Ohio Police & Fire Pension Fund

2014 HEALTH CARE REPORT

Presented to the Ohio Retirement Study Council, July 2015

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Appendices

This report is a historical review of the Ohio Police & Fire Pension Fund health care program and does not supersede OP&F's Health care Plan Document, Medical Plan Document or the Member's Guide to Health Care Coverage.

Executive Summary

The Ohio Police & Fire Pension Fund (OP&F) Board of Trustees recognizes the importance of providing a health care plan for our retirees. The Board, along with OP&F staff, strives to offer secure health care benefits; including medical, prescription drug, dental and vision coverage. While health care costs have continued to rise, OP&F has managed costs by cutting administrative expenditures, outsourcing and actively managing the plan design. OP&F is committed to working with our vendors to implement recommendations that allow OP&F to continue to offer a dependable and cost effective health care plan.

OP&F moved administration of the health care plan to a single national plan administrator in a strategy to take advantage of the economies of scale offered by the OP&F retiree population located across the country. The partnership with one provider, UnitedHealthcare (UHC) affords leverage and results in a focused plan design and the ability to positively influence claim costs, drug ingredient cost, and administrative fees.

This structure also permits a customized plan that meets the needs of the retired police officers and firefighters of Ohio and affords controls to benefit future plan participants. It is a focused plan administered by one provider, which includes a self-insured medical plan for the under 65 population, a Medicare supplement plan for Medicare eligible retirees, and a self-insured pharmacy plan.

The current structure allows maximum integration, as well as creative solutions to such areas as educating members on the importance of consumer driven health care, wellness, and controlling health care costs, which ultimately secures the stability of the OP&F health care trust. OP&F's Health Care Stabilization Fund (HCSF) ensures the integrity of health care benefits and seeks to minimize the impact of market conditions on the ability to provide health care.

2014 Highlights include:

- New Road to Health & Wellness program including logo
- New Clinical Pharmacy programs to help manage costs including
  - Quantity Level Limits
  - Quantity Per Duration
  - Notification/Prior Authorization
  - Select Designated Pharmacy
- Polycarbonate Lenses covered at 100% when using in-network providers;
- New hearing aid discount programs are available to UHC medical and vision plan members in-network;
- Continuing to offer a reimbursement of Medicare Part B premiums that is not less than $96.40 for most retirees; and
- Continuing to offer a 30 percent premium discount program for those retirees whose income falls below 200 percent of the poverty level established by the U.S. Department of Health and Human Services.

The OP&F Board of Trustees and staff are committed to maintaining and improving a health care plan for its membership. OP&F continues to preserve the solvency of the HCSF by looking at best practices and alternatives to a traditional plan.

Introduction

OP&F sponsors a health care benefits plan including coverage for medical, prescription drug, dental and vision for its eligible members and dependents. In 2014, a total of 27,097 retirees, survivors and their dependents were enrolled in the medical benefits sponsored by OP&F. The prescription drug plan sponsored by OP&F had 24,309 covered lives enrolled in 2014.

When OP&F began sponsoring health care benefits in 1974, health care expenditures were approximately $3 million. Forty years later, in 2014, OP&F's gross health care expenses totaled over $199 million. The cost per covered life in 2014 was $7,208 per participant in the under 65 medical group, $3,240 per participant in the pharmacy plan, and $1,857 for the AARP group. The following sections will chronicle the OP&F health care plan from a historical perspective, describe how OP&F anticipates addressing funding of these benefits into the future and detail the current health care funding structure.

Health Care History:

The plan amendments in 2004 changed the amount of the member's premium that OP&F would subsidize. The amount of the subsidy depended on when the benefit recipient retired, as well as their age and years of service at retirement. Three subsidy levels were established. As a benefit recipient aged, their subsidy level would increase until they reach the highest level available, which was 75 percent for the retired member, and 50 percent for dependents.

In 2005, OP&F evaluated the impact of the new Medicare Part D program being implemented effective Jan. 1, 2006. OP&F decided to continue offering prescription drug coverage to Medicare eligible individuals and seek the 28 percent subsidy offered by the Centers for Medicare and Medicaid Services (CMS).

Under the plan for 2006, benefit recipients paid a set percentage of the full cost of benefits. Contribution rates ranged from 25 percent to 100 percent, depending on the level for which a benefit recipient qualified. To maintain equality from a funding standpoint, benefit recipients selecting a higher cost program paid the difference in the cost. In April 2006, the OP&F Board of Trustees recommended and approved several changes to the OP&F-sponsored health care plan for 2007. These changes included the following:

- HMOs discontinued effective Dec. 31, 2006;
- Establishment of a lifetime maximum of $2.5 million per covered person;
- Offering a single health care plan;
- Co-pays, deductibles and out-of-pocket expenses for medical and prescription drug coverage increased; and
- The OP&F subsidized health care premium methodology was changed.

Contribution rates for the 2007 OP&F–sponsored medical and prescription drug plans were based on when the member retired or began receiving OP&F pension benefits. If the member began receiving OP&F pension benefits on or prior to July 24, 1986, OP&F would subsidize the health care premium 75 percent for the benefit recipient and 50 percent for the benefit recipient's eligible dependents. If the OP&F member began receiving pension benefits on or after July 25, 1986, OP&F would subsidize 75 percent of the benefit recipient's premium and 25 percent for the benefit recipient's eligible dependents' premium.

Eligibility for enrollment in the OP&F-sponsored health care plan has become more restrictive and the opportunities for re-enrollment significantly reduced. Enrollment opportunities currently include:

- At the time of the benefit recipient's retirement;
- Three years after the benefit recipient's OP&F retirement or commencement of OP&F benefits;
- With proof of change in family status (i.e., marriage, death, divorce);
- With proof of involuntary loss of group coverage;
- At the time of Medicare eligibility;
- With proof of eligibility in CHIP/ Children's Medicaid; and
- With proof of loss of your or a dependent child's Medicaid plan coverage.

OP&F benefit recipients who were re-employed and eligible for health care through their employer still had the option of enrolling in the OP&F-sponsored health care plan in 2007. However, they were responsible for paying the full premium with no OP&F-provided subsidy (See Appendix G).

If benefit recipients or their enrolled dependents did not enroll in Medicare Parts A or B when eligible, OP&F's health care administrator processed claims as if the individual were enrolled. The benefit recipient would then be responsible for all fees and expenses incurred that Medicare would have paid. In addition, OP&F would seek to recover any reimbursements that were erroneously processed for these individuals by the administrator.

Whether eligible for both Medicare Parts A and B, or only Medicare Part B, OP&F's medical plans were designed to supplement Medicare coverage for benefit recipients and their enrolled dependents. As a result, OP&F plans became secondary coverage for benefit recipients and their enrolled dependents who are eligible for Medicare. All medical expenses covered under the OP&F plans are reduced by the Medicare benefits available for those expenses. This is done before the medical benefits of the selected OP&F plan are calculated.

For the 2008 health care plan year, the OP&F Board of Trustees approved a health care program with one provider. Effective Jan. 1, 2008, UHC became the OP&F third party administrator and administers all healthcare benefits relating to medical, prescription drug, voluntary dental and vision for eligible benefit recipients and their eligible dependents. UHC also administers a self-insured medical plan for members who are not eligible for Medicare Parts A and B and a premium-based AARP plan for members who are over 65 and eligible for both Medicare Parts A and B.

In 2009, contracts were renegotiated to improve the pharmacy rebate structure and reduce the cost of prescriptions. The specialty pharmacy was also enhanced and simplified to have a single provider for distribution.

Effective Jan. 1, 2010, OP&F enhanced the Mental Health/ Substance abuse benefit removing the annual maximum limit. OP&F extended coverage for full-time students who need a medically necessary leave of absence. OP&F also added qualifying events to the current limited opportunities for enrollment. The long-term care provider was changed from Aetna to Prudential. Enrollees in the Aetna Long-Term Care through Dec. 31, 2009, were grandfathered into that plan. New enrollees effective Jan. 1, 2010, were offered long- term care with Prudential. OP&F switched from a Traditional Prescription Drug List (PDL) to the Advanced PDL, thus allowing members and OP&F to achieve a better cost savings on drugs.

The 2011 plan year brought additional coverage benefits that included a Diabetes Health Plan (DHP) that provided a co-pay incentive for diabetic and pre-diabetic members. OP&F extended dependent coverage to age 28 and eliminated the healthcare plan lifetime maximum.

Effective Jan. 1, 2012, OP&F added coverage for Cochlear Implants on the UnitedHealthcare benefit plan.

In 2013, OP&F discontinued the Diabetes Health Plan effective Dec. 31, 2013, and focused on overall wellness. A "Get Screened" wellness campaign was implemented to incentivize our members to complete annual exams or preventive health screenings. This was also the year that UHC transitioned their pharmacy benefits manager from Medco to their in house pharmacy benefits manager, OptumRX. This transition was effective June 1, 2013. OP&F enrolled in the Bridge2Health vision program. This is a program to educate our members on the importance of vision care to improve overall health.

Health Care Financing: Funding strategies

OP&F's Board of Trustees continues to confront the challenge of funding the rising cost of health care benefits without jeopardizing future pension, survivor, and disability benefits. In addition to the fact that the costs for health care services across the country keep rising, other factors affecting OP&F benefit funding include continued increases in Medicare premiums and deductibles and the extended life span of retirees.

As part of the Health Care Funding Policy (See Appendix F) adopted by the OP&F Board in December 1997, the Board will utilize forecast studies prepared by the actuary on at least a quinquennial basis (every five years) or other studies commissioned by the Board on an ad hoc basis to determine the affordable level of health care. The forecast studies will be prepared following each quinquennial experience study to best assess current and expected OP&F pension and health care liabilities.

As of Dec. 31, 2014, the OP&F HCSF balance was \$1,031,941,202. This represents a decrease in the balance from 2013 of two percent or \$22 million. This was a result of interest generated on the balance of the HCSF along with retiree contributions, rebates and recoveries, and employer contributions, expressed as a percentage of payroll (.50 percent from Jan. 1, 2014 to Dec. 31, 2014). Non-investment earnings generated \$97,870,795 in revenue to fund health care. Benefit recipients contributed 35 percent toward OP&F's overall health care costs.

The remaining 65 percent was paid from the HCSF. The specific breakdown of the HCSF over the last six years is shown on the Schedule of Changes in Net Assets Available for Post Employment Health Care Benefits (See Appendix B).

The medical plan for OP&F members not eligible for Medicare, along with the retiree prescription drug plan, is self-funded. OP&F pays the full cost of claims dollars for this program plus an administrative fee to the third party administrator (TPA). Members over the age of 65 are offered a fully-insured premium based Medicare Supplement program. OP&F's actuary sets rates for the self-funded medical and prescription drug plans and reports annually on the solvency of the Health Care Stabilization Fund, but performs a full review of all assumptions and methods every five years.

Health Care Financing: Chronology of Progress

2000

- Health care costs increased to $111.8 million
- OP&F covered 34,499 lives

2001

- Board of Trustees changed the contribution structure for health care
- Benefit recipients contributed 6 percent of projected costs
- OP&F began giving a 30% discount on health care and Rx premiums for qualified members in July
- Health care costs went up to $129.1 million
- OP&F covered 35,290 lives

2002

- Board of Trustees, again, changed the contribution structure for health care
- Health Care Contributions Increased
- Single $41.20, 2-Party $82.40, Family $123.60
- Health care costs totaled $153.6 million
- 35,452 Covered lives

2004

- Additional changes to the health care program
- Three-pronged approach
  1. Plan Design
  2. Contributions/OP&F subsidy levels
  3. Eligibility

2005

- OP&F joins the Ohio Retirement Systems in the Irrevocable Waiver Program, allowing members to select under which system their medical costs will be covered
- Health care costs continue to rise, but covered lives are decreased because of members enrolling in their employer sponsored coverage

2006

- In December, OP&F terminated its last HMO plans
  - Aetna, Kaiser, Paramount

2007

- The irrevocable waiver program through the ORS is
- discontinued. Members or dependents were grandfathered into the system if an irrevocable waiver was executed on or before Dec. 31, 2007
- A new health care plan design introduced:
- One plan, two vendors (Aetna, Medical Mutual)

2008

- OP&F outsources to UnitedHealthCare to administer program
  - Reduces administrative cost

2009

- Maintain co-pay and coinsurance levels as previous year
- Enroll in dental and/or vision coverage at qualifying event
- No increase in vision premiums
- Enhanced the specialty drug co-pays to reflect existing mail order co-pay structure

2010

- No increase in member contributions from the previous year
- Enhanced the mental health benefit
- Extended coverage for full-time students on medically necessary leave of absence
- Added qualifying events to the limited opportunities
- Long-term care vendor changed from Aetna to Prudential
- Vision premiums remain the same as previous year

2011

- Diabetes Health Plan (DHP)
- Dependent coverage to age 28
- Elimination of lifetime maximums
- Medicare Improvement for Patients and Providers Act (MIPPA)

2012

- Cochlear Implant Benefit

2013

- Retiree wellness program implemented
- Diabetes Health Plan terminated Dec. 31, 2013
- Vision premiums remain the same as previous year
- Transition to OptumRx June 1, 2013
- Get Screened wellness raffle

2014

- New Wellness Program that included logo
- New Physical Activity Challenge
- New Clinical Pharmacy Programs
- Polycarbonate Lenses covered at 100% when using in-network providers
- A new hearing aid discount program available to UHC medical and vision plan members through hi HealthInnovations

Health Care Eligibility

In 2014, OP&F continued to offer a health care plan to retired members and their eligible dependents. Eligibility guidelines for all benefit recipients, including surviving spouses, along with dependents and children are described below. Enrollment information is also included in this section.

Benefit Recipients and Dependents

New benefit recipients and their dependents qualify for OP&F's medical, prescription drug, dental and vision benefits on the effective date of the member's retirement.

Surviving Spouses

Surviving spouses who receive a statutory survivor benefit through OP&F are eligible for participation in the OP&F-sponsored health care plan unless they are eligible for a service or disability benefit through another Ohio Retirement System (ORS) or they were legally separated from the member on or after Jan. 1, 2004, but are subject to limited waivers. Health care for the eligible survivors of retirees continues without interruption upon a retiree's death. Survivors of active members become eligible for OP&F's health care plan on the effective date of their statutory survivor benefit.

Surviving spouses who remarry are still eligible for OP&F health care as long as they are not eligible for health care through another ORS; however, the new spouse cannot be covered. Unless the deceased member is the child's parent, children born to the survivor after the member's death are also not eligible for coverage.

Surviving Child/Orphan

A child who is eligible and is receiving a statutory survivor benefit from OP&F is eligible for the OP&F-sponsored health care coverage. Children may be covered on their own or under the surviving spouse as a dependent.

Dependents

With limited exceptions, benefit recipients must be enrolled in an OP&F plan in order to enroll their dependents in that plan.

Beginning Jan. 1, 2004, the dependents eligible to participate in the OP&F-sponsored health care program included the retiree's spouse, excluding a spouse who is eligible for health care coverage through another ORS or from whom the benefit recipient was legally separated on or after Jan. 1, 2004.

Child

A dependent child is eligible to participate if he or she meets the following criteria:

- The benefit recipient must be the child's natural parent or have legally adopted the child in order for the child to be eligible for the OP&F-sponsored health care coverage (the legal adoption provision does not apply to children added to coverage prior to Jan. 1, 2004, who have had continuous coverage);
- A stepchild who has not been legally adopted by the member can be added if the member certifies, in a form acceptable with UHC, that coverage is not available through either natural parent and the child meets all other eligibility guidelines;
- A dependent child who is 18-25 years of age who is not eligible to enroll in an employer-sponsored health plan (as described by law) is eligible to enroll in the OP&F-sponsored health care coverage. A dependent application must be completed and approved by UHC and the following criteria are met;
- The child is the natural child, stepchild or adopted child of the benefit recipient;
- The child is not employed by an employer offering any health benefit plan under which the child is eligible for coverage.
- In addition, an unmarried dependent child who is 26 and up to 28 years of age is eligible to enroll in the OP&F-sponsored health care coverage if a Dependent Application is completed/approved by UHC and only if all of the following are true:
  - The child is the natural child, stepchild or adopted child of the benefit recipient;
  - The child is not employed by an employer offering any health benefit plan under which the child is eligible for coverage; and
  - The child is not eligible for Medicare or Medicaid coverage.

This coverage will only be provided at the request of the benefit recipient.

Other Ohio Retirement Systems

Individuals who are eligible for medical, prescription drug or voluntary dental and vision coverage through one of the other ORS may not be eligible under the OP&F health care plan. These other systems include:

- Ohio Public Employees Retirement System;
- School Employees Retirement System;
- State Highway Patrol Retirement System; and
- State Teachers Retirement System

There is no coordination of benefits between OP&F and the other ORS. The specific impact to members, survivors and dependent spouses is indicated below.

OP&F Retirees:

Benefit recipients who receive a service or disability benefit from OP&F and one from another ORS can participate in the OP&F-sponsored health care plan if they have more service credit with OP&F.

If they have the same amount of service credit with OP&F and the other system, they can choose to participate in OP&F's health care plan. Retirees cannot receive health care benefits from more than one retirement system.

Surviving Spouses:

If survivors receive a statutory survivor benefit from OP&F and are receiving a service or disability benefit from another retirement system, they cannot participate in the OP&F health care plan. If they are receiving only statutory survivor benefits from more than one system, they can enroll in the OP&F plan if their OP&F commencement of benefits is prior to the other ORS.

Surviving Children:

Surviving children will always have primary medical coverage under the surviving spouse; however, children cannot receive health care benefits from more than one retirement system. A child who is receiving a statutory survivor benefit from OP&F can participate in OP&F coverage.

Dependent Spouses:

Dependent spouses who are active members of another ORS can participate in the OP&F health care plan until they retire and become eligible for health care through that retirement system.

Dependent Children:

If a child has one parent who is eligible for coverage through OP&F and another parent who is eligible for coverage through another system, the parent may select OP&F or the other system for the child's health care; however, children cannot receive health care benefits from more than one retirement system.

Waiving coverage with the intent to participate in health care sponsored by another ORS

The irrevocable waiver program through the ORS was discontinued on Dec. 31, 2007. Members or dependents who had executed an irrevocable waiver on or before Dec. 31, 2007, were grandfathered into the program on the date in which the system discontinued the waiver program.

Current enrollment figures

As of Dec. 31, 2014, there were 26,457 OP&F benefit recipients who were eligible for health care coverage. Benefit recipients include retirees, orphans and survivors. Of those, approximately 70 percent participated in the OP&F medical program and 65 percent participated in the OP&F prescription drug program. As of December 2014, the breakdown of enrollees and dependents (spouses and dependent children) enrolled in OP&F-sponsored health care plan was as follows:

Number Enrolled in Health Care Program	
Benefit recipients, medical	18,355
Benefit recipients, Rx	17,277
Dependents, medical	8,187
Dependents, Rx	7,032

Compared to enrollment figures from Dec. 31, 2013, the OP&F-sponsored health care program had an increase in enrolled participants. The total covered lives enrolled for 2014 was 27,097 or 50 more than the 2013 figures.

In 2014, re-employed retirees and dependents that had a health care plan available to them from an employer were eligible for the OP&F-sponsored plan. However, they did not receive an OP&F subsidy. Also, changes in 2004 have made the cost of the OP&F-sponsored plan more closely associated with other retirement systems' plans. As a result, eligible members with spouses who are eligible for health care coverage through another employer may choose not to enroll in the OP&F plan. Members participating in DROP are not eligible for the OP&F-sponsored health care plan.

Ensuring accuracy of eligibility information

To keep OP&F files accurate, all benefit recipients whether enrolled or not enrolled in the health care plan sponsored by OP&F receives an Annual Change Period Form in the fall of each year. This form requests updates to current information, including address, covered dependents and other insurance information, Medicare Part B reimbursement information and gives the enrolled benefit recipients the opportunity to change coverage for the upcoming year.

Health Care Coverage Options

In 2014, OP&F sponsored health care benefits included coverage for medical, prescription drug, and voluntary dental and vision coverage. Each of these optional health care benefits is described below.

Medical

The 2014 health care plan offered one plan design through one carrier, UHC, for all non-Medicare eligible benefit recipients and dependents, early Medicare recipients, Medicare A only recipients, Medicare B only recipients, or OP&F retirees residing outside of the U.S.

OP&F benefit recipients and dependents age 65 and over that are Medicare eligible and enrolled in both Medicare Parts A and B are eligible to enroll in AARP Medicare Supplement Plans B, F, or L offered through AARP Health Care Options. OP&F's subsidy is based on the Ohio Plan L premium.

The Medicare Improvements for Patients and Providers Act (MIPPA) required Medicare Supplement plans to be "modernized" as of June 1, 2010 and offer new plans. OP&F encouraged Medicare Supplement participants enrolled prior to June 1, 2010 to contact UHC's AARP division and determine if they were eligible for a lower rate by switching to one of the new modernized plans.

Anyone who was not Medicare-eligible, resided in a network area and enrolled should have utilized participating network providers to receive maximum benefits. A plan participant simply chooses a doctor or hospital from the administrator's provider listing at the time services were needed.

There are definite advantages for members who utilize network providers. Special, reduced fees had been negotiated with all network providers, and benefit recipients and their enrolled dependents would not be responsible for paying the difference between the provider's normal charge and specially negotiated fees. In addition, when using network providers, there were no claim forms to file and deductibles and the maximum yearly out-of-pocket cost was lower.

Benefit recipients and their enrolled dependents that chose to utilize a provider outside of the network, even though network providers were available, incurred higher out-of-pocket costs. Because special fees had not been negotiated with non-network providers, benefit recipients and their enrolled dependents were responsible for paying any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined by UHC.

The UHC plan does not have networks in all areas of the country. Benefit recipients and their enrolled dependents who resided in one of these out-of-network areas could still choose UHC as their claims administrator. These benefit recipients and their enrolled dependents could then use any provider or hospital and still receive most benefits at the network benefit level. However, when utilizing out-of-area providers, these benefit recipients may need to file their own claim forms and notify UHC themselves for procedures that needed to be pre-certified. The benefit recipient would pre-certify procedures with UHC and pay any difference between the provider's fee and the UCR allowance determined by UHC (See Appendix H for a chart describing the various benefit levels).

Prescription drug coverage

In 2014, OP&F offered one prescription drug plan through OptumRx Pharmacy, as a separate coverage, with separate contribution amounts.

(See Appendix G for a chart describing the various contributions and co-pays).

The mail service pharmacy program

OptumRx Pharmacy was used for the distribution of the mail order prescriptions beginning June 1, 2013. For the greatest savings, benefit recipients and their enrolled dependents could order medications through the mail. The mail service program was ideal for medications taken on a regular or long-term basis. With the mail service program, there were no deductibles and no claim forms to file. Plan participants simply mailed their prescription and co-payment directly to the mail pharmacy, which then promptly processed and mailed the filled prescription. Refills could also be ordered over the phone or via the Internet.

The retail pharmacy program

The OptumRx Pharmacy program is designed for medications that would be taken on a short-term or immediate need basis and features a network of quality pharmacies throughout the country. With this program, participants could utilize any pharmacy, although members would save more when visiting a network pharmacy. When using a network pharmacy, there were no deductibles or claim forms to file.

Voluntary vision and dental plans

For the 2014 plan year, OP&F continued to sponsor voluntary dental coverage through UHC. The voluntary vision coverage was offered through UHC Vision, underwritten by UnitedHealthcare Insurance Company.

Routine vision and dental services are not covered under OP&F's medical plans. Therefore, OP&F does not subsidize the cost of these plans. To supplement medical coverage, benefit recipients have the option of enrolling in a separate vision and dental plan. Benefit recipients and their eligible dependents may enroll in either one or both types of coverage. These plans are offered in addition to the medical and prescription drug programs and have separate contribution amounts. Benefit recipients may also enroll in these plans if they do not elect to enroll in an OP&F-sponsored health care plan.

Eligible dependents may only enroll in the plan(s) in which the benefit recipient is enrolled (Please see Appendix I for a breakdown of dental coverage and contributions, and Appendix J for vision coverage and contributions).

Enrollment in supplemental vision and dental plans is permitted with a qualifying event and once every year during the Annual Change Period. Once enrolled, benefit recipients and their eligible dependents must remain enrolled for the remainder of the calendar year, unless there is a valid change in family status.

UnitedHealthcare vision coverage

UnitedHealthcare vision coverage helps pay the costs of an annual eye exam, eyeglasses, contact lenses and frames. All eligible benefit recipients and their dependents may enroll in this plan regardless of their area of residence.

Under the vision plan, benefit recipients and their enrolled dependents may visit any UHC vision provider. Benefit recipients and their enrolled dependents have minimal co-payments for the exam, lenses and frames at the time of service. In 2014, OP&F had 9,101 benefit recipients enrolled in the UHC Vision plan.

UnitedHealthcare dental coverage

The UHC dental plan provides coverage for preventive, diagnostic and basic restorative care. All benefit recipients and their eligible dependents may enroll in the dental plan, regardless of their area of residence.

Under the UHC dental plan, benefit recipients and their enrolled dependents may choose any dentist in the country. The maximum benefit level is achieved by utilizing UHC's network of participating dentists, as these dentists have agreed to a discounted fee schedule. When utilizing a dentist who does not participate in UHC's Network, benefit recipients and their enrolled dependents will be responsible for paying directly to the dentist any amount above the usual and customary rates prevailing in the geographic area in which the expense is incurred.

In 2014, OP&F had 10,596 benefit recipients enrolled in UHC dental coverage. The UHC dental plan offers a consumer-driven feature, Consumer Max Multiplier, which allows members to carry forward a portion of their unused annual dental maximum into an account for future use based on specific plan guidelines.

Coordination of dental and vision benefits

Benefits under the vision and dental plans are coordinated with those of another dental and vision plans in which a benefit recipient or eligible dependent is enrolled.

Long-term care coverage

Long-term care insurance can provide a wide range of personal health care services for people of all ages who need custodial care because of a chronic illness or long-lasting disability. To help pay the cost of long-term care, OP&F sponsored a separate long-term care plan administered by Prudential as a third party administrator, effective July 1, 2009. This plan was available to active OP&F members, their spouses and parents, as well as current OP&F benefit recipients and their dependents. In 2013, OP&F had 97 members and/or benefit recipients were enrolled in long-term care coverage. However, Prudential has exited the market and no longer provides long term care coverage as of June 30, 2013. Pursuant to Ohio Administrative Code 742-7-10, providing long term care access to OP&F retirees became discretionary due to a lack of long term care providers in the market. As a result, existing participants remained enrolled in the program. However, no new members were enrolled after that date.

Annual Change Period

In the fall of every year, plan participants will receive the Member's Guide to Health Care Coverage and personalized Annual Change Period form that provides more details about the upcoming OP&F-sponsored health care coverage, describes the Annual Change Period process, and announces any changes to the plan or contribution rates. The form can be used to verify or waive current enrollment, ensures that any pre-printed information contained on the form is accurate, as well as waiving or enrolling in the voluntary dental and vision coverage. This major project involves creating a customized form for health care participants and a booklet specifically outlining the available health care plans.

OP&F and Medicare

Part A

Individuals must have earned a pre-determined quantity of eligible quarters of employment to become eligible for enrollment in Medicare Part A, which is hospital insurance. If an individual is not eligible for the AARP Medicare Supplement insurance and chooses to enroll in the OP&F-sponsored health care coverage, UHC will pay a percentage of covered hospital expenses not paid by Medicare Part A after the individual's deductible is met.

Part B

Members are eligible to enroll in Medicare Part B once they turn 65 years of age (or have a qualifying illness or disability prior to age 65.) OP&F requires members to enroll in Medicare Part B as soon as they are eligible. If members do not sign up, refuse or stop Medicare Part B enrollment, UHC will estimate what Medicare Part B would pay and deduct that amount from the charges before making payment. The member is then responsible for what Medicare Part B would have paid.

Part B Reimbursements

Upon eligibility for Medicare Part B, benefit recipients are eligible for reimbursement of the Medicare Part B premium through OP&F (as required by ORC Section 742.45 (B), See Appendix A), if they are not receiving reimbursement from another source.

Reimbursement is made in the monthly benefit payment at the rate established by the Board of Trustees (not less than $96.40). Dependent spouses are not reimbursed for the Medicare Part B premium until such time as they become a benefit recipient. In 2014, OP&F paid more than $17.5 million in Medicare B reimbursements. When becoming eligible for Medicare Part B, benefit recipients must send UHC a copy of their Medicare card (or a letter from Medicare) and a properly completed Medicare Part B Reimbursement Statement in a UHC-approved format. UHC typically sends the Medicare Part B Reimbursement Statement to benefit recipients three months prior to their 65th birthday. Upon notification of a retiree's death, the surviving spouse will receive instructions regarding applying for the Medicare Part B reimbursement. Reimbursement will begin when OP&F receives the information indicated above. The Board of Trustees has determined that OP&F will not make retroactive reimbursements.

Part D Subsidy

CMS began offering a new prescription drug plan (Medicare Part D) to Medicare eligible retirees effective Jan. 1, 2006. The OP&F Board of Trustees reviewed the prescription drug options under Medicare Part D and decided to file for the 28 percent subsidy offered to plan sponsors such as OP&F. The 28 percent subsidy is only allowed for prescription drug expenses incurred by retirees who chose to stay with the OP&F-sponsored prescription drug plan. If a retiree is eligible for Medicare Part D, they must decide to enroll in either Medicare Part D or stay with the OP&F-sponsored prescription drug plan. The retiree cannot be enrolled in both. Among the qualifications for subsidy is that a qualified actuary submits attestation to CMS that the OP&F plan's actuarial value is at least equal to the actuarial value of the defined standard prescription drug plan under Medicare Part D. The actuary, a member of the American Academy of Actuaries, certified that OP&F was actuarially equivalent. A Notice of Creditable Coverage is provided to all OP&F retirees annually within the Annual Change Period communications.

In 2014, OP&F received a little over $9 million in subsidy dollars for deposit into the HCSF. However, CMS requires a reconciliation of cost reporting for the subsidy within 15 months of the 2014 plan year. The final subsidy amount may fluctuate slightly once the reconciliation is complete due to year-end cost adjustments.

APPENDIX A

Statutory Authority for Health Care Benefits

§ 742.45. Deduction from benefit payment for group health insurance

(A) The Board of Trustees of the Ohio police and fire pension fund may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving service or disability pensions or survivor benefits subscribing to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the eligible individual's sponsored dependents as the Board considers appropriate.

If all or any portion of the policy or contract premium is to be paid by any individual receiving a service, disability, or survivor pension or benefit, the individual shall, by written authorization, instruct the Board to deduct from the individual's benefit the premium agreed to be paid by the individual to the company, corporation, or agency.

The Board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the Ohio police and fire pension fund. The cost paid from the funds of the Ohio police and fire pension fund shall be included in the employer's contribution rates provided by sections 742.33 and 742.34 of the Revised Code.

The Board may provide for self-insurance of risk or level of risk as set forth in the contract with the companies, corporations, or agencies, and may provide through the self-insurance method specific benefits as authorized by the rules of the Board.

(B) Except as otherwise provided in this division, the Board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service, disability, or survivor benefits under the Ohio police and fire pension fund who is eligible for coverage under part B of the medicare program established under Title XVIII of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, an amount specified by the Board or determined pursuant to a formula established by the Board that is not less than ninety-six dollars and forty cents, for such coverage, except that the Board shall not pay an amount that exceeds the amount paid by the recipient for the coverage.

The Board shall pay not more than one monthly premium under this division to an eligible benefit recipient even if the recipient is receiving more than one monthly benefit from the fund. The Board shall not pay a monthly premium under this division to an eligible benefit recipient who is receiving reimbursement for the premium from any other source.

(C) The Board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

(D) The Board shall make all other necessary rules pursuant to the purpose and intent of this section.

APPENDIX B

Schedule of Changes in Net Assets Available for Post Employment Health Care Benefits

2009–2014

	2009	2010	2011	2012	2013	2014
Additions:						
Employer Contributions	$126,649,859	$128,774,894	$129,297,720	$130,285,935	$69,426,521	$9,895,274
Benefit Rec. Contributions	59,148,831	58,923,329	62,528,377	65,066,253	66,564,696	69,965,747
Investment Income	103,601,197	100,524,721	18,994,817	126,894,129	158,418,556	80,862,561
Recoveries and Rebates	14,775,646	16,709,612	28,647,013	21,226,179	15,565,560	18,009,774
TOTAL ADDITIONS	304,175,533	304,932,556	239,467,927	343,472,496	309,975,333	178,733,356
Deductions						
Health Care Expenses	168,744,032	159,913,915	176,340,482	187,445,986	191,335,860	199,594,201
Administrative Expenses	690,478	687,854	715,756	562,689	710,855	732,022
TOTAL DEDUCTIONS	169,434,510	160,601,769	177,056,238	188,008,675	192,046,715	200,326,223
Net Increase/Decrease	$134,741,023	$144,330,787	$62,411,689	$155,463,821	$117,928,618	$(21,592,867)

Net assets held in trust for post employment health care benefits:

Balances						
Beginning of Year	$438,658,131	$573,399,154	$717,729,941	$780,141,630	$935,605,451	$1,053,534,069
END OF YEAR	$573,399,154	$717,729,941	$780,141,630	$935,605,451	$1,053,534,069	$1,031,941,202

APPENDIX C

Accounting, Asset Valuation and Funding Methods

1. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by OP&F.

Basis of Accounting: *OP&F's financial statements have been prepared using the accrual basis of accounting. Revenues are recognized when earned and expenses are recorded when a liability is incurred.*

Investments: **Investment purchases and sales are recorded on a trade date basis. Dividend income is recognized on the dividend date, while interest and rental income is recognized when earned. Investments are reported at fair value. Securities traded on a national or international exchange, are valued at the last reported sales price at current exchange rates. Mortgages are valued on the basis of future principal payments discounted at prevailing interest rates for similar instruments. The fair value of real estate and timber are based on independent appraisals and internal valuations. Investments that do not have an established market are reported at estimated fair value. Private equity limited partnership interest is based on values established by each partnership's valuation committees.**

Net appreciation is determined by calculating the change in the fair value of investments between the end of the year and the beginning of the year, less the cost of investments purchased, plus sales of investments at fair value. Investment expense consists of administrative expenses directly related to OP&F's investment operations and a proportional amount of all other administrative expenses allocated based on the ratio of OP&F's investment staff to total OP&F staff. OP&F has no individual investment that exceeds five percent of net assets available for benefits.

Federal Income Tax Status: **OP&F was determined to be a trust under section 401(a) of the Internal Revenue Code that is exempt from federal income taxes under section 501(a) of the Internal Revenue Code. OP&F's DROP plan was also determined to be part of the 401(a) trust.**

Property and Equipment: **Property and equipment are recorded at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets. The range of estimated useful lives is as follows:**

Buildings and improvements .... 40 years
Furniture and equipment......................... 3 to 10 years
Computer software and hardware .... 2 to 10 years

Contributions and Benefits: **Employer and Member contributions are recognized when due or in the period the related member salaries are earned. Benefits and refunds are recognized when due and payable in accordance with the terms of the plan.**

2. Asset Valuation Method

The difference between actual market value and expected market value is recognized over five years (20 percent per year). The actuarial value is the market value adjusted by the total unrecognized gains or losses incurred during the five year period.

3. Funding Method

Health care benefits are funded on a pay-as-you-go basis. This fund is credited with a portion of employer contributions equal to 0.5 percent of active member payroll from Jan. 1, 2014 to Dec. 31, 2014; all benefit recipient health care contributions, as well as an equal share of investment income to the balance of the HCSF. The HCSF is charged with all health care expenses and administrative costs. As of Dec. 31, 2014, the balance in the HCSF was $1,031,941,202.

APPENDIX D

Plan Net Assets Available for Post-Employment Health Care Benefits

as of Dec. 31, 2014 (un-audited)

Assets:	Cash and Short-term Investments	$74,060,631
Receivables:	Employers' Contributions	1,008,812
	Accrued Investment Income	2,444,952
	Investment Sales Proceeds	1,643,129
	Total Receivables	5,096,893
Investments, at fair value:	Bonds	$202,532,895
	Mortgage & Asset Backed Securities	27,121,581
	Stocks	272,432,988
	Real Estate	105,433,392
	Commercial Mortgage Funds	2,763,087
	Private Equity	64,691,574
	International Securities	230,291,928
	Timber	13,871,387
	Master Limited Partnerships	56,987,522
	Total Investments	976,126,354
	Collateral on Loaned Securities	86,900,619
	TOTAL ASSETS	**$1,142,184,497**
Liabilities:	Health Care Payable	$19,346,343
	Investment Commitments Payable	3,996,333
	Reverse Repurchase Agreements	0
	Obligations Under Securities Lending	86,900,619
	TOTAL LIABILITIES	**$110,243,295**
NET ASSETS HELD IN TRUST FOR POST-EMPLOYMENT HEALTH CARE BENEFITS:		**$1,031,941,202**

APPENDIX E

Statement of Changes in Plan Net Assets Available for Post-Employment Health Care Benefits

(Year ending Dec. 31, 2014)

Additions:	*From Contributions:*	
	Employers	$9,895,274
	Member Health Care Premiums	69,965,747
	TOTAL CONTRIBUTIONS	**$79,861,021**
	From Investment Income:	
	Net Appreciation (Depreciation) of Fair Value of Investments	54,589,460
	Bond Interest	12,719,304
	Dividends	9,441,158
	Alternative Investment Income	5,079,802
	Repurchase Agreement Interest	84,194
	Master Limited Partnerships	2,910,819
	Other	82,676
	Less Investment Expenses	(4,433,938)
	NET INVESTMENT INCOME/(LOSS)	**$80,470,475**
	From Securities Lending Activities:	
	Securities Lending Income	410,394
	Securities Lending Expense:	(18,308)
	NET INCOME FROM SECURITIES LENDING	**$392,086**
	Interest on Local Funds Receivable	0
	Other Income	18,009,774
	TOTAL ADDITIONS	**$178,733,356**
Deductions:	*Benefits:*	
	Health Care	199,594,201
	Administrative Expenses	732,022
	TOTAL DEDUCTIONS	**$200,326,223**
	NET INCREASE (DECREASE)	**$(21,592,867)**

NET ASSETS HELD IN TRUST FOR POST-EMPLOYMENT HEALTH CARE BENEFITS:	
BALANCE, BEGINNING OF YEAR	$1,053,534,069
BALANCE, END OF YEAR	**$1,031,941,202**

APPENDIX F

Health Care Funding Policy

The OP&F Board of Trustees recognizes the limitations imposed by law on the cost of health care benefits. OP&F will manage the terms of the health care benefits program in a manner that, over the long-term, ensures the solvency of OP&F with respect to providing pension and disability benefits.

To determine the affordable level of health care costs, the Board will utilize forecast studies prepared by the actuary on at least a quinquennial basis (every five years) or other studies commissioned by the Board on an ad hoc basis. The forecast studies will be prepared following each quinquennial experience study, so as to best reflect current expectations of OP&F pension and health care liabilities.

The cost of health benefits is funded through benefit recipient paid contributions and through contributions that employers pay on behalf of active members. OP&F understands that the employer's contribution for all benefits, both pension and health care has been set by statute as a percentage of payroll. The assumed level percentage of active member payroll was determined in 1991, via a forecast study, to be the long-term affordable level to be devoted to health care based on actuarial experience at that time. OP&F will adjust the percentage of active member payroll used for health care benefits at least every five years to the maximum level consistent with OP&F's primary obligation to pay pension benefits.

Based on the projected health care costs included as part of the forecast studies and after paying costs covered by the current percentage of active member payroll and the amount of HCSF deemed prudent by the Board, the monthly contributions for benefit recipients and dependents will be adjusted to pay all remaining health care costs. When adjusting contributions paid by the benefit recipients, the Board will apportion the contributions among the benefit recipient and dependent population after considering many factors.

If changes in benefit recipient monthly contributions and active member payroll contributions fail to offset rising health care costs, the Board will consider changes to health care benefit levels.

OP&F will ensure that this funding policy is effectively communicated to OP&F's membership and will work toward improving member understanding of the issues surrounding the funding of health care benefits.

APPENDIX G

2014 Premiums and Contributions

If a member or their spouse is employed and eligible for medical or prescription drug coverage through their employer, they can participate in the OP&F–sponsored health care plan. However, OP&F will not subsidize the health care contributions. Also, if a member's spouse is eligible for medical or prescription drug coverage though his or her retirement system, as long as it is not another ORS, he or she will be eligible for the OP&F–sponsored health care plan but will be responsible for paying the full premium.

Full premiums for OP&F–sponsored medical and prescription drug coverage

The chart below outlines the full premiums paid by the benefit recipient for both the UHC and AARP medical and prescription drug coverage for 2014. Figures shown may vary slightly due to rounding.

	Not eligible for Medicare		*Medicare eligible*	
	Full premium for medical coverage	Full premium for prescription drug coverage	Full premium for medical coverage	Full premium forprescription drug coverage
Benefit Recipients	$830.78	$267.37	See AARP Plan	$267.37
Spouse	$549.98	$251.86	See AARP Plan	$251.86
Child(ren)	$287.45	$74.86	See AARP Plan	$74.86

	Non-AARP eligible	
	Full premium for medical coverage	Full premium for prescription drug coverage
Benefit Recipients	$269.24	$267.37
Spouse	$226.96	$251.86
Children	$226.96	$74.86

Contribution rates for the 2014 OP&F–sponsored medical and prescription drug plans were based on Medicare status and when the member retired or began receiving OP&F benefits. If the member began receiving OP&F benefits on or before July 24, 1986, OP&F will subsidize the health care premium 75 percent for the benefit recipient and 50 percent for the benefit recipient's eligible dependents. If the OP&F member began receiving benefits on or after July 25, 1986, OP&F will subsidize 75 percent of the benefit recipient's premium and 25 percent for the benefit recipient's eligible dependents' premium.

The charts below and on the next page outline the monthly contribution amounts that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage of both the UHC and the AARP Medicare Supplement Plans for 2014. Figures shown may vary slightly due to rounding.

Medical contribution rates

Began receiving OP&F benefits on or before July 24, 1986:

	Not eligible for Medicare		*Non-AARP eligible*	
	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount
Benefit Recipients	$207.69	$623.09	$67.31	$201.93
Spouse	$274.99	$274.99	$113.48	$113.48
Child(ren)	$143.72	$143.73	$113.48	$113.48

Began receiving OP&F benefits on or after July 25, 1986:

	Not eligible for Medicare		*Non-AARP eligible*	
	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount
Benefit Recipients	$207.69	$623.09	$67.31	$201.93
Spouse	$412.49	$137.49	$170.22	$56.74
Child(ren)	$215.59	$71.86	$170.22	$56.74

AARP Medicare Supplement Plan – Benefit Recipients (Ohio residents) Plan L

The final contribution a member/dep pays depends on Med B eff date and discounts available.

Base Rate	Benefit Recipient (75% subsidy)	Dependent (50% subsidy)	Dependent (25% subsidy)
$134.50	OP&F pays: $100.88 Member pays: $33.62	OP&F pays: $67.25 Dependent pays: $67.25	OP&F pays: $33.63 Dependent pays: $100.87

Prescription Drug contribution rates

Began receiving OP&F benefits on or before July 24, 1986:

	Not eligible for Medicare		Medicare eligible	
	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount
Benefit Recipients	$66.85	$200.52	$66.85	$200.52
Spouse	$125.93	$125.93	$125.93	$125.93
Child(ren)	$37.43	$37.43	$37.43	$37.43

Began receiving OP&F benefits on or after July 25, 1986:

	Not eligible for Medicare		Medicare eligible	
	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount	Benefit recipient's monthly contribution	OP&F's monthly subsidized amount
Benefit Recipients	$66.85	$200.52	$66.85	$200.52
Spouse	$188.90	$62.96	$188.90	$62.96
Child(ren)	$56.14	$18.72	$56.14	$18.72

Prescription Drug co-pays:

	Retail pharmacy co-pay Up to a 30-day supply	Mail order pharmacy co-pay Up to a 90-day supply	Specialty pharmacy co-pay Up to a 90-day supply
Tier 1	$5 co-pay	$10 co-pay	$3 co-pay
Tier 2	$20 co-pay	$40 co-pay	$13 co-pay
Tier 3	$30 co-pay	$60 co-pay	$20 co-pay

Contribution Discount Program

OP&F's Contribution Discount Program offers a reduction in the contribution level for benefit recipients with total annual household income under an amount established annually by the Board of Trustees, which in 2014 was 30 percent in each medical and prescription coverage category for those retirees whose income falls below 200 percent of the poverty level established by the U.S. Department of Health and Human Services.

Annually, benefit recipients must apply for the contribution discount. Benefit recipients who enroll in health care and prescription drug benefits sponsored by OP&F throughout the year may apply for the discount when they are first eligible for coverage. However, to qualify UHC must receive a completed Application for Health Care Contribution Discount and a copy of the benefit recipient's signed Federal Income Tax return for the most recent filing period. If they do not file a Federal Income Tax return, UHC can supply the member with the required affidavit. In 2014, 473 benefit recipients received the contribution discount.

APPENDIX H

Comparing network, non-network and out-of-area benefits

Benefit recipients and dependents enrolled in UHC during 2014 may have experienced a difference in coverage between network, non–network and out-of-area providers as outlined in the chart below.

	Network	Non-Network	Out-of-Area***
Annual Deductible			
Individual / family	$500 / $1,000	$1,000 / $2,000	$500 / $1,000
Co-Insurance limit	$1,500 / $3,000	$5,000 / $10,000	$1,500 / $3,000
Co-Insurance	80%	50%	80%
Physician Services			
Office visit	$30 / 100%	50%	80%
Emergency Care			
Emergency department	$100 / 80%	$100 / 80%*	80%
Non-emergency services rendered in emergency room	$100 / 50%	$100 / 50%*	50%
Urgent care	$50 / 80%	50%	80%
Hospital In-Patient Services			
Prior admission testing	80%	50%	80%
Scheduled in-patient admit	$250 / 80%	$250 / 50% **	$250 / 80%
Emergency in-patient admit *	$250 / 80%	$250 / 80%	$250 / 80%
Ambulatory Services			
Diagnostic lab / x-ray	80%	50%	80%
Ambulatory surgery center	$150 / 80%	50%	$150 / 80%
Mental Health and Substance Abuse			
Scheduled in-patient admit	$250 / 80%	$250 / 50% **	$250 / 80%
Emergency in-patient admit *	$250 / 80%	$250 / 80%	$250 / 80%
Out-patient	$30 co-pay/visit/100%	50%	80%
Out-patient mental / drug	$30 co-pay/visit/100%	50%	80%
Out-patient alcohol	$30 co-pay/visit/100%	50%	80%
Preventive Care			
Physician office visit	$30/100%/100% lab	50%	80% office visit/100% lab
Other Services			
Rehab therapies	$30 co-pay/visit/80%	50%	$30 co-pay/visit/80%
Chiropractor	$30 co-pay/visit/80%	50%	$30 co-pay/visit/80%
Durable medical equipment	80%	50%	80%
Home health care services	80%	50%	80%
Private duty nursing	80%	50%	80% (20 visits/year)
Skilled nursing facility	$250 / 80%	$250 / 50%**	$250 / 80%
Sub-acute rehabilitation center	$250 / 80%	$250 / 50%**	$250 / 80%
Ambulance	80%	50%	80%
Hospice (in-patient/out-patient)	100%	50%	100%

* Contact carrier within 48 hours of an emergency admission to an out -of–network hospital; emergency department co–pay not applied if admitted to hospital.

** $200 penalty applied if scheduled admission to non–participating hospital is not pre–certified through the carrier.

*** Benefits for Medicare Part B Services are estimated to pay secondary to Medicare Part B whether enrolled in Medicare Part B or not.

APPENDIX I

Voluntary Dental Plan Design/Premium Amounts

As shown below, enrolled members would have less out-of-pocket expenses by using a network dentist.

	UnitedHealthcare	Dental
	Network	***Non-network***
Deductible	$50 single/$150 family	$100 single/$300 family
Calendar Year maximum per person	$1,500 per person	$750 per person
Class I Benefits		
Diagnostic Services	100% (with no deductible)	75% (with no deductible)
Preventive Services	100% (with no deductible)	75% (with no deductible)
Fluoride Treatment	100% (with no deductible)	75% (with no deductible)
Emergency Palliative	100% (with no deductible)	75% (with no deductible)
Radiographs	100% (with no deductible)	75% (with no deductible)
Class II Benefits		
Oral Surgery	80% (after deductible)	50% (after deductible)
Minor Restorative	80% (after deductible)	50% (after deductible)
Periodontics	80% (after deductible)	50% (after deductible)
Endodontics	80% (after deductible)	50% (after deductible)
Class III Benefits		
Prosthodontics	50% (after deductible)	30% (after deductible)
Major Restorative	50% (after deductible)	30% (after deductible)

Voluntary Dental Plan Premium Amounts

	UHC Dental
Benefit Recipient (including survivors)	$30.99
Benefit Recipient & Spouse	$58.46
Benefit Recipient & Child(ren)	$60.90
Benefit Recipient, Spouse & Child(ren)	$101.78

APPENDIX J

Voluntary Vision Plan Design/Premium Amounts

	UnitedHealthcare Vision	
Voluntary Vision Features:	**Network Providers**	**Non-Network Providers**
Plan Frequency	Pair of lenses for eyeglasses: once every 12 months; Contact lenses in lieu of eyeglasses: once every 12 months; Frames: once every 24 months	Pair of lenses for eyeglasses: once every 12 months; Contact lenses in lieu of eyeglasses: once every 12 months; Frames: once every 24 months
Exam Co-pay	$10, one per year	Up to $50 reimbursement
Materials Co-pay	$0 co-pay	Not applicable
Single Vision Lenses	$0 co-pay	Up to $60 reimbursement
Lined Bifocal Lenses	$0 co-pay	Up to $80 reimbursement
Lined Trifocal Lenses	$0 co-pay	Up to $120 reimbursement
Lined Lenticular Lenses	$0 co-pay	Up to $200 reimbursement
Scratch Coating	$0 co-pay	Not applicable
Frames	*$0 co-pay; $130 allowance plus up to 50% over allowable at discretion of provider	Up to $78.00 reimbursement
Contact Lens Fitting and Evaluation	$0 co-pay under UnitedHealthcare Vision's contact lenses package	Elective contacts in lieu of eye glasses: $200; Necessary contacts Contact in lieu of eye glasses $210.

- A benefit recipient's individual provider may offer discounts in addition to the vision coverage offered through UHC
- Underwritten by UnitedHealthcare Insurance Company

Voluntary Vision Plan Premium Amounts

	UHC Vision
Benefit Recipient (including survivors)	$5.48
Benefit Recipient & Spouse	$10.29
Benefit Recipient & Child(ren)	$10.09
Benefit Recipient, Spouse & Child(ren)	$15.63

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