2023

OPERS Health Care Program Guide

OPERS

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You can find the following documents within the *2023 Required Documents* publication at opers.org/health-care/resources.shtml.

- General Notice of COBRA Continuation Coverage Rights
- Notice of Privacy Practices
- Notice of Special Enrollment Rights
- Other legal documents as required

What OPERS Offers: The OPERS Health Care Program

While OPERS is not required to provide health care coverage by law, the Ohio Public Employees Retirement System recognizes the important role it plays as part of a secure retirement. When considering retirement, you should keep in mind that once retired you will no longer be covered under your employer's group medical plan. As you transition to retirement, you'll also need to enroll in new health care coverage. This guide provides information about what health care options OPERS offers, eligibility requirements and enrollment.

The OPERS health care program features a Health Reimbursement Arrangement (HRA) for eligible Pre-Medicare and Medicare benefit recipients as well as optional vision and dental plans. To help benefit recipients find a medical plan which fits their needs, we also offer the services of the OPERS Connector.

Please see the following pages for more details.

Learn about the following within this Guide:

- ✓ Health Reimbursement Arrangement
- ✓ Role of the Pre-Medicare and Medicare Connector
- ✓ OPERS Vision Plan
- ✓ OPERS Dental Plan

Whether you are preparing to retire or have been retired for years, everything you need to know about the OPERS health care program can be found within this Guide. Resources can also be found at opers.org. We're here to help, please call OPERS at 1-800-222-7377 with questions.

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

Who is eligible for the Health Reimbursement Arrangement (HRA)?

OPERS offers a Health Reimbursement Arrangement (HRA) to benefit recipients meeting certain age and service credit requirements. The HRA is an account funded by OPERS that provides tax-free reimbursement for qualified medical expenses such as monthly post-tax insurance premiums, deductibles, co-insurance, and copays incurred by eligible benefit recipients and their dependents.

OPERS members retiring with an effective date of Jan. 1, 2022 or after will be eligible for the HRA by meeting one of the following criteria:

Age 65 or older

- Minimum of 20 years of qualified health care service credit

Age 60 - 64

- **Group A** – 30 years of total service with at least 20 years of qualified health care service credit
- **Group B** – 31 years of total service with at least 20 years of qualified health care service credit
- **Group C** – 32 years of total service with at least 20 years of qualified health care service credit

Age 59 or younger

- **Group A** – 30 years of qualified health care service credit
- **Group B** – 32 years of qualified health care service credit at any age or 31 years of qualified health care service credit and at least age 52
- **Group C** – 32 years of qualified health care service credit and at least age 55

Aging into eligibility

- Provided that a member has at least 20 years of qualified health care service credit at retirement, they will eventually be eligible for the HRA even if they are not eligible when they first retire.
- Members retiring at age 65 or older with at least 20 years of qualified service credit will be eligible for the HRA on their retirement date.
- Members retiring prior to reaching age 65 will be eligible at retirement or become eligible when they turn 60 or when they turn 65 depending on their service credit at retirement (see criteria above).

Who is eligible for the Health Reimbursement Arrangement? (HRA) *(continued)*

HRA eligibility for OPERS disability benefit recipients

OPERS requires that disability benefit recipients apply for a disability benefit (SSDI) through the Social Security Administration and notify OPERS of the enrollment. If you are not eligible to receive a disability benefit through SSA, you may still be eligible for Medicare.

If you receive a disability benefit from OPERS with an effective date on or before Dec. 1, 2013, you are eligible for the OPERS health care program. You are eligible to receive monthly HRA deposits from OPERS and enroll in the OPERS vision and dental plans, regardless of age and/or years of qualifying service credit.

If you receive a disability benefit from OPERS with an effective date on or after Jan. 1, 2014, you will have access to the OPERS health care program only during the first five years you receive the disability benefit.

You may continue to be eligible for the OPERS health care program and receive monthly HRA deposits beyond five years if you are enrolled in Medicare on the basis of a disability prior to the end of your first five years. Upon turning 65, or if you are not enrolled in Medicare on the basis of disability, you must meet one of the following criteria to continue to be eligible:

- **Have a disability benefit effective date on or between Jan. 1, 2014 and Dec. 31, 2014 and have 10 years of qualified health care service credit.**

- **Have a disability benefit effective date on or between Jan. 1, 2015 and Dec. 31, 2021 and meet one of the age and service credit criteria:**

  Age 60 or older
  - Minimum of 20 years of qualified health care service credit

  Age 59 or younger
  - Group A – 30 years of qualified health care service credit
  - Group B – 32 years of qualified health care service credit at any age or 31 years of qualified health care service credit and at least age 52
  - Group C – 32 years of qualified health care service credit and at least age 55

- **Have a disability benefit effective date on or after Jan. 1, 2022 and meet one of the age and service credit criteria as listed on page 3.**

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

Please see the "How does the OPERS Health Care Program work with Medicare?" section on page 11 for Medicare enrollment.

The OPERS Health Reimbursement Arrangement (HRA)

An HRA is an account funded by OPERS that provides tax-free reimbursement for qualified medical expenses such as monthly post-tax insurance premiums, deductibles, co-insurance, and copays incurred by eligible benefit recipients and their dependents.

Via Benefits administers the HRA. This means they review and process reimbursement requests and release the money from the HRA into your personal bank account. To be reimbursed for qualified medical expenses, you must submit a request for reimbursement for paid expenses and include supporting documentation to Via Benefits for them to approve and issue a reimbursement. For some expenses, you may be able to set up automatic reimbursement, which allows you to receive reimbursements without submitting a request. Via Benefits will deduct a monthly fee of $2.60 from your HRA to administer the HRA.

Expenses are determined to be eligible for reimbursement based on IRS guidelines. Reimbursements for qualified medical expenses are not taxable income and are not reported on any tax form.

Monthly HRA deposit

If you are eligible for the HRA, OPERS will fund the HRA with a monthly deposit. The amount of this deposit will be a percentage of a base allowance amount.

Your allowance percentage is determined by:

1. Your years of qualified health care service credit as of your benefit effective date; and
2. Your age when you first become eligible for the HRA.

2023 base allowance amounts:

- **Pre-Medicare benefit recipients:** $1,200 per month
- **Medicare benefit recipients:** $350 per month

Your individual monthly HRA deposit amount is provided on your annual Open Enrollment statement. Or, if you are a new benefit recipient, this amount will be provided in your health care confirmation letter. The amount can also be found within your OPERS online account. You can check your HRA balance at any time by logging into your Via Benefits online account.

Open vs. closed HRA

The HRA for Pre-Medicare benefit recipients is an open HRA. An "open HRA" means that benefit recipients can receive monthly deposits into their HRA and use the funds to be reimbursed for qualifying expenses even if they don't enroll in a medical plan through the OPERS Pre-Medicare Connector.

The HRA for Medicare benefit recipients is a closed HRA. A "closed HRA" means that Medicare-eligible benefit recipients must be enrolled in a Medicare medical plan through the OPERS Connector to receive monthly HRA deposits from OPERS.

Once you begin receiving HRA deposits, Via Benefits will provide a *Getting Reimbursed Guide* containing more details. The guide will include instructions for managing your account, how to submit expenses for reimbursement, how to set up automatic premium reimbursement, and a list of eligible expenses. You can find additional educational resources on opers.org under the "Retired Members" menu by selecting "Education Resources." OPERS also offers a *How to use your HRA* webinar. Visit the member Education Center on opers.org to register or watch a recorded presentation.

VIA BENEFITS™ | Processing Time When Submitting Reimbursements

Mail versus Online or Mobile App

Mail

Submitting a reimbursement request
Mail submissions take **2-10 days** to arrive at our facility

Processing a request
Our processing team takes **2-5 days** to validate and process your request

Your request is approved
Receive the money in your bank account in **3 days**

> ! If there are any issues with your request submitted by mail, it could take an additional 10 days to address.

Up to 10 days → Up to 5 days → Up to 3 days

Total Reimbursement Time: 7-18 days!

Online or Mobile App

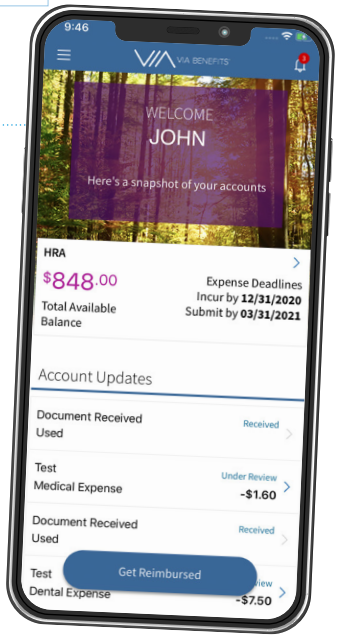
Validated instantly
Submitting a reimbursement request
Electronic submissions online or via our mobile app are validated instantly with correct information

Up to 5 days
Processing a request
Our processing team takes **2-5 days** to review and process your request

Up to 3 days
Your request is approved
Receive the money in your bank account in **3 days**

> ! If there are any issues with your request submitted online or by mobile app, Via Benefits notifies you immediately; you can fix the request and re-submit the same day.

Total Reimbursement Time: 5-8 days!



Via Benefits makes it easy to manage your OPERS HRA

Receiving reimbursements from your OPERS HRA is safe, quick, and easy when you use Via Benefits' online tools or mobile app. Search for "Via Benefits Accounts" in the App Store or Google Play and download it to your smartphone or tablet.

GET IT ON Google Play

Download on the App Store

Are you a new retiree?

If you are a new retiree, be sure to carefully read the materials that OPERS and Via Benefits will mail to you once we've received your retirement application. Via Benefits will reach out to you to make an enrollment appointment and provide you with an Enrollment Guide. This guide provides instructions for shopping for and enrolling in a medical plan. It also provides introductory information about your OPERS HRA. Once your HRA has been established, Via Benefits will send you a Getting Reimbursed Guide with more detailed information about how to manage your OPERS HRA. You may call Via Benefits at 1-833-939-1215 (Pre-Medicare) or 1-844-287-9945 (Medicare) with any questions.

Aging in to eligibility for the HRA at age 60

If you retired prior to age 60 and will become eligible for the Health Reimbursement Arrangement (HRA) when you reach age 60, you will need to take action to begin receiving HRA deposits from OPERS.

To begin receiving HRA deposits from OPERS, you must opt in to the HRA through the OPERS Pre-Medicare Connector. Approximately four months prior to your 60th birthday, OPERS will send you a letter containing the monthly HRA deposit amount you are eligible to receive and a deadline by which you must opt in to the HRA. If you do not opt in to the HRA by contacting Via Benefits by this deadline, your next opportunity to opt in will be during open enrollment with an effective date of January 1 the following year.

If you decide to opt out of the HRA on or before your deadline to opt in, your election to opt out is effective the first of the month you became eligible for the HRA. If you change your election, the last election made as of your deadline to opt in is final and will be effective the first of the month you became eligible for the HRA.

Contact the OPERS Pre-Medicare Connector by calling 1-833-939-1215 or going to www.marketplace.viabenefits.com/opers to opt in to the HRA and begin receiving monthly deposits from OPERS.

You can enroll in any medical plan you choose. Although it's not required, if you are looking for a new medical plan, we highly recommend exploring coverage options with the OPERS Pre-Medicare Connector (Via Benefits). Via Benefits is a resource that helps benefit recipients understand and navigate individual and family health plan options and will provide ongoing advocacy services to you at no cost to help you make the most of your medical plan coverage.

Via Benefits provides:

1. *Consulting* - Via Benefits helps Pre-Medicare benefit recipients understand their funding options. If you qualify for a federal subsidy, Via Benefits will walk you through a side-by-side comparison to help decide between taking advantage of the federal subsidy or opting in to the OPERS HRA. By law, you can't have both at the same time.

2. *Education, support, and assistance* - Via Benefits provides these services to benefit recipients and their dependents when selecting and enrolling in an individual or family medical plan.

3. *HRA administrative services* - Via Benefits reviews claims and issues reimbursements.

4. *Ongoing benefit recipient support after medical plan enrollment* - Via Benefits is an experienced, informed, and unbiased Connector.

Communications to Expect

As you approach your 60th birthday, keep an eye out for important communications from OPERS and Via Benefits.

Four months prior to your 60th birthday	OPERS will send you a letter containing the monthly HRA deposit that you are eligible to receive, the deadline by which you must opt in to the HRA and instructions for contacting the OPERS Pre-Medicare Connector.
Approximately 90 days prior to your 60th birthday	Via Benefits will call you to schedule an enrollment call and mail you an *Enrollment Guide*.
14 days after enrollment call	Via Benefits will mail a letter confirming your plan enrollment (if applicable). This letter restates what was discussed on your enrollment call, but it is not an enrollment confirmation. If you enroll in a medical plan, you will also receive a *Plan Acceptance Letter* from your insurance carrier when your application is processed.
Two to three weeks prior to plan coverage effective date	Via Benefits will mail the *Getting Reimbursed Guide*.

OPERS Vision and Dental Coverage

If you are enrolled in the OPERS vision or dental plans when you become eligible for the HRA, you will remain enrolled. You may only make changes or cancel your enrollment through OPERS during open enrollment for an effective date of January 1 the following year or with a qualifying event. For your convenience, OPERS sends a file to Via Benefits the first of every month that includes all premiums paid for that month. If you want to opt out of Automatic Premium Reimbursement for a particular product (vision or dental), you may do so after you receive your first premium reimbursement for that product. To opt out, call Via Benefits or sign into your online profile. Select *View Accounts* under *Funds & Reimbursement* and scroll to your *Automatic Premium Reimbursement*.

If you are currently enrolled in Medicare or become eligible for Medicare prior to turning 65, you must enroll in Medicare Parts A and B upon being notified of your eligibility. *Failure to notify OPERS of your Medicare eligibility within 30 days of being notified by SSA may result in retro-termination of the HRA deposits. A retro-termination means you may be required to repay all HRA reimbursements you have received since you were first eligible for Medicare.*

The OPERS Connector, administered by Via Benefits

Via Benefits serves as the OPERS Connector for both Pre-Medicare and Medicare-eligible OPERS benefit recipients. When you select a medical plan through Via Benefits, you can use Via Benefits' ongoing support for HRA administration, carrier claim resolution and medical plan questions. All OPERS benefit recipients are welcome to use the OPERS Connector to find a medical plan, even if they don't qualify for the HRA. Dependents can also enroll in a plan with the help of Via Benefits.

VIA BENEFITS™

Via Benefits – Pre-Medicare
1-833-939-1215
marketplace.viabenefits.com/opers

Via Benefits – Medicare
1-844-287-9945
my.viabenefits.com/opers

Pre-Medicare Benefit Recipients

As a Pre-Medicare benefit recipient, you can enroll in any medical plan you choose. Although it's not required, if you are looking for a medical plan, we highly recommend exploring coverage options with the OPERS Pre-Medicare Connector.
Via Benefits is a resource that helps benefit recipients understand and navigate individual and family health plan options.

Via Benefits isn't an insurance carrier. It's a company that provides:

- **Consulting** – Via Benefits helps Pre-Medicare benefit recipients understand their funding options. If a benefit recipient qualifies for a federal subsidy, Via Benefits will walk the benefit recipient through a side-by-side comparison to help them decide between taking advantage of the federal subsidy or opting in to the OPERS HRA. By law, you can't have both at the same time.

- **Education, support, and assistance** – Via Benefits provides these services to benefit recipients and their dependents and can help them select and enroll in individual or family coverage options.

- **HRA administrative services** – Via Benefits reviews claims and issues reimbursements.

- **Ongoing benefit recipient support after medical plan enrollment** – Via Benefits is an experienced, informed, and unbiased Connector.

Pre-Medicare Funding Options

In addition to the HRA funded by OPERS, depending on income level, some Pre-Medicare benefit recipients may also be eligible for subsidies from the federal government in the form of a Premium Tax Credit (PTC) and/or a Cost Sharing Reduction (CSR). By law, you can't accept the OPERS HRA and get a federal subsidy at the same time. If you're eligible for both, you'll need to decide which type of funding support works best for you.
Via Benefits can help you evaluate your options.

As a Pre-Medicare benefit recipient, you are not required to enroll in a medical plan through Via Benefits to receive monthly HRA deposits or receive reimbursements. However, you will be required to do so once you become Medicare-eligible. This is a good reason to begin your relationship with Via Benefits now.

Medicare-eligible Benefit Recipients

Benefit recipients enrolled in Medicare Parts A and B are required to enroll and remain enrolled in a Medicare medical plan through Via Benefits in order to receive monthly HRA deposits from OPERS.

With the help of a Via Benefits Licensed Benefit Advisor, benefit recipients enrolled in both Medicare Parts A and B select a Medicare Advantage plan or Medigap (Medicare Supplement) as well as a Medicare Part D prescription drug plan on the individual Medicare market. Via Benefits is a resource, providing access to a wide assortment of Medicare plans from over 90 of the largest and most popular national and regional health insurance companies.

How does the OPERS Health Care Program work with Medicare?

Medicare is federal health insurance for people age 65 and older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease or ESRD (permanent kidney failure requiring dialysis or kidney transplant). Medicare costs vary depending on plan, coverage and the services used.

As an OPERS benefit recipient, you must enroll in both Medicare Parts A and B as soon as you become eligible. Once enrolled, you will select a Medicare Advantage plan or a Medigap plan (Medicare Supplement) and a Medicare Part D prescription drug plan using the OPERS Connector. Please note that most Medicare Advantage plans have prescription coverage included so you may not need to enroll in a separate Part D plan. During your enrollment appointment with the OPERS Medicare Connector, a Licensed Benefit Advisor will walk you through the plan selection process.

	Medicare Part A HOSPITALS	**Medicare Part B** OUTPATIENT SERVICES
Coverage includes	Inpatient care in hospitals and some skilled nursing facilities and some health and hospice care	Doctor's services (physicians and specialists) and some lab work, X-rays, therapy and durable medical equipment
Coverage *does not* include	Long-term nursing home stays or non-medical, in-home care	Vision, dental or non-prescription drugs and supplies
Eligibility needs	40 quarters of Medicare Social Security credit, meaning the participant and employer paid for Medicare Part A through payroll deductions, or the participant worked for a job covered by Social Security - OR - Through a spouse's work record, if the participant does not have enough quarters to receive Medicare Part A at no cost	Participants are eligible to enroll at the age of 65 or with qualifying illness or disability
Note	Most public employees pay into Medicare even though they don't pay into Social Security	There is a monthly premium based on income

	Medicare Advantage (Part C) ALTERNATIVE TO MEDICARE PARTS A AND B. PROVIDES HIGHER COVERAGE.	**Medicare Part D** PRESCRIPTIONS	**Medigap** INSURANCE THAT FILLS IN THE "GAPS" WHERE MEDICARE PARTS A AND B LEAVE AN INDIVIDUAL UNCOVERED
Coverage	Sometimes covers dental and vision. Plan is usually combined with Medicare Advantage Prescription Drug (MAPD) plan	Prescription drugs including generic, brand name and specialty drugs at participating retail pharmacies and home delivery	*Prescription drug coverage is not provided.* Individuals who select this generally also select a Medicare Part D prescription drug plan
Private Company Plans	Medicare Advantage plans have provider networks: **HMO:** Health Maintenance Organizations **PFFS**: Private Fee-for-Service **PPO**: Preferred Provider Organizations	Prescription drug coverage is a separate policy for Medigap plans purchased from a private prescription drug company	Medigap plans do not have networks, therefore policy holders can use any provider who accepts Medicare

Medicare Part A Reimbursement

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

OPERS provides a monthly reimbursement for your Medicare Part A premium cost and also provides a 50 percent Medicare Part A premium reimbursement to eligible spouses. Please contact OPERS or visit opers.org/health-care/resources.shtml to obtain the *Medicare Part A Reimbursement Form.*

You will be responsible for repaying OPERS the amount OPERS reimbursed you if any of the following occur:

- If the retiree (or a spouse they are receiving reimbursement for) disenroll or fail to pay their Medicare Part A premium to CMS.
- If the Medicare retiree (or a spouse they are receiving reimbursement for) disenroll from their medical plan through the OPERS Medicare Connector. Or, if the retiree is Pre-Medicare but is not opted in to receive the HRA.
- If the premium amount changes for the retiree (or a spouse they are receiving reimbursement for) or they no longer pay a premium. Please notify OPERS immediately by submitting the *Notice of Award* or other documentation from Social Security that states the new amount and date the new amount went into effect (other than a premium bill).

Medicare Enrollment at Age 65

When you become eligible for Medicare, you must enroll in Medicare Parts A and B. Medicare provides about 80 percent coverage and will be considered your primary insurance. Once enrolled in Medicare, you will then choose an individual Medicare plan (Medigap or Medicare Advantage) using the OPERS Medicare Connector administered by Via Benefits. A Medigap plan will pay after Original Medicare; a Medicare Advantage plan replaces Original Medicare. As an enrollee in either a Medigap or Medicare Advantage plan, you are responsible for paying your Medicare Part B premium.

Eligible OPERS benefit recipients enrolled in an individual Medicare plan through Via Benefits will receive a monthly HRA deposit from OPERS. If you decide to not enroll in Medicare coverage because of active employment or any other reason or if you fail to enroll in a Medicare medical plan through Via Benefits, you will not be eligible to receive HRA deposits.

Medicare Enrollment

The Social Security Administration permits enrollment in Medicare Parts A and B during certain times depending on your circumstances. While most have access to premium-free Medicare Part A coverage, there is a monthly premium for Medicare Part B coverage. For more information about enrolling in Medicare Parts A and B, visit ssa.gov or call 1-800-772-1213.

Medicare Enrollment Periods

- **Initial enrollment period:** Three months before and three months after the month in which you turn 65.
- **General enrollment period for Medicare Parts A and B:** Jan. 1 through March 31 with an effective date of July 1.
- **Annual Medicare enrollment period:** Oct. 15 through Dec. 7.
- **Special enrollment period:** Occurs when you are 65 or older and your coverage, or your spouse's coverage ends through an employer. Other situations could be subject to this enrollment period. Reach out to Via Benefits for more detailed information.
- **Early Medicare:** If you become eligible for Medicare before the month in which you turn 65, you must enroll in Medicare Parts A and B, enroll in a Medicare medical plan with Via Benefits and notify OPERS of your Medicare eligibility immediately.

Are you still working and need help understanding how the OPERS health care program works in retirement? Give OPERS a call at 800-222-7377 to learn more.

Selecting a Medicare plan through Via Benefits

Via Benefits is a resource providing access to a wide assortment of Medicare plans from over 90 of the largest and most popular national and regional health insurance companies. OPERS has partnered with Via Benefits to help Medicare-eligible benefit recipients find and enroll in an individual Medicare plan.

It is important to understand what to expect and how to prepare in the months leading up to selecting a plan.

Selecting an individual Medicare plan

- Enroll in Medicare Parts A and B with Social Security.
- Call Via Benefits or go online to schedule your enrollment call.
- Enroll in your plan(s) either online or during your scheduled enrollment call.

Communications to Expect

As you approach Medicare-eligibility, keep an eye out for important communications from Social Security, Via Benefits and your insurance carrier.

Twelve, nine, seven and six months prior to your 65th birthday	Via Benefits will send you a number of mailings outlining their services, the plan selection process and necessary action steps. They will also reach out to you by phone.
Five months prior to your 65th birthday	OPERS will send you a letter describing the Medicare enrollment process and the requirements for receiving a monthly HRA deposit as a Medicare-eligible OPERS benefit recipient.
Four months prior to your 65th birthday	Via Benefits will call you and mail you an *Enrollment Guide*.
90 days prior to your 65th birthday	Social Security will send a notification that you are now eligible to enroll in Medicare.
Seven to 10 days after enrollment call	Via Benefits mails a *Selection Confirmation Letter*. This letter restates what was discussed on your call. It is not enrollment confirmation. You will receive a *Plan Acceptance Letter* from your insurance carrier when your application is processed.
Two to three weeks prior to plan coverage effective date	Via Benefits mails the *Getting Reimbursed Guide* if this is the first time a benefit recipient is receiving an OPERS HRA deposit.

Social Security disability benefits and Medicare eligibility prior to age 65

If you are or become eligible for Medicare due to a qualifying Social Security disability or End Stage Renal Disease*, you must enroll in Medicare Parts A and B and provide proof of your enrollment (a copy of the Medicare card or Notice of Award) to OPERS.

If you are under age 65 and currently enrolled in Medicare or become eligible for Medicare prior to turning 65, you must complete the following steps:

- Enroll in Medicare Parts A and B upon being notified of your eligibility.
- Provide OPERS with a copy of your Notice of Award or documentation issued by the Social Security Administration (SSA) that includes all the information listed here. You may find this information by logging into your "*my* Social Security" account by going to www.ssa.gov/myaccount or calling 1-800-772-1213.
    1. The date that you were first notified that you were eligible for Medicare
    2. Your Medicare effective date(s) of coverage
    3. Your Medicare claim number
- Enroll in a medical plan through the OPERS Medicare Connector to receive a monthly HRA deposit.

Failure to notify OPERS of your eligibility for Medicare within 30 days of being notified by SSA may result in retro-termination of the HRA deposits. A retro-termination means you may be required to repay all HRA reimbursements you have received since you were first Medicare eligible.

** If you have ESRD and are within your first 30 months of dialysis you are not required to apply for Medicare. However, if you become eligible for Medicare, you will need to enroll in both Medicare Parts A and B and enroll in a medical plan through the OPERS Medicare Connector to continue to receive an HRA.*

How does the OPERS HRA work for re-employed retirees?

A re-employed retiree is one who is receiving an OPERS pension benefit and is also employed in an OPERS-covered position. This includes re-employment in a full-time, part-time or seasonal/occasional OPERS position. It also includes a surviving spouse who is employed in an OPERS-covered position and receives a survivor benefit payment from OPERS. Classification of a re-employed retiree is not dependent upon contribution or earnings.

In the event you become re-employed by an OPERS-covered employer, you must inform the employer that you are receiving an OPERS benefit. If you know of your intention to become re-employed when you apply for retirement, you can provide that information within your retirement application.

Potential re-employment plans should be discussed with the employer to determine whether there are any restrictions or policies on re-employment. Contributions to OPERS must begin from the first day of re-employment. ***Your employer must certify and return to OPERS a Notice of Re-employment or Contract Services of an OPERS Benefit Recipient by the end of your first month of employment.***

How re-employment impacts your Health Reimbursement Arrangement

The OPERS HRA is a *retiree-only* plan, which means it works a little differently for re-employed retirees.

Medical plan enrollment requirements

Pre-Medicare – Pre-Medicare re-employed retirees can accrue HRA deposits during their re-employment period. Same as a Pre-Medicare benefit recipient who is not re-employed, you can enroll in any medical plan you choose; however, you must be opted in to the HRA to receive monthly HRA deposits from OPERS. **Even though you are accruing HRA deposits while re-employed, any expenses incurred during your re-employment period are not reimbursable.**

Medicare – Medicare-eligible re-employed retirees can accrue HRA deposits during their re-employment period. You must be enrolled in a medical plan through the OPERS Medicare Connector administered by Via Benefits to receive HRA deposits. **Even though you are accruing HRA deposits while re-employed, any expenses incurred during your re-employment period are not reimbursable.**

Accruing HRA deposits during your re-employment period

Your monthly HRA deposits from OPERS will accrue in a **Re-employed Accumulated HRA** for the month(s) you are employed in an OPERS-covered position. Your Re-employed Accumulated HRA will not be accessible during your re-employment period.

You may use any balance you had in your HRA prior to your re-employment period to be reimbursed for expenses incurred prior to your re-employment period, but not for expenses incurred during your re-employment period.

Administrative fees will not be deducted while you are re-employed. To view or print your Re-employed Accumulated HRA balance at any time, log into your OPERS online account.

When Your Re-employment Period Ends

The monthly HRA deposits accrued in your Re-employed Accumulated HRA will be deposited into your primary HRA account. The accrued deposits will have an administrative fee of $2.60 deducted for every month in which you accrued funds within your Re-employed Accumulated HRA.

You may use your HRA to receive reimbursement for expenses incurred before and/or after your re-employment period. **However, you may not use your HRA to receive reimbursement for expenses incurred during your re-employment period.**

How does the OPERS HRA work for re-employed retirees? *(continued)*

What is a Re-employment Period?

Your re-employment period begins the first day of the month in which your employment in an OPERS-covered position started and ends the last day of the month in which your employment is terminated. **You will never be able to receive reimbursement for expenses incurred during your re-employment period.**

HRA Overpayments

Depending on when your employer notifies OPERS of your re-employment, you may have received HRA reimbursements for expenses that were incurred during your re-employment period. If this happens, you will receive notification from the OPERS Connector regarding the overpayment not being satisfied. As the HRA plan sponsor, OPERS may assist in the collection of those reimbursements if they are not settled with the OPERS Connector in a timely manner.

Action steps when entering a Re-employment Period

Once you make the decision to become employed in an OPERS-covered position as an OPERS retiree, be certain to complete the following:

- ✔ Inform your employer that you are receiving an OPERS benefit.
- ✔ Make sure your employer does the following:
  - o Completes a *Notice of Re-employment or Contract Services of an OPERS Benefit Recipient* form.
  - o Submits the completed and certified form to OPERS by the end of your first month of employment.
- ✔ Create an OPERS online account to track your Re-Employed Accumulated HRA balance. You can do this by clicking on "Account Login" from the opers.org homepage.

OPERS Vision and Dental Plans

Anyone receiving a monthly OPERS benefit payment qualifies to enroll in the optional OPERS vision or dental plans, even if you don't qualify for the Health Reimbursement Arrangement (HRA). You may also enroll the following eligible dependents.

1. The spouse of a primary benefit recipient.

2. A biological or legally adopted child of the primary benefit recipient who is under the age of 26 (regardless of marital status) or the minor grandchild of the primary benefit recipient if the grandchild is born to an unmarried, unemancipated minor child and you are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

Surviving spouses

If you receive a monthly benefit from OPERS as the surviving spouse of a deceased OPERS retiree or member, you may enroll in the OPERS vision and dental plans. You may also enroll only those dependents who would have been eligible dependents of the deceased retiree or member as defined on this page.

It is your responsibility to notify OPERS, in writing, within 30 days of the date your dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid claims or reimbursement for which you will be responsible to repay.

When can I enroll in the vision and/or dental plan?

You may enroll only prior to or within 30 days of receiving your first benefit payment or during the annual open enrollment period. Outside of open enrollment, you can also enroll if you have experienced a life change (or a qualifying event). A qualifying event can be an involuntary loss of coverage from another source. You must tell us of such an event, complete an enrollment application and provide supporting documentation of the qualifying event within 60 days. If OPERS does not receive the required supporting documents within 60 days, you cannot be enrolled. Visit https://www.opers.org/health-care/resources.shtml for a copy of the enrollment application. After you enroll, you (and any enrolled dependents) 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. In order to avoid any overpayments, you must notify OPERS immediately if you have a change in family status.

If you are enrolled in a vision and/or dental plan with both OPERS and another insurance carrier, take some time to review your coverage needs to determine if both plans are needed.

When can I enroll eligible dependents?

If you are enrolled in the OPERS vision and/or dental plan, you may enroll eligible dependents in the same plan, and at the same level option (low or high), when you first enroll or during open enrollment. Outside of open enrollment, you can enroll eligible family members if you have experienced a life change (or a qualifying event). A qualifying event can be a benefit recipient's marriage, the birth or adoption of a child, or an involuntary loss of coverage from another source on the part of an eligible dependent. You must tell us of such an event, complete an enrollment application and provide supporting documentation of the qualifying event within 60 days. If OPERS does not receive the required supporting documents within 60 days, eligible dependents cannot be enrolled. Visit https://www.opers.org/health-care/resources.shtml for a copy of the enrollment application.

How will premiums for the OPERS vision and dental plans be paid?

Your net benefit payment must be enough to cover the full premium amount to be enrolled. Your premium cost for the plan(s) in which you are enrolled will be deducted from your benefit payment each month. If a change occurs and your net benefit payment is not enough to cover the full premium, **ALL** enrollments will be terminated.

Are my premiums automatically reimbursed from my HRA?

If you are receiving a monthly Health Reimbursement Arrangement (HRA) deposit from OPERS, for your convenience, we send a file to Via Benefits the first of every month that includes all premiums paid for that month. If you want to opt out of Automatic Premium Reimbursement for a particular product (vision or dental), you may do so after you receive your first premium reimbursement for that product. To opt out, call Via Benefits or sign into your online profile. Select *View Accounts* under *Funds & Reimbursement* and scroll to your *Automatic Premium Reimbursement*.

MetLife Vision Plan

MetLife Vision, administered by Superior Vision Network, is a vision coverage option available to you and your eligible dependents. If you choose to enroll in a vision plan, the entire premium for this coverage will be deducted monthly from your OPERS benefit payment. For more detailed information about covered services and limitations, refer to metlife.com/opers or call MetLife.

Plan Features

- Your plan offers coverage on eye exams. Even if you don't wear glasses or contacts, regular visits to your eye doctor may help contribute to your overall health. Routine vision exams can help catch serious problems, such as diabetes and high blood pressure[1].
- Your plan offers coverage on frames and lenses. Discounts are also available for polycarbonate (shatter-resistant) lenses, ultraviolet (UV) coating, scratch-resistant and anti-reflective coatings and progressive lenses.
- Choose from thousands of ophthalmologists, optometrists and opticians or popular retail locations. You can also access the top 50 retailers in network like America's Best Contacts & Eyeglasses, Costco Optical, Eyeglass World, LensCrafters, Pearle Vision, Target Optical, VisionWorks, Walmart and more[2].
- Plus, shop at online in-network eyewear stores, including Glasses.com, ContactsDirect, 1-800 Contacts and Befitting.com.

Added Benefits

- **You have two options of vision coverage to choose from:** High or Low. For more information you can view the plan summaries found under resources at metlife.com/opers. Once enrolled you can view your Certificate of Coverage for additional details.
- **Laser Vison Correction:** Savings of 40 to 50 percent off the national average price of traditional LASIK are available at over 1,000 locations across the nationwide network of laser vision correction providers.[3]
- **Replacement Contact Lens Purchases:** Visit contactsdirect.com to order replacement contact lenses for shipment to your home at less than retail price.

If you choose an out-of-network provider, you will have increased out of pocket expenses, pay in full at the time of services and file a claim with MetLife for reimbursement.

[1]Population Health Management, The role of comprehensive eye exams in the early detection of diabetes and other chronic diseases in an employed population, https://pubmed.ncbi.nlm.nih.gov/20465530/, accessed August 2021.
[2]Please see Superior Vision by MetLife's provider directory for a full list of participating providers.
[3]Laser vision correction services administered by QualSight, LLC

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1-888-262-4874

MetLife Vision Plan for All Plan Participants

Plan Options

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

2023 OPERS Vision Plan Monthly Premiums		
Vision Coverage	**Per Adult**	**Per Child**
High Option	$4.64	$3.59
Low Option	$1.95	$1.36

2023 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	Up to $65 allowance	$0 copay	Up to $50 allowance
Contact lens fit and evaluation				
• Standard	Covered in full after $17 copay	Applied to contact lens allowance	Covered in full after $32 copay	Applied to contact lens allowance
• Specialty	$50 retail allowance after $17 copay	Applied to contact lens allowance	$50 retail allowance after $32 copay	Applied to contact lens allowance
Frames	$140 retail allowance	Up to $78 allowance	$50 retail allowance after $5 copay	Up to $44 allowance
Lenses[1]				
• Single Vision	$0 copay	Up to $45 allowance	$5 copay	Up to $35 allowance
• Bifocals	$0 copay	Up to $60 allowance	$5 copay	Up to $55 allowance
• Trifocals	$0 copay	Up to $80 allowance	$5 copay	Up to $75 allowance
• Most premium progressives	$55 - $225 copay	Up to $60 allowance	$55 - $225 copay	Up to $55 allowance
Contact lenses	$240 retail allowance	Up to $228 allowance	$200 retail allowance	Up to $180 allowance
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.*

[1]Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

MetLife Dental Plan

MetLife dental coverage is optional for you and your dependents. If you choose to enroll in a dental plan, the entire premium for this coverage will be deducted monthly from your OPERS benefit payment. For more detailed information about covered services and limitations, refer to metlife.com/opers or call MetLife.

Plan Highlights

- Choose a dentist within the MetLife network to help 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 410,000 participating Preferred Dentist Program dentist locations nationwide, including over 96,000 specialist locations. It is encouraged to have your dentist provide a printed 'Pre-treatment Estimate' prior to having services rendered.

Plan Options

- You have two options of dental coverage to choose from: High or Low. For more information you can view the plan summaries found under resources at metlife.com/opers. Once enrolled you can view your Certificate of Coverage for additional 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 even receive email alerts when a claim has been processed. The claim form can be found under Resources at metlife.com/opers or you can call MetLife.

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

[2] Negotiated fees for non-covered services may not apply in all states. Plans in LA, MS, MT and TX vary.

Please call MetLife for more details.

MetLife Dental Plan for All Plan Participants

2023 OPERS Dental Plan Monthly Premiums		
Dental Coverage	**Per Adult**	**Per Child**
High Option	$30.96	$18.39
Low Option	$18.37	$11.16

2023 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	$2,000	$1,250	$2,000	$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 Type C services.

MetLife Dental Plan

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 14th birthday (once per lifetime)
Sealants	One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd permanent 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 Recementations	Once per 12-month period
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 in any 24-month period Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year

Major Services and Restorative – Type C

Bridges and Dentures	Initial placement to replace one or more natural teeth Dentures and bridgework replacement: one every 10 calendar 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 calendar years
Endodontics	Molar root canal treatment as needed
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontal Surgery	Periodontal surgery once per quadrant in any 3 calendar years

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.

Resources

Health Insurance Marketplace
1-800-318-2596
healthcare.gov

Medicare
1-800-MEDICARE
(1-800-633-4227)
medicare.gov

Medicare Fraud Reporting Pro-Seniors
(also legal services)
1-800-488-6070
proseniors.org

MetLife Vision & Dental
1-888-262-4874
metlife.com/opers

Ohio Department of Aging
1-800-266-4346
aging.ohio.gov

Ohio Department of Insurance
Consumer Services
1-800-686-1526
insurance.ohio.gov

Ohio Department of Medicaid
1-800-324-8680
jfs.ohio.gov/ohp
medicaid.ohio.gov

Ohio Senior Health Insurance Information Program (OSHIIP)
1-800-686-1578
insurance.ohio.gov

Social Security Administration
1-800-772-1213
ssa.gov

U.S. Dept. of Health & Human Services Office of Inspector General
1-800-HHS-TIPS
(1-800-447-8477)
medicare.gov/fraud

Via Benefits - Medicare
1-844-287-9945
my.viabenefits.com/opers

Via Benefits – Pre-Medicare
1-833-939-1215
marketplace.viabenefits.com/opers

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Ohio Public Employees Retirement System

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