

# Member's Guide to Health Care Coverage for 2009



The Ohio Police & Fire Pension Fund (OP&F) continues to sponsor a health care plan for eligible benefit recipients and their dependents according to the plan design and enrollment guidelines. Adoption of this plan came as a result of a vote by the Board of Trustees to reaffirm their commitment to provide current and future retirees with quality health care and to develop a plan that would ensure availability of some form of health care subsidy.

## **OP&F continues to partner with UnitedHealthcare to deliver health care coverage to OP&F eligible benefit recipients and their dependents, effective January 1, 2009.**

UnitedHealthcare brings more than 30 years of plan stability as a reputable carrier to the health care industry. UnitedHealthcare is a national carrier with a strong national network across the country. This will allow one carrier to provide the administration for all OP&F-sponsored health care coverage. This will include health care, prescription drug, voluntary dental and vision coverage options.

All information described in this guide is effective for the OP&F-sponsored health care plan beginning January 1, 2009. For information about the OP&F-sponsored health care plan and contribution amounts prior to this date, please contact UnitedHealthcare at 1-888-832-0964.

For the purposes of reviewing the Statement of Rights Under the Newborns' Mothers' Health Protection Act; Notice of Women's Health and Cancer Rights Act; Notice of Creditable Prescription Drug Coverage; and Notice of Privacy Practices, please refer to pages 50 through 54.

This publication summarizes the most important provisions of the governing law and administrative rules on the reporting requirements and employment restrictions related to the OP&F-sponsored health care plan. This summary cannot sufficiently represent all of the details applicable to this guide. Nothing contained in this summary is meant to interpret, extend or change, in any way, the governing statute, administrative rules and governing documents. As a result, your rights can only be determined by the provisions of the plan's governing documents, which are subject to change.

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors or hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules carefully, including the "coordination of benefits" section on page 26, and compare them with the rules of any other plan that covers you or your family.

## Here's where to find the details of your 2009 coverage.

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# Who is eligible for coverage?

## **Eligibility guidelines for the OP&F-sponsored health care coverage**

Retirees, qualified surviving spouses, surviving children who are receiving the statutory survivor benefit, and eligible dependents who are students between the ages of 18 and 23, may qualify to participate in the OP&F-sponsored health care coverage if determined eligible according to the terms of the health care plan. The limited enrollment opportunities for the OP&F-sponsored health care coverage can be found in this guide.

## **Benefit recipient eligibility guidelines**

Generally, a benefit recipient is defined as an OP&F member who is receiving a service retirement or disability benefit, or surviving spouse, a surviving child/orphan, or dependant parent who is receiving statutory survivor benefits from OP&F.

### ***Retiree***

An OP&F member who is receiving a service pension or disability benefit from OP&F is eligible to participate in health care and or prescription drug coverage on the effective date of their retirement or the first day of the month following their effective date of retirement. The required paperwork must be filed with UnitedHealthcare within 60 days of receiving your first benefit check.

### ***Surviving spouse***

Upon the effective date of the statutory survivor benefits, a surviving spouse who receives a statutory survivor pension from OP&F is eligible to participate in the OP&F-sponsored health care plan as long as they are not participating or waived health care coverage through another Ohio retirement system or were legally separated from an OP&F member on or after January 1, 2004. Health care coverage for an eligible surviving spouse continues without interruption upon the member's death for a limited period. In this event, a *Survivor Health Care Eligibility and Enrollment Form* must be filed with UnitedHealthcare within 90 days.

A surviving spouse who remarries may still participate in the OP&F-sponsored health care coverage as long as he or she is not participating or waived health care coverage provided through another Ohio retirement system. The new spouse and any child born to the surviving spouse after the OP&F member's death are not eligible for coverage, unless the OP&F member is the child's parent.

### ***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.

### **Dependent eligibility guidelines**

#### ***Spouse***

A spouse who is not eligible for (or who has irrevocably waived) health care coverage through another Ohio retirement system is eligible as a dependent under the OP&F-sponsored health care coverage, but a spouse who is legally separated on or after January 1, 2004 is not an eligible dependent.

#### ***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 January 1, 2004).
- A stepchild who has not been legally adopted by the member can be added if the member certifies, in a form acceptable with UnitedHealthcare, that coverage is not available through either parent and the child meets all other eligibility guidelines.

#### ***Student***

A child between the ages of 18 and 23 is eligible for enrollment in the OP&F-sponsored health care coverage if primarily dependent upon you for support, is attending an accredited institution\* and is enrolled for at least two-thirds of the minimum number of credit hours required to be considered a full-time student.

With certain exceptions, financial dependency is demonstrated if the benefit recipient can validly claim the child as an exemption for federal income tax return purposes and file the appropriate paperwork with UnitedHealthcare.

\* An institution is considered a school if it offers a regular schedule of courses on an annual or more frequent basis, it employs a full-time faculty and permanent administration, and includes formal classroom sessions rather than on-the-job training. Home schooling is permitted if recognized by the appropriate educational association. Verification of student status must be submitted to UnitedHealthcare each quarter or semester.

A student must be enrolled in the plan on the benefit recipient's effective date of retirement or on January 1, 2004, whichever is later, and must have been continuously enrolled to qualify, or meet the enrollment requirements previously described.

Students will be covered during one semester or quarter-long break in school during each 12-month period. For example, college students who would attend school in the fall and winter quarter of 2008 and spring quarter in 2009, would be eligible for coverage over the summer break in 2009 as long as the student returned to school for the fall quarter of 2009. If the student did not return to school for the fall quarter of 2009, then UnitedHealthcare would terminate coverage for the student. The benefit recipient will be responsible for repaying UnitedHealthcare the full unsubsidized monthly premiums incurred during the period of ineligibility.

A *Student Eligibility Form* must be completed and returned to UnitedHealthcare for each quarter or semester that the student attends school. If the benefit recipient fails to file the *Student Eligibility Form* by the date requested or UnitedHealthcare determines that the student no longer attends school for the required number of hours, coverage will be terminated. It is the benefit recipient's responsibility to notify UnitedHealthcare in cases when an enrolled dependent is no longer eligible for coverage, such as loss of student status, within 60 days of the event for timely termination and adjustments in health care contributions. Reinstatement will occur on the day the form is received by UnitedHealthcare.

### ***Incapacitated child***

A child, regardless of age, who is financially dependent upon the benefit recipient for support, is unable to earn a living because of a physical or mental handicap and became incapacitated prior to age 18 or 23 if then attending school, can be eligible for the OP&F-sponsored health care coverage. With limited exceptions, a disabled child over age 23 may apply for the OP&F-sponsored health care coverage at the time the benefit recipient is first eligible for this plan. However, the disabled child must have met the eligibility requirements previously listed prior to age 23. Also, the benefit recipient must be the child's natural parent or must have legally adopted the child. Application guidelines and restrictions do apply. The *Statement of Dependent Eligibility Beyond Limiting Age Form* must be completed and returned to UnitedHealthcare for certification in 2009. This form will be reviewed by UnitedHealthcare's medical director for determination of incapacitation. A letter of acceptance or denial will be mailed to the benefit recipient's address on file. Depending on medical condition, certification may be refused at a later date. Please contact UnitedHealthcare at 1-888-832-0964 to request a form.

# When is it possible to enroll?

## **Opportunities to enroll in the OP&F-sponsored health care coverage**

Enrollment for the OP&F-sponsored health care coverage is coordinated through UnitedHealthcare, with the exception of OP&F-sponsored Long Term Care plan. Please read this section carefully since there are limited opportunities for you to enroll in the OP&F-sponsored health care plan.

### ***Health care and prescription drug coverage***

You and your eligible dependents may participate in the OP&F-sponsored health care and prescription drug coverage under the following circumstances:

- at the time of your OP&F retirement;
- three years after your OP&F retirement or commencement of OP&F benefits;
- with proof of change in family status (i.e. marriage, death, divorce);
- with proof of loss of group coverage; or
- at the time you become eligible for Medicare.

You must notify UnitedHealthcare in writing of these changes within 60 days of the qualifying event in order to be eligible for enrollment.

If you or your spouse are employed and eligible for health care or prescription drug coverage through the employer, you can participate in the OP&F-sponsored health care coverage. However, OP&F will not subsidize your contributions. Also, if your spouse is eligible for health care or prescription drug coverage through his or her retirement system, as long as it is not another Ohio retirement system (ORS), he or she will be eligible for the OP&F-sponsored health care coverage but will be responsible for paying the full premium. Please see page 42 for the OP&F-sponsored health care full premiums, and pages 11 & 12 for information on benefits through an ORS eligibility.

### ***Voluntary dental and vision plans***

Voluntary dental and vision coverage are separate plans offered as a supplement to health care coverage. Enrollment in these plans is offered annually to all eligible benefit recipients during the Annual Change Period that occurs in the fall with coverage taking effect January 1 of the following year.

Unless there is a valid change in family status (i.e. death, divorce, or other loss of eligible status), you and your enrolled dependents must remain in the voluntary dental and vision plans for 12 consecutive months in 2009. The appropriate contributions will be deducted from your benefit check for the entire period. In addition, if you enroll in these plans, you can only enroll additional dependents during the Annual Change Period, unless there is a valid change in your family status.

### ***OP&F-sponsored Long-Term Care***

More information on Long-Term Care can be found on page 40. Please contact OP&F at 1-800-860-9599.

### ***Pre-existing conditions***

The OP&F-sponsored health care plan provides coverage for pre-existing conditions upon enrollment.

### **Enrolling as a new retiree**

As a new retiree, you qualify to enroll in the OP&F-sponsored health care coverage. The 2009 health care plan will offer one plan design through one carrier, UnitedHealthcare, 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. UnitedHealthcare is a national carrier with a strong national network across the country. This will allow one carrier to provide the administration for all benefits.

OP&F benefit recipients and dependents age 65 and over that are Medicare eligible and enrolled in both Medicare Parts A & B will be eligible to enroll in AARP Medicare Supplement Plan B, Plan F, or Plan L underwritten by United HealthCare Insurance Company. Medicare Supplement plans help you control your out-of-pocket expenses, like deductibles and coinsurance, and offer flexibility by providing a wide variety of coverage options. If you are enrolled in Medicaid you may not be eligible for AARP Medicare Supplement Plans. Please contact AARP for additional information at 1-888-832-0964.

In most states, up to 12 standardized Medicare supplement plans may be offered. OP&F will subsidize Plan B, Plan F or Plan L. The OP&F subsidy will be based on the AARP Medicare Supplement Plan L premium rate for the state of Ohio, with the option to buy-up to Plan B or Plan F. These plans are guaranteed renewable and do not require you to submit any claim forms. Unlike Medicare Advantage Plans which have limited networks, with standardized Medicare supplement plans, you have total freedom to choose any doctor, specialist, hospital or other provider that accepts Medicare anywhere in the United States. No referrals are required.

UnitedHealthcare will also be providing prescription drug benefits through UnitedHealthcare Pharmacy for all OP&F retirees, both non-Medicare and Medicare, unless you enroll in Medicare Part D.

To enroll in health care and/or prescription drug coverage as a new retiree, you must complete a *Health Care Eligibility and Enrollment Form* within 60 days of receiving your first benefit check. However, if you have not received your *Health Care Eligibility and Enrollment Form*, you must contact UnitedHealthcare at 1-888-832-0964 and request an enrollment kit, which will be mailed directly to your home. You may also call UnitedHealthcare to set up an appointment to review your health care coverage options.

If you want to waive or change your coverage, you must do so within 60 days of receiving your first benefit check. Coverage for new benefit recipients and dependents will take effect at the effective date of retirement or the 1st day of the month following the effective date of retirement as designated on the benefit recipient's *Health Care Enrollment and Eligibility Form*. The effective date of retirement is the default date. You may enroll in the OP&F-sponsored voluntary dental and vision plans only during the Annual Change Period.

Even though you and your dependents are eligible for health care and prescription drug coverage on the effective date of your retirement or the 1st of the month following your effective date of retirement, until your first benefit check is mailed or direct deposited, you and your dependents are considered to be in the "window period." During this period, you must pay for any health care or prescription drug services up front and submit claim forms for reimbursement. Claims for health care services or prescription drugs during the window period must be submitted to UnitedHealthcare. You must follow the procedures in this guide to submit claims to UnitedHealthcare for reimbursement without penalty of health care and prescription drug expenses that you received during the window period. Please see page 55 for claims mailing address.

#### ***UnitedHealthcare ID card***

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., if enrolled, you will receive a combined health care/prescription drug ID card from UnitedHealthcare, which will be mailed directly to your home.

OP&F benefit recipients and dependents age 65 and over that are Medicare eligible, enrolled in both Medicare Parts A & B and enrolled in an AARP Medicare Supplement Plan will receive a health care ID card from United HealthCare Insurance Company and a prescription drug ID card from UnitedHealthcare, unless you are enrolled in Medicare Part D.

## Enrolling your dependents

You may enroll your eligible dependents in the OP&F-sponsored health care coverage, using the *Health Care Eligibility and Enrollment Form*, within 60 days of a qualifying event (listed on page 6) making them eligible for coverage. If you enroll eligible dependents in the OP&F-sponsored health care coverage, the following information must also be submitted to UnitedHealthcare:

### **Spouse**

- a copy of the spouse's birth certificate;
- a copy of the spouse's Social Security card; and
- a copy of the solemnized marriage certificate that indicates the date of marriage and is signed by the person with legal authority to conduct the ceremony.

### **Natural child, adopted child or step-child**

- a copy of the child's birth certificate;
- a copy of the child's Social Security card; and
- if applicable, certified copies of the court order granting adoption.

In some cases, UnitedHealthcare may request additional materials to determine dependent eligibility.

Eligible newborn children must be enrolled within 60 days from birth with coverage effective on the date of birth.

Coverage for eligible dependents listed on a benefit recipient's *Health Care Eligibility and Enrollment Form* will take effect on the effective date of the qualifying event or the 1st day of the month following the qualifying event as designated by the benefit recipient on the *Health Care Eligibility and Enrollment Form*. If there is no designation on the form the effective date of the qualifying event is the default date.

## Dependent only eligibility

Upon a qualifying event listed on page 6, if you are not enrolled in the OP&F-sponsored health care coverage, you may still enroll an eligible dependent if that dependent does not have access to coverage elsewhere. For example, if you are working part-time and have access to single coverage for yourself only, with no available coverage for your spouse or other dependents, you may enroll your dependents in the OP&F-sponsored health care coverage without enrolling yourself. Written proof that your dependents do not have access to coverage is required.

### **Enrolling as a survivor**

Upon an OP&F retiree's death, coverage continues without interruption for the surviving spouse as long as the proper paperwork is filed with UnitedHealthcare within 90 days.

#### ***Survivors who were not enrolled***

Upon notification of a retiree's or active member's death, the survivor who was not enrolled in the OP&F-sponsored health care coverage will receive a *Survivor Health Care Eligibility and Enrollment Form*. To enroll in the OP&F-sponsored health care coverage, the survivor must complete and file the form within 90 days.

#### ***Survivors who were enrolled***

Upon notification of a retiree's death, the survivor who was enrolled in the OP&F-sponsored health care coverage will be enrolled in the same coverage as previously enrolled. UnitedHealthcare will mail a *Survivor Health Care Eligibility and Enrollment Form* to the survivor upon notification of the retiree's death.

The survivor must file the enrollment form with UnitedHealthcare within 90 days of receiving notification or commencement of benefits. If the form is not received by that time, UnitedHealthcare will terminate the OP&F subsidy, but continue coverage until the form is received.

If the survivor waives health care or prescription drug coverage, he or she may only enroll under the circumstances previously described on page 6. The survivor may only enroll in the OP&F-sponsored voluntary dental and/or vision coverage during the Annual Change Period.

For purposes of health care contributions, upon the retiree's death, the survivor assumes the role of the benefit recipient.

If a surviving child's pension is extended or terminated, then reinstated due to student eligibility, that surviving child also qualifies to have the health care benefits extended. A *Survivor Health Care Eligibility and Enrollment Form* must be returned to UnitedHealthcare within 90 days.

### **Married couples both receiving OP&F retirement benefits**

Married couples that individually receive their own OP&F service pension or disability benefit may enroll in OP&F-sponsored health care or prescription drug coverage under one of the following methods:

- both individuals are enrolled as benefit recipient and dependent and health care contributions are being withheld from the benefit recipient's pension benefit; or

- each individual is enrolled separately under his or her own plan, with health care contributions being withheld from each benefit recipient's pension benefit.

Married couples individually receiving a service pension or disability benefits may not enroll in two OP&F-sponsored plans at the same time. In addition, only one parent can cover eligible children. Please contact UnitedHealthcare Customer Service at 888-832-0964 for more information.

### **Other Ohio retirement system benefits**

An individual who is eligible to receive health care coverage through another Ohio retirement system is not eligible to enroll in the OP&F-sponsored health care, prescription drug, dental or vision plans. Other Ohio systems include: Ohio Public Employees Retirement System, School Employees Retirement System, State Highway Patrol Retirement System, and State Teachers Retirement System.

### **OP&F retirees**

If you receive a service retirement or disability benefit from OP&F and another ORS, you can participate in the OP&F-sponsored health care coverage if you have the same or more service credit with OP&F. Under the OP&F-sponsored health care plan, you cannot receive health care benefits from OP&F and another ORS. Keep in mind, however, each retirement system establishes their own eligibility guidelines.

#### ***Surviving spouse***

If you receive a statutory survivor benefit from OP&F and are receiving service retirement or disability benefits from another ORS, you are not eligible to participate in the OP&F-sponsored health care coverage. If you are only receiving statutory survivor benefits from more than one system, you can enroll in the OP&F-sponsored health care plan if your OP&F commencement of benefits is prior to the other ORS. Under the OP&F-sponsored health care coverage, you cannot receive health care benefits from OP&F and another ORS.

#### ***Dependent spouse***

A dependent spouse who is an active member of another ORS can participate in the OP&F-sponsored health care coverage until he or she retires and becomes eligible for health care through that retirement system. At that time, a dependent spouse who becomes a retiree of another ORS will not be eligible to participate in the OP&F-sponsored health care coverage.

### ***Surviving child***

A surviving child will always have primary health care coverage under the surviving spouse. However, a child cannot be a dependent for the purpose of health care benefits offered by more than one system. A child who is receiving a statutory survivor benefit from OP&F, however, can participate in OP&F coverage, but cannot receive health care benefits from OP&F and another ORS.

### ***Dependent child***

If a child has a parent who is eligible for coverage through OP&F and another eligible for coverage through another ORS, the parent may select OP&F or the ORS for the child's health care. However, the child cannot be a dependent of OP&F and another ORS.

### **Waiving OP&F-sponsored coverage to enroll in another ORS health care plan**

Effective January 1, 2008, the irrevocable waiver process between the Ohio retirement systems has been discontinued. Benefit recipients and/or dependents who have executed a waiver form prior to December 31, 2007 will be grandfathered into the program.

# How does this plan work with Medicaid and Medicare?

## Medicaid, Medicare and the OP&F-sponsored health care plan

The OP&F-sponsored health care coverage should be used in combination with benefits offered by Medicaid and Medicare, which are financed and coordinated by the state and federal governments. Most individuals become eligible for Medicare at age 65, however, individuals with certain disabilities may be eligible prior to age 65\*. Contact your local Social Security office for more information. It is essential that you and your dependents enroll in Medicare when becoming eligible.

## Medicaid eligibility

Medicaid provides medical assistance for certain benefit recipients and their enrolled dependents with low income and financial resources. Each state administers its own Medicaid program, establishes its own eligibility guidelines and determines the scope of its services. Medicare coverage, for Medicare beneficiaries who are also fully eligible for Medicaid, is supplemented by health care services available under the state's Medicaid program. If a Medicaid recipient is also a Medicare beneficiary, the Medicare program makes payments for any services covered by Medicare before the Medicaid program makes any payments. Please note that when enrolling in Medicaid, it is important to notify UnitedHealthcare, as Medicaid may enroll an individual in Medicare Part D prescription drug coverage. Under OP&F's health care coverage, the benefit recipient and/or dependents may not be enrolled in Medicare Part D and the OP&F-sponsored prescription drug program. UnitedHealthcare will also need to know if Medicaid is paying your Medicare Part B premium so an overpayment will not occur. For more information on Medicaid, please contact your state's Social Security office.

## Enrolling in Medicare

It is extremely important that you and your dependents enroll in Medicare when you are first eligible. If you or your enrolled dependents fail to enroll in Medicare Parts A or B when you are first eligible, the OP&F-sponsored coverage requires UnitedHealthcare to process claims as if you or your dependent were Medicare eligible and you will be responsible for all fees and expenses incurred that Medicare would have paid. In addition, OP&F reserves the right to recover any reimbursements erroneously processed for these individuals by UnitedHealthcare.

\* If you become eligible for Medicare prior to age 65 due to a certain disability, UnitedHealthcare will pay secondary to Medicare to cover your eligible medical expenses. If you become eligible for Medicare at age 65 or over and are enrolled in Medicare Parts A and B and enrolled in an AARP Medicare Supplement Plan, then Medicare will pay primary for your eligible expenses and your Medicare supplement plan will pay secondary.

If you are not already enrolled in Medicare, you and your dependents enrolled in the OP&F-sponsored health care coverage will receive Medicare enrollment information from UnitedHealthcare and materials for the AARP Medicare Supplement Plans approximately three months before you turn age 65 at the address on file. Therefore, you should make certain that UnitedHealthcare has your most current address on file. While this is a service to eligible benefit recipients, it is your responsibility to contact UnitedHealthcare if this paperwork is not received. Your health care contribution is adjusted to reflect your Medicare eligibility status.

If you or any of your dependents are enrolled in the OP&F-sponsored health care coverage and are not eligible for Medicare, you will need to utilize network providers, unless residing in an out-of-area location. See pages 21 and 22 for more information on network providers.

### **Enrolled dependents not eligible for Medicare**

All dependents enrolled in UnitedHealthcare who are not eligible for Medicare and reside in a network area are required to utilize network providers, even if the benefit recipient is eligible for Medicare. However, if the benefit recipient is age 65 and over and enrolled in both Medicare Parts A & B and enrolled in an AARP Medicare Supplement Plan, they will not be required to utilize network providers.

### **If you are eligible to receive Medicare Part A and B**

If you are entitled to receive both Medicare Parts A and B, it is imperative that you enroll when you first become eligible. Your OP&F-sponsored health care coverage with UnitedHealthcare will terminate at the end of the month prior to your effective date of Medicare eligibility. Once enrolled in both Medicare Parts A and B you will have the opportunity to enroll in AARP Medicare Supplement Plan B, F, or L through AARP Medicare Supplement Insurance underwritten by United HealthCare Insurance Company. You will receive an enrollment kit from AARP Medicare Supplement Insurance in the mail, which will include plan information, rates and enrollment instructions for enrollment into the AARP Medicare Supplement Plan.

### **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 you are not eligible for the AARP Medicare Supplement insurance and you choose to enroll in the OP&F-sponsored health care coverage, UnitedHealthcare will pay a percent of covered hospital expenses not paid by Medicare Part A after your deductible is met.

### **Not eligible for Medicare Part A**

If you are not eligible for Medicare Part A because you have worked an insufficient amount of quarters, send a copy of your ineligibility letter from the Social Security Administration to UnitedHealthcare. Upon UnitedHealthcare's receipt of this letter, and provided that you have enrolled in OP&F-sponsored health care coverage, you will receive the equivalent of Medicare Part A from UnitedHealthcare at no additional cost if you live in a network area and use network hospitals and facilities. For more information on network, non-network and out-of-area coverage, please see pages 21 & 22.

### **Medicare Part B**

Everyone who is eligible for Medicare, at least 65 years of age, is eligible to enroll in Medicare Part B, which is health care insurance, regardless of the number of quarters they have worked. If you are not eligible for AARP Medicare Supplement Insurance and you choose to enroll in the OP&F-sponsored health care coverage, UnitedHealthcare will pay a percentage of covered expenses, according to the plan design, for health care expenses not covered by Medicare Part B.

If you are not eligible for AARP Medicare Supplement Insurance and you choose not to enroll in Medicare Part B, UnitedHealthcare will only pay what it would have paid if you were enrolled in Medicare Part B. This typically leaves about 80 percent of the cost of coverage as your responsibility. It is essential that you enroll in Medicare Part B on the first date you are eligible in order to receive the most comprehensive health care benefits. You or your dependents enrolled in Medicare Part B only or not eligible for Part A are still required to use network hospitals and facilities to receive maximum coverage.

### **Early Medicare Automatic Claim Filing Program**

Through the Automatic Claim filing Program, Medicare forwards claims directly to UnitedHealthcare on behalf of you and your enrolled dependents. Once a copy of your Medicare card is received, UnitedHealthcare will enroll you in the Automatic Claim Filing Program between Medicare and UnitedHealthcare. This will allow Medicare to automatically send your Explanation of Medical Benefits to UnitedHealthcare for secondary coverage consideration. If OP&F is your tertiary (third) coverage, you will need to notify UnitedHealthcare so that you can be disenrolled from the Automatic Claim Filing Program. If you are enrolled in the AARP Medicare Supplement Plan, then your Medicare carrier will automatically file your Part B claims to United HealthCare Insurance Company for you.

### **Medicare becomes primary coverage**

If you and your dependents are age 65 and over, and are eligible for both Medicare Parts A and B, Medicare is the primary coverage and the AARP Medicare Supplement Insurance is designed to supplement the Medicare coverage.

### ***Eligible for AARP Medicare Supplement Insurance Plans***

OP&F benefit recipients and dependents age 65 and over that are Medicare eligible and enrolled in both Medicare Parts A and B will be eligible to enroll in an AARP Medicare Supplement Plan B, Plan F or Plan L underwritten by United HealthCare Insurance Company. Medicare supplement plans help you control your out-of-pocket expenses, like deductibles and coinsurance, and offer flexibility by providing a wide variety of coverage options. In most states, up to 12 standardized plans can be selected for OP&F retirees. OP&F will subsidize Plan B, Plan F or Plan L. These plans are guaranteed renewable and do not require you to submit any claim forms. With standardized Medicare supplement plans, you have total freedom to choose any doctor, specialist, hospital or other provider that accepts Medicare anywhere in the United States. No referrals are required. If you are enrolled in Medicaid, you may not be eligible for AARP Medicare Supplement Insurance. Please contact AARP for additional information. Call UnitedHealthcare at 1-888-832-0964 to request an enrollment kit, which must be returned prior to your effective date.

### ***Not Eligible for AARP Medicare Supplement Insurance Plans***

OP&F benefit recipients and dependents who are early Medicare, Medicare A only, Medicare B only, or both Medicare A & B and not enrolled in an AARP Medicare Supplement Plan the OP&F-sponsored health care coverage becomes secondary coverage after Medicare. All health care expenses covered under the OP&F-sponsored health care coverage becomes secondary coverage after Medicare. All health care expenses covered under the OP&F-sponsored health care coverage will be reduced by your Medicare benefits available for those expenses. This is done before the health care benefits of the selected OP&F-sponsored coverage are calculated. Even if you do not enroll in Medicare, claims are processed as Medicare primary.

## **Medicare Part B reimbursement**

### ***Benefit recipient eligibility***

OP&F will reimburse you for your Medicare Part B basic insurance premium provided that you are not eligible to receive this reimbursement from any other source and you file the appropriate paperwork with UnitedHealthcare. "Basic premium" means the amount of the standard monthly premium for individuals enrolled in Medicare Part B coverage, as determined by the Secretary of the Health and Human Services, before any adjustments made to the premium, such as an increase in premium for late enrollment or an increase in premium due to a reduction in the premium subsidy based on income. Regardless of your enrollment in the OP&F-sponsored medical plan, reimbursement will begin the month following UnitedHealthcare's receipt of your fully completed *Medicare Part B Reimbursement Statement* or Medicare billing statement and a

copy of your Medicare card, unless it is the month that you are first eligible. If a copy of the benefit recipient's Medicare card and completed *Medicare Part B Reimbursement Statement* are received any time during the month of your 65th birthday, you will receive that month's reimbursement. As a service to you, UnitedHealthcare will send you information on Medicare Part B reimbursement about three months before you turn 65. However, it is your responsibility to enroll in Medicare Part B at the earliest date you become eligible and submit the appropriate paperwork to obtain reimbursement for your Medicare Part B "basic premium". If you are eligible for Medicare Part B before age 65, it is your responsibility to contact UnitedHealthcare to request the *Medicare Part B Reimbursement Statement*. OP&F will not make retroactive reimbursement payments of the Medicare Part B premium.

### ***Dependent spouse eligibility***

Ohio law only permits reimbursement of the Medicare Part B premium for the benefit recipient. OP&F will not reimburse the Medicare Part B insurance premium for your dependent spouse. Should you die before your dependent spouse, and your spouse receives a statutory survivor's pension, your surviving spouse may become eligible for the Medicare Part B reimbursement provided your surviving spouse is not eligible to receive the reimbursement from any other source. Your surviving spouse will then be required to submit a *Medicare Part B Reimbursement Statement* or Medicare billing statement and a copy of the Medicare card within 90 days. As a service to you, UnitedHealthcare will send your surviving spouse information on Medicare Part B reimbursement about three months before he or she turns 65. However, it is his or her responsibility to enroll in Medicare Part B at the earliest date your surviving spouse becomes eligible and submits the appropriate paperwork to obtain reimbursement for Medicare Part B premium. If your surviving spouse is eligible for Medicare Part B before age 65, please contact UnitedHealthcare to request this form. OP&F will not make retroactive reimbursement payments of the Medicare Part B premium. OP&F will only reimburse the standard monthly Part B "basic premium".

### **Receiving Medicare Part B reimbursement from another source**

If you are eligible to receive the Medicare Part B reimbursement from another Ohio retirement system, Medicaid, or from any other source, you are not eligible for this reimbursement from OP&F. If you do receive the Medicare Part B reimbursement from OP&F and another source, or if OP&F overpays you for the reimbursement, UnitedHealthcare will recover these funds on behalf of OP&F from your monthly benefit check or in a manner prescribed by OP&F policy. You must annually certify to UnitedHealthcare that OP&F is the only entity reimbursing you for the Medicare Part B premium. OP&F reimbursements will be terminated if OP&F is not the only source of this reimbursement.

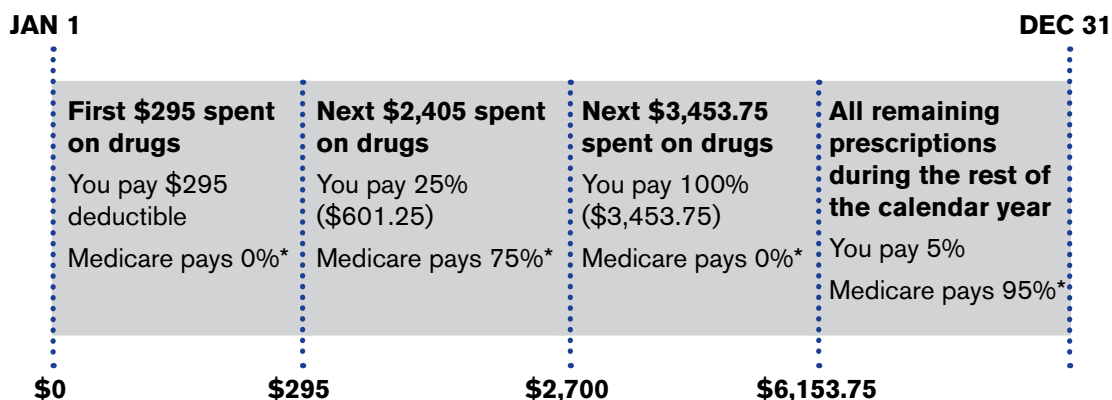
## Medicare Part D and OP&F-sponsored prescription drug coverage

Medicare Part D is Medicare's prescription drug coverage. If you are eligible for Medicare Part D, you will need to decide which prescription drug plan will best fit your personal circumstances. If you choose to enroll in Medicare Part D, you are not permitted to remain enrolled in the OP&F-sponsored prescription drug coverage. The Centers for Medicare & Medicaid Services (CMS) will notify UnitedHealthcare of your dual enrollment and UnitedHealthcare will require you to disenroll from one of the programs. If you waive your OP&F-sponsored prescription drug coverage to enroll in Medicare Part D, you will need to notify UnitedHealthcare. You will also have limited opportunities to re-enroll in the OP&F-sponsored prescription drug coverage. For more information on Medicare Part D, please see the chart below.

### Medicare Part D benefits chart

Medicare Part D offers prescription drug coverage plans for those eligible for Medicare. Unlike the OP&F-sponsored prescription drug coverage, Medicare Part D has a yearly deductible of \$295. Once you reach the \$295 deductible, however, Medicare will cover 75 percent of your next \$2,405 spent on prescription drugs. After your costs reach \$2,700 on prescription drugs within a given year, you are responsible for 100 percent of your prescription drugs for the next \$3,453.75. After you spend \$6,153.75 during a year, Medicare will cover 95 percent of the cost of whatever prescription drugs you require for the rest of the year. In summary, you have to spend \$4,350 before Medicare will cover 95 percent of your drug costs. The OP&F-sponsored prescription drug coverage will be available to you and your dependents for a monthly contribution, co-pays and no annual deductibles. Please see page 28 for specific prescription drug benefits sponsored by OP&F.

UnitedHealthcare will annually provide enrolled Medicare eligible benefit recipients a Notice of Creditable Coverage (NOCC), so if you would like to enroll in Medicare Part D at a later date, there would be no penalty. The NOCC can be found on page 51.



\*The above chart only applies to Medicare Part D approved drugs.

# How do I waive or terminate coverage?

## Waiving or terminating coverage

Enrollment in the OP&F-sponsored health care coverage is not mandatory and health care or prescription drug coverage can be waived at any time for either yourself or your dependents. The re-enrollment guidelines are highlighted on pages 19 & 20, which include a list of the limited opportunities to re-enroll.

## Waiving coverage

To waive health care or prescription drug coverage, you must submit a waiver to UnitedHealthcare. Waivers will take effect the last day of the month for requests received prior to the 15th of that month. If written requests are received after the 15th, coverage will be waived on the last day of the following month, with exceptions for qualifying events. Adjustments to contributions will be made on the date received as previously listed.

## Court Orders

UnitedHealthcare may not be able to process a waiver or termination if contrary to the terms of an existing court order that prohibits you from removing a child from coverage.

## Terminating Coverage

Coverage will terminate the last day of the month in which you or your enrolled dependent(s) were eligible. You and your enrolled dependents whose coverage has terminated may be eligible for conversion to a personal medical policy through UnitedHealthcare. It is your responsibility to notify UnitedHealthcare when an enrolled dependent is no longer eligible for coverage, such as divorce, death or loss of student status, and provide appropriate documentation within 60 days of the event for timely termination and adjustments to your contributions. If divorced, please provide the address of your former spouse and a certified copy of the divorce decree for UnitedHealthcare records.

For terminations that exceed 60 days, coverage will be terminated and you will be responsible for remitting to OP&F the full, unsubsidized monthly premiums incurred during the period of ineligibility. Terminating the OP&F-sponsored dental and vision plans are only permitted during the Annual Change Period, unless there is a valid change in family status.

## Re-enrollment

If you waive or terminate OP&F-sponsored health care or prescription drug coverage for yourself or your dependents, you have limited opportunities to re-enroll. Re-enrollment is

permitted only under the following circumstances and provided the appropriate documentation is timely filed with UnitedHealthcare.

- three years after your OP&F retirement or commencement of OP&F benefits;
- with proof of change in family status (i.e. marriage, death, divorce);
- with proof of loss of group coverage; or
- at the time of Medicare eligibility.

If you believe you or a dependent qualify for enrollment, please contact UnitedHealthcare Customer Service at 1-888-832-0964, Mon.-Fri., 8 a.m.-4:30 p.m. EST to request a *Health Care Eligibility and Enrollment Form*.

You must submit a *Health Care Eligibility and Enrollment Form* within 60 days of a qualifying event to be eligible to re-enroll. If UnitedHealthcare does not receive the form within 60 days, coverage will not be available. If UnitedHealthcare receives the form on time, coverage will be effective as of the date following the qualifying event or the 1st of the month following the event with corresponding contributions due to UnitedHealthcare. If you do not designate a coverage effective date, UnitedHealthcare will use the date of the qualifying event to determine the effective date of coverage. For example, if you marry on the 15th of the month, submit an enrollment form to add your new spouse to your coverage and do not designate a coverage effective date, UnitedHealthcare will determine the date of marriage (15th of the month) to be the effective date of coverage.

### **Annual Change Period**

Each fall, you will receive an Annual Change Period Guide and form that provides more details about the upcoming OP&F-sponsored health care coverage, describes the Annual Change Period process, announces any changes to the plan or contributions rates, and directs you to sources for more information. Seminars are typically held throughout the state of Ohio during the Annual Change Period to provide more information to members.

### **Annual Change Period Form**

UnitedHealthcare sends a pre-printed Annual Change Period Form (ACPF) to every benefit recipient each year. You should use the form to verify or waive your current enrollment and make sure that any pre-printed information, such as your address, phone number, birth date, worker's compensation claims and Medicare status, is accurate. Currently, you can also use the ACPF to enroll or dis-enroll in the OP&F-sponsored voluntary dental and vision plans.

You may not use this form to enroll yourself or eligible dependents in OP&F-sponsored health care or prescription drug coverage. Contact UnitedHealthcare Customer Service to request a *Health Care Eligibility and Enrollment Form* to enroll, if eligible. Read about the limited opportunities to enroll in the OP&F-sponsored health care coverage on page 6.

# What are the details of my health care coverage?

## Health care coverage

The 2009 health care plan will offer one plan design through one carrier, UnitedHealthcare, 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. UnitedHealthcare is a national carrier with a strong national network across the country. This will allow one carrier to provide the administration for all benefits.

OP&F benefit recipients and dependents age 65 and over that are Medicare eligible and enrolled in both Medicare Parts A & B will be eligible to enroll in an AARP Medicare Supplement Plan underwritten by United HealthCare Insurance Company. Medicare supplement plans help you control your out-of-pocket expenses, like deductibles and coinsurance, and offer flexibility by providing a wide variety of coverage options.

In most states, up to 12 standardized Medicare supplement plans may be offered. These plans are guaranteed renewable as long as your premium is paid on-time, and do not require you to submit any claim forms. With standardized Medicare supplement plans, you have total freedom to choose any doctor, specialist, hospital or other provider that accepts Medicare-anywhere in the U.S. No referrals are required.

## Using network providers

If you reside in a network area and enroll in the UnitedHealthcare network, you should utilize participating network providers to receive maximum benefits. You may choose a doctor or hospital from United Healthcare's provider listing at the time services are needed.

There are definite advantages if you and your enrolled dependents utilize network providers. Special, reduced fees have been negotiated with all network providers, and you will not be responsible for paying the difference between the provider's normal charge and specially-negotiated fees. You will, however, still pay your co-pay and deductible. In addition, when using network providers you do not have to file claim forms, deductibles are lower and the maximum yearly out-of-pocket limit is lower.

### ***Who should use network providers***

Benefit recipients and dependents that are not eligible for early Medicare Parts A & B should use network providers. Also, benefit recipients and dependents that are only enrolled in Medicare Part B must use network hospital and facilities.

### **Using non-network providers**

Under the plan, if you or your enrolled dependents reside in a network area and utilize a non-network provider, you will incur higher out-of-pocket costs. Because special fees have not been negotiated with non-network providers, you and your enrolled dependents have a lower benefit level and will be responsible for paying any amount between the provider's fee and the usual, customary and reasonable allowance determined by UnitedHealthcare. Benefit recipients and dependents should avoid non-network providers whenever possible. This results in higher out of pocket costs. If you are having difficulty finding a network provider, please contact UnitedHealthcare.

### **Residents out-of-area**

UnitedHealthcare has active provider networks in virtually all states including the entire state of Ohio. However, network coverage may differ from state to state. If you reside out-of-area or are early Medicare Parts A & B eligible, you may use any provider or hospital and still receive most benefits at the network benefit level. When utilizing out-of-area providers, you may need to file your own claim forms, notify UnitedHealthcare yourself, and pay any difference between the provider's fee and the usual, customary and reasonable allowance determined by UnitedHealthcare.

### ***Who should use out-of-area providers***

Benefit recipients that are not required to use network providers because they are eligible for early Medicare Parts A & B or permanent residents of an area without access to UnitedHealthcare's network should use out-of area providers. When utilizing out-of-area providers, any difference between the provider's fee and the usual, customary and reasonable rates allowance, as determined by UnitedHealthcare, may be required to be paid by the benefit recipient. The benefit recipient may try to negotiate with the provider on the amount owed.

### ***Residence change***

The health care plan has eligibility guidelines based on area of residence. If you are changing your area of residence, you should notify UnitedHealthcare in writing immediately. If the move affects health care coverage, UnitedHealthcare will contact you to make arrangements to place you in a network or out-of-area status.

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

Benefit recipients and dependents enrolled in UnitedHealthcare may experience a difference in coverage between network, non-network and out-of-area providers as outlined in the below chart. For complete information, please contact UnitedHealthcare directly.

	Network	Non-Network	Out-of-Area
<b>Annual Deductible (2.5 million lifetime maximum per person)****</b>			
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%
<b>Physician Services</b>			
Office Visit	\$30/100%	50%	80%
<b>Emergency Care</b>			
Emergency department	\$100/80%	\$100/80%	\$100/80%
Non-emergency services rendered in emergency room	\$100/50%	\$100/50%	\$100/50%
Urgent care	\$50/80%	50%	80%
<b>Hospital In-Patient Services</b>			
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%
<b>Ambulatory Services</b>			
Diagnostic lab/x-ray	80%	50%	80%
Ambulatory surgery center	\$150/80%	50%	\$150/80%
<b>Mental Health (No Annual Maximum) and Substance Abuse (\$3,100 Annual Max)</b>			
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/ 80%	50%	\$30 co-pay/visit/ 80%
Out-patient mental/drug	\$30 co-pay/visit/ 80%	50%	\$30 co-pay/visit/ 80%
Out-patient alcohol	\$30 co-pay/visit/ 80%	50%	\$30 co-pay/visit/ 80%

\* 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.

\*\* Office visit co-pay when applicable; Vaccines for travel are not covered.

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

\*\*\*\*The most that will be paid under the health care plan for any person during his or her lifetime commencing on January 1, 2007, which excludes previous claims prior to January 1, 2007.

### Comparing network, non-network and out-of-area benefits (continued)

	Network	Non-Network	Out-of-Area
<b>Preventive Care**</b>			
Carrier standard	Office visit co-pay/ 100%	50%	80% office visit/ 100% lab
<b>Other Services</b>			
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)	(20 visits / year)	(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.

\*\* Office visit co-pay when applicable; Vaccines for travel are not covered.

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

\*\*\*\*The most that will be paid under the health care plan for any person during his or her lifetime commencing on January 1, 2007, which excludes previous claims prior to January 1, 2007.

# What are the limitations of my coverage?

## Health care coverage limitations/exclusion

There are some items that may not be covered under UnitedHealthcare, which include, but are not limited to:

- Coverage for bariatric surgery above \$10,000, that is not performed in a network facility, and/or patient has not maintained the two-year physician-directed weight loss management program prerequisite;
- Care for an on-the-job illness or injury (i.e., workers' compensation claims. If benefit recipients agree upon a lump sum medical settlement through workers' compensation, future claims relating to that occupational injury or illness will not be covered by either workers' compensation or the OP&F-sponsored health care plan);
- Custodial care whether institutionalized or not;
- Care that is not medically necessary;
- Services that are considered experimental and/or investigational; and
- Routine, employment and sports physicals.
- AARP Medicare Supplement Insurance claims that are not filed within 15 months from the date of service;
- Medical claims that are not filed with UnitedHealthcare within 24 months from the date of service;
- Prescription drug claim that are not filed within 12 months from the date of service;

You should contact UnitedHealthcare for complete details regarding plan limitations.

## Appeals procedures for coverage denied or reduced

### *Internal review*

If a claim or request for coverage of a service not yet performed is denied or reduced, you are entitled to have the decision reconsidered through UnitedHealthcare's internal review process. If your health would be jeopardized if the requested service were delayed, you may request an expedited review. For example, an internal review might be initiated if, during the notification process, the network administrator denied a planned surgical procedure

as being experimental. Contact the customer service number on your medical ID card for more information.

### **Coordination of benefits**

The coordination of benefits procedure is used to pay health care expenses when a person is covered by more than one plan. If you or your eligible dependents are covered by more than one plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals. Therefore, it may be impossible to comply with the requirements of both plans at the same time.

Coordination of benefits might apply if, for example, your employed spouse is covered under a family plan through his or her employer while you are covered under a family plan through UnitedHealthcare.

UnitedHealthcare follows rules established by Ohio law to decide which health care plan pays first. The objective is to ensure that the combined payments of all health care plans are no more than your actual bills.

To facilitate accurate claims payment, inform UnitedHealthcare of any other coverage that you or your eligible dependents might have.

### **Subrogation**

Subrogation occurs when a covered person's medical claims are the result of an injury caused by a third party. For example, an auto accident resulting in medical claims from covered members would be subrogated-or processed-under the liable person's auto insurance. Contact UnitedHealthcare if you have questions regarding a possible subrogation issue.

### **Traveling with OP&F-sponsored health care coverage**

If you or your dependents are non-Medicare eligible, early Medicare, Medicare A only or Medicare B only, the OP&F-sponsored health care coverage plan will cover you either traveling in the United States or abroad. If you receive medical treatment in a foreign country, you will have to pay for services when you receive them. You may submit an itemized bill, in English, to UnitedHealthcare for reimbursement. Only benefits that are covered under the health care plan will be covered when received outside the United States. Please call UnitedHealthcare for more information.

### **If your physician stops participating**

If your physician or preferred hospital chooses to terminate their contract with UnitedHealthcare, you must choose another provider or facility that participates with UnitedHealthcare in order to maximize your benefits. If you are in the middle of a treatment plan (i.e., Chemotherapy), contact UnitedHealthcare for the transition of care policy.

### **Hospital notification**

Notification means obtaining approval for coverage before receiving certain types of services. Notification can protect you from undergoing unnecessary medical procedures and paying bills for services that your plan does not cover.

Notification must be requested for hospital confinements, outpatient treatment of mental health and chemical dependency, and ancillary services, such as durable medical equipment. A request for notification can be made by you, your enrolled dependent, a family member, or your doctor or hospital. It is your responsibility to make sure that your notification process has been completed.

### ***Who must notify***

Participating network providers and hospitals will notify UnitedHealthcare for patients but in some cases, it will be the responsibility of the patient. Please refer to your Medical Plan Description for details.

### ***When to notify***

For non-emergency procedures, UnitedHealthcare should be contacted to request notification at least 5 days before admission. For emergency procedures or admissions, a notification call should be made within 4 business days of the admission or on the same day as admission if reasonably possible.

### ***Failing to notify***

Failure to notify UnitedHealthcare of a hospital confinement may result in a coverage penalty. For medically necessary days that UnitedHealthcare is not notified, UnitedHealthcare's utilization review unit will determine the penalty.

## What are my prescription drug coverage options?

In 2009, OP&F will continue to offer one prescription drug plan through UnitedHealthcare Pharmacy, as a separate coverage, with separate contribution amounts. The OP&F-sponsored prescription drug coverage allows you and your enrolled dependents to purchase your medications at discounted rates at either a retail location or, for the greatest savings, through the mail.

### **Retail pharmacies**

Whether at home or traveling, you should have easy access to one of UnitedHealthcare's participating retail pharmacies. The retail pharmacy is best used to purchase medications that you take on a short-term or immediate need basis. You will still save money when purchasing medications at a retail pharmacy for long-term medication, but the co-payments will be higher than through mail order.

You will have lower out-of-pocket expenses by purchasing your medications at a participating retail pharmacy. In addition, when you use a participating retail pharmacy, you will have no deductible or claim forms to file.

### **Mail service pharmacies**

UnitedHealthcare's Pharmacy plan uses Medco for the distribution of the mail order prescriptions. For a greater co-payment savings and convenience for medications you take on an ongoing basis, you can order your prescription medications through Medco by Mail. With mail order, there are no deductibles, no claim forms to file and no waiting for reimbursement. Simply mail your prescription and co-payment directly to Medco by Mail for processing. Once received, our mail order service processes the script within 2 business days and will be sent to the patient's home. Prescription refills can be ordered over the phone by calling the refill line at 1-800-473-3455, through the mail at Medco, P.O. Box 747000, Cincinnati, OH, 45274-7000, or via the Internet at [myuhc.com](http://myuhc.com).

## Prescription drug coverage changes

The OP&F-sponsored prescription drug coverage for 2009 includes:

- All OP&F benefit recipients who are currently enrolled will participate in the UnitedHealthcare pharmacy program (unless enrolled in Medicare Part D)
- More than 60,000 pharmacies participate in UnitedHealthcare's national retail pharmacy network, so you should have immediate access to a participating pharmacy
- Prescriptions are categorized by tiers
  - > Tier 1 drugs is the lowest co-payment level which includes predominantly generic drugs. There may be generic drugs which fall into other Tier levels.
  - > Tier 2 drugs is the middle co-payment level which includes many brand name drugs.
  - > Tier 3 drugs is the highest co-payment level which includes several products with a Tier 1 or Tier 2 alternative.
- Prescription drugs may change tiers annually. For example, a drug may move from Tier 1 to Tier 2, or from Tier 3 to Tier 1, which may result in a higher or lower co-payment amount. Prescription drugs also may tier down six times per year. For example, a drug may move from Tier 3 to Tier 2 to Tier 1, which will result in a lower co-payment amount. You will receive a written notification 30 days in advance of any drug that is scheduled to move up from one tier to another. No notification will be sent if a drug moves down a tier.
- Nexium capsule is excluded from the pharmacy benefit coverage on UnitedHealthcare's Prescription Drug List (PDL); however, Nexium suspension packets will be covered on Tier 3.
  - > 5 alternatives to Nexium are available on all three Tiers as well as Over the Counter alternatives such as Prilosec.
- Specialty Drugs
  - > The copay amounts for the Specialty drug program are \$3, \$13, \$20 for tiers 1, 2 and 3.
  - > We have created a designated network of specialty pharmacies that offer superior assistance and support services to you during your treatment. Using a designated specialty pharmacy is beneficial to you because the pharmacy is experienced in storing, handling, and distributing these unique medications. Many times, the

specialty pharmacy is able to provide products and services that are not available through a traditional retail pharmacy. The designated specialty pharmacies have nurses and pharmacists on staff with expertise in complex and high cost diseases. Additionally, you will receive comprehensive education and support, access to free supplies such as syringes and needles, and development of a care plan if necessary.

>To locate a designated specialty pharmacy 24/7, call our Specialty Pharmacy Referral Line at 1-866-429-8177. A representative will answer questions you may have about the program and transfer you directly to a designated specialty pharmacy based on your medication needs.

Contact UnitedHealthcare’s customer service at 1-888-832-0964 for more information on how these changes could affect you.

### **Enrolling in Medicare Part D**

You are not permitted to enroll in both Medicare Part D and the OP&F-sponsored prescription drug coverage at the same time. For more information on Medicare Part D, please see page 18.

### **New benefit recipients**

When you enroll in the OP&F-sponsored prescription drug coverage, you may need to use your prescription drug coverage, but are waiting to receive your ID card. During this period, you can be reimbursed for your prescription drugs, without penalty, by filing a claim according to UnitedHealthcare guidelines at the time the prescription drug was dispensed, and submitting a claim form once your prescription drug card is received.

### **Comparing prescription drug co-pays**

The chart below compares the co-pays for the OP&F-sponsored prescription drug plan between retail and mail order pharmacies. For more information, contact UnitedHealthcare.

	<b>Retail pharmacy co-pay Up to a 30-day supply</b>	<b>Mail order pharmacy co-pay Up to a 90-day supply</b>
Tier 1	\$5	\$10
Tier 2	\$20	\$40
Tier 3	\$30	\$60

# What are the details of my voluntary dental coverage?

## **Voluntary dental coverage**

In 2009, OP&F will continue to sponsor voluntary dental coverage through UnitedHealthcare as a separate plan, with a separate non-subsidized contribution amount since routine dental services are not covered under the OP&F-sponsored health care coverage. You have the option of enrolling in the separate voluntary dental coverage every year as long as you or your eligible dependents are not covered under another Ohio retirement system.

## **Enrolling in voluntary dental coverage during the annual change period**

You may enroll in voluntary dental coverage even if you do not elect to enroll in an OP&F-sponsored health care coverage. Your dependents may only enroll in the voluntary dental plan in which you are enrolled. A list of monthly contributions for the OP&F-sponsored voluntary dental coverage is on page 38.

## **Terminating dental coverage**

Once you enroll in voluntary dental coverage, you cannot terminate your coverage until there is a valid change in your family status or the next Annual Change Period. You and your enrolled dependents must remain in your selected coverage throughout the entire year and have monthly contributions deducted from your benefit check. You will have an annual opportunity to re-enroll during the Annual Change Period.

## **Coordination of dental benefits**

Benefits under the dental plan will be coordinated with those of another dental plan in which you or a dependent may be enrolled. Please contact UnitedHealthcare for more information on the coordination of benefits.

## **UnitedHealthcare coverage**

UnitedHealthcare provides coverage for preventive, diagnostic and basic restorative dental care. You and your eligible dependents may enroll in the voluntary dental plan, regardless of your area of residence and may choose to use any dentist you prefer. However, you will have less out-of-pocket expense by using a participating network dentist.

Orthodontia services are not covered under the UnitedHealthcare Dental plan. Other exclusions and limitations may apply. Contact UnitedHealthcare Voluntary Dental Plan at 1-877-816-3596 for more information.

**Visiting network dentists versus non-network dentists**

You will receive the maximum benefit level by using dentists that participate in UnitedHealthcare’s network because these dentists have agreed to a discounted fee schedule with UnitedHealthcare.

**Non-network dentist**

When using a dentist that does not participate in UnitedHealthcare’s network, you and your enrolled dependents will be responsible for paying any amount above the usual and customary rates prevailing in the geographic area in which the expense is incurred. Claims will not be filed on your behalf to UnitedHealthcare when using a non-network dentist. You will be required to make payment directly to the dentist.

**Consumer Max Multiplier (CMM)**

CMM is a consumer-driven feature that allows you to carry forward a portion of your unused annual dental maximum into an account for future use. Members must use their dental benefits at least once per year. If the total of all submitted claims paid for a particular member does not exceed the established threshold amount, an award balance is established. The award balance can accumulate each year to a total annual maximum.

**Voluntary dental coverage**

As shown below, you and your enrolled dependents will have less out-of-pocket expenses by using a participating network dentist. For a listing of the network dentists in your area, please visit [www.myuhcdental.com](http://www.myuhcdental.com) or call 1-877-816-3596.

Benefit class	UnitedHealthcare Voluntary Dental		
	Network	Non-network	
Deductible	\$50 single / \$150 family	\$100 single / \$300 family	
Calendar year maximum per person	\$1,500	\$750	
I	Diagnostic services (with no deductible)	100%	75%
	Preventive services (with no deductible)	100%	75%
	Emergency palliative (with no deductible)	100%	75%
	Radiographs (with no deductible)	100%	75%
II	Oral surgery (after deductible)	80%	50%
	Minor restorative (after deductible)	80%	50%
	Periodontics (after deductible)	80%	50%
	Endodontics (after deductible)	80%	50%
III	Prosthodontics (after deductible)	50%	30%
	Major restorative (after deductible)	50%	30%

# What is covered by my vision coverage?

## **Voluntary vision coverage**

In 2009, OP&F will continue to offer voluntary vision coverage through UnitedHealthcare Vision, underwritten by UnitedHealthcare Ins. Co., as a separate plan, with a separate non-subsidized contribution amount since routine vision services are not covered under the OP&F-sponsored health care coverage. You have the option of enrolling in separate voluntary vision coverage every year as long as you or your eligible dependents are not covered under another Ohio retirement system.

## **Enrolling in voluntary vision coverage during the annual change period**

You may enroll in voluntary vision coverage even if you do not elect to enroll in an OP&F sponsored health care coverage. Your dependents may only enroll in the voluntary vision plan in which you are enrolled. A list of monthly contributions for the OP&F-sponsored voluntary vision coverage is on page 38.

## **Terminating vision coverage**

Once you enroll in voluntary vision coverage, you cannot terminate your coverage until there is a valid change in your family status, or the next Annual Change Period. You and your enrolled dependents must remain in your selected coverage throughout the entire year and have monthly contributions deducted from your benefit check. You will have an annual opportunity to re-enroll during the Annual Change Period.

## **Coordination of vision benefits**

Coverage under the vision plan will be coordinated with those of another vision plan in which you or a dependent may be enrolled. Please contact UnitedHealthcare Vision for more information on the coordination of benefits.

## **UnitedHealthcare Vision Care coverage**

UnitedHealthcare Vision, underwritten by UnitedHealthcare Insurance Company, helps pay the costs of many of the regular vision services that may be encountered throughout the year. By choosing UnitedHealthcare Vision, you and your eligible dependents will have access to a broad national network of vision care providers, conveniently located retail chain eyewear stores, as well as private practice providers.

Features of the plan include coverage for vision exams, spectacle lenses and frame coverage, contact lens coverage (in lieu of lenses and frames), all at low out of pocket costs to you and your eligible dependents. You will also have access to discounts for lasik surgery and cosmetic extras that normally may not be covered under a vision plan.

You and your enrolled dependents may visit any of the many UnitedHealthcare Vision providers through the national network. You pay minimal co-pay at the time of service for the exam, lenses and frames. Plan provides coverage for either lenses for glasses or contacts every 12 months, but not both.

### Voluntary vision coverage chart

This chart is a summary of some of the benefits available. For a complete listing of benefits, contact UnitedHealthcare Vision. See page 54 & 55 for contact information.

Vision Feature	UnitedHealthcare Vision
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
Exam Copay	\$10
Materials Copay	\$0
Single vision Lenses	\$0 copay
Lined Bifocal Lenses	\$0 copay
Lined Trifocal Lenses	\$0 copay
Lined Lenticular Lenses	\$0 copay
Scratch Coating	\$0 copay
Frames	*\$0 copay; \$130 Allowance plus up to 50% over allowable at discretion of provider
Contact Lens Fitting and Evaluation	\$0 copay under UnitedHealthcare Vision's Contact Lenses Package

\* The additional 50% is at the discretion of the provider. Currently DOC and Eyemaster will offer up to 50% discount over the \$130 allowable benefit, however, Costco and Wal-Mart do not offer a discount. For example, you go to either DOC or Eyemaster for frames and the frames cost \$200. Your vision plan with UnitedHealthcare Vision would pay the \$130 allowable benefit, and then you would be responsible for up to 50% of the remaining \$70 which would be \$35.

\* Underwritten by UnitedHealthcare Insurance Company

## **Monthly contributions**

Contributions for the health care, prescription drug, voluntary dental and voluntary vision coverages are deducted from your monthly pension benefit when you are enrolled. If the amount of your monthly health care, prescription drug, voluntary dental and/or voluntary vision contributions exceeds the amount of your monthly OP&F benefit payment, then OP&F will bill you for the outstanding balance on a monthly basis. Orphans enrolled in health care coverage on their own will be given the lesser of the benefit recipient or child rate. If you have one child that is eligible for Medicare, but your other children are not, all of your children will be charged the non-Medicare rate.

## **Paying full premiums if eligible through an employer or retirement system**

If you or your spouse is employed and eligible for health care or prescription drug coverage through the employer, you can participate in the OP&F-sponsored health care coverage. However, OP&F will not subsidize your health care contributions. Also, if your spouse is eligible for health care or prescription drug coverage through his or her retirement system, as long as it is not another Ohio Retirement System (ORS), he or she will be eligible for the OP&F-sponsored health care coverage but will be responsible for paying the full premium. Please see page 42 for the OP&F-sponsored health care full premiums and pages 11 & 12 for information on benefits through an ORS.

## **2009 Contribution rates for health care and prescription drug coverage**

Contribution rates for the 2009 OP&F-sponsored health care and prescription drug coverages will be based on when you retired or began receiving OP&F benefits.

If you began receiving OP&F benefits on or prior to July 24, 1986, OP&F will subsidize the health care premium 75 percent for you and 50 percent for your dependents. Please see page 36 for these contribution rates.

If you began receiving OP&F benefits on or after July 25, 1986, OP&F will subsidize the health care premium 75 percent for you and 25 percent for your dependents. Please see page 37 for these contribution rates.

If you or your dependents age 65 and over are Medicare eligible and enrolled in Medicare Parts A & B the contributions that will be deducted from your benefit payment each month beginning January 1, 2009 will be based on AARP Medicare Supplement Plan L rates for the state of Ohio with discounts if applicable. These rates that will be included in your AARP Medicare Supplement Plan enrollment kit will reflect the total cost of your health care coverage options only, and does not reflect any OP&F health care subsidy. Please call UnitedHealthcare at 1-888-832-0964 if you have any questions.

**Contribution rates for benefit recipients and eligible dependents who are non-Medicare eligible, early Medicare A & B, early Medicare A only, Medicare B only or OP&F benefit recipient residing outside of the United States and who began receiving OP&F benefits on or prior to July 24, 1986**

This chart outlines the monthly contribution amounts that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage for the UnitedHealthcare program for 2009.

	Not Eligible for Medicare		Not AARP Medicare Supplement Eligible	
	Benefit recipient's monthly contribution	OP&F's monthly amount	Benefit recipient's monthly contribution	OP&F's monthly amount
Benefit recipient	\$158.74	\$476.22	\$51.44	\$154.32
Spouse	\$210.17	\$210.17	\$86.73	\$86.73
Child	\$109.85	\$109.85	\$86.73	\$86.73

**Contribution rates for benefit recipients and eligible dependents who are non-Medicare eligible, early Medicare A & B, early Medicare A only, Medicare B only or a OP&F benefit recipient residing outside of the United States and who began receiving OP&F benefits on or after July 25, 1986**

This chart outlines the monthly contribution amount that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage for the UnitedHealthcare program for 2009.

	Not Eligible for Medicare		Not AARP Medicare Supplement Eligible	
	Benefit recipient's monthly contribution	OP&F's monthly amount	Benefit recipient's monthly contribution	OP&F's monthly amount
Benefit recipient	\$158.74	\$476.22	\$51.44	\$154.32
Spouse	\$315.25	\$105.08	\$130.10	\$43.37
Child	\$164.77	\$54.92	\$130.10	\$43.37

**Not eligible for Medicare:** You and your eligible dependents who have not reached age 65.

**Not AARP Medicare Supplement Eligible:** You and your eligible dependents who are early Medicare, early Medicare A, early Medicare B, early Medicare A & B, age 65 and older and Medicare A only, age 65 and older and Medicare B only or reside outside the United States.

**Prescription drug contribution rates for benefit recipients and eligible dependents who began receiving OP&F benefits on or before July 24, 1986**

This chart outlines the monthly contributions that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage for the UnitedHealthcare programs for 2009.

	Not Eligible for Medicare		Medicare Eligible	
	Benefit recipient's monthly contribution	OP&F's monthly amount	Benefit recipient's monthly contribution	OP&F's monthly amount
Benefit recipient	\$62.95	\$188.86	\$62.95	\$188.86
Spouse	\$118.61	\$118.61	\$118.61	\$118.61
Child	\$35.25	\$32.25	\$35.25	\$32.25

**Prescription drug contribution rates for benefit recipients and eligible dependents who began receiving OP&F benefits on or after July 25, 1986**

This chart outlines the monthly contributions that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage for the UnitedHealthcare programs for 2009.

	Not Eligible for Medicare		Medicare Eligible	
	Benefit recipient's monthly contribution	OP&F's monthly amount	Benefit recipient's monthly contribution	OP&F's monthly amount
Benefit recipient	\$62.95	\$188.86	\$62.95	\$188.86
Spouse	\$177.91	\$59.30	\$177.91	\$59.30
Child	\$52.88	\$17.63	\$52.88	\$17.63

**Voluntary dental and vision coverage contribution rates for benefit recipients and eligible dependents**

This chart outlines the monthly contribution amounts that the benefit recipients are responsible for paying for the 2009 OP&F sponsored voluntary dental and vision coverage. OP&F does not subsidize the voluntary dental and vision programs.

	<b>UnitedHealthcare Voluntary Dental</b>	<b>UnitedHealthcare Vision</b>
Benefit recipient (including survivors)	\$24.95	\$5.48
Benefit recipient and spouse	\$47.06	\$10.29
Benefit recipient and child(ren)*	\$49.02	\$10.09
Benefit recipient, spouse, child(ren)*	\$81.93	\$15.63

\*Contribution rate remains the same regardless of the number of children enrolled.

Voluntary vision rates will remain the same through December 31, 2010.

**Health Care and Prescription Drug Discount Program**

In 2009, UnitedHealthcare may grant a 30 percent discount on the monthly contributions for health care and prescription drug coverage if you are enrolled in the OP&F-sponsored health care and prescription drug coverages and have a low household income.

**Eligibility**

To be eligible for the contribution discount for 2009, you must have had a total household income in 2007 equal to or less than 200 percent of the poverty level established annually by the Department of Health and Human Services. As a result, the gross income levels that OP&F will use for the 2009 discount period are indicated in the following chart. For example, if there were a total of two individuals residing in your household in 2007 and your combined income was less than or equal to \$28,000, you would be eligible for the discount.

**Application process**

Benefit recipients may apply annually during the annual change period to participate in this program via a UnitedHealthcare Health Care and Prescription Drug Discount Form and attaching a copy of the benefit recipient's signed Federal Income Tax return for the most recent filing period. If you do not file a Federal Income Tax return, please contact UnitedHealthcare to request an affidavit. New retirees and survivors may apply for the discount when they are first eligible for coverage. However, to qualify, UnitedHealthcare must receive a completed Health Care and Prescription Drug Discount Form within 60 days if you are the benefit recipient. Survivors have 90 days from the date that UnitedHealthcare sent the application to apply.

**Eligibility for discount program**

Use this table to determine if you are eligible for the 2009 Health Care and Prescription Drug Discount Program.

<b>Size of family unit</b>	<b>Household income less than or equal to</b>
1	\$20,800
2	\$28,000
3	\$35,200
4	\$42,400
5	\$49,600
6	\$56,800
7	\$64,000
8	\$71,200
9	\$78,400
10	\$85,600

For each additional person, add \$7,200

**Household income**

All income received by members of the household from OP&F, any earnings related to service retirement or disability benefits, and any other income that is reportable according to the Internal Revenue Service.

**Members of the household**

You, your spouse and any other person residing in your home who is primarily dependent upon you for support.

### **Long-Term Care coverage**

Long-term care refers to 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. This does not include acute medical care, which helps people recover from an illness or injury. The OP&F-sponsored health care coverage does not cover custodial care, and Medicaid only covers long-term care for people living at or below the poverty level. For most people, the personal and financial burdens of this care are left up to a spouse and family who often spend their life savings in less than a year.

Long-Term Care enrollees are eligible for benefits toward custodial nursing home expenses, home care, adult day care or other long-term care expenses.

### ***Enrollment and contribution amounts***

Monthly premiums for OP&F's Long-Term Care are determined by a person's age at the time of enrollment and do not increase as the enrollee ages. You can receive more information on long-term care by calling OP&F at 1-800-860-9599.

### **Employer sponsored health care or prescription drug coverage**

OP&F currently subsidizes, or pays a portion, of the health care and prescription drug coverage for eligible benefit recipients and spouses. However, under certain circumstances, OP&F will not subsidize the health care or prescription coverage and the benefit recipient will be required to pay the full premium listed on page 42.

### ***Eligible for health care or prescription drug coverage through an employer***

#### ***Employed and eligible for health care or prescription drug coverage through an employer***

If you or your spouse are employed and are eligible for health care or prescription drug coverage through the employer, you will be eligible to participate in the OP&F-sponsored health care coverage. However, you will be responsible for paying the full premium for the coverage that you select.

***Retired and eligible for health care or prescription drug coverage through a former employer***

If your spouse is eligible for health care or prescription drug coverage through his or her retirement system, as long as it is not another Ohio retirement system, he or she will be eligible for the OP&F-sponsored health care coverage. However, you will be responsible for paying the full premium for the coverage you select for your spouse. For more information on eligibility for health care or prescription drug coverage through another Ohio retirement system, see pages 11 & 12.

***Dependent-only coverage***

If your dependents are not eligible for health care or prescription drug coverage through you or your spouse's employer, you may enroll your eligible dependents in the OP&F-sponsored health care or prescription drug coverages without enrolling yourself. UnitedHealthcare requires documentation that coverage is not available for your dependents through your employer.

***Loss of coverage through employer***

If you lose health care or prescription drug coverage through your employer, you will then be permitted to enroll in the OP&F-sponsored plans and receive the subsidy. You must notify UnitedHealthcare in writing within 60 days of losing your health care or prescription drug coverage, as well as provide proof of loss of coverage upon receipt from the employer. If you fail to do so, you will have limited opportunities to re-enroll. Upon receipt of the proper documentation stating that you are no longer eligible for health care or prescription drug coverage through your employer, UnitedHealthcare will adjust your premiums appropriately.

***Coordination of benefits***

If you or your dependents are enrolled in other health care coverage, UnitedHealthcare will coordinate your benefits with the other plan. To determine how those benefits will be handled, please contact UnitedHealthcare at 1-888-832-0964.

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

This chart outlines the full premiums paid by the benefit recipient for UnitedHealthcare coverage and UnitedHealthcare prescription drug coverage for 2009.

	Not eligible for Medicare		Medicare eligible	
	Full premium for health care coverage	Full premium for prescription drug coverage	Full premium for health care coverage	Full premium for prescription drug coverage
Benefit recipient	\$634.95	\$251.82	See Medicare Supp. Plan	\$251.82
Spouse	\$420.34	\$237.21	See Medicare Supp. Plan	\$237.21
Child	\$219.69	\$70.51	See Medicare Supp. Plan	\$70.51

	Not AARP Medicare Supplement Eligible	
	Full premium for health care coverage	Full premium for prescription drug coverage
Benefit recipient	\$205.77	\$251.82
Spouse	\$173.46	\$237.21
Child	\$173.46	\$70.51

If you or your dependents are 65 and older and you are not eligible for the OP&F subsidy, you will pay the full premium for the AARP Medicare Supplement plan.

### Health care plan

OP&F continues to sponsor health care benefits to eligible benefit recipients and their dependents according to the plan design and enrollment guidelines implemented.

The OP&F Board of Trustees is committed to providing current and future retirees and their dependents with quality health care and offering a plan that ensures the availability of some form of health care subsidy. For this reason, the Board is continuously researching and modifying the OP&F-sponsored health care coverage.

## **Summary of common covered and non-covered health care plan services**

The following is a brief summary of common covered and non-covered health care plan services. Contact the customer service numbers on your ID cards for any questions regarding coverage and/or prior notification requirements for inpatient admissions, ambulatory services, tests, and procedures.

### ***Abortion***

Therapeutic abortion to save the life of the mother or to treat a miscarriage is covered. Elective medical and surgical abortions are not covered.

### ***Acupuncture***

Acupuncture services are not covered.

### ***Allergy tests and treatments***

Allergy tests that are performed or related to medically appropriate diagnoses are covered.

### ***Allergy injections***

An office visit co-pay is required if seeing the allergist for periodic allergy testing; otherwise, the office visit co-pay is waived. However, the co-insurance, which is 20 percent of the cost of each allergy injection, is required.

### ***Ambulance services***

To be covered, UnitedHealthcare must receive prior notification of all elective transportation services, including ground and air.

### ***Care Coordination***

Case managers are highly educated and skilled nurses who work to ensure that appropriate and cost-effective care is received in complex cases. There is no additional charge for this service. To find out if care coordination services are appropriate, call UnitedHealthcare's customer service number on the ID card.

### ***Dental services for accidental injury***

To be covered, UnitedHealthcare must receive prior notification of treatment for injuries of the mouth, jaw or teeth.

### ***Emergency and urgent care services***

Emergency care is covered for an emergency medical condition that a prudent layperson believes to be potentially life threatening, such as difficulty breathing, hemorrhage, or chest pain.

Urgent medical conditions are those that require immediate attention, but are not life threatening, such as a minor bone fracture or a cut that requires stitches.

### ***Home health care services***

To be covered, UnitedHealthcare must receive prior notification of all home health care services, including private duty nursing services.

### ***Hospice services***

Hospice services may be provided in the home (outpatient) or in a designated facility (inpatient). To be covered, UnitedHealthcare must receive prior notification of all hospice services. Hospice services are not subject to the hospital admission co-pay.

### ***Infertility***

Any and all services related to the treatment of infertility, including sterilization reversal, are not covered.

### ***Inpatient hospital services***

To be covered, UnitedHealthcare must receive prior notification of all inpatient confinements. Coverage is not provided when it is not medically necessary to be an inpatient to receive the services.

A private room, if medically necessary, will be paid at the semi-private room rate.

### ***Medical supplies and equipment***

Medical supplies, such as surgical dressings that might be used in a home health care setting, are covered if approved by UnitedHealthcare. Compression gradient hose are covered in specific circumstances. Contact UnitedHealthcare for additional information regarding coverage for compression gradient hose and other medical supplies.

### ***Contact lenses and eyeglasses***

The health care plan covers contact lenses and/or eyeglasses that are prescribed after surgery for cataract or detached retina. Coverage is provided for one pair of contact lenses and one pair of eyeglasses, if both must be worn at the same time.

### ***Durable medical equipment***

Durable medical equipment (DME) is equipment that can stand repeated use and includes, but is not limited to, wheelchairs and ventilators. Contact UnitedHealthcare to find out what DME is covered and what medical necessity criteria is required to purchase, rent and/or repair the equipment.

### ***Orthotics and prosthetics***

Orthotics are semi-rigid support devices, such as braces and corsets. Orthotics, such as custom fabricated shoe inserts, are covered for heel spurs and the accompanying plantar fasciitis (inflammation of the heel of the foot). Prosthetics includes artificial limbs and eyes. UnitedHealthcare must receive prior notification of all orthotics and prosthetics, including the replacement and/or repair of existing appliances.

### ***Wigs***

Wigs are not covered.

### ***Male erectile dysfunction drugs***

Male erectile dysfunction drugs (MEDs), such as Viagra and Muse, will be covered for up to three doses every 30 days – or nine doses every 90 days. Injectable MEDs, such as Caverject, are covered up to two doses every 30 days, or six doses every 90 days.

### ***Medications administered in the office setting***

Medications that are supplied by and administered in the office, ambulatory services, outpatient or clinic setting will be paid through the health care carrier. An example of this type of service would be chemotherapy treatment.

### ***Mental health and substance abuse services***

#### ***Mental health***

To be covered, UnitedHealthcare must receive prior notification of inpatient mental health admissions.

#### ***Substance abuse***

Substance abuse services include treatment for drug abuse and/or alcoholism.

Detoxification and rehabilitation services are provided for the treatment of drug abuse and/or alcoholism. To be covered, UnitedHealthcare must receive prior notification of inpatient care. Detoxification without rehabilitation is not covered.

### ***Nexium***

Coverage for Nexium has been discontinued from the prescription drug list. However, the Nexium suspension packets, which contain a delayed-release oral suspension, will be covered under Tier 3.

### ***Nonsedating antihistamines***

Coverage for all prescription strength nonsedating antihistamines (NSAs) has been discontinued, such as Claritin, Allegra, Clarinex and Zyrtec as well as prescription strength generic formulations.

### ***Preventive services***

#### ***Diabetes education***

Diabetic education services are provided for covered persons with a diagnosis of diabetes. To be covered, diabetes education must be prescribed by a physician and provided by a network provider.

#### ***Immunizations***

Standard adult immunizations are covered and include, but are not limited to, pneumonia vaccine and annual flu shots.

Standard pediatric immunizations are covered.

Immunizations for foreign travel are not covered for either benefit recipients or eligible dependents.

#### ***Nutrition counseling***

Nutrition counseling is covered for gestational diabetes and chronic disease states with coexisting medical conditions that are felt to be obesity related. To be covered, nutrition counseling must be prescribed by a physician, provided by a network provider and prior notification made to UnitedHealthcare.

### ***Screening tests***

Screening tests are used to make an early diagnosis of a treatable condition. Deductibles and co-insurance do not apply to screening tests. Screening tests are covered within specified time periods, as recommended by such organizations as the American Cancer Society.

#### ***Colorectal screening***

Screening tests for colorectal cancer, including screening colonoscopy (every 10 years) and fecal occult blood tests (once per calendar year) are covered.

#### ***Mammogram***

A routine screening mammogram is covered once per calendar year.

**Pap test**

A routine screening Pap test is covered once per calendar year.

**Prostate Specific Antigen (PSA)**

A routine screening PSA lab test is covered once per calendar year.

**Skilled nursing facility services**

Skilled nursing facility (SNF) care is covered as long as the services constitute skilled rather than custodial care and UnitedHealthcare has been notified prior to services being rendered. SNF care is subject to hospital admission co-pay.

**Sub-acute rehabilitation services**

Sub-acute rehabilitation services are managed the same as skilled nursing facility care. As with SNF care, sub-acute rehabilitation services are subject to hospital admission co-pay.

**Surgical services**

Coverage is provided in specified circumstances. Contact UnitedHealthcare if you have any questions about specific procedures.

**Elective sterilization**

Elective sterilization procedures such as tubal ligation and vasectomy are not covered.

**Eye surgery**

Cataract surgery and surgery to repair a detached retina are covered when medically necessary. UnitedHealthcare must be notified prior to the procedures being rendered. Surgery to correct a refractive error (vision surgery) is not covered.

**Obesity surgery**

To be considered for bariatric (obesity) surgery, you must first meet UnitedHealthcare's medical criteria for the procedure. Once you meet criteria to be considered for the procedure, you must follow a two-year medically directed weight reduction program that is supervised by a case manager. If you are not in compliance with the medically supervised weight reduction program or if you no longer meet the surgical criteria at the end of the two-year period, the surgery may not be approved by UnitedHealthcare. There is a limit of coverage for bariatric surgery of \$10,000 and is restricted to network facilities maintaining the two-year physician-directed weight loss management program prerequisite.

### ***Reconstructive surgery***

UnitedHealthcare must be notified of any type of plastic or reconstructive surgery. Cosmetic procedures that are designed solely to improve appearance are not covered.

### ***Second surgical opinion***

A second surgeon's opinion and related diagnostic services are not required but are covered. The purpose of a second surgical opinion is to help consider an elective surgical procedure.

### ***Sex change surgery***

Any and all services related to sex change surgery and/or gender identity disorders are not covered.

### ***Transplant services***

To be covered, UnitedHealthcare must receive prior notification of all transplant services. Access to the United Resource Networks (U.R.N.) and the facilities contained within the U.R.N. transplant network are available to you. Participation in the U.R.N. transplant network is not considered mandatory.

### ***Therapies***

Outpatient therapy services must be ordered by a physician and must be used to promote recovery from a covered medical condition. Therapies are subject to deductible and co-insurance. Therapies include, but are not limited to:

- Cardiac rehabilitation;
- Chiropractor;
- Osteopathic Manipulative Therapy (OMT); and
- Pulmonary rehabilitation.

### ***Physical therapy, occupational therapy and speech therapy***

Physical therapy, occupational therapy and speech therapy services may be limited to an annual maximum. Contact UnitedHealthcare before starting therapy.

## **Frequently used terms**

### ***Co-Insurance***

The percentage of expenses that you are responsible for is called co-insurance and is not included in the annual deductible amount. For example, if the plan pays 80 percent, your co-insurance is 20 percent.

### ***Co-insurance limit***

The annual co-insurance limit, which does not include deductibles and co-pays, is the maximum amount of co-insurance that you are responsible for paying per calendar year.

### ***Co-pay***

The amount you are responsible for at the time designated services are rendered. Co-pays are not included in the deductible amounts or in the co-insurance limit.

### ***Deductible***

The amount that you pay before UnitedHealthcare begins to pay claims.

### ***Lifetime maximum***

The most that will be paid under the health care plan for any person during his or her lifetime is \$2.5 million commencing on January 1, 2007, and excludes previous claims prior to January 1, 2007. Once a member enrolls in an AARP Medicare Supplement Plan, there is no lifetime maximum.

## **Statement of Rights Under the Newborns' and Mothers' Health**

### **Protection Act**

Under federal law, group health plans and health insurers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceeds 48 hours (or 96 hours). For information on pre-certification, contact UnitedHealthcare.

### **Notice Regarding the Women's Health and Cancer Rights Act**

Through the OP&F-sponsored health care plan, coverage will be provided to a person who is receiving a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and co-insurance provisions that apply for mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the UnitedHealthcare member services number on the back of your ID card.

## **Notice of Creditable Prescription Drug Coverage (NOCC)**

The Medicare prescription drug program, which is known as Medicare Part D, requires OP&F to notify benefit recipients that the drug coverage under the OP&F-sponsored health care plan is “creditable” and that OP&F will continue to offer eligible members and their dependents prescription drug coverage in 2009.

Prescription drug coverage provided by a plan like the OP&F-sponsored plan is “creditable” if, on average for all participants, the plan is expected to pay out at least as much as the standard Medicare Part D coverage would pay. OP&F’s actuarial consultant has verified that the coverage under the OP&F-sponsored plan is creditable.

It is important for individuals to have either Medicare Part D coverage, or plan provided creditable drug coverage such as prescription drug coverage sponsored by OP&F, since a penalty applies to people who enroll late in Medicare Part D or who go without Medicare Part D or creditable coverage for 63 or more days. People who are now in a creditable coverage plan, but who later lose or drop that coverage, also will pay a penalty if they do not enroll in Medicare Part D or another creditable coverage plan within 63 days after their drug coverage ends.

If the penalty applies, your monthly premium under Medicare Part D will go up at least one percent per month for every month you did not have either Medicare Part D or creditable coverage. You also may have to wait until the next open enrollment period, which is November 15-December 31, 2009, to enroll.

If your income is limited, extra help paying for a Medicare part D prescription drug plan is available. For more information about this extra help, contact the Social Security Administration at [www.socialsecurity.gov](http://www.socialsecurity.gov) or call 800-772-1213 (TTY 800-325-0778).

Because the OP&F coverage is creditable you do not need to purchase Medicare Part D coverage. If you do purchase Medicare Part D, you will lose your prescription drug coverage under the OP&F-sponsored plan. You will not be permitted to re-enroll in the OP&F-sponsored prescription drug plan unless you meet one of the eligibility requirements listed on page 6.

You will receive a creditable coverage notice each year. You will receive a new notice if the OP&F coverage is changed so that it is no longer creditable. You may request a copy of this notice at any time by calling UnitedHealthcare Customer Service at 888-832-0964.

Please do not discard this notice, as you may need it as proof of creditable coverage.

## **Notice of Privacy Practices**

As part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Ohio Police & Fire Pension Fund (OP&F) is required to outline the procedures and practices it follows for handling and exchanging the protected health information of all health care program participants. Additionally, each insurance carrier and provider is required to send similar notifications to all participants, which describe each company's privacy practices, which can vary to a certain extent. HIPAA was established to govern the way in which a health plan sponsor communicates, uses and secures its participants' protected health information.

This notice describes the privacy practices of OP&F. The notice applies to medical information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services. OP&F is required by law to maintain the privacy of your health information and to provide you with this notice, which explains how OP&F will use and disclose protected health information. OP&F is also required to abide by the terms of this notice.

## **How we will use and disclose your health information**

### ***For payment***

OP&F may use and disclose your health information so that your health care claims and other benefits can be paid and to determine whether you are eligible for benefits or coverage or if you are covered. As part of this, OP&F may disclose your health information to a family member or friend consistent with OP&F's governing HIPAA Policies and Procedures.

### ***For health care operations***

OP&F may use and disclose your health information for our health care operations. For example, OP&F may use your health information, including claims, to renew a contract for health insurance with an insurance company.

### ***As required by law***

OP&F will use and disclose your health information when required to do so by federal, state or local law.

### ***Judicial and administrative proceedings***

If you are involved in a legal proceeding, OP&F may disclose your health information in response to a request from a court or other administrative body. OP&F may also disclose your health information in response to a subpoena or discovery request if OP&F believes

there has been reasonable effort to tell you about the request or there is not an order protecting the information requested.

### ***Business Associates***

Certain aspects of the plan's operations are performed by unrelated parties with whom the Plan has service arrangements. For example, the Plan is assisted in its operations by third-party administrators. These persons who assist the Plan are called business associates. At times, the Plan may disclose PHI to its business associates so they can provide services to the Plan. The Plan will require that any business associate who receives PHI safeguard the privacy of that information.

### ***Other uses and disclosures of your protected health information***

OP&F will not use or disclose your health information in other ways without your written authorization.

## **Your rights regarding your protected health information**

### ***Right to request restrictions***

You have the right to ask that OP&F limit the uses and disclosures of your health information. You also have the right to request that OP&F not disclose your health information to your friends and family who are involved in your health care or payment for your health care. OP&F is not required to agree with your request for restrictions.

### ***Communications***

You have the right to request that OP&F communicate with you about your personal health matters confidentially, in a particular way or at a particular location.

### ***Right to inspect and copy***

You have the right to inspect and copy your health information.

### ***Right to amend***

You have the right to request that OP&F amend health information that OP&F has created about you if it is incorrect or incomplete.

### ***Right to an accounting of disclosures***

You have the right to request that OP&F amend health information that OP&F has created about you if it is incorrect or incomplete.

***Right to a paper copy of this notice***

You may obtain a copy of this notice on OP&F's website, [www.op-f.org](http://www.op-f.org).

To exercise any of these rights, you will need to obtain the appropriate form and submit your request in writing to the OP&F Privacy Officer.

***Changes to this notice***

OP&F reserves the right to change the terms of this notice and to make the new provisions effective for all of your health information that we maintain. OP&F will mail a copy of any revised notice to you.

***Complaints***

If you believe your privacy rights have been violated, you may file a complaint in writing with the OP&F Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint, contact OP&F for the complaint form.

***Contact***

If you have any questions about this notice, please contact the OP&F Privacy Officer at 1-800-860-9599.

**Contact information**

Understanding your options under the OP&F-sponsored health care plan is essential. OP&F encourages you to contact UnitedHealthcare to discuss your options and coverage or to request a provider directory. OP&F does not carry these directories and cannot fulfill such requests.

***Eligibility***

UnitedHealthcare  
9200 Worthington Road  
Westerville, OH 43082  
1-888-832-0964  
[www.myuhc.com](http://www.myuhc.com)

***Medical***

UnitedHealthcare  
Attn: Claims Unit  
P.O. Box 30555  
Salt Lake City, UT 84130  
1-888-332-8885  
[www.myuhc.com](http://www.myuhc.com)

**AARP Medicare Supplement Insurance**

1-888-832-0964  
www.aarphealthcare.com

**Prescription Drug**

UnitedHealthcare Pharmacy Plan  
Attn: Claims Unit  
P.O. Box 30555  
Salt Lake City, UT 84130  
1-888-332-8885  
www.myuhc.com

Prescription Mail Order:

Medco  
P.O. Box 747000  
Cincinnati, OH 45274-7000  
1-800-473-3455

**Voluntary Dental**

UnitedHealthcare Voluntary Dental Plan  
Attn: Claims Unit  
P.O. Box 30567  
Salt Lake City, UT 84130-0567  
1-877-816-3596  
www.myuhcdental.com

**Voluntary Vision**

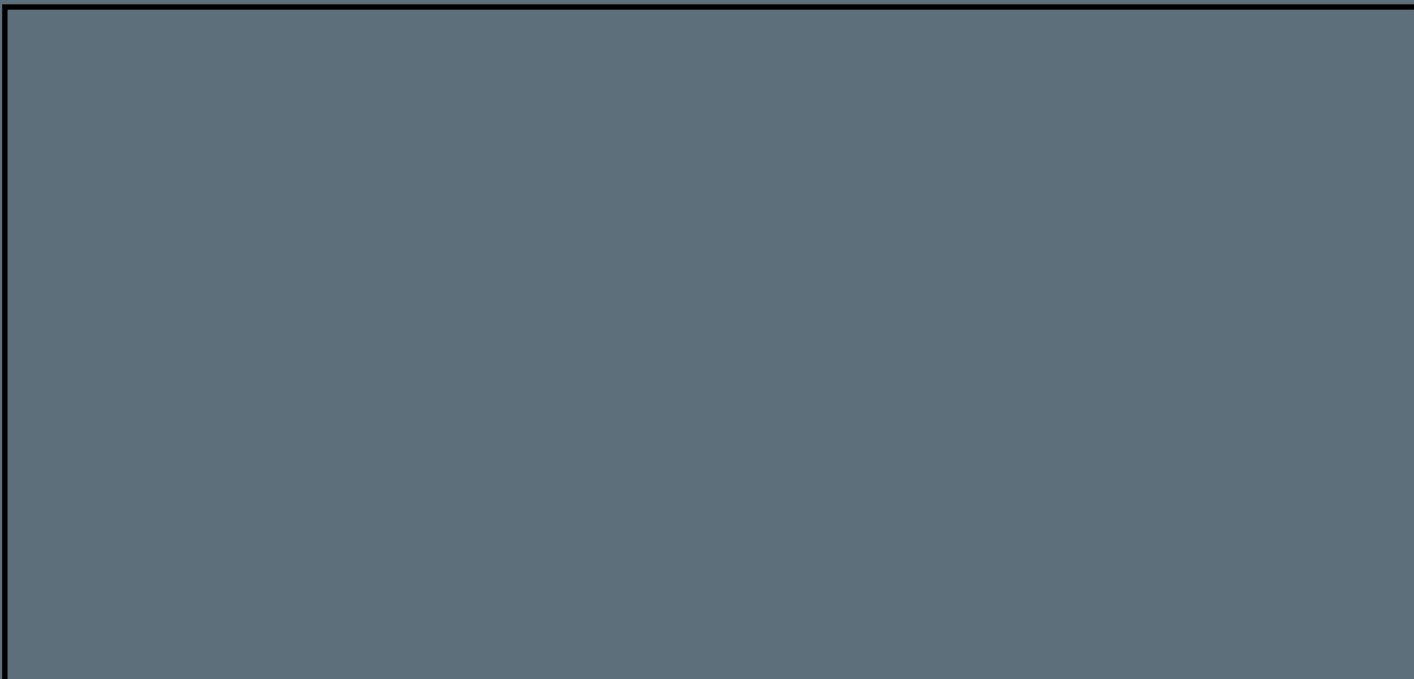
United Health Vision Claim Department  
P.O. Box 30978  
Salt Lake City, UT 84130  
1-800-638-3120  
www.myuhcspecialtybenefits.com

**Medicare**

Centers for Medicare and Medicaid Services (CMS)  
1-800-633-4227  
www.Medicare.gov

**Remember to notify UnitedHealthcare in writing within 60 days when:**

- There is a change in your address;
- There is a change in family status (i.e., divorce, separation, death) with the exception of a newborn child who must be enrolled within 60 days from birth;
- You or a dependent become eligible for or lose group health care coverage;
- You or a dependent become eligible for Medicare;
- You become eligible for Medicare Part B reimbursement through a source other than OP&F;
- Your child enrolled in the OP&F-sponsored health care plan between the ages of 18-23 does not return to school;
- You file a workers' compensation claim or receive a settlement involving any workers' compensation claims; or
- You or any dependents enroll in Medicare Part D.





UnitedHealthcare  
9200 Worthington Rd  
Westerville, OH 43082  
Phone: (888) 832-0964  
Fax: (614) 410-7449