Pre-Medicare Eligible

Retiree Health Plan Guide

for changes effective July 1, 2019

Ohio Police & Fire Pension Fund

Ohio Police & Fire Pension Fund Pre-Medicare Retiree Health Plan

IMPORTANT:
Your current health and prescription drug plans end June 30, 2019

This guide helps you to prepare to enroll in a new Individual & Family health insurance plan, which includes prescription drug coverage, and will replace your current group benefits. Aon Retiree Health Exchange™ will help you understand the requirements of the Affordable Care Act (ACA), your plan options, and will help guide you through the process — so you can choose a plan that is right for your needs.

The ACA is constantly changing. While every attempt is made to keep information accurate and up to date, we can only guarantee accuracy at the time of printing. Aon Retiree Health Exchange cannot be held liable for any actions taken as a result of using the information presented in this guide.

After reviewing this guide, if you have any questions, please contact Aon Retiree Health Exchange at **844-290-3674**, 8 a.m. – 9 p.m. Eastern Time.

Enrollment

If you are already enrolled in the retiree health care plan sponsored by the Ohio Police & Fire Pension Fund (OP&F), you will need to enroll in a new health care plan for 2019. Aon's Retiree Health Exchange is available to help you with these decisions. You can do so during your Special Enrollment Period, May 1 – June 15, 2019, for coverage that begins July 1, 2019.

If you experience a life event such as a change in marital status, moving to a new state, adopting a child or other qualifying circumstance, you may be able to change your coverage outside of the Open Enrollment window. Ask one of our licensed Benefits Advisors for more information or visit healthcare.gov.

A look ahead

4 | Changes to your Ohio Police & Fire Pension Fund retiree health care plan

4-5 | The value of Aon Retiree Health Exchange

6-7 | The Affordable Care Act

8 | Getting started

9-10 | Shopping for a plan

11 | Financial assistance

12-13 | Deciding on a plan

14 | Getting ready to enroll

15 | Frequently asked questions

16-18 | Your Health Reimbursement Arrangement and stipend

19 | Important dates

You do not have to face health insurance decisions alone

Aon Retiree Health Exchange helps you understand your health care choices and the variety of plan options currently available in the individual Marketplace™. This service is provided to you to help make finding an Individual & Family plan easy and worry-free. There is no extra cost to you to use this service. You only pay for the coverage you enroll in.

That is the value of Aon Retiree Health Exchange.

When it comes to your health,
change can be good

Ohio Police & Fire Pension Fund (OP&F) is making a change in how you get health care coverage. As of July 1, 2019, you will no longer have health, prescription, dental or vision coverage through OP&F. Instead, you can shop for coverage through Aon Retiree Health Exchange and their enrollment partner, eHealth. You will be able to choose an Individual & Family plan through the individual Marketplace; these plans could have several benefits: you cannot be denied coverage; you are automatically covered for a set of essential health benefits; you can choose a plan that best fits your family's needs, including the network of providers and level of coverage; you may pay less; and you may be eligible to get help paying your plan's premiums.

For most pre-Medicare eligible retirees in a group health plan, the cost of coverage is increasing. The ACA creates new advantages that may make individual health insurance just as good — if not better in many cases — than traditional group health insurance.

Among U.S. employers, the idea of moving retirees from group health benefits to individual coverage is catching on quickly. Today, a growing number of retirement systems have replaced, or plan to replace, a traditional group health plan with an "exchange" of individual coverage options for their retirees.

Introducing
Aon Retiree Health Exchange

Transitioning from group health coverage to buying a health care plan from the individual Marketplace is a big change, and understanding the ACA is complex. That's why OP&F has partnered with Aon Retiree Health Exchange — to help make understanding, choosing and enrolling in coverage easier for you. Aon Retiree Health Exchange partners with eHealth to address all aspects of the early retiree experience. eHealth is the nation's leading online source for health insurance[1], offering comprehensive health care, dental and vision insurance plans specifically designed for individuals and families.

As a national private health exchange, Aon Retiree Health Exchange specializes in helping retirees navigate health care in order to help you make important decisions. Through eHealth, you will have access to health care, dental and vision plans from regional and national carriers you know and trust.

[1]ehealthinsurance.com/about-ehealth/our-story

Whether you prefer to research your options on your own time, through online tools and resources, or with professional assistance, you get the convenience of choice, personalized service and ongoing support.

- There are four metal plan levels: Platinum, Gold, Silver and Bronze. Not all plans are available in all areas.
- Plans vary by covered benefits, premiums, deductibles and other cost-sharing features
- To learn more, you can attend an in-person educational meeting or an online webinar

The benefits you get from working with Aon Retiree Health Exchange start before you enroll in coverage, and extend through future plan years and as your coverage needs change. You are entitled to advisory services, online tools and educational information, and enrollment assistance. Aon also serves as advocates to help you with billing issues, claims processing, access to appointment scheduling assistance for specialists, and much more.

Because Aon Retiree Health Exchange and eHealth are not insurance carriers, you can count on objective guidance — giving you confidence knowing that the coverage you choose is right for you. Best of all, **these services are provided at no cost to you.** You only pay for the coverage you enroll in.

As you turn 65 and become eligible for Medicare, count on Aon Retiree Health Exchange to help you transition to an individual Medicare plan that can support your changing health care needs. There is a lot to understanding Original Medicare (Parts A and B) and why it may not be enough. They provide comprehensive education and helpful tools that make navigating your decisions easier.

By your side

You will have access to licensed insurance agents who have the expertise to help you compare health plan benefits, coverage options and costs. When you have a question or need personal assistance, you can contact Aon or an eHealth licensed agent for answers and unbiased advice. Once you enroll in a health care plan, they will continue to provide support, to serve as your advocate with the health insurance company, and to help you with your future health insurance needs.

Keep in mind: if you enroll in an Individual & Family plan directly through an insurance carrier or independent insurance agent, after-enrollment support may not be available.

The ACA, also referred to as health care reform, was designed to make quality, affordable health care available to all Americans. The OP&F Board of Trustees unanimously approved the implementation and framework for a new health care model. As a result, your group coverage will end and you will have the opportunity to select and enroll in an Individual & Family plan through the individual Marketplace.

With help from Aon Retiree Health Exchange, you will learn:

- How the ACA affects you
- What types of insurance plans are available and how they work
- Which plan is right for you and your family
- How to get help paying for your plan

Prior to 2018, the law required that you enroll in health care coverage or pay a penalty. Starting in 2019, the ACA individual mandate that requires every eligible American to have health insurance or pay a financial penalty when filing taxes will no longer be required.

Why health insurance is important

At some point, you or a family member may get sick or injured. When you purchase an Individual & Family health care plan, you get two basic kinds of benefits: health and financial.

Health benefits include:

- Visits to doctors' offices, including primary care physicians, specialists and surgeons when needed
- Care at hospitals, emergency rooms and urgent care centers
- Diagnostic laboratory and imaging
- Prescription drugs
- Preventive services like vaccinations and screenings

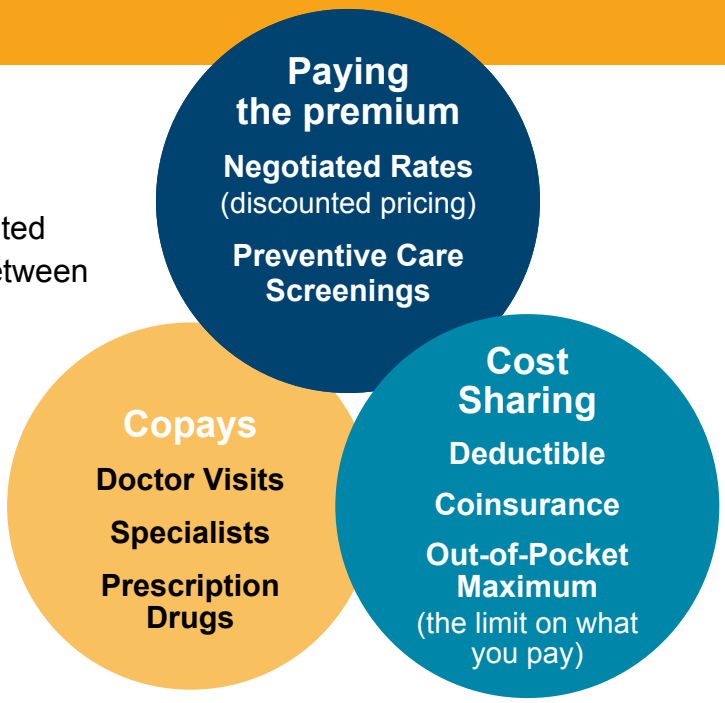
Financial benefits include:

- Lower rates for health care services negotiated by insurance companies
- Reduced costs after you meet your deductible
- Out-of-pocket maximum
- No yearly or lifetime limits

Plans vary from carrier to carrier. Please check plan details to confirm covered benefits.

Understand what you are buying

When you pay a monthly premium, you get discounted rates because your carrier has negotiated prices between hospitals, doctors and other providers, which may significantly cut the cost of health care bills.



Know your rights

As part of the ACA, here are a few other things you should know before enrolling in coverage:

- **You cannot be refused coverage** because of a pre-existing condition. This is known as "guaranteed issue."
- **Preventive care** such as mammograms, colonoscopies and other screenings are included in all plans. Preventive care also includes coverage for some vaccines and certain services for women, like contraception and cervical cancer screenings. Usually you will need to see a provider in the plan's network for the services to be covered at no additional cost.
- Qualified Health Plans cover **essential health benefits**. There is no annual or lifetime dollar limit on coverage of essential benefits. Essential benefits include coverage for:

Preventive, wellness and disease management services

Emergency care

Ambulatory services for outpatient services

Hospitalization

Maternity and newborn services

Pediatric services, including dental and vision

Prescription drugs

Laboratory services

Mental health and substance abuse services, including behavioral health treatment

Rehabilitation and habilitation services

Starting in 2020, each state will have the flexibility to determine which essential health benefits Marketplace insurers must offer, allowing insurance companies to create plans that more directly address the needs of each state's individuals. Each state must still offer at least 10 essential health benefits, but cannot exclude coverage for essential benefits like maternity care or mental health.

- Insurance companies must give you a **Summary of Benefits and Coverage**, so you can compare plans.
- Your insurance company must give you a **30-day notice** before canceling your health coverage, which gives you time to appeal the decision or find new coverage.
- **Insurance companies cannot charge more**, or require pre-approval, for out-of-network emergency care.
- **Children can stay** on their parent's plan up to age 26, as long as they do not have other group coverage available to them.

Let us get started

Your opportunity to enroll in an Individual & Family plan is based upon the Qualifying Life Events in place. When it is time to review your plan options and select a plan and enroll, you will find these details and more online:

- Plan types
- ACA requirements
- Income requirements for financial assistance
- Tax credits
- Coverage calculator
- Health insurance glossary
- Videos
- Answers to frequently asked questions
- How to enroll

You can also speak with licensed agents. So you will have the health insurance you need — and the peace of mind that comes with it.

Attend an educational meeting or webinar

To understand the ins and outs of all your options, join OP&F and Aon Retiree Health Exchange to:

- Learn about the latest updates to health care reform
- Learn about your OP&F stipend
- Understand Qualifying Life Events
- Get more details about your Health Reimbursement Arrangement
- Understand the decisions you will need to make and the associated out-of-pocket costs
- Get answers to your questions

Plan to join an online webinar presentation from the comfort of your own home. If you live nearby, plan to attend the in-person educational meeting being offered. **Please see the enclosed insert for details.**

If you plan to attend, please RSVP online at **myexchangeconnection.com/OP-F** or call **844-290-3674** (TTY 711), Monday through Friday, 8 a.m. – 9 p.m. Eastern Time.

Please bring this guide with you to your educational meeting or have it handy during the webinar. You can use it for reference and to take notes.

Shopping for a health plan

When enrolling in health insurance from the individual Marketplace, there are two opportunities to shop: Open Enrollment and Special Enrollment Periods.

Because your coverage is transitioning from group to individual, you qualify for a Special Enrollment Period. You will also be able to renew or switch plans during the 2019 Open Enrollment Period.

The **Open Enrollment Period** is Nov. 1 – Dec. 15 each year. It is the time when everyone can either enroll in a health care plan or change their plan. If you do not sign up for health insurance during this time, your health care coverage will terminate and **you will not be eligible** for the stipend unless you experience a qualifying life event in the future.

To become eligible for a **Special Enrollment Period,** you must provide proof of a qualifying life event such as becoming Medicare eligible, getting married, adopting a child, losing other health coverage or moving outside the coverage area of your existing plan. Typically, you have 60 days to sign up for a plan during a Special Enrollment Period.

When you **review health plans,** it is important to understand that there are five categories of insurance plans: Bronze, Silver, Gold, Platinum and Catastrophic.

Plans are assigned one of the metallic tiers based on how much of the cost for health care services is covered by the health insurance company. These “metal” categories make it easier for you to compare health plans among health insurance companies. All plans will cover essential health benefits like doctor visits, prescription drugs, X-rays, and hospital stays. The major differences will be in what you pay when you need these services and the monthly cost of the health plan.

While plans differ based on how you and the plan share the costs of your care, they do not differ in the quality of care you get. You will want to compare the level of benefits, doctors and hospitals in the networks, and costs of deductibles, coinsurance and copays before deciding which plan level is right for you.

(See chart next page)

You must complete your health insurance application by the 15th of the month before the month you want your new insurance to start. For example, if you want your coverage to start on July 1, 2019, you must complete and submit your application by June 15, 2019.

Understanding the metal levels

Plan type	Average percentage of health care costs covered (actual costs may vary)	Monthly premium (cost of your health plan)	Potential out-of-pocket costs
Catastrophic*	60%	Lower	Higher
Bronze	60%		
Silver	70%	↓	↑
Gold	80%	Higher	Lower
Platinum	90%		

Generally, plans with lower monthly premiums have higher deductibles (the point at which the plan starts paying benefits) and cost-sharing (coinsurance and copays). The reverse may be true, too. Plans with a lower deductible and cost-sharing often have higher premiums.

Bronze plans have the lowest monthly premiums and Platinum plans have the highest. Only Silver plans may offer additional cost-sharing reductions, and this plan level is available in most areas.

Bronze

This type of plan covers some preventive care like an annual physical, but out-of-pockets costs may be higher for specialists, medications, emergency rooms or hospitals. A Bronze plan offers the lowest premiums. Keep in mind that if you do need care, you will pay for it out-of-pocket until you reach your deductible.

Silver

If you go to the doctor and need medications several times a year, or if you are a parent and your children get sick throughout the year, a Silver plan may have a lower deductible, which may reduce your overall costs.

Gold or Platinum

A higher level plan may be an option if you expect to have routine doctor and specialist visits to monitor one or more chronic conditions. In addition, if you are planning for blood tests, other diagnostic testing and medication costs, these plans may provide you the most financial protection but with higher fixed monthly costs.

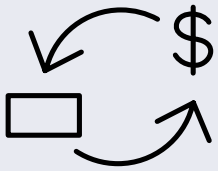
*For people under 30 or with certain exemptions. These plans cover the same essential health benefits as other metal level plans; include coverage for certain preventive services at no cost; and cover at least three primary care visits per year before the deductible is met.

Get help paying for your plan

The ACA limits out-of-pocket costs, deductibles and other forms of cost-sharing based, in part, on your household income. Generally, if your estimated household income for 2019 is between $12,140 and $48,560 (individual) or $25,100 and $100,400 (family of four) you may be able to lower your costs if you qualify for a premium tax credit. If your income is lower, you may be able to get a different kind of coverage, such as Medicaid or Children's Health Insurance Program (CHIP), through your state.

Determine your funding

To help cover the cost of insurance, the federal government offers premium tax credits to qualifying individuals and families based on household income. OP&F provides a stipend, which funds a Health Reimbursement Arrangement (HRA). However, if you qualify for (and choose) a tax credit, you will forfeit your HRA. For more details, see pages 16–18. When it is time to enroll in a plan, you will have access to an income calculator to determine your eligibility.



Paying your premiums

As part of the enrollment process, payment for your first month's premium will be due to the carrier prior to your new plan's effective date. Every carrier has different requirements so it will be up to you to submit payment or have it automatically deducted from your checking account prior to your new plan's effective date. You may want to sign up for automatic payments, if offered by your carrier, to ensure you do not miss a payment.

If you qualify for a premium tax credit, you can apply some or all of this tax credit to your monthly insurance premium payment. Your tax credit will be sent directly to your insurance company, so you will pay less each month. This is called taking an "advance payment of the premium tax credit." *See page 16 for additional financial assistance.*

You may also be eligible to get help paying fees, like deductibles, copayments and coinsurance, when you receive care. These extra savings are available **if you qualify for a cost-sharing reduction plan**. You can use a premium tax credit for a plan in any metal category, but if you do qualify for a cost-sharing reduction plan, the extra savings are only available if you pick a Silver plan.

Deciding what is right for your needs

Before you choose a plan, here are some things to ask yourself and your family members who may need coverage:

- Do you have diabetes, heart disease, high blood pressure or other chronic condition?
- Do you see any type of specialist on a regular basis?
- Do you have any surgeries planned in the next year?
- Do you take or use daily medications like blood pressure medicine, insulin or inhalers?
- Are you planning to adopt a child?
- Will you spend time in another part of the country or travel often?
- How much can you afford to spend on out-of-pocket costs throughout the year?

Keeping in mind the health care needs of your family, understand that health plans typically:

- Have a provider network that includes certain doctors, specialists, hospitals, and other health care professionals. You will save money because of negotiated discounted rates when you use providers in the plan's network.
- Have higher out-of-pocket costs if you choose a lower monthly premium. A plan that pays more of your expenses at the time of service will usually have a higher monthly premium.
- Require a deductible, which means you must pay a certain amount out of pocket before your health plan begins to pay for your health expenses.

No matter which type of health insurance policy you buy, paying for it will involve some combination of these factors:

Premium:	The cost to have a plan, usually billed each month.
Deductible:	The total amount you must pay for health care services each year before your plan begins to pay its share of the cost.
Coinsurance:	The percentage of health care costs you pay after you have reached your deductible amount. Coinsurance is an example of cost-sharing, which defines how you and your plan will share the cost of your health care.
Copayment:	A fixed amount (for example, $30) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.
Annual out-of-pocket maximum:	The most you pay during a policy period (usually one year) before your health plan starts to pay 100% for covered essential health benefits (includes deductibles, coinsurance, copayments, or other qualified expenses).

Types of health plan networks

There are different types of plan networks associated with the metal tier you choose. These networks have certain requirements that you must follow in order for the cost of care to be covered.

Health Maintenance Organizations (HMOs):
This type of plan usually only pays for care that you get within its network of doctors and hospitals. HMOs require that you have a primary care doctor (PCP) for treatment, coordination of care, and specialist referrals.

Exclusive Provider Organizations (EPOs):
A managed care plan requiring the use of in-network services only, except for emergency care. You do not need a referral or a PCP.

Point of Service (POS) Plans:
This type of plan allows you to get care inside and outside the network. You pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. A referral from your primary care doctor is required in order to see a specialist.

Preferred Provider Organizations (PPOs):
PPOs allow you to get care both inside and outside your network. If you stay in-network, you will pay less. No referrals are needed.

Important

The providers (doctors, specialists, hospitals, labs and other places you go to for care) in a network may be different from those that were included under your group coverage. Check the provider network to see if your doctor is in the network or if it includes doctors, hospitals and labs near you.

Low-income Stipend Increase Program

OP&F will continue to assist low income families with their health care expenses by offering a stipend increase of 30 percent. To be eligible for the 30 percent stipend increase for 2019, you must be enrolled in the OP&F health care plan and have had a total household income on your most recently filed federal income tax return that is less than 225 percent of the poverty level established annually by the Department of Health and Human Services. For example, if there were a total of two individuals residing in your household in 2018 and your combined income was less than or equal to $37,035, you would be eligible for the stipend increase.

Benefit recipients may apply annually for this program during your plan's open enrollment period. To apply, contact OP&F or go to the OP&F website for the 2019 Health Care Stipend Increase form. Send the completed form to OP&F and attach a copy of the benefit recipient's signed federal income tax return for the most recent filing period. New retirees and survivors may apply for the discount when they are first eligible for the OP&F health care plan. OP&F must receive a completed 2019 Health Care Stipend Increase form within 60 days of retirement if you are the benefit recipient. Survivors have 90 days from the date that OP&F sent the application to apply.

Contact OP&F for detailed information on eligibility for this program.

Getting ready to enroll

Use this checklist to make sure you have all the documentation you will need to enroll in a plan:

- ○ Social Security numbers for all members of your family
- ○ Employer and income information for everyone in the family (pay stubs or W-2 tax and income statement forms)
- ○ Policy numbers of current health plans for covered family members
- ○ Names of any doctors and hospitals you want to continue to see
- ○ Names and dosages of prescription medications you take
- ○ Planned doctor visits and procedures in 2019

Once you are ready to enroll, you will find all of the information on available plans in one place. You can search for health coverage and easily compare price, quality, benefits and other important features side-by-side.

Frequently asked questions

Q. Do I have to pay to use Aon Retiree Health Exchange services?

A. No, these services are offered at no cost to you. You only pay the cost of the coverage you choose.

Q. What if I am not enrolled in the OP&F group health plan?

A. If you waived coverage under the group-sponsored retiree plan for 2018, but would like to enroll for 2019 (or later) and receive the stipend, you must wait until you experience a Qualifying Life Event (QLE). QLEs include loss of employer group coverage and certain family status changes, such as marriage, birth or divorce. Visit healthcare.gov for eligibility and restrictions.

Q. When can I enroll in coverage?

A. You can enroll beginning May 1 – June 15, 2019 for your coverage to take effect July 1, 2019.

Q. What if I have a pre-existing condition?

A. Under ACA rules, you cannot be charged more or denied coverage or treatment based on your health status.

Q. How do I pick the best plan for myself and my family?

A. The best plan for you is the one that limits your financial responsibility and helps manage your risk. Determining the right balance is up to you.

- If you prefer to pay more up front and so you have no surprises, a Gold or Platinum plan may be a good option, if available in your area.
- If you are looking for the least expensive premium and understand the risks of potentially having to pay health care bills during the year, a Bronze or Silver plan may be a good choice, if available in your area.
- Make sure the doctors, specialists, hospitals and other providers you need are in the network.
- Look up any of your existing doctors and find out which hospital systems they work with.
- All things being equal, if you find more than one plan as a possible option, look for extra perks like fitness rewards, discount programs, prescription mail order and free telemedicine.

Q. Can I get dental and vision coverage?

A. Yes, through eHealth you can compare a variety of well known carriers for both types of coverage options. Your OP&F stipend can be used to help reimburse the cost of these premiums.

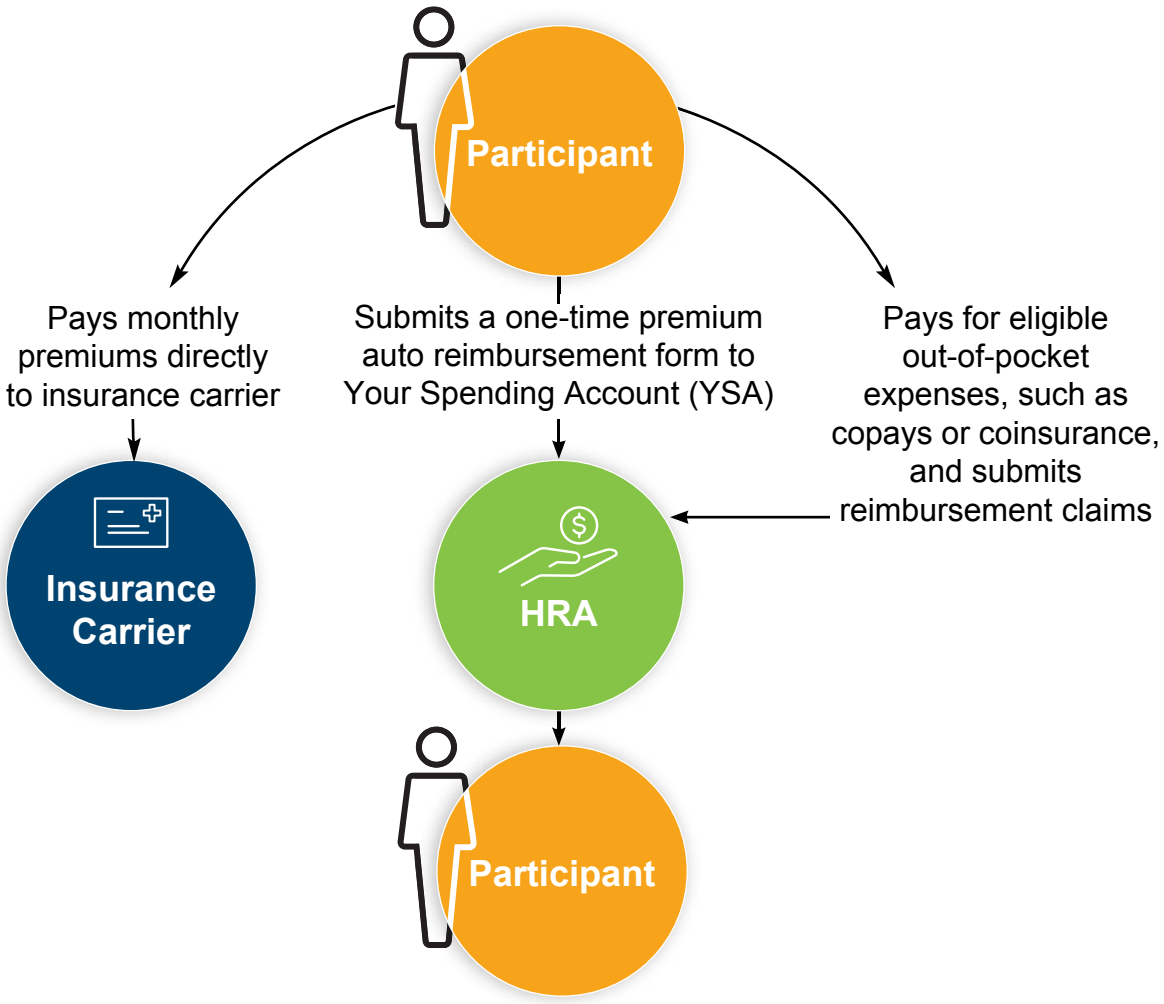
Q. What if there are no plan options in my area?

A. You can choose from a selection of Individual & Family plans online through the federal Health Insurance Marketplace by visiting healthcare.gov.

Your Health Reimbursement Arrangement

Get help paying for your coverage with tax-free money funded by OP&F. OP&F will provide a stipend in the form of an annual contribution to a Health Reimbursement Arrangement (HRA) to eligible members. You can use these funds to help pay for health, prescription drug, dental and vision insurance premiums and other eligible health care expenses. You must be enrolled in an Individual & Family plan through Aon Retiree Health Exchange and eHealth to be eligible for the OP&F stipend. You will forfeit your HRA if you qualify for, and take advantage of, premium tax credits.

To help you fully understand how your HRA works, you will receive a Welcome Kit from Your Spending Account (YSA), the administrator of your HRA, once your enrollment is complete and the insurance carrier confirms enrollment through Aon. This will outline details including the reimbursement process, how to access your account online and support services. Your Welcome Kit will be mailed around the same time as your coverage effective date.



OP&F Monthly Stipends

Coverage	Medicare Status Retiree	Spouse	OP&F Stipend	Part B Reimbursement	Total Subsidy
Retiree Only	Medicare		$ 143	$107	$ 250
	Non-Medicare		$ 685	$ 0	$ 685
Retiree + Spouse	Medicare	Medicare	$ 239	$107	$ 346
	Medicare	Non-Medicare	$ 525	$107	$ 632
	Non-Medicare	Medicare	$ 788	$ 0	$ 788
	Non-Medicare	Non-Medicare	$1,074	$ 0	$1,074
Retiree + Dependent	Medicare		$ 203	$107	$ 310
	Non-Medicare		$ 865	$ 0	$ 865
Retiree + Spouse + Dependents	Medicare	Either Medicare or Non-Medicare	$ 525	$107	$ 632
	Non-Medicare	Either Medicare or Non-Medicare	$1,074	$ 0	$1,074
Surviving Spouse	Medicare		$ 143	$107	$ 250
	Non-Medicare		$ 685	$ 0	$ 685

OP&F reserves the right to change the contribution amount, frequency and account details at any time.

- You can start using your stipend once your enrollment is complete and the insurance carrier confirms enrollment through Aon.
- Once your stipend has been established, you can find a full description of eligible expenses on the Aon Retiree Health Exchange website.
- For tax reasons, your stipend cannot be used to reimburse any before-tax group health plan premium or related health care expenses.
- You must pay your expenses out of pocket first and then be reimbursed.
- In order to receive your premium reimbursement, you must first submit a claim form, proof of payment and service provided. This is a one-time process. Your YSA Welcome Kit will contain more details.
- You may use your stipend to pay for your health, prescription drug, dental or vision insurance premiums.

- You may also use your stipend to pay for eligible expenses such as copays, deductibles and other health-related services.
- You will be reimbursed for eligible expenses up to the amount of your stipend.
- Be sure to use the money in your account by the end of each year or you will forfeit the remaining funds. Funds do not roll over.
- If you or an eligible dependent has access to other group health care or prescription drug coverage, you or your dependent(s) will not be eligible to participate in OP&F-sponsored health care coverage or receive the stipend.

While you are not required to use Aon Retiree Health Exchange and eHealth to help you choose and enroll in an Individual & Family plan, OP&F will not provide you with a stipend unless you do so. In addition, if you do not select a plan through Aon Retiree Health Exchange and eHealth for the 2019 plan year, you will not be eligible for a stipend in the future unless you experience a Qualifying Life Event (QLE). A QLE is a special circumstance such as losing existing health coverage, changes in household, moving to a different zip code or county. You can find a complete list of QLEs online at healthcare.gov.

HRA Opt-out

Some retirees may be eligible to receive federal assistance in the form of premium tax credits to help them purchase qualified health plans through the Health Insurance Marketplace established under the Affordable Care Act. Retirees who qualify for federal assistance will have the opportunity to determine whether it makes sense to accept federal assistance or choose the OP&F HRA. Retirees who qualify for and choose to accept federal assistance are then no longer eligible for the OP&F HRA. The federal government does not allow you to receive federal assistance and participate in the OP&F HRA at the same time.

Retirees who qualify for and choose to accept federal assistance must individually provide notification to opt-out of the OP&F-sponsored HRA in order to receive federal assistance.

You are required to notify OP&F of your election to opt-out of the HRA. OP&F has created a specific form for members to complete and return to make this election. The Termination of Health Care Stipend form is available on the OP&F website or by contacting OP&F Customer Service at **888-864-8363**.

Important dates

You may want to note these important dates so you have an idea of what's ahead.

April 2019	You will receive a letter with information to help you get prepared for Open Enrollment.
April 2019	Attend an in-person health care education meeting or webinar. Please see the enclosed insert for details.
May 2019	Review health care requirements, financial assistance options and online plans. Gather the information you will need to enroll.
May 1 - June 15, 2019	Time to select an Individual & Family plan. Enroll by June 15 for coverage to be effective July 1, 2019.

Notes

As you review this guide and future materials, write down your health care coverage considerations, details that may impact your benefit choices and any questions you have.

Remember to bring this guide to your educational meeting or webinar, so you can follow along and take notes.

For general questions, please call Aon Retiree Health Exchange at **844-290-3674** (TTY 711), Monday through Friday, 8 a.m. – 9 p.m. Eastern Time.

Language assistance services are available to you free of charge. Call Aon Retiree Health Exchange at **844-290-3674** (TTY 711).

About Aon

Aon plc (NYSE:AON) is a leading global professional services firm providing a broad range of risk, retirement and health solutions. Our 50,000 colleagues in 120 countries empower results for clients by using proprietary data and analytics to deliver insights that reduce volatility and improve performance. For further information on our capabilities and to learn how we empower results for clients, please visit **aon.com**.

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