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School Employees Retirement System of Ohio
300 E. Broad St., Suite 100, Columbus, Ohio 43215-3746
614-222-5853 | Toll-free 800-878-5853 | www.ohsers.org

Revised 3/2020
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<thead>
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<th></th>
</tr>
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<tbody>
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</tr>
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General Information

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Eligibility
Dependent Coverage
Reemployment
Enrollment
Coverage Under More Than One Ohio Retirement System
Waiver and Cancellation
Dental/Vision Enrollment
GENERAL INFORMATION

Introduction

This guide is for future retirees and benefit recipients of the School Employees Retirement System of Ohio (SERS) who may be eligible for SERS' health care coverage. It provides information about current health care coverage and addresses a range of topics. The information in this guide is only an overview of the health care plans that are available and does not provide a complete description of each plan's coverage. When you enroll in SERS' health care coverage, you will receive a summary of benefits.

Coverage can be waived at any time. You can reenroll only if you have a qualifying event. Please see page 4 for more information.

To the extent that resources permit, SERS intends to continue offering access to health care coverage. However, SERS reserves the right to change or discontinue any plan or program at any time. If you have questions or need more details, email us at healthcare@ohsers.org or call us toll-free at 800-878-5853. We are available Monday through Friday, 8 a.m. to 4:30 p.m.

This information is effective January 1, 2020.

Eligibility

Service Retiree

You are eligible for coverage if you have at least 10 years of qualified service credit at retirement. Qualified service credit includes:

- Earned or restored service credit
- Contributing service credit from State Teachers Retirement System of Ohio (STRS), Ohio Public Employees Retirement System (OPERS), Ohio Police & Fire Retirement System (OP&F), Ohio Highway Patrol System (HPRS), and the Cincinnati Retirement System, if it was not earned at the same time as SERS' service credit
- Workers’ Compensation credit

Qualified service credit does not include:

- Military (other than free or interrupted military service credit)
- Federal government, private school, or out-of-state service credit
- Exempted service credit
- Service credit purchased by a school employer under an Early Retirement Incentive Plan (ERI)

Disability Benefit Recipient

If you receive a disability benefit, you are eligible for health care coverage. The effective date of coverage is the later of the following dates:

- The effective date of the disability benefit
- The first day of the month following approval of the disability benefit

A disability benefit recipient enrolling in health care coverage is required to file an application with Social Security for Social Security Disability Insurance (SSDI). This determination establishes your eligibility for Medicare based on a disability when you are under age 65.

SERS will assist you with filing the SSDI application.
To be eligible for health care coverage under a conversion retirement, you must have at least 10 years of qualified service credit, which includes the years you received a disability allowance.

**Dependent Coverage**

When you enroll in SERS’ coverage, you may cover your spouse and children as dependents.

A child includes:
- A biological or legally adopted child, stepchild, or child for whom you have legal custody, up to age 26.
- A child, regardless of age, who is permanently and totally disabled, if the disability existed prior to the child reaching age 26.
  - “Permanently and totally disabled” means the child is unable to engage in any substantial gainful activity due to physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of at least 12 months.

If you want to enroll your spouse, you must provide your spouse’s Social Security number, and copies of his or her birth certificate, and your marriage certificate. To enroll dependent children, you must provide the Social Security number, and a copy of the birth certificate or legal custody papers, if applicable, for each child.

If you are enrolling a disabled child, contact SERS’ Health Care Department toll-free at 800-878-5853 for additional forms that may need to be completed.

Service retirees must select a Joint Survivor payment plan A, C, D, or F to provide continuing access to coverage for qualified dependents in the event of the retiree’s death.

**Reemployment**

If you retire and then take a new job or go back to work for a public or private employer, you may temporarily lose eligibility for SERS’ health care coverage while you are reemployed. Once reemployment ends, your eligibility will be restored.

Individuals affected are those:
- Under age 65 not yet eligible for Medicare
- Eligible for Medicare but not enrolled in Part B

Individuals not affected are those:
- Enrolled in Medicare Part A and B
- Enrolled in Medicare Part B only

SERS’ health care eligibility is lost when:
- You are eligible for medical and prescription coverage through your new employer, or
- You are not eligible for medical and prescription coverage through your new employer but other employees in comparable positions are eligible for coverage. The coverage available to employees in comparable positions must be at the same cost as full-time employees.

You will not lose your eligibility for SERS’ coverage if you do not have access to the employer coverage or it costs employees in comparable positions more than full-time employees pay.

Q. Can my spouse be covered by SERS’ health care coverage if I pass away?

A. Yes. If you selected one of the Joint Survivor payment plans (Plans A, C, D, or F) with your spouse as beneficiary, your spouse will be eligible for health care coverage.
Termination of Eligibility

If you are affected by this rule, you will be notified of the date your SERS health care coverage is terminated. Because you must be enrolled in SERS' coverage in order to enroll your spouse and dependents, termination of your eligibility may affect their coverage.

Regaining Eligibility

Your eligibility for SERS' health care coverage will be restored after you stop working. You will have 31 days after you lose employer coverage to enroll in SERS coverage.

Dependent Coverage

This rule also applies to your spouse. If your spouse has SERS' health care coverage, and is or becomes eligible for employer coverage, your spouse will lose eligibility for SERS' coverage. Your eligibility will not be affected by your spouse's loss of coverage.

If your child has SERS' coverage and is or becomes eligible for employer coverage, that child will not lose SERS' coverage. Federal law provides that coverage may continue to age 26, regardless of the child's employment or eligibility for employer coverage.

Please notify SERS if you or your spouse become employed.

Questions: If you have questions on whether this rule affects you, please call SERS toll-free at 800-878-5853.

Enrollment

There are three times when you can enroll in SERS' coverage:

- When you retire or begin receiving a disability benefit
- Within 90 days of becoming eligible for Medicare
- Within 31 days of involuntary termination of other health care coverage or termination of Medicaid
  - Failing to pay the premium or ending coverage because of plan changes does not count as involuntary termination.

If you do not enroll your spouse or children when you enroll, you can enroll them under the following circumstances:

- Within 31 days of marriage
- Within 31 days of the birth, adoption, or custody of a child
- Within 90 days of the dependent becoming eligible for Medicare
- Within 31 days of involuntary termination of other coverage or termination of Medicaid
  - Failing to pay the premium or ending coverage because of plan changes does not count as involuntary termination.

Q. Once I retire, can I ever change my SERS health care plan?

A. Yes. During open enrollment each year, you can change your current plan selection if other SERS plans are available in your area. SERS' Open Enrollment is usually held in the fall.
Coverage Under More Than One Ohio Retirement System

When you retire from SERS, you cannot waive (decline) SERS’ health care coverage in order to enroll in coverage through another Ohio public retirement system. Your primary coverage must be through the retirement system from which you retire. This also applies to spouses and dependents.

Waiver and Cancellation

You can waive coverage at any time. If you choose to waive coverage, dependent coverage for your spouse and children will automatically end. If you waive coverage, you can re-enroll under the following qualifying events:

- Within 90 days of becoming eligible for Medicare
- Within 31 days of an involuntary termination of other coverage or termination of Medicaid.
  - Failing to pay premiums or ending coverage because of plan changes does not count as involuntary termination.

Cancellation of Spouse/Dependent Coverage

To cancel coverage for one or more dependents, you must send a written request to SERS. Both you and your spouse must sign the cancellation request if the cancellation is for your spouse.

Dental/Vision Enrollment

To sign up for dental and/or vision coverage, you have to be eligible for, but you do not have to be enrolled in, SERS’ health care coverage.

You must enroll in dental/vision coverage in order to enroll your spouse and/or children. SERS offers dental and vision coverage through Delta Dental of Ohio and VSP Vision Care.

You can enroll in dental and/or vision coverage at the following times:

- When you retire or begin receiving a disability benefit
- At the time you enroll in SERS’ medical and prescription drug coverage
- Within 31 days of involuntary termination of another dental or vision plan
- During the annual open enrollment period

See pages 32-33 for monthly premiums and benefits.

Q. I will be eligible for SERS’ health care coverage, but I plan to enroll in my spouse’s employer plan until my spouse retires. Will I be able to enroll in SERS’ coverage later?

A. Yes. Once your spouse’s employment or coverage ends, you and your spouse have 31 days to enroll in SERS’ health care coverage.

Q. When will I get my identification cards?

A. Your plan identification cards arrive in the mail approximately 7 to 10 days before your plan takes effect. VSP does not issue ID cards. If your vision provider accepts VSP, it will file any claims for you. If it does not, you will need to submit a VSP manual claims form.
Non-Medicare Coverage

Premiums
Premium Subsidy
2020 Non-Medicare Premiums and Plan Availability
Another Non-Medicare Coverage Option
Non-Medicare Plan Coverage
NON-MEDICARE COVERAGE

The following information is for those under age 65 and not eligible for Medicare coverage.

**Premiums**

The premium you pay for SERS’ health care coverage includes medical and prescription drug coverage.

Premiums are based on:

- Years of qualified service credit
- Eligibility for a premium subsidy
- Health care plan selected

If you enroll in dental and/or vision coverage, you will be charged additional premiums.

SERS automatically deducts the premiums for you and any dependents from your pension.

If your pension is not enough to cover your premiums, you will be responsible for the remaining balance. SERS mails you a bill each month, which can be paid by check or money order, or automatically deducted from your bank account.

If monthly premiums are not paid, SERS’ health care coverage will be cancelled.

**Premium Subsidy**

SERS helps reduce health care premiums by providing a subsidy to those who qualify. To receive a premium subsidy, you must have at least 20 years of qualified service credit, or be receiving a disability benefit. In addition, at the time of retirement or separation from service, you must:

- Be eligible to participate in the health care plan of your last school employer, or
- Have been eligible to participate in the health care plan of your last school employer at least three of the last five years of service

If you are eligible for your employer’s health care coverage but are a few years short of 20 years, it may be beneficial to work until you have 20 qualified years of service.

Spouse premium is based on the qualified service credit of the service retiree or disability recipient.

The chart on page 9 lists the non-Medicare premiums for 2020.
### 2020 Non-Medicare Premiums and Plan Availability

#### Service Retirees

<table>
<thead>
<tr>
<th>YEARS OF QUALIFIED SERVICE CREDIT</th>
<th>Aetna Choice POS II</th>
<th>AultCare PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19.999 years*</td>
<td>$1,282</td>
<td>$1,113</td>
</tr>
<tr>
<td>20-24.999 years</td>
<td>$659</td>
<td>$574</td>
</tr>
<tr>
<td>25-29.999 years</td>
<td>$409</td>
<td>$358</td>
</tr>
<tr>
<td>30-34.999 years</td>
<td>$284</td>
<td>$251</td>
</tr>
<tr>
<td>35-35.999 years</td>
<td>$222</td>
<td>$197</td>
</tr>
</tbody>
</table>

* This is the full premium without a premium subsidy. If you do not qualify for a subsidy (see page 8), you pay this amount regardless of your qualified years of service. There is a 1% premium reduction for each year over 35 years of service.

#### Disability Benefit Recipients

<table>
<thead>
<tr>
<th>YEARS OF QUALIFIED SERVICE CREDIT</th>
<th>Aetna Choice POS II</th>
<th>AultCare PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full premium without a premium subsidy**</td>
<td>$1,282</td>
<td>$1,113</td>
</tr>
<tr>
<td>5-9.99 years</td>
<td>$659</td>
<td>$574</td>
</tr>
<tr>
<td>10-24.999 years</td>
<td>$447</td>
<td>$391</td>
</tr>
<tr>
<td>25 years and over</td>
<td>$253</td>
<td>$224</td>
</tr>
</tbody>
</table>

** This is the full premium without a premium subsidy. If you do not qualify for a subsidy (see page 8), you pay this amount regardless of your qualified years of service.

#### Spouse / Children

<table>
<thead>
<tr>
<th>Spouse premium based on the service retiree, disability, or member’s qualified service credit</th>
<th>Aetna Choice POS II</th>
<th>AultCare PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse up to 24.999 years</td>
<td>$1,032</td>
<td>$896</td>
</tr>
<tr>
<td>25-29.999 years</td>
<td>$932</td>
<td>$810</td>
</tr>
<tr>
<td>30 years and over</td>
<td>$833</td>
<td>$724</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$253</td>
<td>$168</td>
</tr>
</tbody>
</table>

### Non-Medicare Plan Availability

**Aetna Choice POS II**

is available throughout the United States.

**AultCare PPO**

is available in the following Ohio counties:

- Ashland
- Belmont
- Carroll
- Columbiana
- Coshocton
- Guernsey
- Harrison
- Holmes
- Jefferson
- Knox
- Mahoning
- Medina
- Portage
- Richland
- Stark
- Summit
- Tuscarawas
- Wayne
Another Non-Medicare Coverage Option

SERS offers a Health Reimbursement Arrangement (HRA) that works in combination with the Health Insurance Marketplace. You first select a Marketplace plan with the assistance of a counselor from our plan administrator, HealthSCOPE Benefits.

Next, the counselor will help you review the Marketplace plans that are best for you, and assist you in signing up for a plan. The counselor also will tell you whether you are eligible for a federal subsidy to help you pay your Marketplace plan premium.

After you have enrolled in your Marketplace plan, the SERS Wraparound HRA provides reimbursements for eligible medical expenses such as deductibles, co-pays, and other costs. Reimbursement is limited to $1,800 per family, per calendar year in accordance with federal limits.

Important Facts:

- To participate in the SERS Wraparound HRA, you MUST complete the Health Insurance Marketplace enrollment process through HealthSCOPE Benefits.
- You are responsible for paying premiums directly to the Marketplace plan that you selected. SERS cannot deduct Marketplace premiums from your benefit. There is no premium for the SERS Wraparound HRA portion.
- You can sign up for a Marketplace plan during the annual November 1 – December 15 open enrollment period or when you experience a life change, such as losing employer coverage.
- Federal subsidies offered in the Marketplace are based on household size and whole-household income.

Eligibility:

You are eligible for the SERS Wraparound HRA if you are eligible for SERS’ health care coverage. However, this coverage option is NOT available when you:

- Waive SERS coverage
- Are eligible for Medicare
- Are enrolled in Medicaid, or
- Will have a family member enrolled in a SERS Medicare Advantage plan

To Learn More:

If you are retiring soon and want to learn more about Marketplace coverage and the SERS Wraparound HRA, contact HealthSCOPE Benefits toll-free at 888-236-2377. Be sure to tell the representative that you are a member of the School Employees Retirement System of Ohio.
SERS' Wraparound Plan Benefits

The SERS Wraparound Plan provides reimbursement for the following cost-sharing expenses:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Maximum Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible up to $1,800</td>
<td>Reimbursements are limited to $1,800 per family, per calendar year in accordance with federal limits.*</td>
</tr>
<tr>
<td>Covered prescription drugs (50% of the Marketplace plan’s prescription drug co-payment/coinsurance up to $200 per prescription*)</td>
<td></td>
</tr>
<tr>
<td>Physician office visit co-payment up to $50 per visit*</td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital admission co-payment/coinsurance up to $300 per admission*</td>
<td></td>
</tr>
<tr>
<td>Imaging (X-rays, CT/PET Scans, MRI) co-payment or coinsurance up to $100 per service*</td>
<td></td>
</tr>
</tbody>
</table>

*All benefit category costs in the aggregate are subject to the overall total Maximum Amount under this Plan. Such costs can be used in various combinations but shall not, in the aggregate, exceed the Maximum Amount. Reimbursement is limited to cost sharing after the Participant's Marketplace plan has adjudicated any claim(s). Actual reimbursement may vary according to the Participant's Marketplace plan’s terms, but will in no event exceed the Participant's actual out-of-pocket expenses under the applicable Marketplace plan.

The SERS Wraparound HRA eligible expenses noted above only apply to covered services under your Marketplace plan. Claims for non-covered services are not eligible for reimbursement.

Questions and Answers:

Q: What plans can I select on the Marketplace?

A. The Marketplace offers a variety of plans at different prices and benefit levels. You may choose any plan offered through the Marketplace and receive SERS' Wraparound HRA reimbursement for eligible medical expenses.

Q: How much does Marketplace coverage cost?

A. The cost can be different for each person depending upon his or her household income, age, location, and selected coverage.

Q: If I receive SERS’ Wraparound reimbursement, am I still eligible for a federal premium subsidy?

A. Yes. If you are eligible for a federal premium subsidy, the Wraparound reimbursement will not affect your subsidy. Combining the federal premium subsidy and the Wraparound reimbursement make the SERS Wraparound HRA an affordable option, particularly for lower-income households.

Q: Can I enroll in a Marketplace plan outside the annual November 1 – December 15 Marketplace Open Enrollment Period?

A. Yes. If you experience a life change — such as getting married, getting divorced or legally separated, or losing employer health coverage — you would qualify for a Special Marketplace Enrollment Period.

Q: What if I decide to cancel my Marketplace plan? Could I enroll in another SERS health care plan?

A. Yes. If you cancel your Marketplace plan, you have 31 days to enroll in a SERS’ health care plan. Before making any changes, you should contact SERS’ Health Care Services at 800-878-5853 to discuss your group plan option and premium costs.

Q: What happens when I become eligible for Medicare?

A. SERS will contact you three months before you turn 65, or become eligible for Medicare, to offer you the opportunity to enroll in SERS’ Medicare Advantage coverage. You should terminate your Marketplace plan when your Medicare Advantage coverage becomes effective.
Non-Medicare Plan Coverage

2020 Non-Medicare Plan Coverage

<table>
<thead>
<tr>
<th>Aetna Choice POS II</th>
<th>Available Throughout the U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Network</td>
</tr>
<tr>
<td>Deductible</td>
<td>$2,000 per person</td>
</tr>
<tr>
<td>Coinsurance applies after the deductible is met.</td>
<td>$4,000 per family</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Outpatient Diagnostic X-ray and Lab</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Retail Walk-In Clinic</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 co-pay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>20% coinsurance after $250 co-pay</td>
</tr>
<tr>
<td>Outpatient Surgery / Procedures</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Skilled Nursing Facility (100-day max.)</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitation (PT, OT, Speech, Cardiac)</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>Per Person: $7,350 Per Family: $14,700 Not Limited</td>
</tr>
<tr>
<td>• This is the most you will pay in a calendar year. Once you reach the maximum, your medical and prescription plans pay 100%. • Your maximum includes what you pay toward deductibles, co-pays, and coinsurance for certain covered services.</td>
<td></td>
</tr>
</tbody>
</table>

Use of out-of-network providers will increase your out-of-pocket costs.

Prescription drug co-pays are listed on page 27.

In the event of a conflict between this information and the plan documents, the plan documents prevail.

**Coinsurance:** Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Your health care coverage or plan pays the rest of the allowed amount.
### Early Detection Health Screenings

Many early detection screenings are 100% covered by SERS health care plans. The Summary of Coverage provided by your health plan includes detailed information on all screenings.

---

**Q. I am 62 years old, and I have selected Aetna Choice POS II. Does the $20 office visit co-pay count toward my deductible?**

**A. No. Co-pays do not count toward your deductible. However, co-pays do count toward your out-of-pocket maximum.**

---

**AultCare PPO**

*Available in Select Northwestern Ohio Counties (See page 9)*

<table>
<thead>
<tr>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000 per person</td>
<td>$4,000 per person</td>
</tr>
<tr>
<td>$4,000 per family</td>
<td>$8,000 per family</td>
</tr>
<tr>
<td>$20 co-pay</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>$40 co-pay</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>$20 co-pay</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>$40 co-pay</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>$150 co-pay</td>
<td>$150 co-pay</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>20% coinsurance after $250 co-pay</td>
<td>35% coinsurance after $290 co-pay</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>Inpatient: 100% coverage</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient: 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td>20% coinsurance</td>
<td>35% coinsurance</td>
</tr>
</tbody>
</table>

**Annual Out-of-Pocket Maximum**

- Per Person: $7,350
- Per Family: $14,700
- Per Person: $14,700
- Per Family: $29,400
Medicare Coverage

Medicare Basics
Medicare Initial Enrollment Period
Medicare Coverage Choices
Premiums
Premium Subsidy
Premium Discount Program
2020 Medicare Premiums and Plan Availability
Medicare Plan Coverage
MEDICARE COVERAGE

Medicare Basics
Medicare is health insurance for people who are:

- 65 or older
- Under 65 with certain disabilities or end-stage renal disease requiring dialysis or a kidney transplant

Parts A, B, C, and D

Medicare Part A (hospital insurance) helps cover:

- Inpatient care in hospitals
- Skilled nursing facility care, not custodial or long-term care
- Hospice care
- Some home health care

Part A is premium-free for most people, based upon either their own work history or a spouse’s or former spouse’s work history in Social Security.

Medicare Part B (medical insurance) helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Some home health care
- Durable medical equipment
- Some preventive services

Everyone is eligible for Part B, and pays a Part B premium. In 2020, the premium for most new enrollees was $144.60 per month.

Medicare Part C (Medicare Advantage Plans):

- Includes Part A and Part B benefits
- Offered by Medicare-approved private insurance companies that have contracts with Medicare
- Usually includes prescription drug coverage (Part D)
- Can include extra benefits, such as fitness memberships

Medicare Part D (prescription drug coverage):

- Helps cover prescription drug costs
- Offered by private insurance companies
- Purchased separately unless you enroll in a Medicare Advantage plan that includes Part D

Q: I just received my Medicare card. Does SERS need to have a copy of my card?
A: Yes, if you plan to enroll in SERS’ health care coverage. Be sure to include your SERS member ID or the last four digits of your Social Security number on the copy.
Medicare Initial Enrollment Period

If you are receiving a Social Security check:

- Social Security automatically enrolls you in Medicare Parts A and B, and
- Social Security mails you a Medicare card.

If you are not receiving a Social Security check:

- You will need to sign up for Medicare in person at a Social Security office or online at www.ssa.gov/medicare.

Medicare charges a lifetime penalty of 10% for each 12-month period you are eligible for Medicare Part B but do not sign up for it. The penalty does not apply if you are enrolled in an employer health plan. See “Working Past Age 65” on page 18.

To have your Medicare coverage effective the month you turn 65, sign up as soon as you are eligible. When you enroll during the last four months of your Initial Enrollment Period, your Medicare coverage is delayed.

See the charts below for more details.

### Medicare Initial Enrollment Period

<table>
<thead>
<tr>
<th>3 months prior</th>
<th>2 months prior</th>
<th>1 month prior</th>
<th>Your 65th Birthday Month</th>
<th>1 month after</th>
<th>2 months after</th>
<th>3 months after</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you enroll:</td>
<td>Then, your Part B Medicare coverage starts:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One to three months prior to your 65th birthday month</td>
<td>The month of your 65th birthday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The month in which you reach age 65</td>
<td>One month after your 65th birthday month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One month after you reach age 65</td>
<td>Three months after your 65th birthday month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two months after you reach age 65</td>
<td>Five months after your 65th birthday month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three months after you reach age 65</td>
<td>Six months after your 65th birthday month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signing up for Medicare

**Medicare Part A** – Enroll in premium-free Part A if you are eligible. Eligibility is based on your work record, or a spouse’s or former spouse’s work record. If Social Security says you are not eligible to receive Part A for free, and you are enrolling in SERS’ Medicare coverage, do not sign up for Medicare Part A. Your SERS Medicare Advantage plan covers your Part A services.

**Medicare Part B** – Everyone must enroll in Part B, and everyone pays a monthly premium. Your Part B premium is deducted from a Social Security check, or you pay it directly to Medicare. In 2020, the premium for most new enrollees was $144.60 per month.

Q: I retired at age 60 from my school employer and started receiving my Social Security when I turned 62. I turn 65 this year. Do I have to sign up for Medicare Part A and Part B?

A: No. Since you are already collecting a Social Security benefit, Social Security will automatically send you a Medicare enrollment package.
Working Past Age 65

If you are covered by an employer health plan, either from your own or your spouse’s current employment, you can delay enrolling in Medicare Parts A and B. When you decide to stop working, you have a one-time Special Enrollment Period of up to eight months after your employer coverage ends to enroll in Medicare.

To enroll, fill out an Application for Enrollment in Medicare Part B (CMS-40B) and the Request for Employment Information (CMS-L564) forms. Ask your employer to complete the Request for Employment Information form and return it to you. This form is proof that you delayed your Medicare Part B enrollment because you had employer coverage, and you will not be subject to a late enrollment penalty.

Contact your local Social Security office for these forms or download them at www.SSA.gov.

If you have Medicare Part A only or receive a Social Security check, you cannot file your Medicare Part B application any earlier than 30 days before the month you want your coverage to begin.

If you do not have Medicare Part A and have not started receiving Social Security benefits, you can file your application up to three months before you want coverage to begin.

Call your local Social Security office to schedule an appointment to file your application. It is advisable to request a date-stamped copy of the application for your records.

Working only a few months past your 65th birthday:

If you stop working and enroll in Medicare within three months after you reach age 65, your Medicare Part B coverage will be delayed. This is because Medicare considers you to be in your Initial Enrollment Period and filing after your birthday month causes a delay in coverage. For more details, see the charts on page 17. Remember, a delay in benefits means you may have a gap in coverage, depending on when your employer coverage ends. To avoid a coverage gap, sign up for Medicare during the three months prior to your 65th birthday, or enroll in your employer’s COBRA coverage until your Medicare is effective.

**Q:** I am 65 years old, still employed, and have health care coverage through my employer. Do I need to sign up for Medicare? Will I be penalized for not signing up?

**A:** No. Only sign up for Part B if your employer requires it. As long as you were covered by your employer’s health care plan, or your spouse’s employer plan, there will be no penalty.
Medicare Coverage Choices

When you become eligible for Medicare, you have a choice to make on how to receive your coverage:

Choose either Original Medicare or a Medicare Advantage Plan

Original Medicare

Sign up for Original Medicare.
- Medicare Part A (hospital)
- Medicare Part B (medical - requires a monthly premium

Medicare pays your providers directly for your services. Original Medicare only covers approximately 80% of costs.

Medicare Advantage Plan

Sign up for Original Medicare.
- Medicare Part A (hospital)
- Medicare Part B (medical - requires a monthly premium

Select a Medicare Advantage Plan, also known as Part C.
Private companies provide both Part A and Part B coverage. Most plans cover prescription drugs (Part D) as well. The private companies pay your providers directly for your services.

Do you need supplemental coverage to pay for costs Original Medicare does not cover?

Select a Medicare Supplement Insurance policy.
This is also known as Medigap, and offered by private companies to cover gaps in Medicare coverage. You will pay a separate monthly premium.

Do you need prescription drug coverage?

Select a Medicare Prescription Drug Plan (Part D).
Original Medicare does not include prescription drug coverage. Part D plans are offered by private companies approved by Medicare. You will pay a separate monthly premium.

SERS offers Medicare Advantage plans with prescription drug coverage

SERS' coverage includes:
- Part A, Part B, and Part D
- $0 deductible
- SilverSneakers for Aetna
- Silver&Fit for PrimeTime
- Better prescription drug coverage than most Medicare Part D plans
- Lower out-of-pocket costs than Original Medicare

Each month, you pay your Part B premium to Medicare and a premium to SERS for your Medicare Advantage plan. SERS adds $45.50 to your monthly pension when you take SERS' coverage to help you pay your Part B premium.
Premiums
The premium you pay for SERS’ health care coverage includes medical and prescription drug coverage. Premiums are based on:

- Years of qualified service credit
- Eligibility for a premium subsidy
- Health care plan selected

If you enroll in dental and/or vision coverage, additional premiums are charged. SERS automatically deducts your premiums and the premiums for your dependents from your monthly payment.

If your payment is not enough to cover your premiums, you will be responsible for the remaining balance.

SERS mails you a bill each month, which can be paid by check or money order, or automatically deducted from your bank account.

If monthly premiums are not paid, SERS’ health care coverage will be cancelled.

Premium Subsidy
SERS helps reduce health care premiums by providing a subsidy for those who qualify.

To receive a premium subsidy, you must have at least 20 years of qualified service credit, or be receiving a disability benefit. In addition, at the time of retirement, or separation from service, you must:

- Be eligible to participate in the health care plan of your last school employer, or
- Have been eligible to participate in the health care plan of your last school employer at least three of the last five years of service

If you are eligible for your employer’s health care coverage but are a few years short of 20 years, it may be beneficial to work until you have 20 qualified years of service.

Spouse premium is based on the qualified service credit of the service retiree, or disability recipient.

The chart on page 21 lists the Medicare premiums for 2020.

Premium Discount Program
To apply for the discount program, at least one family member must be enrolled in a SERS Medicare plan, and you must qualify based on your household size and income.

A 25% reduction in your monthly SERS health care premium for medical and prescription drug coverage is available if your total household income falls at or below qualifying income levels. The discount does not apply to dental or vision premiums.

To apply, complete a Health Care Premium Discount Application, and return it to SERS within 90 days of your retirement or disability benefit.
## 2020 Medicare Premiums and Plan Availability

**Premium if you have Medicare Part A and Part B.**
**Contact SERS for premium if you are eligible for Medicare Part B only.**

### Service Retirees

<table>
<thead>
<tr>
<th>YEARS OF QUALIFIED SERVICE CREDIT</th>
<th>Aetna Medicare Plan (PPO)</th>
<th>PrimeTime Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19.999 years*</td>
<td>$198</td>
<td>$265</td>
</tr>
<tr>
<td>20-24.999 years</td>
<td>$117</td>
<td>$150</td>
</tr>
<tr>
<td>25-29.999 years</td>
<td>$84</td>
<td>$104</td>
</tr>
<tr>
<td>30-34.999 years</td>
<td>$68</td>
<td>$81</td>
</tr>
<tr>
<td>35-35.999 years</td>
<td>$60</td>
<td>$70</td>
</tr>
</tbody>
</table>

* This is the full premium without a premium subsidy. If you do not qualify for a subsidy (see page 20), you pay this amount regardless of your qualified years of service. There is a 1% premium reduction for each year over 35 years of service.

### Disability Benefit Recipients

<table>
<thead>
<tr>
<th>YEARS OF QUALIFIED SERVICE CREDIT</th>
<th>Aetna Medicare Plan (PPO)</th>
<th>PrimeTime Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full premium without a premium subsidy**</td>
<td>$198</td>
<td>$265</td>
</tr>
<tr>
<td>5-9.99 years</td>
<td>$117</td>
<td>$150</td>
</tr>
<tr>
<td>10-24.99 years</td>
<td>$89</td>
<td>$111</td>
</tr>
<tr>
<td>25 years and over</td>
<td>$64</td>
<td>$75</td>
</tr>
</tbody>
</table>

** This is the full premium without a premium subsidy. If you do not qualify for a subsidy (see page 20), you pay this amount regardless of your qualified years of service.

### Spouse / Children

<table>
<thead>
<tr>
<th>Spouse premium based on the service retiree, disability, or member’s qualified service credit</th>
<th>Aetna Medicare Plan (PPO)</th>
<th>PrimeTime Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse up to 24.999 years</td>
<td>$198</td>
<td>$265</td>
</tr>
<tr>
<td>25-29.999 years</td>
<td>$198</td>
<td>$265</td>
</tr>
<tr>
<td>30 years and over</td>
<td>$166</td>
<td>$219</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$149</td>
<td>$196</td>
</tr>
</tbody>
</table>

### Plan Availability

**Aetna Medicare℠ Plan (PPO)** is available throughout the United States.

**PrimeTime Health Plan** is available in the following Ohio counties:

- Carroll
- Columbiana
- Harrison
- Holmes
- Jefferson
- Mahoning
- Stark
- Summit
- Tuscarawas
- Wayne
## Medicare Plan Coverage

<table>
<thead>
<tr>
<th>2020 Medicare Plan Coverage</th>
<th>Aetna Medicare Plan (PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Available Throughout the U.S.</td>
</tr>
<tr>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Primary Care Office Visit</strong></td>
<td>$20 co-pay</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$30 co-pay</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic X-ray</strong></td>
<td>$25 co-pay</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Lab</strong></td>
<td>100% coverage</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$40 co-pay</td>
</tr>
<tr>
<td><strong>Emergency Room (co-pay waived if admitted)</strong></td>
<td>$100 co-pay</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>$150 co-pay per day 1-5, then 100% coverage</td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>15% coinsurance up to $200 maximum</td>
</tr>
<tr>
<td><strong>Outpatient Surgery/ Procedures</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong> <em>(100-day max.)</em></td>
<td>Co-pay: $0 per day 1-10, $25 per day 11-20,</td>
</tr>
<tr>
<td></td>
<td>$50 per day 21-100</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>100% coverage</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>Covered by Medicare</td>
</tr>
<tr>
<td><strong>Outpatient Short-Term Rehabilitation</strong></td>
<td>$20 co-pay</td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>$20 co-pay limited to Medicare-covered services</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>This amount is the most you will pay in a calendar year. Once you reach the maximum, your medical plan pays 100%. What you pay in co-pays and coinsurance counts toward your out-of-pocket maximum.</td>
</tr>
<tr>
<td></td>
<td>$3,000 per person</td>
</tr>
<tr>
<td></td>
<td>$6,700 per person</td>
</tr>
</tbody>
</table>

Use of out-of-network providers will increase your out-of-pocket costs.

**Prescription drug co-pays are listed on page 29.**

In the event of a conflict between this information and the plan documents, the plan documents prevail.

**Coinsurance:** Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Your health care coverage or plan pays the rest of the allowed amount.
### Medicare Plan Coverage

Use of out-of-network providers will increase your out-of-pocket costs.

Prescription drug co-pays are listed on page 29.

In the event of a conflict between this information and the plan documents, the plan documents prevail.

#### Coinsurance:

Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Your health care coverage or plan pays the rest of the allowed amount.

---

#### Early Detection Health Screenings

Many early detection screenings are 100% covered by the SERS health care plans. The Summary of Coverage provided by your health plan includes detailed information on all screenings.

---

### PrimeTime Health Plan

*Available in Select Northwestern Ohio Counties (See page 21)*

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$20 co-pay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$30 co-pay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient Diagnostic X-ray</td>
<td>$25 co-pay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient Diagnostic Lab</td>
<td>100% coverage</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$40 co-pay</td>
<td>$40 co-pay</td>
</tr>
<tr>
<td>Emergency Room (co-pay waived if admitted)</td>
<td>$100 co-pay</td>
<td>$100 co-pay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$80 co-pay</td>
<td>$80 co-pay</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>20% coinsurance</td>
<td>$150 co-pay per day 1-5, then 100% coverage</td>
</tr>
<tr>
<td>Outpatient Surgery/Procedures</td>
<td>20% coinsurance</td>
<td>$200 co-pay</td>
</tr>
<tr>
<td>Skilled Nursing Facility (100-day max.)</td>
<td>Co-pay $0 per day 1-10, $25 per day 11-20, $50 per day 21-100</td>
<td>Co-pay $0 per day 1-15, $20 per day 16-30, $0 per day 31-100</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Hospice</td>
<td>Covered by Medicare</td>
<td>Covered by Medicare</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitation</td>
<td>$20 co-pay</td>
<td>$5 co-pay (Cardiac rehab covered at 100%)</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>20% coinsurance</td>
<td>$20 co-pay limited to Medicare-covered services</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

**Annual Out-of-Pocket Maximum**

This amount is the most you will pay in a calendar year. Once you reach the maximum, your medical plan pays 100%.

What you pay in co-pays and coinsurance counts toward your out-of-pocket maximum.

- **$3,000 per person**
- **$6,700 per person**

*You must use PrimeTime providers or you will pay the full cost for services.*

---

**Q. Can I still have SERS’ health care coverage if I move out of Ohio?**

**A.** Yes. Aetna Medicare Plan (PPO) will cover you wherever you live in the United States.
Prescription Drug Coverage

Prescriptions Not Covered
Coverage Rules
Non-Medicare Co-pays
Maintenance Refills (Aetna Choice POS II, AultCare PPO)
Specialty Medications (Aetna Choice POS II only)
Specialty Co-pay Assistance (Aetna Choice POS II only)
Medicare Co-pays
Medicare and Prescription Coverage
Medicare Coverage Gap (Donut Hole)
PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is included in SERS’ health care coverage and does not require a separate premium. All prescription plans have a formulary of covered medications. These are referred to as preferred medications. Medications not on the formulary are referred to as non-preferred. The amount you are responsible for paying, known as the co-pay, is based on the medication’s preferred status. You pay the least for generic medications. You pay the most for brand-name medications that are not preferred.

Prescriptions Not Covered

The following is a partial list of situations or types of medications that are not covered. If you are unsure if a medication is covered, you can call your prescription plan’s customer service.

- Prescriptions or medications dispensed in a hospital
  - These are typically covered under your medical plan
- Prescriptions covered by Workers’ Compensation
- Prescriptions for fertility, erectile dysfunction, or cosmetic drugs
- Over-the-counter drugs and herbal preparations, including homeopathic preparations

With the exception of insulin, Express Scripts does not cover non-preferred medications. You pay the full amount for non-preferred medications, and your costs do not count toward any out-of-pocket maximum or the Medicare coverage gap.

Coverage Rules

All prescription plans include these common coverage rules:

- Prior Authorization - For some medications, your doctor must contact the drug plan before certain prescriptions can be filled. The prescription is only covered if your doctor is able to confirm that the medication is necessary.
- Quantity Limits - Limits how much of a specific medication you can get at a time.
- Step Therapy - A process where certain medications that have proven to be safe and effective are tried as the first choice rather than starting with a more expensive prescribed medication.

If you or your doctor believes that one of these coverage rules should not be applied to your situation, you can ask for an exception. Contact your prescription plan for more information.

Q. Do I have to get my maintenance (long-term) prescription medications through mail order?

A. If you are enrolled in a SERS Medicare plan, you can refill your maintenance medications at a retail pharmacy or through mail order. However, if you are enrolled in a non-Medicare plan, all maintenance medication refills must be obtained through mail order.

Maintenance medications are drugs used to treat conditions that are considered chronic. These conditions require regular or daily use of maintenance medications.
### Non-Medicare Co-pays

#### Express Scripts for Aetna Choice POS II Plan

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Home Delivery (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>$7.50 co-pay max.</td>
<td>$15 co-pay max.</td>
</tr>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>25% of cost (min. $25, max. $100)</td>
<td>25% of cost (min. $45, max. $200)</td>
</tr>
<tr>
<td><strong>Specialty medications</strong></td>
<td>25% of cost (min. $25, max. $100) Only certain specialty medications allowed at retail.</td>
<td>25% of cost (min. $15, max. $67 per 30-day supply) Different co-pay amounts apply for medications eligible for SaveonSP, co-pay assistance program.</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td><strong>Insulin Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>$25 co-pay</td>
<td>25% of cost (min. $45, max. $60)</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>25% of cost (max. $45)</td>
<td>25% of cost (max. $115)</td>
</tr>
</tbody>
</table>

#### AultCare PPO Plan

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Home Delivery (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>$7.50 co-pay, max.</td>
<td>$15 co-pay, max.</td>
</tr>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>25% of cost (min. $25, max. $100)</td>
<td>25% of cost (min. $45, max. $200)</td>
</tr>
<tr>
<td><strong>Specialty medications</strong></td>
<td>$100 co-pay</td>
<td>$100 co-pay, 30-day supply only</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>100% of cost</td>
<td>100% of cost</td>
</tr>
<tr>
<td><strong>Insulin Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>$30 co-pay</td>
<td>$60 co-pay</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>$45 co-pay</td>
<td>$115 co-pay</td>
</tr>
</tbody>
</table>

In the event of a conflict between this information and the plan documents, the plan documents prevail.

---

**Co-payment / Co-pay:**

A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service you receive.
Maintenance Medications:
Medications used to treat chronic or long-term conditions, including high blood pressure, heart disease, asthma, and diabetes.

Maintenance Refills (Aetna Choice POS II, AultCare PPO)

Maintenance medications for the Aetna Choice POS II and AultCare PPO plans may only be filled through home delivery. New prescriptions may be filled for the first two times at a retail pharmacy, but all refills must be obtained through home delivery.

Maintenance medications are drugs used to treat conditions that are considered chronic. These conditions require regular or daily use of maintenance medications.

Specialty Medications (Aetna Choice POS II only)

Specialty medications for the Aetna Choice POS II plan must be filled by mail order through Accredo, Express Scripts’ specialty pharmacy. Accredo sends deliveries overnight. The only retail pharmacy exceptions are specialty medications that must be taken within 24 hours of a hospital discharge.

Specialty medications typically require special handling, administration, or monitoring. These drugs treat complex and chronic conditions like cancer, multiple sclerosis, and rheumatoid arthritis.

If you have questions, call Express Scripts toll-free at 866-685-2791.

Specialty Co-pay Assistance (Aetna Choice POS II only)

SERS participates in a co-pay assistance program with SaveonSP, which takes advantage of funds available from drug manufacturers to lower your cost and the amount that SERS pays.

Accredo determines whether your specialty medication is eligible for co-pay assistance. If it is, you will be contacted by SaveonSP to enroll and lower your cost to $0. SaveonSP only contacts you if your specialty medication is eligible for this assistance. If you choose not to participate, you will pay a significant co-pay.

The specialty medications in this program are considered non-essential health benefits under the plan, and your co-pay expenses are not applied toward satisfying the out-of-pocket maximum.

If you take a specialty drug that is not included in the co-pay assistance program with SaveonSP, your prescription is subject to the specialty medication co-pays listed in the chart on page 27.
### Medicare Co-pays

**Express Scripts for Aetna Medicare Plan (PPO)**

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Home Delivery (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>$7.50 co-pay max.</td>
<td>$15 co-pay max.</td>
</tr>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>25% of cost (min. $25, max. $100)</td>
<td>25% of cost (min. $45, max. $200)</td>
</tr>
<tr>
<td><strong>Specialty medications</strong></td>
<td>25% of cost (min. $25, max. $100)</td>
<td>25% of cost (min. $15, max. $67 per 30-day supply)</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

**PrimeTime Plan**

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Home Delivery (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
<td>$7.50 co-pay, max.</td>
<td>$15 co-pay, max.</td>
</tr>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>25% of cost (min. $25, max. $100)</td>
<td>25% of cost (min. $45, max. $200)</td>
</tr>
<tr>
<td><strong>Specialty medications</strong></td>
<td>25% of cost (min. $25, max. $100)</td>
<td>25% of cost (min. $25, max. $100), 30-day supply only</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>50% of cost</td>
<td>50% of cost</td>
</tr>
</tbody>
</table>

**Insulin Only**

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Home Delivery (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred brand name</strong></td>
<td>$25 co-pay</td>
<td>25% of cost (min. $45, max. $60)</td>
</tr>
<tr>
<td><strong>Non-preferred brand name</strong></td>
<td>25% of cost (max. $45)</td>
<td>25% of cost (max. $115)</td>
</tr>
</tbody>
</table>

In the event of a conflict between this information and the plan documents, the plan documents prevail.

### Medicare and Prescription Coverage

You have Medicare Part D prescription coverage through your SERS Medicare coverage. You do not need to buy additional coverage. If you enroll in another Part D plan, SERS is required to cancel your health care coverage.

Some medications and supplies are covered by Medicare Part B, which is part of your medical plan rather than your prescription drug plan. These include but are not limited to:

- Diabetic test strips
- Nebulizer medication
- Transplant-related medications

You will use your medical plan ID card, not your prescription card, to obtain these prescriptions.

### Medicare Coverage Gap (Donut Hole)

If you reach the Coverage Gap, also known as the “donut hole,” your prescription drug co-pays will not change. SERS continues to help pay for generic and preferred brand name drugs. For more information, call Health Care Services toll-free at 800-878-5853.
Dental and Vision Coverage

Dental Plan
Vision Plan
DENTAL AND VISION COVERAGE

Dental Plan

Delta Dental of Ohio is the dental plan provider. Delta gives you access to two large networks of participating dentists, Delta Dental PPO and Delta Dental Premier. In Ohio, more than 5,800 general dentists participate in these networks.

Eligibility

You have to be eligible for, but you do not have to be enrolled in, SERS' health care coverage to sign up for dental coverage. You must enroll in the coverage to enroll your spouse and/or children. You decide each year during open enrollment whether to keep, enroll in, or cancel dental coverage.

Premiums

Premiums are deducted from your monthly payment. If your monthly payment is not enough to cover your monthly premium, SERS will bill you each month.

<table>
<thead>
<tr>
<th>2020 Monthly Premiums:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit recipient</td>
<td>$28.53</td>
</tr>
<tr>
<td>Benefit recipient and one dependent*</td>
<td>$57.06</td>
</tr>
<tr>
<td>Benefit recipient, and two or more dependents*</td>
<td>$85.54</td>
</tr>
</tbody>
</table>

* A dependent can be a spouse or a child

Maximum Coverage

$1,500 per person per calendar year.

Provider Payment

Network dentists have agreed to accept Delta’s negotiated prices for various services. Network dentists cannot charge you more than Delta’s negotiated prices. A non-participating dentist who charges more than the payment schedule can bill you the difference. The chart below shows how much the plan pays. When a service is not covered at 100%, you pay the remaining portion.

<table>
<thead>
<tr>
<th>DENTAL COVERAGE HIGHLIGHTS</th>
<th>PPO Dentist</th>
<th>Premier Dentist</th>
<th>Nonparticipating Dentist*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage effective January 1, 2020</td>
<td></td>
<td>PPO Dentist</td>
<td>Premier Dentist</td>
</tr>
<tr>
<td>Final plan documentation prevails</td>
<td></td>
<td>PPO Dentist</td>
<td>Premier Dentist</td>
</tr>
<tr>
<td>DIAGNOSTIC AND PREVENTIVE (no deductible)</td>
<td></td>
<td>PPO Dentist</td>
<td>Premier Dentist</td>
</tr>
<tr>
<td>Exams, cleanings, fluoride, emergency pain relief, sealants, brush biopsy, bitewing and full-mouth X-rays</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>BASIC SERVICES ($50 deductible applies)</td>
<td></td>
<td>PPO Dentist</td>
<td>Premier Dentist</td>
</tr>
<tr>
<td>Minor restorative services, including fillings, periodontic, and endodontic services, other basic services, other X-rays</td>
<td>80%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>MAJOR SERVICES ($50 deductible applies)</td>
<td></td>
<td>PPO Dentist</td>
<td>Premier Dentist</td>
</tr>
<tr>
<td>Repair to individual crowns, root canals, oral surgery services, crowns and veneers; relines and repairs to bridges, dentures, and implants; prosthodontic services for bridges, implants, and dentures</td>
<td>50%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>

* When you receive services from a nonparticipating dentist, the percentages listed indicate the portion of Delta Dental's nonparticipating dentist fee that will be paid for those services. The nonparticipating dentist fee paid by Delta may be less than what your dentist charges, and you are responsible for the difference.
Vision Plan

The vision coverage is offered through VSP Vision Care, which serves more than 57 million people as the nation’s largest eye care plan provider.

The VSP plan also provides savings on hearing aids through the TruHearing program.

Eligibility

You have to be eligible for, but you do not have to be enrolled in, SERS’ health care coverage to sign up for vision coverage. You must enroll in the coverage to enroll your spouse and/or children. You decide each year during open enrollment whether to keep, enroll in, or cancel vision coverage.

Premiums

Premiums are deducted from your monthly payment. If your monthly payment is not enough to cover your monthly premium, SERS will bill you each month.

<table>
<thead>
<tr>
<th>2020 Monthly Premiums:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit recipient</td>
<td>$7.11</td>
</tr>
<tr>
<td>Benefit recipient and one dependent*</td>
<td>$14.22</td>
</tr>
<tr>
<td>Benefit recipient, and two or more dependents*</td>
<td>$16.70</td>
</tr>
</tbody>
</table>

* A dependent can be a spouse or a child

Providers

- VSP Preferred Providers:

  Get the most out of your benefits and greater savings with a VSP network doctor.

- Non-Network (Open Access) Providers:

  When you see a non-network provider, your costs will be higher. If a non-network provider charges more than VSP allows, the provider can bill you the difference.

VISION COVERAGE HIGHLIGHTS

Coverage with VSP Doctors and Affiliate Providers* Coverage Effective January 1, 2020

<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
<th>Co-pay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellVision Exam</td>
<td>• Focuses on your eyes and overall wellness</td>
<td>$10</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Prescription Glasses</td>
<td>$25</td>
<td></td>
<td>See frame and lenses</td>
</tr>
<tr>
<td>Frame</td>
<td>• $180 allowance for a wide selection of frames</td>
<td>Included in prescription glasses</td>
<td>Every other calendar year</td>
</tr>
<tr>
<td></td>
<td>• $200 allowance for featured frame brands</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 20% savings on the amount over your allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $100 allowance for frames at Costco and Walmart</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>providers*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>• Single vision, lined bifocal, and lined trifocal lenses</td>
<td>Included in prescription glasses</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Lens Options</td>
<td>• Polycarbonate lenses</td>
<td>$0</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• Standard progressive lenses</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Premium progressive lenses</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Custom progressive lenses</td>
<td>$50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average 20-25% off other lens options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts (instead of glasses)</td>
<td>• $150 allowance for contacts; co-pay does not apply</td>
<td>Up to $60</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• Contact lens exam (fitting and evaluation)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Coverage with a retail chain may be different. Once your coverage is effective, visit www.vsp.com for details.

Coverage information is subject to change. In the event of a conflict between this information and your organization’s contract with VSP, the terms of the contract will prevail.
Contact Information
Address and Directions to SERS
Important Websites and Phone Numbers
CONTACT INFORMATION

Most questions can be answered by correspondence or telephone calls. If you would like to visit with a counselor at the SERS office, you can schedule an appointment Monday through Friday. Call SERS toll-free at 800-878-5853 to schedule an appointment. You may obtain more information by:

- Calling SERS locally at 614-222-5853 or toll-free at 800-878-5853
- Visiting the SERS website at www.ohsers.org
- Sending an email to healthcare@ohsers.org

Address and Directions to SERS

SERS is located at 300 E. Broad St., Suite 100, Columbus, Ohio 43215-3746. Free parking is available in SERS’ parking garage. The parking garage entrance is located on Grant Avenue, north of Broad Street.

**From the north:** Take I-71 South to the Broad Street exit #108B and turn right on Broad Street. Turn right on Grant Avenue, and left at the 300 E. Broad parking garage entrance.

**From the south:** Take I-71 North to I-70 East to the Fourth Street /Livingston Avenue exit #100B onto Fourth Street. Turn right on Town Street, then left on Grant Avenue. Cross Broad Street. The SERS parking garage entrance is half a block up Grant Avenue on the left.

**From the west:** Take I-70 East to the Fourth Street /Livingston Avenue exit #100B. Turn left onto Fourth Street. Turn right on Town Street, then left on Grant Avenue. Cross Broad Street. The SERS parking garage entrance is half a block up Grant Avenue on the left.

**From the east:** Take I-70 West to I-71 North. Take the Broad Street exit #108B and turn left on Broad Street. Turn right on Grant Avenue, and then left into the 300 E. Broad parking garage.
Important Websites and Phone Numbers

**Aetna Choice POS II**
www.aetna.com  
Toll-free: 800-826-6259  
TDD: 711

**Aetna Medicare℠ Plan (PPO)**
www.aetna.com  
Toll-free: 866-282-0631  
TDD: 711

**AultCare PPO**
www.aultcare.com  
Local: 330-363-6360  
Toll-free: 800-344-8858  
TDD: 866-633-4752

**Delta Dental**
www.deltadentaloh.com/sersohio  
Toll-free: 800-524-0149  
TDD: 711

**Express Scripts (Medicare)**
www.express-scripts.com  
Toll-free: 866-258-5819  
TDD: 800-716-3231

**Express Scripts (Non-Medicare)**
www.express-scripts.com  
Toll-free: 866-685-2791  
TDD: 800-759-1089

**HealthSCOPE Benefits – for SERS Wraparound HRA**
Toll-free: 888-236-2377  
SERS@healthscopebenefits.com

**Medicare**
www.medicare.gov  
Toll-free: 800-633-4227  
TDD: 877-486-2048

**PrimeTime Health Plan**
www.PTHP.com  
Local: 330-363-7407  
Local TDD: 330-363-7460  
Toll-free: 800-577-5084  
TDD: 800-617-7746

**Social Security Administration**
www.ssa.gov/medicare  
Toll-free: 800-772-1213  
TDD: 800-325-0778

**VSP Vision Care**
www.vsp.com  
Toll-free: 800-877-7195  
TDD: 800-428-4833

**Ohio Senior Health Insurance Information Program (OSHIIP)**
www.insurance.ohio.gov  
Toll-free: 800-686-1578
Notes