Open Enrollment Guide

2016

1. **Read** this Open Enrollment Guide carefully
2. **Determine** if you want (or are required) to make any coverage changes for 2016
3. **Inform** OPERS of any coverage changes by Oct. 31, 2015

Deadline

In order to make changes to your coverage for 2016, ***OPERS must be informed no later than***

October 31, 2015.

If you are not making any changes to your coverage for 2016, ***no action is required on your part.***

opersHealthCare

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General Information - for all plan participants

OPERS Medical coverage changing in 2016

Please see page 2 (Medicare) and page 4 (non-Medicare) for more details.

Medicare-eligible retirees and dependents who are:

- **Enrolled in Medicare Parts A and B** – will select an individual Medicare plan by contacting OneExchange at 1-844-287-9945.
- **Not eligible for premium-free Medicare Part A** – will be enrolled in the Humana Interim Medicare Plan through June 30, 2016.
- **Re-employed in an OPERS-covered position** – must complete the enclosed application to enroll in the Humana Interim Medicare Plan during open enrollment.
- **Under age 65 with end-stage renal disease (ESRD) –** will be enrolled in the Humana Interim Medicare Plan.

Retirees and spouses who are not yet eligible for Medicare will participate in the OPERS Retiree Health Plan administered by Medical Mutual.

- **If you are not eligible for Medicare and are re-employed in an OPERS-covered position,** you will be enrolled in the Medical Mutual Interim Plan.

OPERS retiree health care coverage is not a guaranteed benefit nor is it required by law.

Medicare-eligible plan participants – *What you need to know for 2016*

- Effective Dec. 31, 2015, OPERS will no longer sponsor a group Medicare Advantage plan or Medicare D prescription plan.
- Retirees enrolled in both Medicare Parts A and B will select a Medigap (Medicare Supplement) or Medicare Advantage plan and a Medicare D prescription drug plan using the OPERS Medicare Connector administered by OneExchange.
- Retirees who enroll in a plan through the Connector will receive an allowance in a Health Reimbursement Arrangement (HRA) account that the retiree (and spouse) can use to reimburse the cost of qualified medical expenses.

Dental and vision coverage will still be offered through OPERS. Please review this booklet and follow the directions on page 15 to make changes to this coverage for 2016.

Please call OneExchange now to schedule your enrollment phone appointment. Your appointment will take place between October and December.

OneExchange
1-844-287-9945
www.medicare.oneexchange.com/opers

Humana Interim Medicare Plan

The Humana Interim Medicare Plan is the plan OPERS will provide for Medicare-eligible retirees who are not eligible to participate in the OPERS Medicare Connector. These retirees include:

- **Medicare-eligible re-employed retirees and their eligible Medicare dependents** – A re-employed retiree is one receiving a pension while also being employed by an OPERS-covered employer.
- **Retirees enrolled in Medicare Part B, but not eligible for premium-free Medicare Part A** – These retirees will participate only until June 30, 2016. By then, they should have enrolled in Medicare Part A and should have selected a plan using the OPERS Medicare Connector administered by OneExchange effective July 1, 2016.
- **Medicare-eligible retirees under age 65 with end-stage renal disease (ESRD)**

The 2016 Humana Interim Medicare Plan has many of the same features as the 2015 Humana Medicare Advantage Plan. Some notable differences include:

- ***The annual deductible is $500.***
- ***For retirees not eligible for Premium-free Medicare Part A, the annual deductible for 2016 is $0, not $500.***
- ***This plan will provide secondary coverage, after Original Medicare (Parts A and B) has paid. Effective Jan. 1, 2016, please give your Medicare card to providers along with your new Humana identification card.***
- ***Silver Sneakers (free gym membership) is not offered as part of this plan.***

Prescription drug coverage will be the same as the OPERS Retiree Health Plan Prescription Drug Plan (detailed on page 3) with the exception of a $0 deductible for retirees not eligible for premium-free Medicare Part A.

Humana.
Phone: 1-877-890-4777

Humana Interim Medicare Plan Features

Deductible per calendar year	
Single	$500* (not included in out-of-pocket limit)
Out-of-pocket limit per calendar year	
Single	$850* (excluding deductible)
Lifetime Maximum	None
Medical Services	
Outpatient Hospice	100%, Covered by Medicare at a certified hospice agency
Mental Health	96%
Substance Abuse (including Alcohol)	96%
Surgery	96%
Office Visit (Primary Care Physician)	96%
Office Visit (Specialist)	92%
Emergency Services	
Emergency Room	$50 copay (waived if admitted)
Urgent Care	$50 copay
Preventive**	(must be billed as routine)
Routine Physical Exam	100%
Annual PAP, Mammography, PSA	100%
Colorectal Cancer Screening (for all participants age 50 and over)	100%
Bone Density Testing	100%
Flu, Pneumonia, Hepatitis B vaccines	100%
Other Medical	
Diabetic testing supplies	100%
Diagnostic lab and x-ray	96%, Lab/pathology; 100%, X-ray
Chiropractors (for manual manipulation of the spine to the extent covered by Medicare)	96%
Physical Therapy	96%
Ambulance	96%
Home Health Care	100%
Durable Medical Equipment	96%
Inpatient	
Inpatient Deductible	None
Semi-Private Room	96%
Pre-Admission Testing	100%
Skilled Nursing Facility	100%
Hospice (Respite Care)	95%, Covered by Medicare at a certified hospice agency

For retirees not eligible for Premium-free Medicare Part A, the annual deductible for 2016 is $0, not $500.

**Annual out-of-pocket maximum equals $1350 ($500 deductible plus $850 out-of-pocket limit per year).*

***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. Prescription drug coverage information for Medicare eligible retirees is listed on page 3.

Coverage as shown includes combined payments through Original Medicare (Parts A and B) and the Humana Interim Medicare Plan.

Prescription Drug Coverage – *for all those participating in an OPERS group health care plan*

- The annual out-of-pocket maximum will be reduced from $3,250 to $1,950 per Affordable Care Act guidelines.
- In 2016, there will be an annual deductible in the amount of $100 for generic drugs and $200 for brand name drugs.
- Generic drugs will be subject to a 20 percent co-insurance if filled at a Preferred Pharmacy and a 25 percent co-insurance if filled at a non-Preferred Pharmacy.
- Over-the-counter and brand PPI (heartburn) medications will not be covered.

2016 Prescription Plan	Retail Preferred Network/ Home Delivery	Retail Non-Preferred Network
Deductible (Calendar year)	$200 Brand $100 Generic	$200 Brand $100 Generic
Generic	20% Retail co-insurance ($4 min/$8 max retail) ($10 min/$20 max mail)	25% co-insurance ($7 min/$11 max)
Formulary Brand	30% Retail co-insurance ($30 min/$60 max retail) ($75 min/$150 max mail)	35% co-insurance ($35 min/$65 max)
Non-Formulary Brand	Not covered	Not covered
Formulary Specialty Drugs (Generic and Brand)	40% co-insurance ($150 max)	40% co-insurance ($150 max)
Formulary brand diabetic medications and testing supplies	30% Retail co-insurance ($30 min/$60 max retail) ($75 min/$150 max mail)	30% Retail co-insurance ($30 min/$60 max retail) ($75 min/$150 max mail)
Annual Out-of-Pocket Maximum (100% coverage after you have spent $1,950 in copays/co-insurance)	$1,950 per participant	$1,950 per participant
Value-Based coverage Medications treating certain chronic conditions*	Generic (Retail or Home Delivery) = $0 copay Formulary Brand = co-insurance as listed above	Generic or All Brand = copay or co-insurance as listed above
2016 Proton Pump Inhibitor (PPI) Coverage (Medications treating acid-reflux and heartburn)		
OTC - Examples include: Prilosec, Omeprazole, Prevacid, Zegerid	Not covered	Not covered
Generic - Examples include: Omeprazole, Pantoprazole and Lansoprazole	50% Home Delivery co-insurance ($40 minimum)	50% Home Delivery co-insurance ($40 minimum)
Brand - Examples include Nexium, Prevacid, Aciphex, Prilosec, Protonix, Zegerid and Kapidex	Not covered	Not covered

**Participants will have $0 copays for generic medications treating certain chronic conditions under Value-Based coverage. "Retail" is a 30-day supply. "Mail" is a 90-day supply.*

Specialty Medications - **For non-Medicare participants only:** specialty medications must be purchased through Accredo (formerly CuraScript), Express Scripts' specialty mail order pharmacy. Some exceptions apply. These medications are limited to a 30-day supply. For more information, please contact Accredo at 1-866-654-2174.

EXPRESS SCRIPTS®

Website: www.Express-Scripts.com
Phone: 1-866-727-5873

Non-Medicare eligible plan participants – *What you need to know for 2016*

- OPERS will adopt a coverage maximum policy for 40 common lab tests to help keep lab costs down. (applies only to participants using Medical Mutual's SuperMed network)
- In-network and out-of-network annual deductibles and maximum out-of-pocket amounts will increase.
- Premiums for enrolled children will change from a multiple child rate to a per child rate.
- All office visit copays are increasing.
- Other in-network medical services co-insurance is increasing to 25 percent.
- In an effort to allow participants to adjust to higher costs and plan design changes, OPERS is providing a partial premium reduction over the next three years. This reduction does not apply to spouses, surviving spouses, dependents or re-employed retirees. The costs listed on your open enrollment statement reflect this reduction.

OPERS Retiree Health Plan

The OPERS Retiree Health Plan for participants not yet eligible for Medicare is administered by Medical Mutual.

The OPERS Retiree Health Plan is a network/ PPO plan. This network gives retirees 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.

The OPERS Retiree Health Plan includes the Medical Mutual PPO Plan as well as the Medical Mutual Interim Plan.

Re-employed Retirees – Non-Medicare

A **"re-employed retiree"** is defined as - *An OPERS retiree drawing his or her pension while at the same time being employed by an OPERS-covered employer who is paying into OPERS.* In order to protect the "retiree-only" status of our health care plan, we will enroll re-employed non-Medicare retirees in a separate plan called the **Medical Mutual Interim Plan**. The features and coverage for this plan are exactly the same as the OPERS Retiree Health Plan described on page 5.

However, re-employed retirees will receive a different identification card from Medical Mutual for 2016. You can find additional information regarding re-employment in an OPERS-covered position on the OPERS website, www.opers.org. Retirees considering re-employment in an OPERS-covered position should contact OPERS first to be certain they have a complete understanding of the impact re-employment could have on their OPERS health care coverage.

MEDICAL MUTUAL℠

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

Non-Medicare eligible plan participants – *Medical Mutual PPO and Medical Mutual Interim Plan Features*

All limits and maximums are per covered individual

UCR	In Network	Out of Network	Out-of-Area
Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.			
Deductible per calendar year	$1,000 (not included in out-of-pocket limit)	$2,000 (not included in out-of-pocket limit)	$1,000 (not included in out-of-pocket limit)
Out-of-Pocket limit per calendar year	$3,900 (excluding deductible)	$5,000 (excluding deductible)	$3,900 (excluding deductible)
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Medical Services			
Outpatient Hospice	100%	60%	100%
Mental Health	75%	60%	75%
Substance Abuse *(including alcohol)*	75%	60%	75%
Surgery	75%	60%	75%
Office Visit - *Primary Care Physician*	$25 copay	60%	75%
Office Visit - *Specialist*	$40 copay	60%	75%
Office Visit - *Medical Home*	$15 copay	60%	75%
Emergency Services			
Emergency Room	$150* copay (emergency) $250 copay (non-emergency) 100% facility 75% all other charges	$150* copay (emergency) $250 copay (non-emergency) 100% facility 75% all other charges	$150* copay (emergency) $250 copay (non-emergency) 100% facility 75% all other charges
Urgent Care	$45 copay	60%	75%
Preventive services			
Annual routine physical	100%**	60%**	100%**
Annual PAP, Mammography, PSA	100%**	60%***	100%
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	100%**	60%***	100%
Flu and Pneumonia Vaccines	100%**	60%***	100%

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%.

**Waived if admitted*
***Not subject to co-insurance or deductible*
****Subject to annual deductible*

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

Prescription drug coverage information for non-Medicare retirees is listed on page 3.

Non-Medicare eligible plan participants – *Medical Mutual PPO and Medical Mutual Interim Plan Features*

All limits and maximums are per covered individual

UCR	In Network	Out of Network	Out-of-Area
Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.			
Other Medical			
Lab and Diagnostic	75%	60%	75%
Chiropractors (10 visit limit)	75%	60%	75%
Physical Therapy	75%	60%	75%
Ambulance	75%	80%	75%
Home Health Care	100 visits 100% then 75%	70%	100 visits 100% then 75%
Durable Medical Equipment	75%	60%	75%
All Other	75%	60%	75%
Inpatient			
Inpatient Deductible (per admission)	$150	$250	$150
Semi-Private Room	75%	70%	75%
Pre-Admission Testing	75%	70%	75%
Skilled Nursing Facility	100%	70%	100%
Hospice	100%	70%	100%

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%.

**Waived if admitted*

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

****Subject to annual deductible*

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

Prescription drug coverage information for non-Medicare retirees is listed on page 3.

Vaccines

Shingles

The Shingles Vaccine and administration by provider is covered at 100% for enrollees 60 years of age or older under the Medical Mutual Plan and Express Scripts (100% including administration fee).

Flu and pneumonia

Flu and Pneumonia vaccines along with administration by provider are covered at 100% under the Medical Mutual Plan as well as Express Scripts (100% including administration fee).

MEDICAL MUTUAL™

Website: www.medmutual.com

Phone: 1-877-520-6728

OPERS Wellness Programs in 2016

Recently, OPERS conducted a study to measure the effectiveness of the Medical Mutual Disease Management program. The results showed that overall the program did not improve how participants manage their chronic conditions including COPD, diabetes, chronic heart failure and coronary artery disease. Therefore, OPERS decided to end our program for all conditions as of Dec. 31, 2015.

If you have any of these conditions, your generic medications will still be covered with a $0 copay in 2016. If you are a non-Medicare participant with diabetes and enrolled in the disease management program before Dec. 1, 2015, brand diabetic medications or supplies will still be covered with a $0 copay through the end of 2015 only. Starting Jan. 1, 2016, they will be covered like any other brand medication, subject to the deductible and cost sharing.

If you are a current Disease Management program participant, you will receive a letter later this fall with more information. If you have any questions about the ending of the program, contact Medical Mutual Customer Care at (877) 520-6728.

Other wellness and clinical programs will still be available through Medical Mutual. Non-Medicare participants and participants can earn a $50 RMA deposit for completing one of the following SuperWell® wellness programs without participation interruption:

- QuitLine: a free telephone service that gives members the tools they need to quit tobacco use for good.
- Weight Watchers: a reimbursement program for attending a Community Meeting series to lose weight.
- Lifestyle Coaching: a telephone and web-based coaching program that helps members make life changes to improve their well-being. Each individual has his or her own program that stresses self-responsibility.
- Healthy U: a six-week community-based workshop that helps participants to self-manage their chronic conditions.

Become a healthier YOU with *Healthy U Ohio* in 2016 - *and earn $50!*

Living a healthy, active life with chronic conditions can be a challenge especially as we age. That's why the Ohio Department of Aging and Ohio's area agencies on aging offer the *HEALTHY U Ohio* program. Through a series of in-person workshops held in your community or online workshops, you can learn strategies to effectively manage your symptoms and live the life you want to live. To learn more and find a workshop starting soon near you, visit www.aging.ohio.gov or call your local area agency on aging at 1-866-243-5678. When you sign up, be sure to tell them that you are enrolled in the OPERS Retiree Health Plan.

You will receive a $50 Retiree Medical Account (RMA) incentive from OPERS if you participate in and complete an in-person *Healthy U* workshop that begins Jan. 1, 2016 or after.

General Information – *Aetna Vision Plan 2016*

Aetna Vision Preferred, administered by EyeMed, is a vision coverage option available to you and your eligible dependents. The plan provides:

A comprehensive eye exam which can detect serious vision conditions such as cataracts and glaucoma, but 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.

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

Your Plan Options

Participants in the Aetna vision plan have two options of vision coverage (High or Low) from which they can choose. If participants use an Aetna provider, they will have less out-of-pocket expenses. If participants do not use an Aetna provider they will need to file a claim form and be reimbursed for their expenses. Participants enrolling in a vision plan pay the entire premium for their coverage.

2016 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 $130 retail value, 80% of balance over $130	$78	$5 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
Contact lenses	$0 copay up to $240 retail value	$228	$10 copay up to $200 retail value	$180
Coverage period for exams	Once per 12 months	Once per 12 months	Once per 12 months	Once per 12 months
Coverage period for frames and lenses	Once per 12 months	Once per 12 months	Once per 24 months	Once per 24 months

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

aetna®

Website: www.aetnavision.com

Phone: 1-866-591-1913

General Information – *MetLife Dental Plan*

Once enrolled you will receive a Certificate of Coverage with for additional details. Participants enrolling in a dental plan pay the entire premium for this coverage.

Highlights of the Plan include:

- Choosing a dentist within the MetLife network will reduce your costs.[1] 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.[2]

- You can also choose an out-of-network dentist, but your out-of-pocket costs may be higher. There are more than 187,000 participating Preferred Dentist Program dentist locations nationwide, including over 45,000 specialist locations.

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 may vary. Please call MetLife for more details.

Claims Details:
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and receive email alerts when a claim has been processed. If you need a claim form you can request one by calling 1-888-262-4874.

In 2016:

- The annual maximum (paid by MetLife) will increase from $1,500 to $1,750 for in-network coverage and will decrease from $1,500 to $1,250 for out-of-network coverage.

- The missing teeth provision is excluded from coverage in 2015. For 2016, this exclusion will be removed.

- The replacement period for crowns and bridges will be extended from eight years to 10 years in 2016.

- Monthly premiums will increase by less than one dollar for both the high and low coverage options.

Questions?
For questions or a list of preferred dentists, visit www.metlife.com/mybenefits or call 1-888-262-4874.

MetLife

Website: www.metlife.com/mybenefits
Phone: 1-888-262-4874

2016 MetLife 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*	70% 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	$1,750	$1,250	$1,750	$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

MetLife

Website: www.metlife.com/mybenefits
Phone: 1-888-262-4874

OPERS retiree health care coverage is not a guaranteed benefit nor is it required by law.

The coverage eligibility described here is for the 2016 plan year

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code, retirees receiving a monthly age and service or disability benefit may only enroll:

Legal spouse – Must have a valid marriage certificate.

OPERS does not subsidize the monthly health care premium costs for a spouse if he or she is under the age of 55.

- This rule does not apply to children, spouses of disability recipients, spouses with early Medicare or any spouse who is receiving a benefit as the surviving spouse of an age and service retiree (joint and survivor annuity) or as the surviving spouse of a deceased working member (receiving a survivor benefit).
- Participants may cover a spouse under the age of 55; however, the full health care premium will be charged.
- The month an enrolled spouse reaches age 55, OPERS will begin to pay a portion of his or her health care premium.

Child(ren) – This 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 they are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

In order for a child to be eligible for group coverage, 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 age 26 if the child is permanently and totally disabled prior to age 22. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment, which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

Participants in the OPERS health care plan receiving a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member may only enroll those dependents who would have been eligible dependents of the deceased retiree or member as defined on this page.

It is the participant's responsibility to notify OPERS, in writing, within 30 days of the date his or her dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid health care claims or reimbursement for which the retiree will be responsible.

Multiple OPERS accounts

Retirees eligible for health care coverage from more than one OPERS benefit will be placed in the account that provides the highest allowance, but cannot be covered under more than one account simultaneously.

Other Ohio Retirement Systems

Retirees may only receive primary health care coverage from one of the five Ohio retirement systems (OPERS, STRS, SERS, OP&F, and OHPRS). Retirees or their spouses qualifying for retirement under another Ohio retirement system cannot waive coverage under that system in order to make OPERS their primary health care coverage. They must continue coverage under the other retirement system, but may elect OPERS as secondary.

OPERS spouses or surviving spouses who are eligible for primary health care coverage from another Ohio retirement system but waived that coverage under a waiver agreement between systems, will not have access to the OPERS health care plan after Dec. 31, 2015. This change is being implemented because the waiver agreement between OPERS and the other Ohio Systems will no longer be in place.

Medicare Coverage

Medicare is a health insurance program for:

- People age 65 or older.
  People under age 65 with certain disabilities.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Medicare program consists of:

- Part A (hospitalization) OPERS recommends retirees sign up for Medicare Part A if they are eligible to enroll. For retirees and spouses not eligible for premium-free Medicare Part A, please see page 14 for more information.
- Part B (medical) OPERS requires retirees to sign up for Part B as soon as they are eligible. In 2016, OPERS will reimburse you a portion of the cost of your Medicare Part B monthly premium up to $31.81.

  OPERS will automatically contact retirees prior to their 65th birthday requesting proof of Medicare coverage.

Retirees and dependents enrolled in Medicare Parts A and B will choose an individual plan using the OPERS Medicare Connector administered by OneExchange. Group coverage will not be available to retirees who are eligible for Medicare, but fail to enroll (excluding those without premium-free Medicare Part A.)

Income-Based Discount Program

The OPERS Income-Based Discount Program is designed to help qualified retirees pay for their portion of their monthly medical/pharmacy premiums. The program provides a 30 percent reduction in the premium amount retirees pay each month for medical/pharmacy coverage through OPERS if his or her household income was equal to or less than 200 percent of the federal poverty level.

Participants are required to re-apply for the program each year. Those eligible and currently participating in the program receive a renewal application each October. Dental and vision coverage premiums do not qualify for the reduction offered by the Income-Based Discount Program.

To be eligible in 2016, a participant's household income must have been at or below the following levels based on their 2014 federal income tax return:

Single person	$23,340.00
Single with one dependent	$31,460 .00
Single with two or more dependents	$39,580.00
Married	$31,460.00
Married with one or more dependents	$39,580.00

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

Retirees can only apply for the program at the following times:

- *At the time a retiree first receives monthly benefits and qualifies for health care (application and all supplemental documents must be received within 60 days of release of the initial benefit payment).*
- *During the annual open enrollment period each October (application must be received by OPERS on or before Oct. 31) with a program effective date of the following January.*

If you feel you qualify to participate in the program, you must complete the Income-Based Discount Program Application (HC-IBD). The application can be found online at www.opers.org or you can 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) 2014 filed federal tax return to OPERS.

FAQ

Frequently asked questions

Why did my premium change for 2016?

As part of the health care changes approved in 2012, retirees will experience a greater premium cost share in 2016 due to the allowance percentage transition. Health care inflation also contributes to increased premiums. In 2016, premium allowances for spouses, surviving spouses and children of retirees with less than 20 years will begin the transition to a zero dollar allowance by 2018. This will result in substantial premium increases for participants under age 65 and not yet eligible for Medicare. To help offset these increases, the OPERS Board approved a temporary premium reduction for retirees who are not re-employed. This is a temporary measure for 2016, 2017 and 2018. It may be expanded beyond 2018 at the Board's discretion.

I am Medicare-eligible and moving to the Connector but my spouse is not eligible for Medicare yet. Will our coverage be different next year?

Yes. For the first time, family members both enrolled in OPERS health care coverage may participate in different health care plans.

Medicare participants – Participants enrolled in Medicare Parts A and B will select an individual Medicare medical and pharmacy plan through the OPERS Medicare Connector administered by OneExchange. Please call OneExchange at 1-844-287-9945 with any questions or to schedule your enrollment call for between October 1 and December 31.

Non-Medicare participants – Participants under age 65 and not yet eligible for Medicare will continue to have access to the OPERS retiree health plan through Medical Mutual and Express Scripts. Please see the enclosed cost statement for more information.

Why can't I receive my diabetic supplies/ medications at no cost in 2016?
OPERS is discontining Medical Mutual's disease management program as of Dec. 31, 2015 because the program has not been successful in helping participants manage their chronic conditions. If you are currently participating in a disease management program, your generic medications will still be covered at a $0 copay in 2016. For those currently enrolled in the program or enrolled before Dec. 1, 2015, brand diabetic medications or supplies will be covered with a $0 copay through the end of 2015. Beginning Jan. 1, 2016, brand diabetic medications or supplies will be covered like any other brand medication, subject to the deductible and cost sharing.

Do I have to quit my OPERS-covered job to be eligible for OPERS health care coverage in 2016?
No. However, if your employer offers you health care coverage, you must enroll in it. A "re-employed retiree" is defined as an OPERS retiree drawing their pension while at the same time being employed by an OPERS-covered employer who is paying into OPERS. In order to protect the "retiree-only" status of our health care plan, we will enroll re-employed retirees in a separate plan called the Medical Mutual Interim Plan. Re-employed retirees enrolled in Medicare Parts A and B can enroll in the Humana Interim Medicare Plan. Please refer to the enclosed cost statement and application for details regarding plan enrollment.

I am over age 65, but don't qualify for Medicare Part A. What coverage will I have in 2016?
Retirees and spouses not eligible for premium-free Medicare Part A with a benefit effective date of Sept. 1, 2015 or prior will be enrolled in the Humana Interim Medicare Plan effective January 1 through June 30, 2016. These participants are required to enroll in Medicare Part A through the Social Security Administration between January and March 2016 with an effective date of July 1, 2016. Finally, in order to have supplemental coverage to Medicare, these participants must select a Medicare plan through OneExchange between April and June 2016 with an effective date of July 1, 2016. OPERS will reimburse retirees 100 percent of the Medicare Part A premium and applicable penalties. Eligible spouses can receive a reimbursement of 50 percent of the premium and 100 percent of the penalties. OPERS will provide these participants with more details within a separate mailing.

Why is my Medicare Part B reimbursement amount decreasing?
Your Medicare Part B reimbursement amount will be reduced to $31.81 in 2016. This reduction is part of the gradual elimination of the reimbursement. You'll be reimbursed $31.81 in 2016 and then $0 in 2017 and after.

General Information

Before making any decisions, please read this guide carefully. If you have specific questions about how much the plans pay for certain services, or about the medical professionals or facilities (such as hospitals) that you can use, please call the plan administrators directly. We have printed their phone numbers within the guide.

How to make changes - You can make changes to your current health care plan during this open enrollment period either by phone or by mail. OPERS must receive changes no later than Oct. 31, 2015.

Call 1-800-222-7377 if you would like to make any of the following changes:

1. Discontinue dental and/or vision coverage for yourself or a covered family member
2. Change your vision and/or dental coverage level (low to high or high to low)

Please complete the Health Care Open Enrollment Change Form on the following page if you would like to:

1. Add a new dependent
2. Add medical, vision and/or dental coverage for yourself or your eligible dependents
3. Cancel medical coverage for yourself or your eligible dependents
4. Enroll in the Humana Interim Medicare Plan, if re-employed in an OPERS-covered position.

If you do not want to make any changes to your coverage for 2016, you do not need to complete the Health Care Open Enrollment Change Form or contact OPERS by phone. No action is required on your part.

Deadline

The completed form must be received by OPERS no later than Oct. 31, 2015.

Things to know about completing the Health Care Open Enrollment Change Form:

These forms are electronically processed upon receipt by OPERS. Please follow these suggestions to ensure that your changes are communicated correctly:

- Please complete the form in blue or black ballpoint ink.
- Please do not attempt to correct your address using this form.
- Do not use another person's pre-printed form. If you have misplaced your form, please call OPERS.
- Use the boxes provided to make coverage selections. Do not hand-write your selections or make other notes on the form.
- Please note that because of limited space, all of your covered dependents may not be pre-printed on the form. Your currently covered dependents are listed on page 1 of the statement. If you wish to make changes to coverage for dependents not listed on the form, please indicate these changes on a separate sheet of paper.
- Use Section 4 of the 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 as listed on the form.

OPERS retiree health care coverage is not a guaranteed benefit nor is it required by law.

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 www.opers.org.

opersHealthCare

The plan features within this document are valid only for the 2016 plan year.

Medicare plans are subject to change based on the Centers for Medicare and Medicaid Services (CMS) guidelines.

OPERS retiree health care coverage is not a guaranteed benefit nor is it required by law.

It is your responsibility to be certain that OPERS has your current address on file. If OPERS is not made aware of address changes, we cannot guarantee that you will receive important information pertaining to your OPERS account.

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

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

OPERS

Ohio Public Employees Retirement System

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