

2021

Vision and Dental Plan Guide

for benefit recipients of the Ohio Public Employees Retirement System



Eligibility and Enrollment

Anyone receiving a pension benefit qualifies for OPERS vision and dental coverage, even if you don't qualify for medical or prescription drug coverage. You may also enroll:

- **A spouse** — must have a valid marriage certificate.
- **Child(ren)** — must be a participant's biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, unemancipated minor child and you are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19. The child must be under the age of 26 regardless of enrollment as a full-time student or marital status. For the 2021 plan year only, coverage may be extended beyond the age of 26 if the child is permanently and totally disabled prior to age 22.

If you are in the OPERS health care plan and receive a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member, you may only enroll those dependents who would have been eligible dependents of the deceased retiree or member as defined on this page. It is your responsibility to notify OPERS, in writing, within 30 days of the date your dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid health care claims or reimbursement for which you will be responsible to repay.

When Can I Enroll in the Vision and/or Dental Plan?

You may enroll only when you first retire or during the annual open enrollment period. After you enroll, you and your family members must stay enrolled until the next open enrollment period unless you have a change in family status, including a divorce, death or a child reaches age 26. You must notify OPERS immediately if you have a change in family status.

When Can I Enroll New Family Members?

You may enroll newly eligible family members within 60 days of the date they become eligible (such as the date of marriage or birth). You can complete the enrollment form at the end of this booklet or contact OPERS to request a copy of the form. Complete and return the enrollment form and the required documentation to OPERS within 60 days.

How Will Premiums Be Paid?

Your premium cost for the plan(s) you select will be deducted from your benefit payment each month. If you are a Medicare participant receiving a monthly HRA deposit, your premiums will be automatically reimbursed monthly from your HRA account in 2021. If you do not wish to have your premiums automatically reimbursed, you can contact OPERS by phone to opt out. The change will take effect the following month.

Aetna Vision Plan

Aetna Vision Preferred, administered by EyeMed, is available to you and your eligible dependents. If you choose to enroll in the vision plan, you'll be responsible for paying the entire premium for this coverage and you will remain enrolled for the full year. Once enrolled, changes can only be made during the next open enrollment period.

Plan Feature Highlights

- **A comprehensive eye exam.** Not only can eye exams detect serious vision conditions such as cataracts and glaucoma, but also the early signs of diabetes, high blood pressure and other health conditions.
 - **Savings of approximately 40 percent** on eye exams and eyewear.
 - **Your choice of leading optical retailers** and private practitioners include, LensCrafters, Target Optical and Pearle Vision locations.
 - **Freedom to use any provider.** You can also visit any licensed eye care provider outside the network. Keep in mind that you may pay more out of pocket and may have to file your own claims.
 - **Digital tools.** You can search for providers, manage your benefits and view your ID card on Aetna's mobile app or by visiting aetnavision.com. Search providers by name, location or even by the brand name of the frames you want.
- **Shop online** for contacts or glasses online with retailers in Aetna's network. Your vision benefits will automatically apply when you check out.

Discounts and savings

You can find discounts on products and services through in-network providers. These discounts include:

- 20 percent off any balance over your frame allowance
- 15 percent off any balance over your conventional contact lens allowance
- Up to 40 percent off extra pairs of prescription eyeglasses and sunglasses
- Up to 20 percent off noncovered items, including nonprescription sunglasses and lens extras/add-ons like antireflective coatings
- Up to 15 percent off the retail price or 5 percent off the promotional price for LASIK laser eye surgery or photorefractive keratectomy from U.S. Laser Network
- Discounts on LASIK surgery through QualSight
- 40 percent off hearing exams and special pricing on hearing aids

aetna[®]

Website: aetnavision.com

Phone: 1-866-591-1913



Aetna Vision Plan

2021 Monthly Premium for the OPERS Vision plan

Vision Coverage	Recipient	Spouse	Per Child
High option	\$5.98	\$5.98	\$4.63
Low Option	\$2.51	\$2.51	\$1.75

2021 Vision Coverage

Coverage type	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 copay	\$65	\$0 copay	\$50
Contact lens fit & follow-up				
<ul style="list-style-type: none"> Standard 	\$17 copay	\$23	\$32 copay	\$8
<ul style="list-style-type: none"> Premium 	\$62 copay	\$23	\$77 copay	\$8
Frames	\$0 copay up to \$140 retail value, 80% of balance over \$140	\$78	\$0 copay up to \$50 retail value, 80% of balance over \$50	\$44
Lenses				
<ul style="list-style-type: none"> Single Vision 	\$0 copay	\$45	\$5 copay	\$35
<ul style="list-style-type: none"> Bifocals 	\$0 copay	\$60	\$5 copay	\$55
<ul style="list-style-type: none"> Trifocals 	\$0 copay	\$80	\$5 copay	\$75
<ul style="list-style-type: none"> Most premium progressives 	\$85 - \$110 copay	\$60	\$90 - \$115 copay	\$55
Contact lenses	\$0 copay up to \$240 retail value	\$228	\$10 copay up to \$200 retail value	\$180
Coverage period for exams	Once per calendar year	Once per calendar year	Once per calendar year	Once per calendar year
Coverage period for frames and lenses	Once per calendar year	Once per calendar year	Once every two calendar years	Once every two calendar years

Note: Coverage is available for lenses and frames - OR - contact lenses, but not both.



MetLife Dental Plan

Dental coverage administered by MetLife is optional for you and your dependents. If you choose to enroll in a dental plan, you'll be responsible for paying the entire premium for this coverage and will be enrolled for the full year. Once enrolled, changes can only be made during the next open enrollment period.

Choosing a dentist within the MetLife network can help reduce your costs. You can also choose an out-of-network dentist, but your out-of-pocket costs may be higher. There are more than 410,000 participating Preferred Dentist Program dentist locations nationwide, including over 96,000 specialist locations.

Plan Options

You have two dental coverage options to choose from: High or Low. Once enrolled you can view your Certificate of Coverage for additional details. Please visit the MetLife website for coverage details. These certificates explain the dental options available in the High or Low option dental plans.

Claims Details

Network 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, call MetLife at 1-888-262-4874. For questions or a list of preferred dentists, visit metlife.com/mybenefits.

For more detailed coverage information about covered services and limitations, refer to opers.org or call MetLife.

MetLife

Website: metlife.com/mybenefits

Phone: 1-888-262-4874

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

² Negotiated fees for non-covered services may not apply in all states. Plans in LA, MS, MT and TX vary. Please call MetLife for more details.

MetLife Dental Plan

2021 Monthly Premium for the OPERS Dental plan

Dental Coverage	Recipient	Spouse	1 Child
High Option	\$35.38	\$35.38	\$21.02
Low Option	\$20.99	\$20.99	\$12.75

2021 Dental Summary

Coverage type	High Option		Low Option	
	In-Network: Preferred Dentist Program	Out-of-Network:	In-Network: Preferred Dentist Program	Out-of-Network:
Diagnostic and Preventive Care Type A: Cleanings, Emergency Care, Fluoride treatment, bitewing X-rays, and Oral examinations	100% of Negotiated Fee*	100% of R&C Fee**	100% of Negotiated Fee*	80% of R&C Fee**
Oral Surgery and Minor Restoration Type B: Fillings, Simple extractions and Surgical removal of erupted teeth.	80% of Negotiated Fee*	65% of R&C Fee**	60% of Negotiated Fee*	50% of R&C Fee**
Major Services and Restoration Type C: Prosthodontics, inlays, onlays, crowns, dentures, pontics, implants and surgical removal of impacted teeth.	50% of Negotiated Fee*	35% of R&C Fee**	25% of Negotiated Fee*	25% of R&C Fee**
Deductible[†]:				
Individual	\$0	\$50	\$50	\$50
Family	\$0	\$100	\$100	\$100
Annual Maximum Benefit:				
Per Person	\$2,000	\$1,250	\$2,000	\$1,250

Like most group insurance policies, MetLife group policies contain certain exclusions, limitations, exceptions, reductions, waiting periods and terms for keeping them in force. Please contact MetLife for details about costs and coverage. Dental plan underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

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

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

[†] Applies to type B and C Services.

MetLife Dental Plan

High and Low Option

List of Primary Covered Services & Limitations

Diagnostic & Preventive Care - Type A

Procedure	How Many/How Often:
Prophylaxis (cleanings)	Two per calendar year
Oral Examinations	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to 16th Birthday
X-rays	Full mouth X-rays: one per 60 months; Bitewing X-rays: one set per calendar year
Space Maintainers	Space Maintainers for dependent children up to 14th birthday
Sealants	One application of sealant material every 60 months for each nonrestored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday

Oral Surgery & Minor Restorative – Type B

Fillings	As needed
Simple Extractions	As needed
Crown, Denture, and Bridge Repair/ Recementations	As needed
Endodontics	Root canal treatment as needed (excluding molar root canals)
Minor Oral Surgery - Simple extractions and Surgical removal of erupted teeth	As needed
Periodontics	Periodontal scaling and root planing once per quadrant, every 2 years Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year

Major Services and Restorative – Type C

Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the Plan Dentures and bridgework replacement: one every 10 years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns/Inlays/Onlays	Replacement: once every 10 years
Endodontics	Molar root canal treatment as needed
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontal Surgery	Periodontal surgery once per quadrant, every 24 months

The service categories and plan limitations shown above represent an overview of your Plan of Benefits.

This document presents the majority of services within each category, but is not a complete description of the Plan.



Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642

1-800-222-PERS (7377) www.opers.org



Application for Vision and/or Dental Coverage

Enrollment in the Vision and/or Dental Plan must be for the entire 2021 calendar year. Do not complete this form if you do not wish to enroll in, cancel or change your vision and/or dental coverage options.

Section 1 - Personal Information

Provide all personal information in this section.

Member Social Security Number

Beneficiary Social Security Number (if receiving a survivor benefit)

Month Day Year

Date of Birth

First Name

MI Last Name

Street or Mailing Address

City

State

ZIP Code

Section 2 - Spouse and Dependent Children Enrollment

Complete this Section if you wish to enroll your eligible spouse and/or children in the vision or dental plan. In order to ensure that OPERS is providing coverage only to eligible spouses and children, OPERS must confirm that your spouse and children meet the definition of an "eligible dependent" pursuant to Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. Please review the dependent eligibility information on opers.org to determine if your spouse and/or children are eligible dependents. For a spouse, OPERS requires that copies of your marriage certificate and your spouse's birth certificate accompany this form before eligibility for coverage can be verified. For children, OPERS also requires that a copy of each eligible child's birth certificate or decree of adoption accompany this form before eligibility for coverage can be verified. You must certify your spouse and/or your children's eligibility for coverage at the end of this form and notify OPERS within 30 days of any change in their eligibility. You are responsible for any claim overpayments resulting from your failure to notify OPERS that your spouse and/or child has become ineligible for dental or vision coverage.

Spouse First Name

MI Last Name

Date of Birth

Gender

Social Security Number

1. Child First Name

MI Last Name

Date of Birth

Month Day Year

Male Female

Social Security Number

Is this child incapacitated?*

2. Child First Name

MI Last Name

Date of Birth

Month Day Year

Male Female

Social Security Number

Is this child incapacitated?*

**If yes, OPERS will send you an additional form that must be completed before eligibility can be determined.

Please attach another sheet for any additional children and provide all of the information requested above for each child.

Section 3 - Vision and Dental Coverage Enrollment/Change

I elect VISION coverage in the:

High Option Low Option

I elect this VISION coverage for:

Myself Spouse 1 Child 2+ Children

Name of child(ren) being enrolled: _____

I elect DENTAL coverage in the:

High Option Low Option

I elect this DENTAL coverage for:

Myself Spouse 1 Child 2+ Children

Name of child(ren) being enrolled: _____

Section 4 - Vision and Dental Premium Auto Reimbursement Opt-Out

I confirm that I do NOT want the OPERS vision and/or dental premium(s) that are deducted from my monthly benefit payment to be automatically reimbursed from my HRA.

Section 5 - Cancellation of Current Coverage

I elect to cancel the following coverage for myself: Vision Dental

I elect to cancel the following coverage for my spouse: Vision Dental

If you are canceling coverage because your spouse is no longer eligible, please indicate the date of ineligibility _____

I elect to cancel the following coverage for my child(ren): Vision Dental

Name of child(ren): _____

Section 6 - Acknowledgment and Authorization

Please read the following acknowledgment carefully. Sign and date the form before returning it to OPERS.

I authorize the changes to my vision and/or dental coverage that I have indicated on this form. If I am enrolling dependents, I acknowledge that the information provided on this form is true and accurate and the enrolled dependents are eligible for coverage, as defined by Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code. I acknowledge that it is my responsibility to notify OPERS within 30 days of a dependent becoming ineligible for coverage and that I will be responsible for all overpaid claims resulting from my failure to notify OPERS that an enrolled dependent has become ineligible for coverage. I authorize the appropriate premium (if applicable) for the coverage I am requesting, including dependent coverage (if applicable), to be deducted from my OPERS benefit payment. By not opting out and signing below, I authorize Recurring Reimbursement of dental and vision premiums. I confirm that the premiums were for covered participants while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement.

Recipient
Signature _____

Do not print or type name

Today's Date
Month Day Year

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 opers.org.

The plan features within this document are valid only for the 2021 plan year.

This document reflects information as of the date listed herein. There is no promise, guarantee, contract or vested right to access to health care coverage or a premium allowance. The board has the discretion to review, rescind, modify or change the health care plan at any time. This document is written in plain language for use by members of the Ohio Public Employees Retirement System. It is not intended as a substitute for federal or state law, nor will its interpretation prevail should a conflict arise between it and the Ohio Revised Code, Ohio Administrative Code or Internal Revenue Code. If you have questions about this material, please contact our office or seek legal advice from your attorney.



**Ohio Public
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