

Required Supplemental Documents

What's Inside:

General Notice of COBRA Continuation Coverage Rights

HRA General Notice of COBRA Continuation Coverage Rights

For plan participants whose coverage will end as the result of a qualifying event

Notice of Privacy Practices for OPERS Retiree Health Plan and Health Reimbursement Arrangement

Medicare Part D Notice of Creditable Coverage

For Medicare-eligible retirees who are enrolled in the OPERS prescription drug plan

THESE DOCUMENTS REQUIRE NO ACTION ON YOUR PART.

OPERS is required to provide all health care plan participants with these documents annually. Please keep this booklet for future reference.

General Notice of COBRA Continuation coverage rights

Continuation Coverage Rights Under COBRA for Pre-Medicare plan participants

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. This notice does not fully describe COBRA coverage or other rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under a Qualified Medical Child Support Order (QMCSO) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you are the spouse of a benefit recipient, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-benefit recipient dies;
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the benefit recipient or commencement of a proceeding in bankruptcy with respect to the retirement system, the retirement system must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the benefit recipient and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs as described below in the Section entitled "How to Give Notice." For the qualifying event of divorce of the benefit recipient and spouse, you must also provide to OPERS a copy of your divorce decree. If notice is not provided to the Plan Administrator during the 60-day notice period, all qualified beneficiaries will lose their right to elect COBRA.

Notice Procedures

Warning: If your notice of your intention to elect COBRA coverage is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA coverage.

General Notice of COBRA Continuation coverage rights

Continuation Coverage Rights Under COBRA for Pre-Medicare plan participants

(continued)

How to Give Notice

Notice must be communicated by the qualified beneficiary through any of the following methods within the 60-day of the qualifying event specified in this document:

1. In writing to OPERS at 277 East Town Street, Columbus, OH 43215;
2. Electronically through the Member Benefit System at opers.org.
3. Contact in person to a member counselor at the OPERS address above; or
4. Calling OPERS at 1-800-222-7377.

Information Required for All Notices

Any notice you provide must include the name and address of the benefit recipient who is (or was) covered under the Plan, the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event, the qualifying event and the date it happened, and contact information for the individual providing the notice.

More Information About Individuals Who May be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a benefit recipient during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the covered benefit recipient has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the benefit recipient. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients under QMCSOs

A child of the benefit recipient who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by OPERS is entitled to the same rights to elect COBRA as an eligible dependent child of the covered benefit recipient.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will receive a COBRA continuation packet in the mail and will have an independent right to elect COBRA continuation

coverage. Benefit recipients may elect COBRA continuation coverage on behalf of their enrolled spouses, and parents may elect COBRA continuation coverage on behalf of their enrolled children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is divorce of the benefit recipient and spouse or a dependent child's losing eligibility for coverage as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

Are their other coverage options besides COBRA Continuation Coverage?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Public Health Services Act, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional Office of the U.S. Health and Human Services (HHS) in your area or visit the HHS website at hhs.gov. (Addresses and phone numbers of Regional HHS Offices are available through HHS's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Linda Haney, COBRA Plan Contact Information

1-800-367-3762 extension 14548

Email: mhscobra@mutualhealthservices.com

P.O. Box 5700 Cleveland, OH 44321

This contact information from the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if you do not receive a copy, you may request one from OPERS).

HRA General Notice of COBRA Continuation coverage rights

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan), as defined by the laws governing COBRA continuation coverage. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. This notice does not fully describe COBRA coverage or other rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible, even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you are the spouse of a retiree or disability benefit recipient, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your spouse dies;
- You become divorced from your spouse.

If you are the dependent child of a retiree or disability benefit recipient, you will become a qualified beneficiary if you lose coverage under the Plan due to any of the following qualifying events:

- The parent-benefit recipient dies;
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the benefit recipient or commencement of a proceeding in bankruptcy with respect to the retirement system, the retirement system must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the benefit recipient and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs as described below in the Section entitled "How to Give Notice." For the qualifying event of divorce of the benefit recipient and spouse, you must also provide to OPERS a copy of your divorce decree. If notice is not provided to the Plan Administrator during the 60-day notice period, all qualified beneficiaries will lose their right to elect COBRA.

Notice Procedures

Warning: If your notice of your intention to elect COBRA coverage is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA coverage.

Continuation Coverage Rights Under COBRA

How to Give Notice

Notice must be communicated by the qualified beneficiary through any of the following methods within the 60-day of the qualifying event specified in this document:

1. In writing to OPERS at 277 East Town Street, Columbus, OH 43215;
2. Electronically through your online account at opers.org.
3. Contact in person to a member counselor at the OPERS address above; or
4. Calling OPERS at 1-800-222-7377.

Information Required for All Notices: Any notice you provide must include the name and address of the benefit recipient who is (or was) covered under the Plan, the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event, the qualifying event and the date it happened, and contact information for the individual providing the notice.

More Information About Individuals Who May be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a benefit recipient during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the covered benefit recipient has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the benefit recipient. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients under QMCSOs

A child of the benefit recipient who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by OPERS is entitled to the same rights to elect COBRA as an eligible dependent child of the covered benefit recipient.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will receive a COBRA continuation packet in the mail and will have an independent right to elect COBRA continuation coverage. A former or surviving spouse must elect COBRA

continuation coverage for himself or herself. Parents may elect COBRA continuation coverage on behalf of an enrolled child(ren).

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is divorce of the benefit recipient and spouse or a dependent child's losing eligibility for coverage as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

Are their other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov. A surviving spouse or dependent may also elect to maintain access to the balance of an existing health reimbursement arrangement (HRA) account in lieu of electing COBRA continuation coverage.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Public Health Services Act, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional Office of the U.S. Health and Human Services (HHS) in your area or visit the HHS website at hhs.gov. (Addresses and phone numbers of Regional HHS Offices are available through HHS's website.)

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Linda Haney (COBRA Administrator) at Benefit Services
1-800-367-3762 extension 14548
Mutual Health Services PO BOX 5700 Cleveland, OH 44321
mhscobra@mutualhealthservices.com

This contact information from the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if you do not receive a copy, you may request one from OPERS).

Notice of Privacy Practices

for OPERS Retiree Health Plan and Health Reimbursement Arrangements

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Ohio Public Employees Retirement System (“OPERS”) sponsors a health plan (“Health Plan”) and a health reimbursement arrangement (“HRA”) to provide health care coverage to certain eligible individuals and their dependents. Certain Medicare eligible individuals who are eligible to receive health care coverage through OPERS are eligible to participate in the HRA. Pre-Medicare eligible individuals who are eligible to receive health care coverage through OPERS, and certain Medicare eligible individuals who are eligible to receive health care coverage through OPERS and who are not eligible to participate in the HRA, are eligible to enroll in the Health Plan. The Health Plan and the HRA are affiliated covered entities and part of an organized health care arrangement, and this Notice of Privacy Practices (“Notice”) applies to both the Health Plan and the HRA. The Health Plan and the HRA are referred to collectively in this Notice as the “Plan”.

Medical coverage under the Health Plan is self-insured by OPERS. Self-insured medical coverage provided under the Health Plan to pre-Medicare eligible individuals is administered by Medical Mutual of Ohio, and self-insured medical coverage provided under the Health Plan to certain Medicare eligible individuals is administered by Medical Mutual. Dental and vision coverage under the Health Plan are fully insured, and if you are enrolled in the Health Plan for dental or vision coverage, you will also receive a notice of privacy practices from the insurance company, and the insurance company’s notice will apply to your personal health information maintained by the insurance company.

The Plan maintains the privacy of personal health information of individuals enrolled in the Plan, and is required by law to provide you with notice of the Plan’s legal duties and privacy practices with respect to your personal health information. The Plan is required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by the Plan. Copies of revised notices will be mailed to you and copies may be obtained by mailing a request to:

OPERS Privacy Officer
277 E. Town Street
Columbus, OH 43215

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There are certain uses and disclosures of your personal health information for which we will always obtain prior authorization and these include: Marketing communications unless the communication is made directly to you in person or is simply a promotional gift of nominal value; Sales of your health information and uses or disclosures of Psychotherapy notes unless otherwise permitted or required by law.

Disclosures for Treatment. We will make disclosures of your personal health information as necessary for your treatment. For instance, on rare occasions, a doctor or health facility involved in your care may request certain of your personal health information that we hold in order to make decisions about your care.

Uses and Disclosures. We will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims. We may also forward such information to another health plan which may also have an obligation to process and pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include business management, quality improvement and assurance, enrollment, compliance, auditing, and other functions related to your Plan. We may also disclose your personal health information to a health care facility, health care professional, or another health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient or participant relationship with you.

Use and Disclosures of Genetic Information. We will not use or disclose any genetic information about you or your family members for underwriting or benefit eligibility determinations.

Notice of Privacy Practices

(continued)

for OPERS Retiree Health Plan and Health Reimbursement Arrangements

More Stringent Requirements. In some instances, other laws may impose stricter requirements on how we use or disclose your personal health information. For example, federal and/or Ohio law requires your authorization for some uses and disclosures of mental health and substance abuse treatment information, for the disclosure of HIV test results, and limits how we can use or disclose genetic information. When another law imposes stricter requirements, we will follow the stricter requirements of the other law.

Family and Friends Involved In Your Care. Pursuant to Ohio Revised Code 145.27, the Plan is prohibited from releasing any information without your written consent. As a result, we may only disclose your personal health information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care upon receipt of a written authorization from you, your beneficiary or executor of your estate.

Business Associates. Certain aspects and components of the Plan's services are performed through contracts with outside persons or organizations, such as claims processing and Plan administration, auditing, actuarial services, legal services, etc. At times it may be necessary for us to provide certain personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Communications With You. We may communicate with you regarding your claims, premiums, or other things connected with the Plan. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to OPERS Privacy Officer, 277 E. Town Street, Columbus, OH 43215. We may communicate with you regarding your claims, premiums, or other things connected with the Plan. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy Officer for your coverage listed in the section titled "Where to Send Requests" at the end of this Notice.

Other Health-Related Products or Services. We may, from time to time, use your personal health information to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products or services which may be available to you as an enrollee of the Plan and we may send other health and wellness related information to you. For example, we may use your personal health information to contact you to advise you that a wellness program is available to you as an enrollee of the Plan, or we may use your personal health information to send you prescription refill notices. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of patients by payer source and will need to review a series of records that we hold. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of information.

Notice of Privacy Practices

for OPERS Retiree Health Plan and Health Reimbursement Arrangements

Other Uses and Disclosures. We may be permitted or required by law to make certain other uses and disclosures of your personal health information without your authorization, as described below. However, your written permission for some of these disclosures may be required under Ohio law, and we will obtain your written permission when required under Ohio Revised Code 145.27.

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information to OPERS as the plan sponsor; provided, however, OPERS must certify that the information provided will be maintained in a confidential manner and not used in any other manner not permitted by law.
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your personal health information to coroners and/or funeral directors consistent with law;
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and
- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. You may obtain an access request form by contacting the Privacy Officer for your coverage listed in the section titled "Where to Send Requests" at the end of this Notice.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/ correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form by contacting the Privacy Officer for your coverage listed in the section titled "Where to Send Requests" at the end of this Notice.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information. Requests must be made in writing and signed by you or your representative. Accounting request forms are available by contacting the Privacy Officer for your coverage listed in the section titled "Where to Send Requests" at the end of this Notice.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. A restriction request form can be obtained by contacting the Privacy Officer for your coverage listed in the section titled "Where to Send Requests" at the end of this Notice. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction to sending such termination notice to the Privacy Officer for your coverage listed in the section titled "Where to Send Requests" at the end of this Notice.

Notice of Privacy Practices

for OPERS Retiree Health Plan and Health Reimbursement Arrangements

Breach Notification. In the unlikely event that there is a breach, or unauthorized release of your personal health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints. If you believe your privacy rights have been violated, you can file a complaint in writing and may send your request to OPERS Privacy Officer, 277 E. Town Street, Columbus, OH 43215. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the OPERS Privacy Officer, 277 E. Town Street, Columbus, OH 43215. You retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

WHERE TO SEND REQUESTS

Requests for access to your personal health information, amendments to your personal health information, accounting of disclosures of your personal health information, restrictions on the use or disclosure of your personal health information and confidential communications should be sent to the Privacy Officer designated for your type of coverage under the Plan.

If you are covered under the Health Plan and your coverage is administered by Medical Mutual of Ohio:

Medical Mutual of Ohio
P.O. Box 89499
Cleveland, Ohio 44101-6499

If you are enrolled in the HRA:

OPERS Privacy Officer
277 E. Town Street
Columbus, Ohio 43215

EFFECTIVE DATE

This Notice of Privacy Practices is effective as of October 2017.

Medicare Part D – Notice of Creditable Coverage

Notice of Creditable Coverage

This notice is being provided to you by Ohio PERS as required by Medicare. This notice confirms that your 2017 prescription drug coverage through Express Scripts was Creditable Coverage and enrollment in a plan during 2018 open enrollment is available without penalty to you. Some insurers require proof that your previous plan constituted Creditable Coverage; therefore, you should keep this with your other important health insurance papers.

Important Notice about our prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Express Scripts and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan for 2018. You should compare which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. OPERS has determined that the prescription drug coverage offered by Express Scripts during the 2017 plan year is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your 2017 coverage is Creditable Coverage, you will not pay a higher premium (a penalty) if you decide to join a Medicare drug plan during 2018 open enrollment. The impact of delaying enrollment is discussed later in this notice.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You may pay a higher premium (a penalty) to join a Medicare drug plan if you don't join a Medicare drug plan within 63 continuous days after your current coverage ends.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage

Contact our office at the number below for further information.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug plans:

Call the OPERS Medicare Connector, administered by OneExchange, to speak with a licensed benefit advisor and learn about the Medicare Plans that meet your needs (1-844-287-9945). TYY users should call 1-877-486-2048.

Online at medicare.oneexchange.com/opers.
Visit medicare.gov

Medicare Part D – Notice of Creditable Coverage

(continued)

Updated October 1, 2017

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help, Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember, keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium penalty.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2017

Name of Entity/Sender: Ohio Public Employees Retirement System

Address: 277 E. Town Street, Columbus, OH 43215

Phone: 1-800-222-7377

2018 Prescription Drug Plan

Retail pharmacy network	55,000 pharmacies
Annual deductible(s)	\$100 (generics) \$300 (brands)
Formulary	High performance
Generics	20% co-insurance \$4 min/\$8 max retail \$10 min/\$20 max mail
Formulary brand	30% co-insurance \$30 min/\$60 max retail \$75 min/\$150 max mail
Non-formulary brand	NOT COVERED
Specialty drugs - Brand	40% co-insurance \$200 max
Specialty drugs - Biosimilar/Generic	40% co-insurance \$100 max
Value-based insurance design (VBID) - VBID Generics for chronic conditions including asthma, COPD, heart disease, hypertension, high cholesterol, depression and diabetes	\$0
Generic PPIs - Medications treating acid-reflux and heartburn	50% co-insurance \$25 retail min/\$62.50 mail min
Annual out-of-pocket maximum	\$2,450 (per ACA limits)

Required Supplemental Documents

OPERS Board of Trustees

The 11-member OPERS Board of Trustees is responsible for the administration and management of OPERS. Seven of the 11 members are elected by the groups that they represent (i.e., college and university non-teaching employees, state, county, municipal, miscellaneous employees and retired members); the Director of the Department of Administrative Services for the state of Ohio is a statutory member, and three members are investment experts appointed by the Governor, the Treasurer of State, and jointly by the Speaker of the Ohio House of Representatives and the President of the Ohio Senate. For a current listing of the OPERS Board of Trustees, please visit opers.org.



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.