Open Enrollment Guide

for optional dental and vision coverage

2016

1. **Read** this Open Enrollment Guide carefully
2. **Determine** if you want to make changes to your dental and/or vision coverage for 2016
3. **Inform** OPERS of any dental and/or vision coverage changes by Oct. 31, 2015

Deadline

In order to make changes to dental and/or vision coverage for 2016, ***OPERS must be informed no later than***

October 31, 2015.

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

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Choose an individual Medicare plan with the help of OneExchange

Effective Dec. 31, 2015, OPERS will no longer sponsor a group Medicare Advantage plan or Medicare D prescription plan.

With the help of a OneExchange Licensed Benefit Advisor, 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 on the individual Medicare market. 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. The following pages contain vision and dental coverage information for 2016. Please review this booklet and follow the directons on page 7 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. The OneExchange/OPERS phone number is 1-844-287-9945.

Eligibility and Enrollment

Eligible Family Members
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:

Their legal spouse – They must have a valid marriage certificate.

Their child(ren) – This must be their 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 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 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 retiree'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 for which the retiree will be responsible.

When Can I Enroll in the Vision and/or Dental Plan?
You may enroll only when you first retire, or during our open enrollment period. After you enroll, you and your family members must stay enrolled until the next open enrollment period unless you have a change in family status, including a divorce, death or a child reaches age 26. You must notify OPERS immediately if you have a change in family status.

When Can I Enroll New Family Members?
You may enroll newly eligible family members within 31 days of the date they become eligible (such as the date of marriage or birth). You must contact OPERS for the appropriate enrollment form and return this form, complete and with the required documentation, within 31 days.

How Will Premiums Be Paid?
Your premium cost for the plan(s) you select will be deducted from your pension check each month.

Ohio Public Employees Retirement System offers optional dental and vision coverage. If you receive a monthly benefit from OPERS, you are eligible to enroll.

Participants enrolling in a vision plan pay the entire premium for this coverage.

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 may have more 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.

Other Features:
In addition to the vision coverage the Aetna Vision Preferred plan offers, participants also enjoy additional features including:

- **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% off the promotional price for LASIK or PRK procedures.
- **Replacement Contact Lens Purchases** – Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

aetna®

Website: www.aetnavision.com
Phone: 1-866-591-1913

Aetna Vision Plan

2016 Monthly Premium for the OPERS Vision plan			
Vision Coverage	**Recipient**	**Spouse**	**Per Child**
High option	$5.86	$5.86	$4.54
Low Option	$2.46	$2.46	$1.72

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.

MetLife Dental Plan

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.

- **New 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.

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

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.

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

MetLife Dental Plan

Dental Coverage	2016 Monthly Premium for the OPERS Dental plan Recipient	Spouse	1 Child
High Option	$32.52	$32.52	$19.33
Low Option	$19.60	$19.60	$11.89

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*	80% of R&C Fee**
Oral Surgery and Minor Restoration *Type B:* Fillings, Simple extractions and Surgical removal of erupted teeth.	80% of Negotiated Fee*	65% of R&C Fee**	60% of Negotiated Fee*	50% of R&C Fee**
Major Services and Restoration *Type C:* Prosthodontics, inlays, onlays, crowns, dentures, pontics, implants and surgical removal of impacted teeth.	50% of Negotiated Fee*	35% of R&C Fee**	25% of Negotiated Fee*	25% of R&C Fee**
Deductible†:				
Individual	$0	$50	$50	$50
Family	$0	$100	$100	$100
Annual Maximum Benefit:				
Per Person	$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

High and Low Option

List of Primary Covered Services & Limitations

Diagnostic & Preventive Care - Type A

Procedure	*How Many/How Often:*
Prophylaxis (cleanings)	Two per calendar year
Oral Examinations	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to 16th Birthday
X-rays	Full mouth X-rays: one per 60 months Bitewing X-rays: one set per calendar year
Space Maintainers	Space Maintainers for dependent children up to 16th birthday
Sealants	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

Oral Surgery & Minor Restorative – Type B

Fillings	As needed
Simple Extractions	As needed
Crown, Denture, and Bridge Repair/ Recementations	As needed
Endodontics	Root canal treatment as needed (excluding molar root canals)
Minor Oral Surgery - Simple extractions and Surgical removal of erupted teeth	As needed
Periodontics	Periodontal scaling and root planing once per quadrant, every 3 years Periodontal surgery once per quadrant, every 36 months Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year

Major Services and Restorative – Type C

Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the Plan Dentures and bridgework replacement: one every 10 years 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
Crowns/Inlays/Onlays	Replacement: once every 10 years
Endodontics	Molar root canal treatment as needed
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental 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.

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, 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 dental and/or vision plan coverage 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 vision and/or dental coverage for yourself or your eligible dependents

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 in dental and/or vision coverage. Dependents may only be enrolled in programs in which you are enrolled. Please provide all the required documentation as listed on the form.

If you do not wish to make any changes to your dental and/or vision 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.

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.

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

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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