. Dept. of Health &amp; Human Services Office of Inspector General</td>
<td>1-800-HHS-TIPS (1-800-447-8477)</td>
<td>medicare.gov/fraud</td>
</tr>
</tbody>
</table>