MEDICAL COVERAGE – WHAT YOU NEED TO KNOW FOR 2017

Please see page 1 (non-Medicare) and page 6 (Medicare) for more details.

Medicare-eligible retirees (and dependents) who are enrolled in Medicare Parts A and B and selected a plan through OneExchange for 2016:

Do Nothing

If you are happy with your 2016 medical and/or prescription drug coverage plans, no action is needed. Your plan(s) will automatically carry over into 2017.

Action Required

If you would like to make a change to a new medical or prescription drug plan, call OneExchange at 1-844-287-9945 between Oct. 15 and Dec. 7, 2016 to review plan options. Selecting a Medigap plan may require medical underwriting.

Retirees (and dependents) who are not yet eligible for Medicare will participate in the OPERS Retiree Health Plan administered by Medical Mutual. **In order to make changes to your health plan, you must contact OPERS *no later than Dec. 7, 2016.***

If you are not making any changes to your coverage for 2017, *no action is required on your part.*

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

NEW FOR 2017
If you are interested in discontinuing medical coverage for a dependent, you may now do so by calling 1-800-222-7377.

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Non-Medicare plan participants – What you need to know for 2017

OPERS Retiree Health Plan

The OPERS Retiree Health Plan for participants not yet eligible for Medicare is a network/PPO plan administered by Medical Mutual. The 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.

In an effort to allow participants to adjust to higher costs and plan design changes, OPERS will apply a partial premium reduction. This reduction does not apply to spouses, surviving spouses, dependents or re-employed retirees. The costs listed on your open enrollment statement reflects this reduction.

Spouse premium increase

If you are covering a non-Medicare spouse or child, their 2017 premium will increase considerably. This is due to the continued reduction in allowance amount (reduced to $0 in 2018) and overall plan cost increases. Some retirees may decide the premium to cover a non-Medicare spouse is now more than they can comfortably afford. There are options available through the Health Care Marketplace. Ohio Department of Insurance Consumer Services, Ohio Department of Aging and Ohio Department of Medicaid to name a few. Also, depending on income level, some may qualify for help from the federal government to pay for a plan via the marketplace. The Ohio Department of Insurance provides a wealth of information on their website, insurance.ohio. gov. Another site that provides coverage and cost comparisons for a variety of carriers is ehealthinsurance.com.

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. 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 pages 2 and 3. Re-employed retirees will receive a slightly different identification card from Medical Mutual for 2017. Additional information regarding re-employment in an OPERS-covered position is available at opers.org.

Retirees considering re-employment in an OPERS- covered position should contact OPERS first to receive an estimate and 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%	70%	100%
Mental Health	75%	60%	75%
Substance Abuse (including alcohol)	75%	60%	75%
Surgery	75%	60%	75%
Office Visit - Medical Home	$15 copay	60%	$15 copay
Office Visit - Specialist	$40 copay	60%	$40 copay
Office Visit - Primary Care	$25 copay	60%	$25 copay
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%	$45 copay
Preventive services			
Annual routine physical	100%**	60%***	100%**
Annual PAP, Mammography	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% with the exception of lab services subject to coverage maximums.

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

Prescription drug coverage information is listed on page 4.

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

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%	70%	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 copay (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% with the exception of lab services subject to coverage maximums.

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

Prescription drug coverage information is listed on page 4.

2017 non-Medicare prescription drug plan

2017 Prescription Drug Plan	Retail Preferred Network/ Home Delivery	Retail Non-Preferred Network
Annual deductible(s)	$100 (generics)$200 (brands)	$100 (generics)$200 (brands)
Generic	20% co-insurance $4 min/$8 max retail $10 min/$20 max mail	25% co-insurance $7 min/$11 max
Formulary brand	30% 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
Specialty drugs - Biosimilar/Generic	40% co-insurance $100 max	40% co-insurance $100 max
Specialty drugs - Brand	40% co-insurance $150 max	40% co-insurance $150 max
Annual out-of-pocket maximum	$1,950 (per ACA limits)	$1,950 (per ACA limits)
Value-based insurance design (VBID) - Generics for chronic conditions including asthma, COPD, heart disease, hypertension, high cholesterol, depression and diabetes	$0	25% co-insurance $7 min/$11 max
Generic PPIs - Medications treating acid-reflux and heartburn	50% co-insurance $25 retail min/$62.50 mail min	60% co-insurance $25 retail min

A lower-cost tier specific for biosimilar/generic specialty medications has been added for 2017. **Biosimilars are expected to be up to 30 percent less expensive than brand specialty drugs and will result in savings.** Biosimilar medications are the specialty drug generic alternative.

EXPRESS SCRIPTS®

Website: www.Express-Scripts.com

Phone: 1-866-727-5873

OPERS Wellness Programs in 2017 for non-Medicare participants

After Dec. 31, 2016 visit medmutual.com to take the annual Health Questionaire. Upon completion of the questionaire, you may qualify for wellness programs that may help you improve overall health.

Medical Mutual offers a variety of wellness and clinical programs that include:

- **QuitLine:** free telephone coaching, education and nicotine replacement therapy to help participants quit tobacco use for good.
- **Lifestyle Coaching:** a telephone and Web-based coaching program helping participants to make lifestyle changes to improve their well-being such as lose weight, start an exercise program and manage stress.
- **Case Management:** provides assistance to participants with medically complex or chronic conditions. Registered Nurse Case Managers partner with doctors to develop and implement an individualized plan of care that promotes safe and cost-effective care.

The Medical Mutual plans also cover (at 100 percent under preventive serivice) behavioral counseling to promote a healthy diet and physical activity for cardiovascular disease prevention in adults who are overweight or obese and have additional cardiovascular disease risk factors.

RMA incentive program is coming to a close in 2016

Due to low program participation, Nov. 30, 2016 will be the last date a participant can enroll in a wellness program or complete the 2016 health assessment to qualify for a $50 wellness Retiree Medical Accounbt (RMA) program incentive.

Also, the Ohio Department of Aging and Ohio's area agencies on aging offer the HEALTHY U Ohio program. The program is a series of in-person workshops held locally, where attendees can learn strategies to prevent or manage symptoms associated with chronic conditions like arthritis, diabetes, chronic pain and others. More information is available at aging.ohio.gov or by calling your local area agency on aging at 1-866-243-5678. When you sign up, be sure to tell them you are enrolled in the OPERS Retiree Health Plan.

Choosing Wisely

With the support of Consumer Reports Health, Choosing Wisely can help assist you and your doctor in choosing the most appropriate care for you. Informational videos and articles are available to help you with those conversations and decisions. Visit the wellness section titled Making Smart Health Care Choices at opers.org for easy access to information and tools that may assist you in making important decisions about your medical care.

Medicare-eligible plan participants – What you need to know for 2017

If you are currently enrolled in a medical and/or prescription drug plan through OneExchange, and would like to continue coverage, your plan selections for 2016 will automatically carry over into 2017.

If you are currently enrolled in a medical and/or prescription drug plan through the Connector and would like to change coverage, we encourage you to schedule an appointment ahead of time with OneExchange.

Vision and dental coverage will still be offered through OPERS. Please review this booklet and follow the directions on page 14 to make changes to this coverage for 2017.

Reminders:

- **Retirees enrolled in a plan through the Connector will receive an annual $300 deposit in the Health Reimbursement Arrangement in January.** This amount will be combined with any remaining funds from the previous year.

- **Auto reimbursement:** If you have set up auto reimbursement for plan premiums through OneExchange in 2016 and you do not change plans, these arrangements will continue into 2017; if you are changing medical plan carriers, you will need to set up auto reimbursement through OneExchange (if applicable).

- **Recurring claims:** If you set up recurring claims in 2016 for Medicare Part B premium and dental and/or vision reimbursements you will need to **resubmit your recurring premium claim forms to OneExchange.** The form is located at medicare.oneexchange.com/opers.

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

Spouses (including surviving spouses) enrolled in Medicare Parts A and B

Eligible spouses over age 65 can enroll in an individual Medicare plan with the help of OneExchange. Allowances for Medicare-eligible spouses will continue to be incrementally reduced to $0 by 2018. However, many retirees will find they have sufficient allowance dollars remaining to pay for a spouse's premium. There are resources for Medicare-eligible participants to learn more about plans available outside of the Connector. Please visit opers.org for more information.

OneExchange

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

Humana Interim Plan

The Humana Interim Plan is the plan 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 and Medicare-eligible retirees under age 65 with end-stage renal disease (ESRD). **The 2017 Humana Interim Plan has not changed from the 2016 plan.**

Prescription drug coverage is the same as the Non-Medicare Prescription Drug Plan (detailed on page 4).

The Humana Interim Plan provides secondary coverage after Original Medicare (Parts A and B) has paid. You will need to show your Medicare card to providers along with your Humana identification card.

2017 Humana Interim Plan

Deductible per calendar year	$500* (not included in out-of-pocket limit)
Out-of-pocket limit per calendar year	$850* (excluding deductible)
Medical Services	
Outpatient Hospice	100%, Covered by Medicare at a certified hospice agency
Mental Health/Substance Abuse	96%
Surgery	96%
Office Visit (Primary Care Physician)	96% (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	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	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

**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.

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

General Information – Aetna Vision Plan 2017

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 national and regional 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 vision provider, they will have less out-of-pocket expenses. If participants do not use an Aetna vision 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.

2017 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	$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.

aetna®

Website: www.aetnavision.com

Phone: 1-866-591-1913

General Information – MetLife Dental Plan

Choosing a dentist within the MetLife network can reduce your costs. You can also choose an out-of-network dentist, but your out-of-pocket costs may be higher. There are more than 187,000 participating Preferred Dentist Program dentist locations nationwide, including over 45,000 specialist locations. Participants enrolling in the MetLife dental plan pay the entire premium for this coverage. Once enrolled you will receive a Certificate of Coverage with additional details.

Claims Details:

Dentists may submit your claims for you leaving you with 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. For questions or a list of preferred dentists, visit metlife.com/mybenefits .

2017 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

General Information

ELIGIBLE DEPENDENTS

The coverage eligibility described here is for the 2017 plan year

Spouses – Retirees receiving a monthly age and service or disability benefit may only enroll their legal spouse, and 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 under the primary OPERS account holder.

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.

General Information

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 when they are eligible to enroll.
- Part B (medical) OPERS requires retirees to sign up for Part B as soon as they are eligible.

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 Medicare Connector administered by OneExchange. Group coverage will not be available to retirees who are eligible for Medicare.

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 monthly for OPERS group medical/pharmacy coverage. To qualify, a retiree must have 20 years of qualifying health care service credit and his or her household income must have been equal to or less than 200 percent of the federal poverty level in 2015.

Retirees are required to apply for the program each year. Current participants 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 2017, a participant's household income must have been at or below the following levels based on their 2015 federal income tax return:

Income Guidelines	
Single person	$23,540.00
Single with one dependent	$31,860.00
Single with two or more dependents	$40,180.00
Married	$31,860.00
Married with one or more dependents	$40,180.00

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.

Retirees can only apply for the program 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 (application must be received by OPERS on or before Dec. 7) with a program effective date of the following January.

If you feel you qualify for the program, you must complete the Income-Based Discount Program Application (HC-IBD). The application can be found online at 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) 2015 filed federal tax return to OPERS.

General Information

Frequently asked questions

Why are premiums increasing?
As part of the health care changes approved in 2012, retirees will experience a greater premium cost share in 2017 due to the allowance percentage transition. Health care inflation could also contribute to an increased premium. In 2017, premium allowances for spouses, surviving spouses and children of retirees with less than 20 years of service credit will continue to 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 employed in an OPERS position.

How do I terminate medical coverage for my dependent?
Retirees can complete the open enrollment change form or call OPERS to terminate medical, vision or dental coverage for a dependent. The most efficient way to make these changes may be to call OPERS at 1-800-222-7377. The premium to cover a non-Medicare spouse will be at least $710 per month in 2017 and could be much higher for some spouses. You may consider coverage outside OPERS as a more affordable option, such as the Health Care Marketplace plans available at healthcare.gov or by calling 1-800-318-2596.

I enrolled in a medical plan through OneExchange and receive an HRA. My spouse is under 65 and enrolled in the Medical Mutual plan. Can I reimburse her Medical Mutual plan premiums from my HRA?
Yes, you can submit her plan premiums and you will be reimbursed up to the available balance in your HRA. You can receive reimbursement for her Medical Mutual plan and for both your OPERS vision and dental plan premiums, if enrolled. Please submit a recurring HRA claim form (available at medicare.onexchange/opers) along with an OPERS premium deduction letter (available through your OPERS online account).

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

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

Medicare-eligible - Notification from your employer will trigger correspondence from OPERS that will inform you of your plan options through OneExchange and your monthly Health Reimbursement Arrangement (HRA) amount.

I pay a premium for Medicare Part A and I received a letter from OPERS asking me to send in proof of my 2017 Medicare Part A premium. What do I need to send to OPERS?
Please mail us either your Social Security Income Verification letter or your 2017 Medicare invoice that shows your 2017 Medicare Part A premium amount and effective date. We must receive this information by Jan. 31, 2017 or your Medicare Part A reimbursement may be terminated.

General Information

Frequently asked questions

Why is OPERS discontinuing the $50 wellness incentive?
OPERS chose to end our RMA incentives because we had low participation from our retirees. We could not justify the cost of the incentive due to lack of improvement in overall health for wellness plan participants.

Why is OPERS discontinuing reimbursement for Medicare Part B premiums?
Medicare Part B reimbursement is not sustainable because it costs OPERS an average of $100 million per year. As an alternative, retirees who receive an HRA can request reimbursement for their Medicare Part B premiums as long as the funds are available in their HRA. If you are not currently receiving this reimbursement, please contact OneExchange at 1-844-287-9945.

How does the Cadillac Tax affect our plan coverage?
Now scheduled to be implemented in 2020, the Cadillac tax is a 40 percent excise tax assessed to employers and other sponsors of health care plans when their coverage value exceeds certain thresholds. This would cost OPERS tens of millions of dollars if we kept our health care plan for retirees under 65 the same as it is today. To help minimize the effect of this substantial increase, OPERS is continuing to introduce gradual changes, rather than impose large changes in 2020. And we have been hard at work talking to our representatives in Washington to seek a permanent repeal of the tax.

General Information – Making changes to your coverage for 2017

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

How to enroll or make changes - You can enroll or make changes to your health care plan during this open enrollment period. OPERS must receive changes no later than Dec. 7, 2016. **If you choose to discontinue a dependent's coverage, you may do so over the phone.**

The completed form must be received by OPERS no later than **Dec. 7, 2016**.

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

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

Please complete the Health Care Application on the following pages if you would like to:

1. Add a new dependent.
2. Add medical, vision and/or dental coverage for yourself and/or dependents.

Things to know about completing the Health Care Application - Please follow these suggestions to ensure that your changes are communicated correctly:

- Please complete the form in blue or black ballpoint ink.
- Do not attempt to correct your address using this form.
- Please use the boxes provided to make coverage selections. Do not hand-write your selections or make other notes on the form.
- Use this form to enroll a spouse or child. Dependents may only be enrolled in programs in which you are enrolled. Please provide all the required documentation as listed on the form.