




---

---

---

---

---

---

---

---

### History of OPERS Health Care

- 1962 - OPERS first offered health care coverage to its retirees (retiree paid the entire premium)
- 1974 - OPERS established OPERS health care trust fund
- 1975 - OPERS expanded its health care services to include Kaiser, thereby offering its first HMO
- 1986 - Health care eligibility increased from needing 5 years of service credit at retirement, to 10 years of service credit
- 2007 - Restructured OPERS Health Care Plan

---

---

---

---

---

---

---

---

### Health Care Challenges & Opportunities

- Baby Boomers' Retiring
- Retirees Living Longer
- Benefits Perception (a.k.a. "Pension Envy")
- Economy
- State budget & proposed pension changes
- Increasing Cost of Health Care
- Solvency of Medicare and Social Security
- National Health Care Reform

---

---

---

---

---

---

---

---

### Service Retirement Qualifications

Pension:

- 5 years service credit at 60 years of age
- 25 years service credit at 55 years of age
- 30 years service credit at any age

Health Care:

- You must meet qualifications above and have 10 years of qualifying service credit to be eligible for OPERS health care

---

---

---

---

---

---

---

---

### Eligibility Highlights

- Retiree only eligible for health care from one Ohio retirement system (ORS)
- Spouse of OPERS retiree cannot terminate other ORS coverage to be covered under OPERS
- Under 55 spouses of age & service retirees will pay full health care premium in 2011
- Health Care costs determined by length of service credit & date eligible for retirement

---

---

---

---

---

---

---

---

### Three Groups

Group 1 Retirees

- Hired on or before January 1, 2003 and eligible to retire with health care before January 1, 2007

Group 2 Retirees

- Hired on or before January 1, 2003 and eligible to retire with health care after January 1, 2007

Group 3 Retirees

- Hired after January 1, 2003 and eligible to retire with health care after January 1, 2007

---

---

---

---

---

---

---

---

### 2011 Eligible Dependent Guidelines

- Your Legal Spouse
  - Spouses under age 55 will pay full premium cost
  - Once covered spouse reaches age 55 OPERS will again subsidize portion of premium cost
- Your Children:
  - Biological and/or legally adopted
  - Under age 26 with no other qualifications
- Grandchildren, only if legally adopted or with a court order pursuant to the Ohio Revised Code

See page 14 of 2011 Health Care Coverage Guide

---

---

---

---

---

---

---

---

### Dependent Coverage

- You may add coverage for a dependent during Open Enrollment or within 60 days of a qualifying event such as:
  - Involuntary loss of health insurance
  - Marriage
  - Birth of a child
- You may drop coverage for a dependent at any time

See pages 10 - 11 of 2011 Health Care Coverage Guide

---

---

---

---

---

---

---

---

### Medical Mutual Plan

- Medical Mutual administers plan for all non-Medicare retirees (under 65)
- Lower out of pocket costs by using network providers (PPO Plan)
- Medical Mutual has largest provider network of any insurer in Ohio
- Enhanced plan level
- Intermediate plan level
- Basic plan level

See pages 4 - 6 of 2011 Health Care Guide

---

---

---

---

---

---

---

---

### Humana Medicare Advantage Plan

- Retirees and covered spouses with Medicare A & B or Medicare B only who live in the U.S. and not covering children are enrolled
- Claims are sent directly to Humana for processing & are not sent to Medicare
- Member must meet annual deductible of \$250 before most services are paid at 96% or higher  
*See pages 1 & 2 of 2011 Health Care Guide*

---

---

---

---

---

---

---

---

### Medicare & Your Health Coverage

- Medicare A is your hospitalization coverage
  - 40 credits required by Social Security but you may qualify through a spouse
- Medicare B is medical coverage
  - Everyone is eligible, usually at age 65
  - Enrollment is required when first eligible
  - Proof of Enrollment must be sent to OPERS
- OPERS will reimburse a retiree's Medicare B premium up to \$96.40

*See pages 14 & 15 of 2011 Health Care Guide*

---

---

---

---

---

---

---

---

### Express Scripts (ESI) Prescription Coverage

- ESI administers prescription plan for all retirees
- All Non-Medicare participants will be enrolled in OPERS Non-Medicare Prescription Plan  
*See page 7 of 2011 Health Care Coverage Guide*
- Retail pharmacy preferred for short-term meds
- ESI mail order preferred for maintenance meds
- Formulary brands & generics have lowest copays
- All Medicare participants will be enrolled in OPERS Medicare D Prescription Plan

*See page 3 of 2011 Health Care Coverage Guide*

---

---

---

---

---

---

---

---

**Kaiser Permanente**

- Kaiser Permanente HMO Plan
  - Medical, vision & dental coverage
  - Must use Kaiser network providers
- Contact Kaiser for enrollment materials
- Kaiser is available in select Ohio counties *See page 8 of 2011 Health Care Coverage Guide*

---

---

---

---

---

---

---

---

**2011 Optional Coverage**

- MetLife Dental
  - High Option
  - Low Option
- Aetna Vision
  - High Option
  - Low Option
- Prudential Long Term Care *See page 9 of 2011 Health Care Coverage Guide*
  - Coverage includes custodial nursing home care & home health care
  - Coverage is subject medical underwriting

*See page 17 of 2011 Health Care Coverage Guide*

---

---

---

---

---

---

---

---

**OPERS Wellness Programs**

\$50 deposit in RMA for each of the following with a maximum of \$100 per year:

- Complete a Health Assessment questionnaire
- Have an annual physical exam
- Complete a Lifestyle Coaching Program
- Participate in a Disease Management Program for those with certain chronic conditions *See page 18 of 2011 Health Care Coverage Guide*

---

---

---

---

---

---

---

---

### Retiree Medical Account

- The incentive earned will be placed into the retiree’s RMA
  - An RMA will automatically be created by OPERS
- The RMA can be used for additional/future health care expenditures
  - It is not taxable
  - Can be rolled over from year to year
  - Currently earns interest
  - Administered by Aetna

*See page 19 of 2011 Health Care Guide*

---

---

---

---

---

---

---

---

### Helpful Cost Tools

- Online Health Care cost estimate via My Benefit System (MBS) available at opers.org
- Request health care cost estimate by phone
- Health Care Open Enrollment cost statement

---

---

---

---

---

---

---

---

### Non-Medicare Cost Examples

- Group 2 Non-Medicare Retiree first eligible to retire with health care in 2011 with **10** years  
Retiree covers self & Non-Medicare spouse under the Medical Mutual Enhanced Plan:  
Retiree premium \$407 / Spouse premium \$611
- Group 2 Non-Medicare Retiree first eligible to retire with health care in 2011 with **30** years  
Retiree covers self & Non-Medicare spouse under the Medical Mutual Enhanced Plan:  
Retiree premium \$0 / Spouse premium \$204

---

---

---

---

---

---

---

---

### Medicare Cost Examples

- Group 2 Medicare Retiree first eligible to retire with health care in 2011 with 10 years

Retiree covers self & Medicare spouse under the Humana Medicare Advantage Plan:

Retiree premium \$179 / Spouse premium \$268

- Group 2 Medicare Retiree first eligible to retire with health care in 2011 with 30 years

Retiree covers self & Medicare spouse under the Humana Medicare Advantage Plan :

Retiree premium \$0.00 / Spouse premium \$89

---

---

---

---

---

---

---

---

### Health Care Plan Selection

- Contact OPERS or your employer to receive retirement packet
- Send back health care application before your pension effective date
- Consider needs of your entire family when choosing health care coverage
- Retiree locked into plan level selection (Enhanced, Intermediate or Basic) for two years with the following exception:
  - Retiree will automatically be enrolled in Humana Medicare Advantage Plan upon aging into Medicare at age 65

---

---

---

---

---

---

---

---

### Remember These Points

- Pre-existing conditions accepted
- Employer Plan vs. OPERS Retiree Plan
- If re-employed in an OPERS position retiree must take health care insurance if offered
- Enroll in Medicare as soon as possible
- Under pension plan of payments A, C, D or F your beneficiary may be eligible for health care if you were eligible
- Health care coverage is subject to change

---

---

---

---

---

---

---

---

### Important Phone Numbers

- Humana LTC 4777                      Prudential - 1-877-890-3367
- Medical Mutual Dental 6728                      MetLife - 1-877-520-4874
- Express Scripts Vision - 1-800-789-7416                      Aetna - 1-866-591-1913

---

---

---

---

---

---

---

### Questions?



---

---

---

---

---

---

---

---

# 2011 Coverage Guide

*for participants in the  
OPERS health care plan*



# Contents

## Medicare-eligible Participants

Humana Medicare Advantage Plan.....	1
OPERS Medicare Part D Plan.....	3

## Non-Medicare eligible Participants

Medical Mutual PPO Plan.....	4
Prescription Drug Coverage .....	7

## For plan participants in certain Ohio counties

Kaiser Permanente.....	8
------------------------	---

## General Information - for all plan participants

Aetna Vision Plan .....	9
MetLife Dental Plan .....	11
General Coverage Information .....	13
OPERS Wellness Incentive Programs .....	18
Retiree Medical Account (RMA) .....	19

## Supplemental Required Documents

General notice of COBRA Continuation Rights.....	20
Notice of Medical Privacy Practices for Medicare Retirees.....	21
Notice of Medical Privacy Practices for Non-Medicare Retirees .....	23
Medicare Part D Notice of Creditable Coverage .....	25

## Hints for using this Guide:

Medical/prescription drug coverage information for **Medicare-eligible retirees** is listed first within this guide (pages 1 - 3) followed by medical/prescription drug coverage information for **non-Medicare eligible retirees** (pages 4 - 7).

## Health Care Seminars

The 2011 OPERS health care seminar schedule can be found on the OPERS website, [www.opers.org](http://www.opers.org), and also within each issue of *Ohio PERS NEWS for Retirees*. These seminars are designed to address the needs of those participating in the OPERS health care plan. Topics include medical/pharmacy coverage, dental and vision coverage, preventive coverage and wellness programs. Each seminar will also feature a question and answer session at the end.

### In 2011, we will hold separate seminars for:

- **Medicare-eligible participants**
- **Non-Medicare participants**
- **Active members within five years of retirement**

Registration is required and seminars do fill quickly. Please register by calling OPERS at **1-800-222-7377** or visiting [www.opers.org](http://www.opers.org) to register using My Benefits System (MBS). All seminars last approximately two hours.

## Humana Medicare Advantage Plan

OPERS is pleased to offer the Humana Medicare Advantage Plan to Medicare-eligible retirees and their covered, Medicare-eligible dependents in 2011. The Humana Medicare Advantage Plan is the only medical coverage choice for Medicare-eligible members at retirement. The only exceptions include:

- Retirees covering non-Medicare eligible spouses and/or children,
- Retirees living outside the United States and,
- Retirees in certain Ohio counties who elect to participate in the Kaiser Permanente HMO.

Humana has been an industry leader in providing health care coverage to the Medicare population for over 25 years. With the Humana Medicare Advantage Plan, Humana serves as a single point of contact for medical coverage and processes all medical claims on behalf of both Medicare and OPERS.

Humana has a broad network of primary care doctors, specialists and hospitals. OPERS retirees participating in the the Humana Medicare Advantage Plan are strongly encouraged to use network providers. Using network providers costs OPERS less which helps maintain the solvency of the health care fund. You will not see any cost share difference if an out-of-network provider is used. Humana processes claims for any provider that accepts Medicare or Medicare assignment.

The plan offers numerous features including access to a 24-hour-a-day phone line staffed by registered nurses, a personal web page where retirees can review their coverage, and many resources to help retirees manage their health such as a fitness program which offers free membership at your choice of over 2200 participating fitness centers nationwide through the *SilverSneakers* program.

All plan participants will receive an ID card from Humana once enrolled.



***For questions regarding the Humana Medicare Advantage Plan, please call Humana at 1-877-890-4777 or visit [www.humana.com/opers](http://www.humana.com/opers).***

# Humana Medicare Advantage Plan Features

<b>Deductible per calendar year</b>	
Single	\$250*
<b>Out-of-pocket per calendar year (excluding deductible)</b>	
Single	\$850*
<b>Lifetime Maximum</b>	Unlimited
<b>MEDICAL SERVICES</b>	
<b>Outpatient Hospice</b>	Covered by Medicare at a certified hospice agency, 100%
<b>Mental Health</b>	96%
<b>Substance Abuse</b> (including Alcohol)	96%
<b>Surgery</b>	96%
<b>Office Visit</b> (Primary Care Physician)	96%
<b>Office Visit</b> (Specialist)	92%
<b>EMERGENCY SERVICES</b>	
<b>Emergency Room</b>	\$50 co-pay (waived if admitted)
<b>Urgent Care</b>	\$50 co-pay
<b>PREVENTIVE** (must be billed as routine)</b>	
<b>Routine Physical Exam</b>	100%
Annual PAP, Mammography, PSA	100%
<b>Colorectal Cancer Screening</b> (for all participants age 50 and over)	100%
<b>Bone Density Testing</b>	100%
<b>Flu, Pneumonia, Hepatitis B vaccines</b>	100%
<b>OTHER MEDICAL</b>	
<b>Diabetic testing supplies</b> (excluding supplies for DME)	100%
<b>Diagnostic lab and x-ray</b>	Lab/pathology 100%, X-ray 96%
<b>Chiropractors</b> (for manual manipulation of the spine to the extent covered by Medicare)	92%
<b>Physical Therapy</b>	96%
<b>Ambulance</b>	96%
<b>Home Health Care</b>	100%
<b>Durable Medical Equipment (DME)</b>	96%
<b>INPATIENT</b>	
<b>Inpatient Deductible</b>	None
<b>Semi-Private Room</b>	96%
<b>Pre-Admission Testing</b>	100%
<b>Skilled Nursing Facility</b>	100%
<b>Hospice (Respite Care)</b>	Covered by Medicare at a certified hospice agency, 95%
<p>*Annual out-of-pocket maximum equals \$1100. **This is just a representative list of the preventive services covered.</p> <p><b>All charges subject to medical necessity. Plan Features are general descriptions of coverage. For details, refer to your Plan documents. Prescription drug coverage information for Medicare-eligible retirees is listed on page 3.</b></p>	

# OPERS Medicare Part D Prescription Plan

OPERS is pleased to partner with Express Scripts and offer our Medicare-eligible retirees the OPERS Medicare Part D prescription plan. Medicare-eligible participants enrolled in the Medical Mutual Enhanced plan will pay the prescription co-pays listed on this page. Medicare-eligible participants enrolled in the Intermediate and Basic plans will pay the prescription co-pays listed on page 7. This plan is geared toward Medicare participants, requires no additional premium and will provide OPERS with cost savings. Express Scripts will send Medicare-eligible retirees a new enrollee packet which will include your new ID card, a formulary list and other materials.

**Retail pharmacy program** - Participants can receive up to a 31-day supply of medication, plus refills, as prescribed by their physician from any Medicare-approved retail pharmacy. Your costs could vary based on your choice of pharmacy (in or out of network). Up to a 90-day supply of medication can be obtained from certain Medicare-approved retail pharmacies. In order to use the retail pharmacy network, plan participants must present their prescription drug ID card and prescription(s) to the pharmacist.

**Mail pharmacy program** - Participants can receive up to a 90-day supply of medication, plus refills, as prescribed by their physician. To use the mail pharmacy, retirees can mail their prescription(s) and the correct co-payment in the special order envelope to Express Scripts, they can place their order over the internet, or they can call Express Scripts at **1-800-789-7416**.

**Low Income Subsidy** - The Low Income Subsidy under the OPERS Medicare Part D plan provides financial assistance for retirees who meet annual guidelines for income and assets as established by the Social Security Administration (SSA), such as individuals with both Medicaid and Medicare. Those retirees who meet the SSA guidelines will automatically receive the subsidy. Those who qualify may receive help in the form of lower monthly premiums and lower cost-sharing for their prescription drugs under the OPERS Medicare Part D plan. If a retiree feels they may be eligible for the subsidy, they should call 1-800-MEDICARE for guideline information.

2011 OPERS Medicare Part D Prescription Plan		
Generic	\$4	Retail co-pay
	\$10	Mail co-pay
Formulary Brand	\$20	Retail co-pay
	\$50	Mail co-pay
Non-Formulary Brand	\$50	Retail co-pay
	\$125	Mail co-pay
Medications used to treat Diabetes	Covered at 100%	
Annual Out-of-Pocket Maximum (100% coverage after \$4300 has been spent in pharmacy co-pays)	\$4300	
Proton Pump Inhibitors (PPIs) Coverage*		
Over-the-counter (OTC) Prilosec, OTC Omeprazole	\$5	Retail co-pay
	\$12.50	Mail co-pay
Generic Omeprazole, Pantoprazole and Lansoprazole	\$25	Retail co-pay
	\$62.50	Mail co-pay
Nexium	\$50	Retail co-pay
	\$125	Mail co-pay
Prevacid, Aciphex, Prilosec, Protonix, Zegerid and Kapidex	\$75	Retail co-pay
	\$187.50	Mail co-pay

## New in 2011:

**Coverage is available for the Shingles vaccine at a retail pharmacy certified to administer the vaccine. Call Express Scripts for more information.**

**You will pay three times the retail co-pay for a 90-day supply of medication through a Medicare-approved retail pharmacy.**

**Specialty medications may be purchased through CuraScript (Express Scripts' specialty pharmacy) or a retail pharmacy and are limited to a 30-day supply subject to the appropriate retail co-pay.**

\*PPIs are subject to different co-pays than other medications.

Note: Express Scripts will always dispense a generic medication unless the prescription is marked with "Dispense as Written (DAW)". If retirees choose to purchase a brand name drug when there is an equivalent lower-cost generic available, they will be charged the non-formulary brand co-payment.



**For questions regarding the Express Scripts prescription drug plan for Medicare-eligible retirees, please call Express Scripts at 1-800-789-7416 or visit [www.express-scripts.com](http://www.express-scripts.com).**

## Medical Mutual PPO Plan

The OPERS health care plan for retirees not yet eligible for Medicare and for those Medicare-eligible retirees with a non-Medicare spouse (or vice versa) and/or a child is administered by Medical Mutual.

**Three levels of coverage** - The OPERS health care plan administered by Medical Mutual features a choice between three levels of medical coverage - Enhanced, Intermediate and Basic Plans. These three plans, their coverage levels, and co-pays are described in detail on the following pages. Retirees should review this information carefully before deciding on the best plan for themselves and their family. **Participants may only select their plan level (Enhanced, Intermediate, or Basic) every other year.**

**Network** - Retirees not yet eligible for Medicare coverage and living in a network area will be in the Medical Mutual network/PPO plan. The PPO plan is a program in which a network of doctors and hospitals agree to provide services at discounted fees. These fees tend to be less than the fees of non-network providers. When a network provider is used, OPERS refers to this coverage as "In-Network". Retirees may also choose to obtain services from a provider who

does not participate in Medical Mutual's network. OPERS refers to this coverage as "Out-of-Network".

In Ohio, and several other states, Medical Mutual has a proprietary network of doctors and hospitals. This network gives retirees access to an extensive list of top doctors, hospitals and other health care professionals – more than any other insurer in Ohio. For those participants living outside of Ohio, Medical Mutual has a wide network of providers across the U.S. Call Medical Mutual customer service at the number below to find network providers in your area.

Retirees who have Medicare Part B only and are covering a non-Medicare spouse and/or child will be covered by Medical Mutual and must use "network" hospitals, skilled nursing and hospice facilities in order to receive the highest level of coverage. Non-network facilities will be paid at the "Out-of-Network" level. These retirees will not be required to use participating medical providers (examples include: physicians, laboratory services and radiology) since Medicare Part B is their primary coverage for medical or physician services.



***For questions regarding the Medical Mutual PPO Plan, please call Medical Mutual at 1-877-520-6728 or visit [www.medmutual.com](http://www.medmutual.com).***

# MEDICAL MUTUAL PLAN FEATURES

For: Non-Medicare-eligible retirees living in a network area

All limits and maximums are per covered individual

UCR – Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.	OPERS Medical Plans					
	Enhanced		Intermediate		Basic	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible per calendar year	\$700	\$1,400	\$750	\$1,500	\$2,000	\$4,000
Out-of-Pocket limit per calendar year	\$1,500	\$3,000	\$3,000	\$6,000	\$5,000	\$10,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>MEDICAL SERVICES</b>						
Outpatient Hospice	80%	70%	80%	70%	80%	70%
Mental Health	80%	60%	80%	60%	70%	60%
Substance Abuse (including alcohol)	80%	60%	80%	60%	70%	60%
Surgery	80%	60%	80%	60%	70%	50%
Office Visit - Primary Care Physician	\$20 co-pay	60%	\$25 co-pay	60%	60%	60%
Office Visit - Specialist	\$35 co-pay	60%	\$40 co-pay	60%	60%	60%
<b>EMERGENCY SERVICES</b>						
Emergency Room	\$100* co-pay (emergency) \$200 co-pay (non-emergency) 100% facility, 80% all other charges		80% (emergency) \$250 co-pay (non-emergency) 100% facility, 80% all other charges		70% (emergency) \$250 co-pay (non-emergency) 100% facility, 80% all other charges	
Urgent Care	\$35 co-pay	60%	\$45 co-pay	60%	\$50 co-pay	60%
<b>PREVENTIVE** (must be billed as routine)</b>						
Annual routine physical	\$150	\$150	\$150	\$150	\$150	\$150
Annual PAP, Mammography, PSA	100%	100%	100%	100%	100%	100%
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density	100%	100%	100%	100%	100%	100%
Flu, Pneumonia and Shingles Vaccines	100%	100%	100%	100%	100%	100%
<b>OTHER MEDICAL</b>						
Lab and Diagnostic	80%	60%	80%	60%	70%	50%
Chiropractors (10 visit limit)	80%	60%	80%	60%	70%	50%
Physical Therapy	80%	60%	80%	60%	70%	50%
Ambulance	80%	80%	75%	75%	70%	70%
Home Health Care	100 visits 100% then 80%	70%	80%	60%	70%	50%
Durable Medical Equipment	80%	60%	80%	60%	70%	50%
Medically Necessary Wigs***	\$100 per year	\$100 per year	\$100 per year	\$100 per year	\$100 per year	\$100 per year
All Other	80%	60%	80%	60%	70%	50%
<b>INPATIENT</b>						
Inpatient Deductible (per admission)	\$100	\$200	\$100	\$200	\$100	\$200
Semi-Private Room	80%	70%	80%	60%	70%	50%
Pre-Admission Testing	80%	70%	80%	60%	70%	50%
Skilled Nursing Facility	100%	70%	80%	60%	70%	50%
Hospice	100%	70%	100%	70%	100%	70%

ALL SERVICES SUBJECT TO MEDICAL NECESSITY. \*Waived if admitted

\*\*This is just a representative list of the preventive services covered. \*\*\*Not subject to coinsurance or deductible.

Plan Features are general descriptions of coverage. For details, refer to your Plan documents.

# MEDICAL MUTUAL PLAN FEATURES

## For: 1) Medicare-eligible plan participants enrolled in the Medical Mutual Plan

(Because a covered family member is not eligible for Medicare)

## 2) Retirees living outside of a network area

All limits and maximums are per covered individual

UCR – Usual and Customary Rate - UCR limits generally apply to any service provided out-of-network.	OPERS Medical Plans		
	Enhanced	Intermediate	Basic
Deductible per calendar year	\$700 Out-of-Area / \$250 Medicare	\$750 Out-of-Area / \$400 Medicare	\$2,000 Out-of-Area / \$900 Medicare
Out-of-Pocket limit per calendar year	\$1,500 Out-of-Area / \$850 Medicare	\$3,000 Out-of-Area / \$1000 Medicare	\$5,000 Out-of-Area / \$1500 Medicare
Lifetime Maximum	Unlimited	Unlimited	Unlimited
<b>MEDICAL SERVICES</b>			
Outpatient Hospice	80%	80%	80%
Mental Health	80%	80%	70%
Substance Abuse (including alcohol)	80%	80%	70%
Surgery	80%	80%	70%
Office Visit	80%	80%	60%
<b>EMERGENCY SERVICES</b>			
Emergency Room	\$100* co-pay (emergency) \$200 co-pay (non-emergency) Out-of-Area 100% facility, 80% all other charges	80% \$250 co-pay (non-emergency)	70% \$250 co-pay (non-emergency)
Urgent Care	80%	80%	60%
<b>PREVENTIVE** (must be billed as routine)</b>			
Routine Physical	\$150 each year**	\$150 each year**	\$150 each year**
Annual PAP, Mammography, PSA	100%	100%	100%
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density	100%	100%	100%
Flu, Pneumonia and Shingles Vaccines	100%	100%	100%
<b>OTHER MEDICAL</b>			
Lab and Diagnostic	80%	80%	70%
Chiropractors (10 visit limit)	80%	80%	70%
Physical Therapy	80%	80%	70%
Ambulance	80%	75%	70%
Home Health Care	100% (First 100 visits) 80% (Additional visits)	80%	70%
Durable Medical Equipment	80%	80%	70%
Medically Necessary Wigs***	\$100 per year	\$100 per year	\$100 per year
All Other	80%	80%	70%
<b>INPATIENT</b>			
Inpatient Deductible (per admission)	\$100	\$100	\$100
Semi-Private Room	80%	80%	70%
Pre-Admission Testing	80%	80%	70%
Skilled Nursing Facility	100%	80%	70%
Hospice	100%	100%	100%

ALL SERVICES SUBJECT TO MEDICAL NECESSITY. \*Waived if admitted \*\*This is just a representative list of the preventive services covered.

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

Medicare benefit recipients are not subject to any difference in coverage based on network providers. The OPERS health care plan pays secondary to Medicare and follows their schedule for allowable charges. Plan Features are general descriptions of coverage. For details, refer to your Plan documents.

# Non-Medicare Prescription Drug Coverage

**Retail pharmacy program** - Participants can receive up to a 30-day supply of medication, plus refills, as prescribed by their physician. In order to use the retail pharmacy network, they must present their prescription drug ID card and prescription(s) to the pharmacist.

**Mail pharmacy program** - Participants can receive up to a 90-day supply of medication, plus refills, as prescribed by their physician. Mail the prescription(s) and the correct co-payment to Express Scripts in the special order envelope.

**100% Co-pay Drugs** - Some prescription drugs are covered under the OPERS health care plan, but, are subject to a 100% copay. This means, you can obtain the medications through your OPERS prescription drug plan but you will pay the full cost of the medication minus the Express Scripts discount. Please contact Express Scripts for more information about 100% co-pay drugs.

**Specialty Medications** - Specialty medications must be purchased through CuraScript (Express Scripts' specialty mail order pharmacy) and are limited to a 30-day supply subject to the appropriate retail co-pay below. For more information, please contact CuraScript at 1-866-654-2174.

2011 Non-Medicare Prescription Plan	Enhanced	Intermediate	Basic
Deductible (Calendar year)	\$50 annual deductible for brand medications	\$50 annual deductible for brand medications	\$550 individual
Generic	\$4 Retail co-pay \$10 Mail co-pay	\$6 Retail co-pay \$15 Mail co-pay	35% co-insurance \$6 Retail minimum \$15 Mail minimum
Formulary Brand	30% Retail co-insurance (\$30 min/\$60 max) \$75 Mail co-pay	35% Retail co-insurance (\$40 min/\$75 max) \$125 Mail co-pay	35% co-insurance \$40 Retail minimum \$100 Mail minimum
Non-Formulary Brand	40% Retail co-insurance (\$75 min/\$150 max) \$187.50 Mail co-pay	40% Retail co-insurance (\$75 min/\$150 max) \$200 Mail co-pay	50% co-insurance \$75 Retail minimum \$187.50 Mail minimum
Annual Out-of-Pocket Maximum (100% coverage after \$4300 has been spent in co-pays/co-insurance)	\$4300	\$4300	None
<b>2011 Proton Pump Inhibitor (PPI) Coverage (Medications treating acid-reflux and heartburn)</b>			
OTC Prilosec, OTC Omeprazole	\$5 Retail co-pay \$12.50 Mail co-pay	\$5 Retail co-pay \$12.50 Mail co-pay	\$5 Retail co-pay \$12.50 Mail co-pay
Generic Omeprazole, Pantoprazole and Lansoprazole	\$25 Retail co-pay \$62.50 Mail co-pay	\$25 Retail co-pay \$62.50 Mail co-pay	\$25 Retail co-pay \$62.50 Mail co-pay
Nexium, Prevacid, Aciphex, Prilosec, Protonix, Zegerid and Kapidex	Participant pays full cost. Available only at a retail pharmacy.	Participant pays full cost. Available only at a retail pharmacy.	Participant pays full cost. Available only at a retail pharmacy.

**“Retail” is a 30 day supply. “Mail” is a 90-day supply**

*Note: Express Scripts will always dispense a generic medication unless the prescription is marked with “Dispense as Written (DAW)”. If retirees choose to purchase a brand name drug when there is an equivalent lower-cost generic available, they will be charged the non-formulary brand co-payment (subject to plan deductible and co-payment if applicable).*

**For questions regarding the Express Scripts prescription drug plan for Non-Medicare eligible retirees, please call Express Scripts at 1-866-727-5873 or visit [www.express-scripts.com](http://www.express-scripts.com).**



# Kaiser Permanente HMO

Kaiser Permanente is an alternative to the OPERS health care plan for both Medicare-eligible (Kaiser Permanente Medicare Plus Plan) and non-Medicare eligible retirees. Retirees who wish to enroll in the plan must obtain enrollment materials from Kaiser Permanente (not OPERS). If the retiree or their spouse will be turning age 65 during 2011, his or her premium will change at that time. Retirees should not sign up for Kaiser Permanente if they expect to be outside the service area for more than 90 days. The Kaiser Permanente medical plans include dental and vision coverage. Kaiser Permanente handles the claims for all coverage types they offer.

**Non-Medicare eligible retirees:** Kaiser Permanente requires that participants not eligible for Medicare use network doctors and hospitals to receive coverage. Participants have access to excellent Kaiser Permanente physicians, plus thousands of independent doctors with offices throughout the service area. Many of Kaiser Permanente's 10 medical centers include doctors' offices, pharmacy, lab, and X-ray services all in one facility.

**Non-Medicare eligible retirees have access to coverage in the following counties:** Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Stark, Summit, and Wayne

**Medicare-eligible retirees:** As a Medicare Plus participant, you can use your Original Medicare coverage separate from your Kaiser Permanente coverage and obtain care from non-Plan providers. You are responsible for Medicare coinsurance, any deductibles and for charges from providers who do not participate in Medicare. When you receive services within the provider network your comprehensive coverage will have affordable and predictable co-pays. If you choose to go outside of the network, you will still have your Original Medicare benefits. In addition to the services covered by Original Medicare, Kaiser Permanente Medicare Plus provides routine eye exams, worldwide emergency care, health education classes and programs.

**Medicare eligible retirees have access to coverage in the following counties:** Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, and Summit

**Prescription drug coverage will be administered by Express Scripts.** Non-Medicare eligible retirees will participate in the plan detailed on page 7 at the Enhanced Plan level. Medicare-eligible retirees will be covered under the OPERS Medicare Part D prescription drug plan detailed on page 3.

**For more information: Call 1-800-686-7100 or (216) 621-7100 or TTY (216) 479-5003 or visit [www.kp.org](http://www.kp.org).**

## Kaiser Permanente Plan Features

	You Pay - Non-Medicare	You Pay - Medicare
<b>Health Provider</b>	Plan Provider	Plan Provider
<b>Deductible</b> (per calendar year)	\$250 single / \$500 family	None
<b>Out-of-Pocket/Co-Insurance</b> (per calendar year)	\$2,000 single / \$6,000 family	\$2,500 single / \$6,000 family
<b>Physician Services</b>		
Office Visit/Primary Care	\$15 co-pay	\$15 co-pay
Surgery	10% after deductible	\$15 co-pay
Routine Physical Exam	\$0	\$0
<b>Hospital Coverage</b>		
Admission Deductible	None	None
Semi-private Room	10% after deductible	\$0
Pre-admission Testing	10% after deductible	\$0
<b>Emergency Room</b>	\$50 co-pay (co-pay waived if admitted)	\$50 co-pay (co-pay waived if admitted)
<b>Hearing - Exam</b>	\$15 co-pay	\$15 co-pay
Hearing Aid	Not covered	Not covered
<b>Vision - Exam</b>	\$15 co-pay	\$15 co-pay
Frames and lenses	Up to \$300 / 24 months using VSP provider	Up to \$300 / 24 months using VSP provider
<b>Dental</b>	100% preventive / 70% basic restorative / 60% major restorative / must use Delta Dental dentist	100% preventive / 70% basic restorative / 60% major restorative / must use Delta Dental dentist

All charges are subject to medical necessity. Plan Features are general descriptions of coverage. For details, refer to your Plan documents.

# Aetna Vision Plan

Welcome to Aetna Vision<sup>SM</sup> Preferred, powered by EyeMed. The Ohio Public Employees Retirement System is offering a vision coverage option to you and your eligible dependents to help you obtain affordable, convenient vision care.

- **Eye Health Equals Better Vision:** A comprehensive eye exam not only can detect serious vision conditions such as cataracts and glaucoma, but can also detect the early signs of diabetes, high blood pressure and many other health conditions.
- **Great Savings of Approximately 40%:** You have two plan options to choose from, both offering significant savings on eye exams and eyewear.
- **Convenience and Choice:** With the Aetna Vision Preferred provider network, you have the choice of leading optical retailers including LensCrafters, Target Optical, most Sears Optical and Pearle Vision locations, as well as thousands of private practitioners.

<b>2011 Monthly Premium for the OPERS Vision plan</b>				
<b>Vision Coverage</b>	<b>Recipient</b>	<b>Spouse</b>	<b>1 Child</b>	<b>2+ Children</b>
High option	\$ 5.42	\$ 5.42	\$ 5.12	\$ 6.27
Low Option	\$ 2.27	\$ 2.27	\$ 1.85	\$ 2.46



***For questions regarding the Aetna Vision Plan, please call Aetna at 1-866-591-1913 or visit [www.aetnavision.com](http://www.aetnavision.com).***

# Aetna Vision Plan



## Your Plan Options

Participants in the Aetna Vision Preferred Plan have two coverage options (High or Low) to choose from. If participating retirees use an Aetna provider, they will have less out of pocket expenses. If participants do not use an Aetna provider they will need to file a claim form and be reimbursed for their expenses.

2011 Vision Coverage	HIGH OPTION		LOW OPTION	
	In-Network Retiree Pays	Out-of-Network Reimbursement to retiree	In-Network Retiree Pays	Out-of-Network Reimbursement to retiree
Comprehensive eye exam	\$0 co-pay	\$65	\$0 co-pay	\$50
Contact lenses exam				
● Standard	\$17 co-pay	\$23	\$32 co-pay	\$8
● Premium	\$62 co-pay	\$23	\$77 co-pay	\$8
Frames	\$0 co-pay up to \$130 retail value, 20% off balance over \$130	\$78	\$5 co-pay up to \$50 retail value, 20% off balance over \$50	\$44
Lenses				
● Single Vision	\$0 co-pay	\$45	\$5 co-pay	\$35
● Bifocals	\$0 co-pay	\$60	\$5 co-pay	\$55
● Trifocals	\$0 co-pay	\$80	\$5 co-pay	\$75
Contact lenses	\$0 co-pay up to \$240 retail value	\$228	\$10 co-pay up to \$200 retail value	\$180
Coverage period for exams	Once per 12 months	Once per 12 months	Once per 12 months	Once per 12 months
*Coverage period for frames & lenses	Once per 12 months	Once per 12 months	Once per 24 months	Once per 24 months

\*Coverage is available for lenses and frames - OR - contact lenses, but not both.

### Value Added Features:

In addition to the vision coverage the Aetna Vision Preferred plan offers, participants also enjoy additional, value-added features including:

- Eye Care Supplies - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor's services or contact lenses).
- Laser Vision Correction - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.
- Replacement Contact Lens Purchases - Visit [www.eyemedcontacts.com](http://www.eyemedcontacts.com) to order replacement contact lenses for shipment to your home at less than retail price.

**For questions regarding the Aetna Vision Plan, please call Aetna at 1-866-591-1913 or visit [www.aetnavision.com](http://www.aetnavision.com).**

# MetLife Dental Plan

Your MetLife Dental Plan provides you and your family with the savings<sup>1</sup> you need, the flexibility you want and the service you can count on. Preventive services typically cost a lot less than fillings, root canals, extractions, etc. And routine exams and cleanings may help prevent the incidence of these higher-cost treatments.

## Highlights of the Plan include:

- Lower costs for covered and non-covered services. With negotiated fees that typically range from 15%-45% less than the average fees for the same or similar services charged by dentists in your area.<sup>2</sup> Negotiated fees apply to in-network services and may apply to services not covered by your plan and those provided after you have exceeded your annual plan maximum.<sup>3</sup>
  - Freedom of choice. To visit any dentist, whether they are in the MetLife network or not. To find out if your dentist participates in the Preferred Dentist Program network of over 137,000 dentist locations, call **1-888-262-4874** or logon to **www.metlife.com/dental**.
1. Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the costs for services received.
  2. 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.
  3. Negotiated fees for non-covered services may not apply in all states. Plans in LA, MS, MT and TX may vary. Please call MetLife for more details.

2011 Monthly Premium for the OPERS Dental plan				
Dental Coverage	Recipient	Spouse	1 Child	2+ Children
High Option	\$28.24	\$28.24	\$20.75	\$29.71
Low Option	\$16.98	\$16.98	\$12.48	\$17.85

## 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. If you need a claim form you can request one by calling **1-888-262-4874**.



*For questions regarding the MetLife Dental plan, visit [www.metlife.com/dental](http://www.metlife.com/dental) or call 1-888-262-4874.*

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.

# MetLife Dental Plan



MetLife Dental Summary	High Option		Low Option	
	Preferred Dentist Program In-Network:	Out-of-Network:	Preferred Dentist Program In-Network:	Out-of-Network:
Diagnostic and Preventive Care Type A: Cleanings, Emergency Care, Fluoride treatment, bitewing x-rays, and Oral examinations	100% of Preferred Dentist Program Fee*	100% of R&C Fee**	100% of Preferred Dentist Program Fee*	80% of R&C Fee**
Oral Surgery and Minor Restoration Type B: Fillings, Simple extractions and Surgical removal of erupted teeth.	80% of Preferred Dentist Program Fee*	65% of R&C Fee**	60% of Preferred Dentist Program Fee*	50% of R&C Fee**
Major Services and Restoration Type C: Prosthodontics, inlays, onlays, crowns, dentures, pontics, and surgical removal of impacted teeth.	50% of Preferred Dentist Program Fee*	35% of R&C Fee**	25% of Preferred Dentist Program Fee*	25% of R&C Fee**
Deductible†:	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	\$0	\$50	\$50	\$50
Family	\$0	\$100	\$50	\$100
Annual Maximum Benefit: Per Person	\$1,500	\$1,500	\$1,500	\$1,500

\* Preferred Dentist Program Fee refers to the fees that participating Preferred Dentist Program dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and plan maximums.

\*\* R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

† Applies to type B and C Services

## Qualifying for health care coverage

As an OPERS benefit recipient, you may only receive primary coverage from one of the five Ohio retirement systems (OPERS, STRS, SERS, OP&F, and OSHPRS). If you or your spouse qualifies for retirement under another Ohio retirement system, you may not waive coverage under that system in order to make OPERS your primary health care coverage. You must continue coverage under the other retirement system, but may elect OPERS as secondary.

If you are eligible for health care coverage from more than one OPERS benefit, you may choose the account that provides the lowest cost, but cannot be covered under more than one account simultaneously.

## Service retirement

If you retire on a service retirement and have worked at least 10 years for an OPERS employer, you can apply for the OPERS health plan at the time you retire. You should know, however, that there are some special limits on service that has been purchased. For example, the 10 years may not include out-of-state or military service purchased after January 29, 1981; service credit given under a retirement incentive plan, or credit purchased after May 4, 1992 for exempt service.

If you choose payment option A, C, D or F, your beneficiary will be eligible for health care coverage (as long as you were eligible for coverage) after your death only if your beneficiary meets the definition of an eligible dependent defined in the Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. See page 14 for information regarding eligible family members.

If you choose Plan B, your beneficiary will not be eligible for health care coverage or a monthly benefit after your death. If you choose Plan E, your beneficiary will be eligible for health care coverage only if your death occurs before the end of the guaranteed period you selected, as long as you were eligible for health care and your beneficiary meets the definition of an eligible dependent. Once the guaranteed period expires, your beneficiary will not be eligible for health care coverage.

You choose your plan of payment at the time of retirement. If you have already retired, you can verify your selection using My Benefits System (MBS) on the OPERS website, [www.opers.org](http://www.opers.org).

Even if you do not qualify for our health plan, you will still be able to apply for our dental, vision, and long-term care plans if you receive a monthly OPERS retirement check.

## Disability Retirement

If you receive a disability check from OPERS, you will be able to join our health plan.

## Survivor Benefits

If you die while you are still working, your dependents who are eligible for a monthly benefit may be able to enroll in our health plan if the recipient of the survivor benefit meets the definition of an eligible dependent as defined in this document.

## Waiving your right to OPERS health care coverage

You may waive your right to health care coverage provided by OPERS. If you do this, you will waive your right to any health, medical, hospital, surgical or prescription coverage. This will be true for your dependents as well. We will not be able to pay claims for you or your family once you have waived our coverage. If you waive health care coverage, you will also be required to waive the Medicare Part B premium reimbursement. The waiver does not include the vision, dental or long-term care plans.

If you waive your OPERS health care coverage, you may cancel your waiver to elect coverage by sending OPERS a health care enrollment application at the following times:

- During our annual open enrollment period for health care (October). In this case, you will be able to enroll in our health plan beginning Jan. 1 of the next year.
- Within 31 days after your health coverage is canceled by another group plan. We will ask for evidence of this cancellation (which must be involuntary on your part) at the time you send us your health care enrollment application. In this case, you can enroll in our health plan on the first of the following month (if we receive your application by the fifteenth of the month). For example, if we receive your health plan application (along with proof that your health plan was involuntarily terminated) on April 12, we will enroll you in our plan effective May 1. If we do not receive your application until April 17, you will not be enrolled in our plan until June 1.

## Eligible Dependents

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

**Their legal spouse** - This must be a person of the opposite gender and they must have a valid marriage certificate recognized by Ohio law.

**Effective Jan. 1, 2011, OPERS will no longer subsidize the monthly health care premium costs for your spouse if he or she is under the age of 55.**

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

**Their child(ren)** - This must be their biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, unemancipated minor child and they are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

In order for a child to be eligible for coverage, the child must be under the age of 26 (regardless of enrollment as a full-time student or marital status). Coverage may be extended if the child is permanently and totally disabled prior to age 22. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment, which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

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

dependents of the deceased retiree or member as defined on this page.

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

## Medicare Coverage

Medicare is a health insurance program for people:

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

In the case of the Humana Medicare Advantage Plan, the payment made by Medicare is combined with Humana's payment. When you or your covered spouse become eligible for Medicare, in most cases, the OPERS health plan will pay after Medicare. It is important that you and your covered spouse apply for Medicare three months (or 90 days) before you reach age 65. If you refuse Medicare coverage because of active employment, you and your covered spouse (if eligible) should enroll before the employer's health plan ends.

OPERS will contact you and your spouse (if he or she is covered under our health plan) before your 65th birthday. We will ask about Medicare coverage at that time. If you or any of your covered dependents become eligible for Medicare before reaching age 65, you must tell OPERS immediately by sending us proof of your Medicare enrollment (a copy of the Medicare card).

**There are three parts of Medicare that apply to OPERS:**

**Medicare Part A** is hospital coverage. You need at least 40 quarters of Social Security credit to be eligible for Medicare Part A coverage at no cost. You may also qualify for Medicare Part A coverage through a spouse's work record. If you do not have enough quarters to receive premium-free Medicare Part A, you must send proof of this (a letter from Social Security) to us. Once this letter is received, your OPERS health plan will provide substitute coverage for Medicare Part A. Centers for Medicare and Medicaid Services (CMS) regulations do not allow us to enroll retirees in some HMOs if they are not eligible for free Medicare Part A.

## Medicare Coverage (continued)

**Medicare Part B** is medical coverage. Everyone is eligible to enroll in Medicare Part B once they have reached age 65 (or have a qualifying illness or disability, as discussed above). **You must enroll in Medicare Part B when it is first offered. If you do not sign up, refuse or stop your Medicare Part B enrollment, we still consider you to be eligible for Medicare Part B.** You will still be considered eligible for Medicare Part B if you refuse coverage because you are covered by an employer's plan. The OPERS health plan will estimate what Medicare would have paid and will subtract that amount from total charges before making a payment. In this case you would be responsible for the amount that would have been paid by Medicare Part B. If you or your covered dependents do not enroll in the Medicare Part B program when it is first offered, you cannot be enrolled in an HMO or in the Humana Medicare Advantage Plan.

**Medicare Part D** is prescription drug coverage. OPERS provides a Medicare Part D Plan for Medicare-eligible retirees administered by Express Scripts.

### If you become Medicare eligible prior to age 65

Retirees becoming eligible for Medicare before age 65 must notify OPERS immediately. If they refuse or fail to enroll in Medicare when eligible, the OPERS health care plan will not make up the difference of what Medicare would have paid if they had enrolled. In other words, retirees will be uninsured for a large portion of medical expenses if they fail to enroll in Medicare Parts A and B once eligible. Also, retirees eligible for Medicare B who do not enroll or fail to pay Medicare B premiums to the Center for Medicare and Medicaid Services (CMS) will be responsible for the amount OPERS has paid to them for their Medicare B premiums.

## Medicare B Reimbursement

Retirees with OPERS health care may be eligible to receive reimbursement of all or a portion of their Medicare Part B premium. The OPERS Board sets the Medicare Part B premium reimbursement amount annually not to be less than \$96.40 per month. Based on when you begin receiving Medicare Part B and/or your adjusted gross income, you may pay more than the reimbursement amount allows.

According to Medicare guidelines, members who get Medicare Part B beginning January 1, 2010 or later (new enrollees) will pay an increased premium. Members with annual incomes above \$85,000 (individual tax return) or \$170,000 (joint tax return) will pay an increased premium; in these cases, you will not be reimbursed the full amount of your Medicare Part B premium.

If your monthly Medicare Part B premium is less than the reimbursement amount set by the board, OPERS will only reimburse up to the amount paid for coverage.

Before receiving the Medicare Part B premium reimbursement, proof of enrollment and a signed statement indicating that you are not receiving reimbursement from another source must be received by OPERS. OPERS will not provide this reimbursement if you receive reimbursement or partial reimbursement from another source. It is your responsibility to report to OPERS any amount you receive from another source. If you terminate your Medicare Part B coverage or if you begin receiving reimbursement from another source for your Medicare Part B premium, you must notify OPERS immediately.

OPERS does not provide Medicare Part B reimbursement benefit to spouses or dependents.

## The Medicare Direct Program

If you are enrolled in the Medical Mutual PPO Plan and are also covered by Medicare, our Medicare Direct program will make medical claim filing easier. If you enroll in this program, Medicare will consider your medical claim and then send information directly to Medical Mutual.

Your Medicare Summary Notice will advise you when Medicare begins to forward your claims information to the Medical Mutual Plan. Once Medicare has forwarded your claim information to your health plan, you do not have to file the claim with your plan. Once you are enrolled in this program, it is very important that you notify OPERS if your name and/or Medicare claim number changes. You are only eligible to enroll in this program if the OPERS plan is your secondary coverage after Medicare. You and your covered spouse may enroll in this program at any time, and there is no cost for this service. This program does not apply to the Humana Medicare Advantage Plan.

## Other important facts to know

### When your health care coverage begins

Health care coverage will begin on your benefit effective date but not more than one year from the date OPERS receives your health care application (HC-1). You may delay your enrollment no more than 60 days after the release of your first benefit payment.

### Enrolling eligible family members in the medical/pharmacy plan outside of open enrollment

After you begin receiving benefit payments, you may only enroll your eligible family members if you have experienced a life change (which we call a “qualifying event”). A qualifying event can be a new marriage or a new child because of birth or adoption or 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 will not be able to enroll the eligible family members until the next open enrollment period. OPERS needs 31 days to process the application once we receive it. The effective date of your family member’s coverage will be the first day of the next month (after the 31 days are up). If you enroll a new dependent in our health care plan, he or she will be placed into the same level of coverage that you have selected for yourself.

### Terminating dependents from the medical/pharmacy plan

You must notify OPERS immediately if your covered spouse and/or children become ineligible for coverage due to divorce/dissolution, death or if a child fails to meet eligibility requirements. OPERS will require that you provide a certified copy of your divorce/dissolution decree or your spouse’s or child’s death certificate. If a child fails to meet the eligibility requirements, OPERS requires notification from you indicating the child’s last date of eligibility. If you fail to notify OPERS that a family member is no longer eligible, overpayment of health care or prescription claims could occur and unnecessary premiums could be taken from your benefit check.

You may terminate your spouse and/or children’s coverage under the OPERS health care plan at any time during the year for any other reason. However, you must provide OPERS with a written request to terminate

coverage or you may contact OPERS for a dependent cancellation form. OPERS will terminate your spouse’s and/or children’s medical/pharmacy coverage within 31 days of your written request or completed cancellation form.

If you are enrolled in the Kaiser Permanente plan and wish to terminate your spouse’s coverage, Kaiser Permanente will require you and your spouse’s signature to terminate coverage. You must contact OPERS for the appropriate dependent cancellation form. OPERS will terminate your spouse’s coverage within 31 days of receiving your completed cancellation form.

### Open Enrollment

Open enrollment is held each year during the month of October. We will send you information about your health care choices and costs each year, as open enrollment approaches. Please be sure to read the material carefully, as premiums and plan features often change from year to year.

### Re-employment

As governed by O.R.C. 145.38, if you go back to work in an OPERS-covered position, you must enroll in your employer’s health plan if the employer offers a health plan to other employees in similar positions to yours. You cannot waive your employer’s plan unless you have other health coverage that will pay first, before the OPERS health plan. **If your employer offers health coverage and you do not enroll in it, your OPERS health coverage will be reduced by the amount that would have been covered by your employer’s plan.**

Federal law prohibits you from being covered by the OPERS health care plan as secondary coverage if you are enrolled in a high deductible health plan (HDHP) and a health savings account (HSA).

You do not have to provide coverage for your dependents under your employer’s health plan but you must have coverage in order to provide coverage for dependents. OPERS will not provide you or your eligible dependents health care coverage during a suspension or forfeiture of your retirement allowance.

## Other important facts to know *(continued)*

### Important things to remember after coverage begins

- Identification cards will automatically be sent to you by your plan administrator once your first monthly benefit has been released. Please contact your administrator if you need additional identification cards.
- If you are enrolled in the Kaiser Permanente plan and move outside of the service area, you must contact OPERS immediately to change your health plan.
- If you and/or your spouse are enrolled in the Medicare Direct program, be sure to contact OPERS if your Medicare claim number or name changes with Social Security.

### Income Based Discount Program

The OPERS Income Based Discount Program is designed to help qualified benefit recipients pay for their participation in the OPERS Medical/Pharmacy plan. This program provides a 30 percent reduction in the premium amount you pay each month for medical/pharmacy coverage if your 2009 household income was equal to or less than 150 percent of the federal poverty level. Household income includes all income and wages you earned, plus the income and wages of your spouse and any dependent(s) you claimed on your 2009 federal income tax return.

If you feel that you qualify, you must contact OPERS to receive an *Income Based Discount Program Application*. This form can also be found on the OPERS Web site, [www.opers.org](http://www.opers.org). Complete and return this application along with a copy of your 2009 filed federal tax return. If you and your dependents filed separate returns, you must also include your dependent's 2009 federal tax return(s). Be sure to keep a copy of your application. OPERS will retain this original application and the copies of your tax return(s).

Please remember that this program applies to medical/pharmacy premiums only. Premium costs for dental, vision or long-term care do not qualify.

### Long-Term Care Plan

OPERS offers retirees access to a Long-Term Care Plan through Prudential. The plan is designed to help retirees pay for the costs of care in a nursing home, rehabilitation center or assisted-living facility.

All applicants are subject to medical underwriting. Call the Prudential Long-Term Care member service telephone number, **1-877-893-3367**, for complete details.

### What Is Long-Term Care?

- Long-term care consists of a wide range of personal care, health care and social services for people of all ages who can no longer care for themselves.
- It provides help with usual activities of daily living such as dressing and walking and is often called custodial care.
- It is not just nursing home care, nor is it just for the elderly, although as people age they become more likely to need this type of care.

### Qualifying For Coverage

To be eligible for coverage, the insured person must first suffer a "qualifying loss" after coverage is effective. This loss must result in the need for continual human assistance in at least two of the following five Activities of Daily Living (ADLs):

- Eating
- Dressing
- Bathing/hygiene
- Transferring (getting in and out of bed or chairs)
- Toileting

### A qualifying loss can be caused in two ways:

- By an injury, illness or the effects of aging which makes one physically incapable of performing activities of daily living, or
- By a diagnosed mental impairment, such as Alzheimer's disease, which makes one mentally incapable of performing activities of daily living

# OPERS Wellness Incentive Programs

Actively engaging in the improvement of your health has never been easier - or more rewarding. Retirees and their covered spouses can each earn up to a \$100 deposit into their Retiree Medical Account (RMA) by participating in the OPERS personal health management program. Retirees are eligible to earn \$50 for each of the following activities depending on Medicare status and health plan (up to a maximum of \$100 per year):

- Complete a Health Assessment
- Undergo an annual physical exam
- Complete a Wellness Program
- Successfully participate in a Disease Management Program

Programs vary for those retirees participating in the Humana Medicare Advantage Plan and those participating in the Medical Mutual PPO Plan. **Please call or visit your plan administrator's website for more information, instructions for enrollment and specific completion criteria.**

**Wellness Programs** - participating in a wellness program will help you address specific lifestyle risks and improve your overall health.

## Humana

1-877-890-4777, [www.humana.com/opers](http://www.humana.com/opers)

wellness programs include:

- Smoking Cessation
- Weight Management
- Stress
- Nutrition
- Back Care

## Medical Mutual

1-877-520-6728, [www.medmutual.com](http://www.medmutual.com)

lifestyle coaching programs are six-month programs addressing all lifestyle risks including:

- Tobacco Use Cessation
- Weight Loss & Management
- Exercise
- Nutrition
- Stress

**Disease Management Programs** - participating in a disease management program will help you manage your care for chronic and sometimes life-threatening conditions.

## Humana Disease Management Programs

- COPD - Chronic Obstructive Pulmonary Disease
- Diabetes
- CAD - Coronary Artery Disease
- CHF- Congestive Heart Failure
- ESRD - End Stage Renal Disease
- Rare Diseases (For example: Parkinson's, ALS)

## Medical Mutual Disease Management Programs

- Diabetes
- CAD - Coronary Artery Disease
- Chronic Pain
- Depression
- COPD - Chronic Obstructive Pulmonary Disease
- Asthma
- CHF- Congestive Heart Failure

**New in 2011:** Retirees and eligible dependents with diabetes participating in the Medical Mutual Disease Management Program can receive 100% coverage for diabetes medications and testing supplies.

## Questions?

Questions regarding the wellness and disease management programs and their requirements should be directed to your medical plan administrator (Humana or Medical Mutual). Questions regarding your RMA account and deposits\*, please visit [www.opers.org](http://www.opers.org).

*\*Note: Please allow up to 8 weeks following your achievement of eligibility for an incentive for the appropriate deposit to be made into your RMA account.*

## Medical Mutual health assessments available online

Getting on the path to improved health is now even more convenient. Plan participants can complete a Medical Mutual health assessment online. Completing an assessment is the first step in participating in a personal health management program. And, you can earn a \$50 deposit into your RMA just for completing it.

Online health assessments can be found at [www.medmutual.com](http://www.medmutual.com). Log on, complete an assessment and be on your way to a healthier you!

# Retiree Medical Account (RMA)

## Retiree Medical Account (RMA)

If you participate in an OPERS wellness management program (see page 17) or if the medical plan, dental and vision options you select have a total monthly cost that is less than your monthly health care subsidy from OPERS, you will receive a deposit into a Retiree Medical Account (RMA). **Retirees who choose the Enhanced Plan or participate in the Humana Medicare Advantage Plan will not have an RMA deposit unless a health assessment or wellness program is completed.**

## How does the RMA work?

The RMA is not a comprehensive health care insurance plan. Instead, it is an account you can use to obtain reimbursement for qualified health care expenses. Since the money may only be used to pay qualified health care expenses, your distributions from the RMA are not subject to federal income taxes. You may submit expenses you incur such as deductibles, out of pocket co-payments, or many other qualified health care expenses not otherwise covered by insurance plans.

## What are qualified health care expenses?

The RMA allows for a very broad range of expenses that qualify for payment. Many things not covered by traditional insurance plans will meet the standard for payment. In most cases, qualified health care expenses include medical, dental, and vision expenses normally allowed by the Internal Revenue Service (IRS) as deductions on your tax return. Medical expenses may include the premiums (post-tax) you pay for health insurance under the OPERS health care program, deductibles, co-payments, premiums for spouses and many medical services. They also can include limited amounts paid for any qualified long-term care insurance contract. For more specific information, please contact Aetna for a complete listing of the medical expenses that may be reimbursed if you have available funds in the RMA. **Note: The OPERS RMA will reimburse for premiums you pay for OPERS coverage that are automatically withheld from your benefit payments on a post-tax basis.**

## How will I keep track of my account?

OPERS has partnered with Aetna to provide the administrative services for the RMA. Aetna is responsible for maintaining a record of the balance in your RMA. They will track contributions, interest, and your reimbursements, and will provide you with regular written statements, mailed to your home address, regarding the status of your account. While you are contributing to your RMA, Aetna will provide you with an annual statement of the vested account balance during the second quarter of the year. After you begin receiving reimbursements from the RMA, you will receive quarterly statements. In addition, you will receive an Explanation of Payment in any month a disbursement occurs.

## How do I file a claim?

Aetna provides claim forms. You complete the claim form, attach supporting proof that you have paid for the claimed expense, and if approved, Aetna will reimburse you from your RMA.

## Can I cover my dependents' health care expenses with my RMA funds?

You may use your RMA to pay health care expenses for your qualified dependents as defined by OPERS.

## Will my beneficiary's health care expenses be covered with my RMA funds?

If you die while contributing or while receiving a payment, your beneficiary may use the remaining vested portion of your RMA account for the payment of qualified health care expenses. Your RMA beneficiary must be a qualified dependent under IRS guidelines.



**For questions regarding Retiree Medical Accounts administered by Aetna, visit [www.aetna.com](http://www.aetna.com) or call 1-888-672-9136.**

# OPERS Health Care Plan

## Required Supplemental Documents

### ***INSIDE:***

#### **General Notice of COBRA Continuation Coverage Rights**

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

#### **Notice of Medical Privacy Practices**

For Medicare-eligible retirees

For retirees not eligible for Medicare

#### **Medicare D Notice of Creditable Coverage**

For Medicare-eligible retirees who are not enrolled in the OPERS Medicare Part D prescription drug plan

*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 \*\*

### 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.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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.

### 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, 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. 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 or legally separated 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."

### 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 or legal separation 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.

**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.**

### 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 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 that generally lasts for up to a total of 36 months.

### 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 or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA'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.

### Plan Contact Information

Carrie Estep (COBRA Administrator) at Benefit Services  
1-800-367-3762 extension 14533.

# Notice of Medical Privacy Practices for Medicare-eligible retirees

**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.**

This Notice of Privacy Practices applies to the health care coverage ("Plan") offered by the Ohio Public Employees Retirement System ("OPERS") to certain individuals who are eligible to receive benefits from OPERS and their dependents. The Plan includes a Medicare Advantage Plan offered to Medicare eligible individuals, which is fully insured by Humana. If you are enrolled in the Medicare Advantage Plan, you will also receive a separate notice of privacy practices from Humana, which will apply to your personal health information maintained by Humana under the Medicare Advantage Plan.

The Plan is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Privacy Regulations adopted under the Act to maintain the privacy of personal health information of individuals enrolled in the Plan, and 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. In addition, copies may be obtained by mailing a request to Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202.

## **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.

**Disclosures for Treatment.** We will make disclosures of your personal health information as necessary for your treatment. For instance, 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 for Payment.** 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, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health coverage plan. 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, utilization review and management, quality improvement

and assurance, enrollment, compliance, auditing, and other functions related to your health coverage 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 relationship with you.

**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 state law, we are 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.

**Business Associates.** Certain aspects and components of the Plan's services are performed through contracts with outside persons or organizations, such as medical claims processing and Plan administration, auditing, actuarial services, legal services, etc. At times it may be necessary for us to provide certain of your 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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202.

**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. For example, we may use your personal health information to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you manage your illness better is available to you as an enrollee of the Plan. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

# Notice of Medical Privacy Practices for Medicare-eligible retirees *(continued)*

**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.

**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.

- 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 for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- 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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202.

**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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202.

## 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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202.

## 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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202. . 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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202.

**Complaints.** If you believe your privacy rights have been violated, you can file a complaint in writing with Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202. 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 Humana Privacy Office at P.O. Box 1438, Louisville, KY, 40202. 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.

## EFFECTIVE DATE

This Notice of Privacy Practices is revised as of August 2010.

# Notice of Medical Privacy Practices for Non-Medicare retirees

**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.**

This Notice of Privacy Practices applies to the health plan ("Plan") offered by the Ohio Public Employees Retirement System ("OPERS") to certain individuals who are eligible to receive benefits from OPERS, and their dependents. Medical coverage under the Plan is self-insured by OPERS. However, dental and vision coverage under the Plan are fully insured. If you are enrolled in the Plan for dental or vision coverage, you will also receive a separate 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 is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Privacy Regulations adopted under the Act to maintain the privacy of personal health information of individuals enrolled in the Plan, and 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.

**Disclosures for Treatment.** We will make disclosures of your personal health information as necessary for your treatment. For instance, 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 for Payment.** 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, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health coverage plan. 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, utilization review and management, quality improvement

and assurance, enrollment, compliance, auditing, and other functions related to your health coverage 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 relationship with you.

**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 state law, we are 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.

**Business Associates.** Certain aspects and components of the Plan's services are performed through contracts with outside persons or organizations, such as medical claims processing and Plan administration, auditing, actuarial services, legal services, etc. At times it may be necessary for us to provide certain of your 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.

**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. For example, we may use your personal health information to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you manage your illness better is available to you as an enrollee of the Plan. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

# Notice of Medical Privacy Practices for Non-Medicare retirees *(continued)*

**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.

**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.

- 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 for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- 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 OPERS Privacy Officer, 277 E. Town Street, Columbus, OH 43215.

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

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

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

**Complaints.** If you believe your privacy rights have been violated, you can file a complaint in writing with 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.

## EFFECTIVE DATE

This Notice of Privacy Practices is revised as of August 2010.

# Medicare Part D

## Notice of Creditable Coverage

for Medicare-eligible retirees who are not enrolled in the OPERS Medicare Part D Plan

### Notice of Creditable Coverage

*This notice is being provided to you by Ohio PERS as required by Medicare. It requires no immediate action on your part. It provides certain protection to you should you wish to enroll in a Medicare prescription plan in the future in place of your Ohio PERS prescription plan. 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 OPERS and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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 the OPERS Express Scripts plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

*Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.*

2011 Non-Medicare Prescription Plan	Enhanced	Intermediate	Basic
Deductible (Calendar year)	\$50 annual deductible for brand medications	\$50 annual deductible for brand medications	\$550 individual \$1100 family
Generic	\$4 Retail copay \$10 Mail copay	\$6 Retail copay \$15 Mail copay	35% co-insurance \$6 retail minimum \$15 mail minimum
Formulary Brand	30% Retail co-insurance (\$30 min/\$60 max) \$75 Mail copay	35% Retail co-insurance (\$40 min/\$75 max) \$125 Mail copay	35% co-insurance \$40 retail minimum \$100 mail minimum
Non-Formulary Brand	40% Retail co-insurance (\$75 min/\$150 max) \$187.50 Mail copay	40% Retail co-insurance (\$75 min/\$150 max) \$200 Mail copay	50% co-insurance \$75 retail minimum \$187.50 mail minimum
Annual Out-of-Pocket Maximum (100% coverage after \$4300 has been spent in co-pays/co-insurance)	\$4300	\$4300	None

# Medicare Part D

## Notice of Creditable Coverage *(continued)*

You should also know that if you drop or lose your coverage with Ohio PERS and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

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

Contact our office for further information. **NOTE:** You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Express Scripts changes. You also may request a copy.

### **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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see 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.

For people with 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 [www.socialsecurity.gov](http://www.socialsecurity.gov), or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 amount.

---

Date:	May 15, 2006
Name of Entity/Sender:	Ohio Public Employees Retirement System
Address:	277 E. Town Street, Columbus, OH 43215
Phone Number:	1-800-222-7377

---

## **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, and miscellaneous employees, and retirees); 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 OPERS Board members, please visit [www.opers.org](http://www.opers.org)**

***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 booklet 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.*



Ohio Public Employees  
Retirement System  
277 East Town Street  
Columbus, OH 43215-4642