



Member's Guide to Health Care Coverage for 2017



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Ohio Police & Fire Pension Fund

140 East Town Street / Columbus, Ohio 43215-5164 / Tel. (614) 228-2975 / www.op-f.org

Dear OP&F Member,

As trustees of the Ohio Police & Fire Pension Fund we realize the importance of a quality health care plan. The availability of dependable health care provides peace of mind and affects our quality of life.

At OP&F, our primary concern is the well being of our members. For this reason we continue to sponsor a health care plan for eligible benefit recipients and their dependents.

Although health care expenses continue to increase, the Board of Trustees adopted the current plan. In developing this plan, we achieved our goal to continue to subsidize the cost of health care to those who are eligible. We understand that this plan is costly – to those who enroll and also to OP&F. However, we appreciate that a health care plan is a significant part of a quality retirement.

While there are several changes from the plan offered a year ago, we hope that you understand that these cost increases were necessary in order to preserve a health care option. We continue to explore new funding streams with the goal of providing a quality health care plan for future generations of OP&F retirees.

For 2017, we continue to partner with UnitedHealthcare to deliver health care coverage to OP&F's eligible benefit recipients and their dependents.

Sincerely, the OP&F Board of Trustees:

Edward L. Montgomery, Chair
Columbus Police

William E. Deighton
Retired, Cleveland Fire

Daniel J. Desmond
Toledo Fire

Jeffrey H. Moore
West Chester Fire

Timothy P. Patton, Jr.
Cleveland Police

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J. David Heller
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Investment Expert Member

This publication summarizes the most important provisions of the governing law, administrative rules and governing agreements between OP&F and UnitedHealthcare related to the OP&F-sponsored health care plan. This summary cannot sufficiently represent all of the details applicable to this guide that health care benefits provided by OP&F are discretionary and not mandatory benefits. 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. For a more detailed summary of medical and prescription coverage, you may wish to obtain a copy of the Medical Plan Description (MPD) from UnitedHealthcare.

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 23, and compare them with the rules of any other plan that covers you or your family.

Overview of the OP&F-sponsored health care plan

For the 2017 plan year, the Ohio Police & Fire Pension Fund (OP&F) will offer medical, prescription drug, dental, and vision coverage in accordance with the Benefit Funding Policy and the OP&F Health Care Plan (only medical and RX are subsidized).

The OP&F plan is being offered from one provider, UnitedHealthcare Insurance Company (UnitedHealthcare). The subsidized plans include a medical plan for the under 65 population and a Medicare Supplement plan for those eligible retirees over 65, both offered with the option of a prescription drug plan.

Rates and Discounts for 2017

The OP&F Board of Trustees approved a 5.8% rate increase for the prescription drug coverage and a 3.2% increase in the UnitedHealthcare health care premiums effective January 1, 2017.

In 2017 OP&F will still offer a 30% discount on the monthly contributions for health care and prescription drug coverage to members with lower household incomes. In 2017 this amount will remain at 225% of the poverty level established annually by the Department of Health and Human Services. Specific income levels are listed on page 38.

OP&F Wellness Program

We hope you have been participating in the OP&F Road



to Health & Wellness initiatives. The program is designed to help you adopt and maintain healthy behaviors as a way of life. It aims to increase your awareness of your own health status and provides the education and resources to help you stay healthy, get healthy, or live better with an existing illness.

Over 540 members participated in our past Get Screened campaign. This campaign encouraged members to obtain an annual exam and recommended preventive care screenings.

In 2017, we will continue bringing you important health and program information in our monthly Wellness Online e-mails. Be sure to be on the lookout for future announcements on wellness activities.

New for 2017

Medical and Prescription Cards

2017 UnitedHealthcare Medical and Prescription ID cards will be issued

For Non AARP medical plans:

- new copays, deductibles, out of pocket maximums;
- plan will now require prior authorization following principles of medical necessity for certain services for non Medicare participants living in a network area;
- preventive care covered at 100%;
- preventive care benefits for women at 100% which include prenatal visits, voluntary sterilization and certain contraceptives;
- addition of external review for appeals;

Please reference the benefit summaries starting on page 20 of this guide

Prescriptions

- new copays and new 4th Tier for medications;
- new Value Network of participating pharmacies;
- plan will now follow principles of medical necessity;
- certain preventive medications will be covered at 100%;
- new annual prescription out of pocket maximum;

Please reference the benefit information starting on page 28 of this guide

Eligibility

- dependent children now covered to age 26 and stepchildren no longer eligible unless covered under OP&F-sponsored plan prior to January 1, 2017
- retirees and dependents no longer eligible if covered under another plan offering healthcare benefits unless covered with OP&F-sponsored plan prior to January 1, 2017

Annual Change Period

During the Annual Change Period, in the Fall, you and your family members will have the opportunity to participate in the health care plans sponsored by OP&F provided that eligibility requirements are met and you file the required paperwork by October 31st. This Member's Guide to Health Care Coverage provides more details about the OP&F-sponsored health benefit plan and directs you to sources for more information.

If you have any questions regarding the Annual Change Period, please contact UnitedHealthcare Customer Service at 888-832-0964, 8 a.m. to 5 p.m. Eastern Standard Time, Monday through Friday.

Annual Change Period Form (ACPF)

UnitedHealthcare sends the enclosed, preprinted ACPF to every benefit recipient each year. You should use the form to verify or change your current enrollment and make sure that any preprinted information is accurate, such as your address, telephone number, Social Security number and birth date.

You need to return the ACPF if you:

- Are eligible for Medicare Parts A or B and are enrolling in Medicare Part D
- Make changes to any personal information preprinted on this form (such as change your Medicare Part B reimbursement, receive benefits from another Ohio retirement system, etc.)
- Waive any coverage type for yourself or your dependents (limited re-enrollment opportunities)
- Enroll or waive voluntary dental or vision coverage for yourself or your dependents
- Apply for the Health Care and Prescription Drug Discount Program
- Or your spouse are newly employed, retired or have terminated employment

Deadline to return your ACPF

The deadline to return your ACPF is October 31, 2016. If you make changes or corrections to the ACPF, you must mail the entire form to UnitedHealthcare in the enclosed envelope to ensure your changes or corrections are accurately recorded. Please do not cut or tear the form.

Annual Dependent Child Coverage Application

A Dependent Child Coverage Application needs to be completed and returned annually for each dependent currently enrolled and over the age of 18 in order to continue coverage. This application should be notarized and returned by the October 31st deadline to avoid termination of your dependent(s) effective December 31, 2016. For more information on dependent eligibility guidelines please reference page 6. The required contribution will be deducted from your monthly pension benefit.

Annual Change Period Seminars

UnitedHealthcare has scheduled a series of informational presentations across Ohio to help retirees and survivors make informed decisions about the OP&F-sponsored health care plan. Presentations will start at the beginning of each session for approximately one hour, followed by a one hour question-and-answer session. Representatives from UnitedHealthcare will be available to answer questions at each open house. Parking is free.

Free health screenings will be provided at each informational presentation. A representative will be available to provide blood pressure and glucose level screenings.

Tuesday, October 4, 2016

Akron, Ohio
Hilton Garden Inn - Akron
1307 E. Market Street,
Akron, OH 44305
10:00 a.m.

Wednesday, October 5, 2016

Cleveland, Ohio
Hilton Garden Inn -
Cleveland East/Mayfield Village
700 Beta Drive
Cleveland, OH 44143
10:00 a.m.

Thursday, October 6, 2016

Toledo, Ohio
Hilton Garden Inn - Toledo/Perrysburg
6165 Levis Commons Blvd.
Perrysburg, OH 43551
10:00 a.m.

Tuesday, October 11, 2016

Cincinnati, Ohio
Hilton Garden Inn -
Blue Ash/Cincinnati
5300 Cornell Rd.
Blue Ash, OH 45242
10:00 a.m.

Wednesday, October 12, 2016

Dayton, Ohio
Hilton Garden Inn
Dayton/Beavercreek
3520 Pentagon Park Blvd.
Dayton, OH 45431
10:00 a.m.

Thursday, October 13, 2016

Columbus, Ohio
Courtyard Columbus West
2350 Westbelt Drive
Columbus, OH 43228
10:00 a.m.

Teleconference call

We will be hosting a teleconference call on:

Friday, October 14, 2016 at 1:00 p.m. EST Dial in: (866) 216-6835

Participant Access Code: **263577**

Call and reference the **Ohio Police & Fire ACP Call**.

Webcast

The Annual Change Period presentation will be recorded and posted on the Ohio Police & Fire Pension Fund website at www.op-f.org.

Who is eligible for coverage?



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

Retirees, survivors who are receiving the statutory survivor benefit, and dependents, may qualify to participate in the OP&F-sponsored health care coverage if they are determined to be 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 on page 9 of 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, a surviving spouse, a surviving child/orphan, or dependent parent who is receiving statutory survivor benefits from OP&F.

Retiree

An OP&F member who is receiving a service retirement 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 unless they have access to another group health care plan. The required paperwork must be filed with UnitedHealthcare within 60 days of receiving your service or disability pension benefit payment.

Surviving spouse

Upon the effective date of the statutory survivor benefits, a surviving spouse who receives a statutory survivor benefit 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, unless they have access to another group health care plan. Health care coverage for an eligible surviving spouse continues without interruption provided that the *Survivor Health Care Eligibility and Enrollment Form* is returned to 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. However, 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 unless they have access to another group health care plan. 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 health care coverage through another Ohio retirement system is eligible as a dependent under the OP&F-sponsored health care coverage unless they have access to another group health care plan, 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 and has had continuous coverage).
- Stepchildren if they were covered under the OP&F-sponsored health care coverage prior to January 1, 2017.
- A dependent child who is 18 up to 26 years of age, who is not eligible to enroll in an employer-sponsored health plan (as described by law) is eligible to enroll in the OP&F-sponsored health care coverage. A dependent application must be completed and approved by UnitedHealth and the following criteria are met:
 - The child is the natural child or adopted child of the Benefit Recipient.
 - The child is not employed by an employer offering any health benefit plan under which the child is eligible for coverage. (Please note that being offered any type of healthcare through an employer makes the dependent ineligible for participation in any healthcare through Ohio Police & Fire.)

Dependent parent

If you are an eligible dependent parent as described in the Ohio Revised Code Section 742, you may be eligible for OP&F sponsored health care coverage.

Dependent only eligibility

If you are not enrolled in the OP&F-sponsored health care plan, your dependents cannot enroll unless you are enrolled in other group coverage and your dependents are not eligible and have no access to coverage on their own. 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. Dependent-only coverage may be required by a qualified medical child support order.

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, the benefit recipient and/or dependents may not be eligible for coverage.

Eligibility limitations for alternative coverage

Retirees and Dependents eligible for coverage through an employer or former employer

If you or your dependents are eligible for **any** other group coverage including employer and retirement coverage, you will not be eligible for enrollment in any of the OP&F sponsored health care plans. Members and/or dependents already enrolled with access prior to January 1, 2017 will be grandfathered and continue to pay full premium.

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.

Other Ohio retirement system benefits

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

It is the benefit recipient's responsibility to notify OP&F when he/she or a spouse is eligible for health care benefits through another ORS. If a member fails to notify OP&F within 60 days of this eligible coverage, OP&F will terminate coverage and charge the difference in the subsidized amount and full premium back to the date the member or spouse was first eligible for this ORS coverage.

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 coverage 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. Temporarily delaying your pension does not allow you to enroll in the OP&F coverage.

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, or had previously irrevocably waived coverage, will not be eligible to participate in the OP&F sponsored health care coverage.

Surviving child

A surviving child will 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 pension 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 parent 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.

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 26 can be eligible for the OP&F-sponsored health care coverage. With limited exceptions, a disabled child over age 26 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 26. 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 2017. 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. Please read this section carefully since there are limited opportunities for you to enroll in the OP&F-sponsored health care plan.

Health care, prescription drug, dental and vision coverage

You and your eligible dependents may participate in the OP&F-sponsored health care, prescription drug, dental and vision 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 statutory survivor benefits;
- with proof of change in family status (i.e. marriage, death, divorce);
- with proof of involuntary loss of group coverage;
- at the time you become eligible for Medicare;
- with proof of a determination of your or a dependent child's eligibility for premium assistance with respect to OP&F-sponsored health care coverage under a Medicaid plan (under Title XIX of the Social Security Act) or state children's health plan (under Title XXI of the Social Security Act, also known as CHIP/Children's Medicaid); or
- with proof of loss of your or a dependent child's Medicaid plan coverage or state children's health plan coverage due to a loss of eligibility for such coverage.

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

Enrollment Requirements

- Member must submit a completed Health Care Eligibility and Enrollment Form and any other necessary paperwork and it must be received by UnitedHealthcare within 60 days of the qualifying event;
- If UnitedHealthcare receives the form on time, coverage will be effective either the date following your qualifying event or the first of the month following as selected on the enrollment form. If a date is not designated, UnitedHealthcare will use the date following the qualifying event as the enrollment date;
- Contributions will be deducted from the member's OP&F monthly pension benefit.

Voluntary dental and vision plans

Voluntary dental and vision coverage are separate non-subsidized 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 or per qualified event as listed previously.

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 through the end of the plan year. The appropriate contributions will be deducted from your benefit check for the entire period.

Pre-existing conditions

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

Enrolling as a new retiree

UnitedHealthcare Medical

As a new retiree, you may qualify to enroll in the OP&F-sponsored health care coverage. The 2017 health care plan will offer one plan design through 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.

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 & B will be eligible to enroll in AARP Medicare Supplement Insurance Plan B, Plan F, or Plan L, insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for NY residents). If you are enrolled in Medicaid you may not be eligible for an AARP Medicare Supplement Insurance Plan. Please contact UnitedHealthcare for additional information at 1-888-832-0964.

In most states, up to 7 AARP Medicare Supplement Insurance Plans may be offered. OP&F will subsidize Plan B, Plan F or Plan L. The OP&F subsidy will be based on the standardized AARP Medicare Supplement Insurance 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 as long as premiums are paid on time and do not require you to submit any claim forms. Unlike Medicare Advantage Plans which have limited networks, with 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, except those required by Medicare, are required.

Prescriptions

UnitedHealthcare will also be providing prescription drug coverage through UnitedHealthcare Pharmacy for all OP&F retirees, both non-Medicare and Medicare, unless you enroll in Medicare Part D. (See page 14 for more information.)

To enroll in health care, prescription drug, dental and/or vision coverage as a new retiree, you must complete a *Health Care Eligibility and Enrollment Form* within 60 days of receiving your first benefit payment. 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.

Waiving Coverage

If you want to waive or change your coverage, you must do so within 60 days of receiving your first benefit payment. 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. In some instances, your employer may provide health care coverage beyond the first of the month following your retirement date. You may elect to have your OP&F coverage begin the day after your employer coverage terminates or the first of the month following. You will be required to provide proof of the termination within 60 days of receiving your first OP&F benefit check.

Window 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 payment 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 based on the terms of the health care plan. 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 based on the guidelines of the plan without penalty of health care and prescription drug expenses that you received during the window period. Please see page 47 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 Insurance Plan will receive a health care ID card from UnitedHealthcare Insurance Company and a separate prescription drug ID card from UnitedHealthcare.

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 9) 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 solemnized marriage certificate that indicates the date of marriage and is signed by the person with legal authority to conduct the ceremony.

Natural child or adopted child

- a copy of the child's birth certificate;
- if applicable, certified copies of the court order granting adoption; and;
- dependent application for children age 18 up to age 26.

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.

If you have dependents that become eligible for the premium assistance subsidy under CHIP/Children's Medicaid, you must notify OP&F with proof of this eligibility within 60 days. In order to be eligible for OP&F coverage, the dependents must first meet OP&F dependent eligibility guidelines listed on page 6.

Enrolling as a survivor

A *Survivor Health Care Eligibility and Enrollment Form* must be returned to UnitedHealthcare within 90 days, regardless of enrollment.

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, prescription drug, dental or vision 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.

If the form is not received within 90 days, UnitedHealthcare will terminate the OP&F subsidy, but continue coverage until the form is received.

If the survivor waives health care, prescription drug, dental or vision coverage, he or she may only enroll under the circumstances previously described on page 9.

Upon the retiree's death, the survivor assumes the role of the benefit recipient for health care purposes.

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 coverage extended.

Married couples both receiving OP&F 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 benefit; or
- each individual is enrolled separately under his or her own plan, with health care contributions being withheld from each benefit recipient's 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.



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. Enrollment in these programs may affect your eligibility in the OP&F-sponsored programs.

If you become eligible for Medicare prior to age 65 due to a certain disability, the UnitedHealthcare Medical Plan 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.

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 regarding eligibility and 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. Enrollment in these programs may affect your eligibility in the OP&F-sponsored programs.

Enrolling in Medicare

It is extremely important that you and your dependents enroll in Medicare when you are first eligible. Medicare will become primary to your supplement insurance plan offered through OP&F. 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. Please forward a copy of the Medicare card or letter of enrollment to UHC. This will allow for any eligible premium adjustments and ensure that claims are paid correctly.

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 Insurance 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.

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, the benefit recipient will not be required to utilize network providers.

If you are eligible to receive Medicare A & B and are turning 65

Your OP&F-sponsored health care coverage administered through UnitedHealthcare will terminate at the end of the month prior to your effective date of Medicare eligibility. Once enrolled in both Medicare Parts A & B, you will have the opportunity to enroll in AARP Medicare Supplement Insurance Plan B, F, or L insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for NY residents). You will receive an enrollment kit in the mail, which will include plan information, rates and instructions for enrollment.

Medicare Details

Medicare Part A (Hospitalization)

- Must have pre-determined quantity of Social Security credits to be eligible at no cost.
- Send a copy of your ineligibility letter or copy of your Medicare card to UnitedHealthcare.
- If not eligible for Part A, and 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.

Medicare Part B (Medical)

- Everyone is eligible to enroll in Medicare Part B once they reach age 65 years of age (or have a qualifying illness or disability prior to age 65.)
- You must enroll in Medicare Part B when it is first offered. If you do not sign up, refuse or stop your Medicare Part B enrollment, UnitedHealthcare will estimate what Medicare Part B would have paid, and deduct that amount from the charges before making payment. You will be responsible for the amount that Medicare Part B would have paid.

Medicare Part D (Prescription Drug)

- You cannot be enrolled in both the OP&F-sponsored prescription drug coverage and Medicare Part D.
- Terminating Medicare Part D does not allow enrollment into the OP&F-sponsored prescription drug plan (see qualifying events, page 9.)
- Please forward proof of your enrollment to UnitedHealthcare if signed up for this plan.

Early Medicare Automatic Claim Filing Program

Through the Automatic Claim filing Program, Medicare forwards medical 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 third-party coverage, you will need to notify UnitedHealthcare so that you can be disenrolled from the Automatic Claim Filing Program. If you are enrolled in an AARP Medicare Supplement Insurance Plan, then your Medicare carrier will automatically file your Part B claims to UnitedHealthcare 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 Plans are 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 & B will be eligible to enroll in an AARP Medicare Supplement Insurance Plan B, Plan F or Plan L insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for NY residents). Medicare supplement plans help you control your out-of-pocket expenses. In most states, up to 7 AARP Medicare Supplement Insurance Plans may be offered. OP&F will subsidize Plan B, Plan F or Plan L. The OP&F subsidy will be based on the standardized AARP Medicare Supplement Insurance Plan L premium rate for the state of Ohio. All standardized Medicare supplement insurance plans are guaranteed renewable and no claims forms are needed. As with all Medicare supplement plans, you have total freedom to choose any doctor, specialist, hospital or other provider that accepts Medicare patients 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 UnitedHealthcare Insurance Company (UnitedHealthcare) at 1-888-832-0964 for additional information or to request an enrollment kit, which must be returned prior to your enrollment or Medicare 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 Insurance Plan the OP&F-sponsored medical 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 insurance premium established by the OP&F Board of Trustees, provided that you are not eligible to receive this reimbursement from any other source and you file the appropriate paperwork with UnitedHealthcare. Regardless of your enrollment in the OP&F-sponsored medical plan, reimbursement will begin after UnitedHealthcare's receipt of:

- your fully completed *Medicare Part B Reimbursement Statement*; and
- a copy of your Medicare card or letter of enrollment.

If a copy of the benefit recipient's Medicare card and completed Medicare Part B Reimbursement Statement are received any time during the month that you are effective, 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 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* 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.

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 notify UnitedHealthcare if another source other than OP&F is 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.

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 subject to certain limited circumstances. The re-enrollment guidelines are highlighted on page 9, 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. Please be sure to mark the specific plan that you are waiving on the form.

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. It is your responsibility to notify UnitedHealthcare when an enrolled dependent is no longer eligible for coverage or subsidy, such as:

- divorce, dissolution of marriage or legal separation;
- death; or
- is eligible for other employer or retirement coverage

It is also your responsibility to provide appropriate documentation within 60 days of the event for timely termination and adjustments to your contributions. If you become divorced, your marriage is dissolved or if you became legally separated, please provide the address of your former spouse and a certified copy of the court entry or decree for UnitedHealthcare's 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.

What are the **details of my health care coverage?**

Health care coverage

UnitedHealthcare Medical Plan

The 2017 health care plan will continue to be administered through UnitedHealthcare for all non-medicare 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.

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 & B will be eligible to enroll in an AARP Medicare Supplement Insurance Plan, insured by UnitedHealthcare 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 7 AARP Medicare Supplement Insurance Plans may be offered. These plans are guaranteed renewable as long as your premium is paid on-time and no material misrepresentations have been made on the application. You are not required to submit any claim forms. With all Medicare supplement plans, you have total freedom to choose any doctor, specialist, hospital or other provider that accepts Medicare – anywhere in the U.S, there are no networks. No referrals are required. You will receive more details about these plans in your enrollment kit.

More details about the UnitedHealthcare Medical Plan

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 coverage. You may choose a doctor or hospital from UnitedHealthcare'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;
- you will not be responsible for paying the difference between the provider's normal charge and specially-negotiated fees;
- when using network providers you do not have to file claim forms; and
- deductibles are lower and the maximum yearly out-of-pocket limit is lower.

You will, however, still be responsible for paying your co-pay and deductible.



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.

Out-of-area plan

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 plan

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 the out-of-area plan. 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.

Worker's Compensation

The OP&F-sponsored healthcare plan does not cover expenses that arise from on the job injuries or illness. If you agree to a lump sum medical settlement through worker's compensation, any future claims relating to that occupational injury or illness are excluded from OP&F-sponsored coverage.

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.

Members enrolled in this plan are subject to Medical Necessity which requires prior authorization of certain services.

You are eligible for the following coverage if you are:

- a Non-Medicare Participant living in a Network Area

	Network (Participating Providers)	Non-Network (Non-Participating Providers)
Annual Deductible		
Individual /Family	\$750/\$1,500	\$2,250/\$4,500
Out of Pocket Maximum	\$2,000/\$4,000	\$10,000/\$20,000
Co-Insurance	80%	50%
Physician Services		
Primary Care Office Visit	\$30/100%	50%
Specialist Office Visit	\$45/100%	50%
Emergency Care		
Emergency department*	\$200/80%	\$200/80%**
Non-emergency services rendered in emergency room*	\$200/50%	\$200/50%**
Urgent care	\$50/80%	50%
Hospital In-Patient Services		
Prior Admission Testing	80%	50%
Scheduled in-patient admit	\$400/80%	\$400/50%**
Emergency in-patient admit*	\$400/80%	\$400/80%
Ambulatory Services		
Diagnostic lab/x-ray	80%	50%
Ambulatory surgery center	\$150/80%	50%**
Mental Health and Substance Abuse		
Scheduled in-patient admit	\$400/80%	\$400/50%**
Emergency in-patient admit*	\$400/80%	\$400/80%
Out-patient mental/drug/alcohol	\$30 co-pay/visit/100%	50%
Preventive Care		
Physician office visit	100%	50%
Other Services¹		
Rehab therapies	\$45 copay/visit/80%	50%
Chiropractor	\$45 copay/visit/80%	50%
Durable medical equipment	80%	50%**
Home health care services	80%	50%**
Private duty nursing	80%	50%**
Skilled nursing facility	\$400/80%	\$400/50%**
Sub-acute rehabilitation center	\$400/80%	\$400/50%**
Ambulance	80%	50%**
Hospice (In-patient/Out-patient)	100%	50%

* 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.

** If no prior authorization and service is medically necessary then \$200 penalty applies.

¹ Visit myuhc.com or call Customer Service for specific visit limits.

Members enrolled in this plan are subject to Notification which requires prior notification of certain services.

You are eligible for the following coverage if you are:

- a Participant under age 65 with Medicare Parts A & B
- a Participant who has Medicare Part A only (Medicare Part B payment is estimated)
- a Non Medicare Participant under age 65 that lives Out-of-Area***

	Network or Non-Network (Out-of-Area)
Annual Deductible	
Individual /Family	\$750/\$1,500
Out of Pocket Maximum	\$2,000/\$4,000
Co-Insurance	80%
Physician Services	
Office Visit	80%
Emergency Care	
Emergency department*	80%**
Non-emergency services rendered in emergency room*	50%**
Urgent care	80%
Hospital In-Patient Services	
Prior Admission Testing	80%
Scheduled in-patient admit	\$400/80%
Emergency in-patient admit*	\$400/80%**
Ambulatory Services	
Diagnostic lab/x-ray	80%
Ambulatory surgery center*	\$150/80%**
Mental Health and Substance Abuse	
Scheduled in-patient admit	\$400/80%
Emergency in-patient admit*	\$400/80%**
Out-patient mental/drug/alcohol	80%
Preventive Care	
Physician office visit	100%
Other Services¹	
Rehab therapies	\$30 co-pay/visit/80%
Chiropractor	\$30 co-pay/visit/80%
Durable medical equipment	80%**
Home health care services	80%**
Private duty nursing	80%** (20 visits / year)
Skilled nursing facility	\$400/80%
Sub-acute rehabilitation center	\$400/80%
Ambulance	80%**
Hospice (In-patient/Out-patient)	100

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

** \$200 penalty with no notification.

*** Benefits for Medicare Part B Services will be estimated to pay secondary to Medicare Part B regardless if you have Medicare Part B or not.

¹ Visit myuhc.com or call Customer Service for specific visit limits.

Members enrolled in this plan are subject to Notification which requires prior notification of certain services.

You are eligible for the following coverage if you are:

- a Participant eligible for Medicare Part B Only living in a Network Area

	Network (Participating Providers)	Non-Network (Non-Participating Providers)
Annual Deductible		
Individual /Family	\$750/\$1,500	\$2,250/\$4,500
Out of Pocket Maximum	\$2,000/\$4,000	\$10,000/\$20,000
Co-Insurance	80%	80% or 50%
Physician Services		
Office Visit	80%	80%
Emergency Care		
Emergency department*	\$200/80%	\$200/80%**
Non-emergency services rendered in emergency room*	\$200/50%	\$200/50%**
Urgent care	80%	80%
Hospital In-Patient Services		
Prior Admission Testing	80%	80%
Scheduled in-patient admit*	\$400/80%	\$400/50%**
Emergency in-patient admit*	\$400/80%	\$400/80%**
Ambulatory Services		
Diagnostic lab/x-ray	80%	80%
Ambulatory surgery center*	\$150/80%	\$150/80%**
Mental Health and Substance Abuse		
Scheduled in-patient admit*	\$400/80%	\$400/50%**
Emergency in-patient admit*	\$400/80%	\$400/80%**
Out-patient	100%	
Out-patient mental/drug/alcohol	80%	80%
Preventive Care		
Physician office visit	100%	100%
Other Services¹		
Rehab therapies	80%	80%
Chiropractor	80%	80%
Durable medical equipment	80%	80%**
Home health care services	80%	80%**
Private duty nursing	80%	80%**
Skilled nursing facility	\$400/80%	\$400/50%**
Sub-acute rehabilitation center	\$400/80%	\$400/50%**
Ambulance	80%	80%**
Hospice (In-patient/Out-patient)	100%	100%

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

** \$200 penalty with no notification.

¹ Visit myuhc.com or call Customer Service for specific visit limits.

What are the **details of my health care coverage? (cont'd)**

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.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you. 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. It may not be beneficial to be covered under more than one plan.

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.

Notification

If you are one of the following participants, then your Plan requires Notification:

- **a Participant under age 65 with Medicare Parts A & B**
- **a Participant who has Medicare Part A only (Medicare Part B payment is estimated)**
- **a Non Medicare Participant under age 65 that lives Out-of-Area**

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.

Check your Medical Plan Description for Services that require notification or call customer service for more details. 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. For additional questions or to notify, please call the number on the back of your ID card.

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

You are responsible for the cost of services if you fail to notify UnitedHealthcare for services requiring notification. Please see your Medical Plan Description for a full list of these services.

Prior Authorization

If you are one of the following participants, then your Plan requires Prior Authorization:

- **a Non-Medicare Participant living in a Network Area**

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Check your Medical Plan Description for Services that require prior authorization or call customer service for more details. 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 is responsible for obtaining prior authorization?

Generally, members in plans with Prior Authorization can rely on their network physician to obtain Prior Authorization for services on the standard Prior Authorization requirements list. Members will be responsible for obtaining Prior Authorization if they access a non-network provider.

Wait for a coverage determination.

For services that require Prior Authorization, please wait for a determination before having a planned service performed. In most cases, planned services require you or your physician to submit a request for Prior Authorization five business days before the scheduled service to allow time for the clinical review and coverage determination.

When am I responsible for the cost of services?

You are responsible for the cost of services in the following situations:

1. The service is deemed not covered or not medically necessary in accordance with your benefit plan, and the determination was communicated before the service was rendered and you have given your provider an attestation acknowledging your responsibility for the service.
2. You were responsible for obtaining Prior Authorization, but failed to do so.
3. During an inpatient (overnight) stay in a hospital or facility, an inpatient day is determined to be custodial. Custodial care includes any of the following services:
 - Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
 - Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

What are the details of the AARP Medicare Supplement Insurance Plans?

OP&F benefit recipients and dependents age 65 and over who are Medicare eligible and enrolled in both Medicare Parts A & B will be eligible to enroll in an AARP Medicare Supplement Insurance Plan, insured by UnitedHealthcare Insurance Company.

Why is Medicare Supplement Insurance Important?

Medicare doesn't pay for everything. In fact, Medicare Part B only covers about 80% of your medical expenses. That means the rest is up to you.

Medicare supplement insurance plans work with Medicare and are standardized. They help reduce the costs you have to pay out of your own pocket by helping to pay some or all of the costs Medicare doesn't pay, like deductibles and coinsurance.

How to choose the right AARP Medicare Supplement Insurance Plan for you

Because everyone's health care needs are different, there are several AARP® Medicare Supplement Insurance Plans to choose from. The following table outlines the features of plans B, F and L, so you may choose the plan that best fits your health care needs. Enrollment is voluntary and OP&F provides a subsidy for plans B, F & L. If a plan other than B, F, or L is chosen, this will be considered an individual plan. As a result, premiums will not be deducted from the OP&F pension check, nor will OP&F be able to help with any claims or enrollment issues.

My plan lets me focus on what's most important to me.



	Plan B	Plan F	Plan L
Hospitalization Co-Insurance ¹	✓	✓	✓
Medical Co-Insurance & Co-Payments	✓	✓	75% ²
Hospice/Respite Care Co-Insurance	✓	✓	75%
Blood (first 3 pints each year)	✓	✓	✓
Skilled Nursing Facility Care		✓	75%
Part A Deductible	✓	✓	75%
Part B Excess Charges		✓	
Foreign Travel Emergency Care Co-Insurance ³		80%	
Annual Out of Pocket Spending Limit ²			\$2,480
Subsidy Eligible	✓	✓	✓

Medicare Supplement Insurance Plan Features

All Medicare Supplement Insurance Plans provide the following features:

- **Keep your own doctor.** You can go to any doctor who accepts Medicare patients.
- **No physician referrals needed unless required by Medicare.** You don't need a referral to see a specialist, so you won't have to deal with the hassles and paperwork of referrals.
- **No hospital networks.** You can choose any hospital that accepts Medicare patients.
- **Are guaranteed renewable.** As long as your premium is paid on-time and no material misrepresentations were made on the application.
- **Coverage travels with you.** When you travel or move anywhere in the United States.

Value-added Services*

24-hour Nurse HealthLine: speak directly with registered nurses, toll-free, 24 hours a day, 7 days a week. Get treatment decision support and prescription and medication information, and have your symptoms reviewed.

Vision discounts: Save on eye exams, eyeglasses and contact lenses. (Note: This is not an insurance program and may be discontinued at any time.)

SilverSneakers: Live healthier with free access to fitness centers and classes. Get a free gym membership at participating locations with amenities like exercise equipment and fitness classes included. (Not available in all states.)

Subsidized by OP&F

OP&F provides a subsidy for AARP Medicare Supplement Insurance Plans B, F & L. The subsidy amount is based upon the cost of plan L in OH.

For More Information

Please call: 1-800-392-7537 to learn more about AARP Medicare Supplement Insurance Plans and to find out if you qualify for a subsidy.

¹ 365 additional hospital days after Medicare benefits end.

² While most AARP Medicare Supplement Plans do not have an annual out-of-pocket maximum, Plan L has an out-of-pocket maximum of \$2,480. Services under Plan L that do not count toward out-of-pocket maximums include Part B excess charges and any service not covered by Medicare. After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$166 in 2016), the Plan pays 100% of covered services for the rest of the calendar year. Plans B & F pay 100% for the first 3 pints of blood each year. Plan L pays 75%. Medicare pays costs after 3 pints.

³ Under Ohio law, a physician may not charge or collect fees from Medicare patients. Foreign Travel Emergency benefit is 80% and beneficiaries are responsible for 20% after the \$250 annual deductible with a \$50,000 lifetime maximum.

* These are additional insured member services apart from the AARP Medicare Supplement Plan benefits, are not insurance programs, are subject to geographical availability, and may be discontinued at any time.

EyeMed Vision Care (EyeMed) is the network administrator of AARP Vision Discounts. **These are not insurance programs and may be discontinued at any time.** These discounts cannot be combined with any other discounts, promotions, coupons, or vision care plans. All decisions about medications and vision care are between you and your health care provider. Products or services that are reimbursable by federal programs including Medicare and Medicaid are not available on a discounted or complimentary basis. EyeMed pays a royalty fee to AARP for use of the AARP intellectual property. Amounts paid are used for the general purposes of AARP and its members. Eye exams available by Independent Doctors of Optometry at or next to LensCrafters, Pearle Vision, Sears Optical and Target Optical in most states. Doctors in some states are employed by the location. In California, optometrists are not employed by LensCrafters, Sears Optical and Target Optical, which do not provide eye exams. For LensCrafters, eye exams are available from optometrists employed by EYEXAM of California, a licensed vision health care service plan. For Sears Optical and Target Optical, eye exams are available from self-employed doctors who lease space inside the store. Eye exam discount applies only to comprehensive eye exams and does not include contact lens exams or fitting. Contact lens purchase requires valid contact lens prescription. At LensCrafters locations, contact lenses are available by participating Independent Doctors of Optometry or at LensCrafters locations. Cannot be combined with any other offer, previous purchases, or vision and insurance plans. Some restrictions apply. Some brands excluded. See store for details. Void where prohibited. Valid at participating locations. The Sears trademark is registered and used under license from Sears Brands LLC. Target Optical® is a registered mark of Target Brands, Inc. used under license.

Optum is the provider of Nurse HealthLine. Optum nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. **These services are not an insurance program and may be discontinued at any time.** All decisions about medications, vision care, and health and wellness care are between you and your health care provider.

The services provided by the SilverSneakers program are made available as a courtesy to AARP members insured by UnitedHealthcare Insurance Company (United) **and are not part of insurance coverage and may be discontinued at any time.** AARP and United do not endorse and are not responsible for the services or information provided by this program. Consult a health care professional with questions about your health care needs.

What are my prescription drug coverage options?

In 2017, OP&F will continue to offer one prescription drug plan through UnitedHealthcare, 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 either a retail pharmacy or through OptumRx® Mail Service Pharmacy.

Retail pharmacies: New Value Network

Whether at home or traveling, you have access to OptumRx's New Value Network of 35,000 participating pharmacies. Major chains, supermarkets and mass merchants make up a large part of this select pharmacy network. The participating retail pharmacy is best used when you:

- purchase medications that you take on a short-term or immediate need basis;
- want to avoid a deductible or filing claim forms for an out-of-network benefit

To see if your pharmacy still participates in the New Value Network, please call the number on back of your ID card or log into myuhc.com and use the Locate a Pharmacy tool.

OptumRx Mail Service Pharmacy

For greater co-payment savings and convenience for medications you take on an ongoing basis, you can order your prescription medications through OptumRx Mail Service Pharmacy. With mail service:

- there are no deductibles;
- no claim forms to file;
- no waiting for reimbursement; and
- you can possibly save money by purchasing long-term medications through mail service.

Simply mail your prescription and co-payment directly to OptumRx by mail for processing. Once received, OptumRx Mail Service Pharmacy processes the prescription and will send the prescription to your home within 10 business days. Prescription refills can be ordered over the phone by calling customer service at 1-888-496-3984, through the mail at OptumRx, P.O. Box 2975, Mission, KS 66201, or via the Internet at myuhc.com®.

Specialty pharmacies

UnitedHealthcare has a designated network of specialty pharmacies that serve members taking specialty medications often used to treat complex conditions. To locate a designated specialty pharmacy 24 hours a day, seven days a week, call our Specialty Pharmacy Referral Line at 1-888-739-5820.

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 14.

New benefit recipients

When you enroll in the OP&F-sponsored prescription drug coverage, you may need to use your prescription drug benefit before you receive your ID card. During this period, you can be reimbursed for your prescription drugs based on the guidelines of the plan, 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. For more information contact UnitedHealthcare.

Comparing prescription drug co-pays

The chart below compares the co-pays for the OP&F-sponsored prescription drug plan between retail and OptumRx Mail Service Pharmacy. Limited coverage is available at non-network pharmacies. For more information contact UnitedHealthcare or see your Medical Plan Description.

	Retail pharmacy co-pay Up to a 30-day supply	Mail service pharmacy co-pay Up to a 90-day supply	Specialty pharmacy co-pay Up to a 30-day supply
Tier 1	\$15	\$30	\$15
Tier 2	\$50	\$100	\$50
Tier 3	\$70	\$140	\$70
Tier 4	50% up to \$300	50% up to \$600	50% up to \$300

An Annual Prescription Drug Out-of-Pocket Maximum of \$5,150 for Individual and \$10,300 for Family applies to your Network Benefits, which is separate from the Out-of-Pocket Maximum for your medical coverage.

4th Tier added for 2017

The medications on Tier 4 include many high-cost brand name, specialist and some generic medications used to treat complex conditions. Many Tier 4 drugs have lower cost options available in Tiers 1, 2, or 3. You may want to discuss these options with your physician to help identify a lower Tier medication that will still work for you.

Clinical Pharmacy Programs

Supply Limits

Quantity Level Limit & Quantity Per Duration

Supply Limits help address safety concerns and minimize waste by setting limits on the amount of medication that can be dispensed for 1 month or one copayment (i.e. 1-month supply for one copayment). These limits are carefully considered by the United Healthcare National Pharmacy and Therapeutics (P&T) Committee and are based on guidelines included in FDA labeling, dosing recommendations, medical literature and our claims data.

Medical Necessity

Medical Necessity requires physicians to provide additional prescribing information to evaluate the clinical appropriateness of a medication in terms of condition being treated, severity of condition, type of medication, frequency of use, and duration of therapy.

Step Therapy

Step Therapy helps curb the cost of medications and lower the total costs in categories where clinically similar, more cost-effective medications are available. The program directs members to a lower-cost medication (known as Step 1) before providing coverage for a higher-cost alternative (known as Step 2).

Refill and Save

The first-of-its-kind program encourages members with certain chronic disease states to comply with their treatment regimen. It rewards members with a discount on their copayment for timely prescription refills on select medications.

Multiple Copay

The Multiple Copay Program helps realign the benefit of one copayment per 1-month supply by applying an additional copayment where packages are so large they contain more than a month's worth of medication.

Half Tablet

The Half Tablet Program is an easy way to save money by splitting select medications in half. When members choose to split their pills, they get a new prescription for half the quantity and double the strength, resulting in their current dosage when split.

What are the **details of my voluntary dental coverage?**

Voluntary dental coverage

In 2017, 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 during the Annual Change Period or a qualifying event as long as you or your eligible dependents are not covered under another Ohio retirement system.

Enrolling in voluntary dental coverage

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 37.

Terminating dental coverage

Once you enroll in voluntary dental coverage, you cannot terminate your coverage until there is a change in your qualifying family status (ie death, divorce) or the next Annual Change Period. You and your enrolled dependents must remain in your selected coverage throughout the entire plan year.

Features of the plan

- 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, but may choose to use any 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;
- Coordination of benefits if enrolled in other dental coverage;
- Monthly contributions deducted from benefit check;
- Dental implants; and
- Oral cancer screening.



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. Please contact UnitedHealthcare customer service for more information regarding the details of this benefit.

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 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%
Fluoride treatment (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%
Dental implants (after deductible)	50%	0%

* Maximum payment in one year, per person, is \$1,500.

What is covered by my vision coverage?



Voluntary vision coverage

In 2017, 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 37.

Terminating vision coverage

Once you enroll in voluntary vision coverage, you cannot terminate your coverage until there is a change in your qualifying family status (ie death, divorce) 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);
- 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;
- 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 (Vision Plan network is different from the UnitedHealthcare Medical network);

For a listing of network providers, visit www.myuhcvision.com or call 1-800-638-3120.

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 47 for contact information.

UnitedHealthcare Vision		
Vision Feature	Network Providers	Out-of-Network Providers
Plan Frequency	Pair of lenses for eyeglasses: once every 12 months; contact lenses in lieu of eyeglasses: once every 12 months; frames: once every 24 months	Pair of lenses for eyeglasses: once every 12 months; contact lenses in lieu of eyeglasses: once every 12 months; frames: once every 24 months
Exam	\$10 copay; one per year	Up to \$50.00 reimbursement
Materials	\$0 copay	Not applicable
Single vision Lenses	\$0 copay	Up to \$60.00 reimbursement
Lined Bifocal Lenses	\$0 copay	Up to \$80.00 reimbursement
Lined Trifocal Lenses	\$0 copay	Up to \$120.00 reimbursement
Lined Lenticular Lenses	\$0 copay	Up to \$200.00 reimbursement
Polycarbonate Lenses	\$0 copay	Not applicable
Standard Progressive	\$0 copay	Not applicable
Deluxe Progressive	\$0 copay	Not applicable
Premium Progressive	\$0 copay	Not applicable
Platinum Progressive	\$0 copay	Not applicable
Scratch Coating	\$0 copay	Not applicable
Frames	*\$0 copay; \$130 Allowance plus up to 50% over allowable at discretion of provider	Up to \$78.00 reimbursement
Contact Lens Fitting and Evaluation	\$0 copay under UnitedHealthcare Vision's Contact Lenses Package	Elective contacts in lieu of eye glasses: \$200.00, Necessary contacts in lieu of eye glasses \$210.00.

* Your individual provider may offer discounts in addition to the vision coverage offered through UnitedHealthcare.

* Underwritten by UnitedHealthcare Insurance Company

How much are **my contributions?**

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. OP&F has the right to withhold monies from your OP&F benefits to offset against any premiums owed. Coverage can be terminated after 91 days of unpaid contributions. 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.

Access to other group health care coverage

If you or any dependent has access to other group health care or prescription drug coverage, you can not participate in the OP&F-sponsored health care coverage.

2017 Contribution rates for health care and prescription drug coverage

Contribution rates for the 2017 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 pages 36 and 37 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 pages 36 and 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 April 1, 2017 will be based on the Standardized base rate for the AARP Medicare Supplement Plan L in the state of Ohio. These contributions will be communicated in your Annual Change Period Confirmation letter that you will receive at the end of December. The 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.

UnitedHealthcare Medical Plan health care contributions

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 contributions that you are responsible for paying and the subsidized portion that OP&F pays for coverage.

	Not Eligible for Medicare			Non-AARP Medicare Supplement Insurance Plan		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage
Benefit recipient	\$226.28	\$678.84	\$905.12	\$73.34	\$220.00	\$293.34
Spouse	\$299.60	\$299.59	\$599.19	\$123.64	\$123.63	\$247.27
Child(ren)	\$156.58	\$156.59	\$313.17	\$123.64	\$123.63	\$247.27

Medicare Eligible	
Benefit recipient	For those members and dependents that are age 65 and over and enrolled in both Medicare Parts A and B, please contact UnitedHealthcare at 1-888-832-0964 for full premium information.
Spouse	
Child(ren)	

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 contributions that you are responsible for paying and the subsidized portion that OP&F pays for coverage.

	Not Eligible for Medicare			Non-AARP Medicare Supplement Insurance Plan		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage
Benefit recipient	\$226.28	\$678.84	\$905.12	\$73.34	\$220.00	\$293.34
Spouse	\$449.39	\$149.80	\$599.19	\$185.45	\$61.82	\$247.27
Child(ren)	\$234.88	\$78.29	\$313.17	\$185.45	\$61.82	\$247.27

Medicare Eligible	
Benefit recipient	For those members and dependents that are age 65 and over and enrolled in both Medicare Parts A and B, please contact UnitedHealthcare at 1-888-832-0964 for full premium information.
Spouse	
Child(ren)	

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

Non-AARP: 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 Contributions

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 paying and the subsidized portion that OP&F pays for coverage.

	Not Eligible for Medicare			Medicare Eligible		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for prescription drug coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for prescription drug coverage
Benefit recipient	\$74.30	\$222.92	\$297.22	\$74.30	\$222.92	\$297.22
Spouse	\$139.99	\$139.99	\$279.98	\$139.99	\$139.99	\$279.98
Child(ren)	\$41.61	\$41.61	\$83.22	\$41.61	\$41.61	\$83.22

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 paying and the subsidized portion that OP&F pays for coverage.

	Not Eligible for Medicare			Medicare Eligible		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for prescription drug coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for prescription drug coverage
Benefit recipient	\$74.30	\$222.92	\$297.22	\$74.30	\$222.92	\$297.22
Spouse	\$209.99	\$69.99	\$279.98	\$209.99	\$69.99	\$279.98
Child (ren)	\$62.41	\$20.81	\$83.22	\$62.41	\$20.81	\$83.22

Voluntary dental and vision coverage contribution rates

This chart outlines the monthly rates that the benefit recipients are responsible for paying for the 2017 OP&F sponsored voluntary dental and vision coverage. OP&F does not subsidize the voluntary dental and vision programs.

	UnitedHealthcare Voluntary Dental	UnitedHealthcare Vision
Benefit recipient (including survivors)	\$34.71	\$7.18
Benefit recipient and spouse	\$65.48	\$13.48
Benefit recipient and child(ren)*	\$68.22	\$13.22
Benefit recipient, spouse, child(ren)*	\$114.02	\$20.47

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

Health Care and Prescription Drug Discount Program

In 2017, 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 2017, you must have had a total household income on your most recently filed Federal Income tax return that is less than 225 percent of the poverty level established annually by the Department of Health and Human Services. As a result, the gross income levels that OP&F will use for the 2017 discount period are indicated in the following chart. For example, if there were a total of two individuals residing in your household in 2015 and your combined income was less than or equal to \$36,045, 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 2017 Health Care and Prescription Drug Discount Program.

Size of family unit	Household income less than or equal to
1	\$26,730
2	\$36,045
3	\$45,360
4	\$54,675
5	\$63,990
6	\$73,305
7	\$82,642
8	\$92,002
9	\$101,362
10	\$110,722

For each additional person, add \$9,360

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.

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-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.

Maximum Out of Pocket

The annual amount you are responsible for paying for medical and prescription out of pocket per calendar year.

Medical Necessity

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Out of Pocket Maximum

The annual co-insurance limit, which include deductibles and co-pays, is the maximum amount of co-insurance that you are responsible for paying per calendar year.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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 2017.

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 October 15-December 7, 2017, 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 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 9.

You will receive this creditable coverage notice each year. You will receive a new notice if the OP&F coverage is changed so that it is no longer credible.

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

Notice of Privacy Practices

In order to protect members personal health information, OP&F follows the standards for procedures and practices for handling and exchanging the protected health information of all health care program participants as outlined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. OP&F will send notifications to all participants, which describe (company’s privacy practices.) 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 protects the privacy of your health information and provides you with this notice, which explains how OP&F will use and disclose protected health information. OP&F abides by the terms of this notice.

Patient Protection and Affordable Care Act (PPACA) Required Notices for Plan Year beginning January 1, 2017

Notice of Dependent Coverage to at Least Age 26

This notice is being provided to you by the Ohio Police & Fire Pension Fund (OP&F) as required by the Department of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the "Agencies") to meet requirements under the Patient Protection and Affordable Care Act (PPACA). OP&F allows coverage for all eligible adult children up to age 26, in accordance with the rules of the plan, including, but not limited to the necessity of a qualifying event as listed on page 9 of this guide.

Following are the eligibility guidelines effective 1/1/2017:

Ages 18 up to 26:

- must be natural or adopted child of member
- can be married or unmarried
- not employed and offered healthcare through that employer***

** If a child is incapacitated they may qualify for continued coverage as an incapacitated dependent. If a child will lose the adult dependent child eligibility and is incapacitated, you will need to complete the UnitedHealthcare Incapacitated Verification Form.

*** Please note that being offered any type of healthcare through an employer makes the dependent ineligible for participation in any healthcare through OP&F.

In order to enroll new dependents or for your eligible dependents to have continuous coverage, you must complete a Dependent Eligibility Form. For new dependents these additional documents must be included with the form:

- a copy of the birth certificate;
- a copy of the adoption papers (if applicable); and
- a copy of the Medicare/Medicaid card.

For more information contact: **UnitedHealthcare at 1-888-832-0964.**

Notice that Lifetime Limit No Longer Applies and Enrollment Opportunity

This notice is being provided to you by The Ohio Police & Fire Pension Fund (OP&F) as required by the Department of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the "Agencies") to meet requirements under the Patient Protection and Affordable Care Act (PPACA).

The lifetime limit on the dollar value of benefits under The OP&F Health Care Plan does not apply.

OP&F is allowing coverage for all eligible adults. For more information contact: **UnitedHealthcare at 1-888-832-0964.**

Patient Protection and Affordable Care Act reporting requirements in 2017

The individual shared responsibility provision of the Patient Protection and Affordable Care Act (PPACA) says that every person has to have basic health insurance coverage or face a penalty. A person must have what is known as minimum essential coverage (MEC). OP&F's health care plan meets these MEC requirements under the PPACA and satisfies enrollees' individual mandate to obtain insurance. Enrollees compliance will be reported to the federal government in 2017 and statements will be provided to the member for the member and member dependents to demonstrate compliance with the individual mandate of the PPACA.

CHIPRA Disclaimer

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2016. You should contact your State for further information on eligibility.

ALABAMA – Medicaid; Website: <http://www.medicaid.alabama.gov>; Phone: 1-855-692-5447

ALASKA – Medicaid; Website: <http://health.hss.state.ak.us/dpa/programs/medicaid>; Phone (Outside of Anchorage): 1-888-318-8890; Phone (Anchorage): 907-269-6529

ARIZONA – CHIP; Website: <http://www.azahcccs.gov/applicants>; Phone (Outside of Maricopa County): 1-877-764-5437; Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid; Medicaid Website: <http://www.colorado.gov>; Medicaid Phone (In state): 1-800-866-3513; Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid; Website: <https://www.flmedicaidtprecovery.com>; Phone: 1-877-357-3268

GEORGIA – Medicaid; Website: <http://dch.georgia.gov>; Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP); Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP; Medicaid Website: www.accesstohealthinsurance.idaho.gov; Medicaid Phone: 1-800-926-2588; CHIP Website: www.medicaid.idaho.gov; CHIP Phone: 1-800-926-2588

INDIANA – Medicaid; Website: <http://www.in.gov/fssa>; Phone: 1-800-889-9949

IOWA – Medicaid; Website: www.dhs.state.ia.us/hipp; Phone: 1-888-346-9562

KANSAS – Medicaid; Website: <http://www.kdheks.gov/hcf>; Phone: 1-800-792-4884

KENTUCKY – Medicaid; Website: <http://chfs.ky.gov/dms/default.htm>; Phone: 1-800-635-2570

LOUISIANA – Medicaid; Website: <http://www.lahipp.dhh.louisiana.gov>; Phone: 1-888-695-2447

MAINE – Medicaid; Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>; Phone: 1-800-977-6740; TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP; Website: <http://www.mass.gov/MassHealth>; Phone: 1-800-462-1120

MINNESOTA – Medicaid; Website: <http://www.dhs.state.mn.us>; Click on Health Care, then Medical Assistance; Phone: 1-800-657-3629

MISSOURI – Medicaid; Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>; Phone: 573-751-2005

MONTANA – Medicaid; Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>; Phone: 1-800-694-3084

NEBRASKA – Medicaid; Website: www.ACCESSNebraska.ne.gov; Phone: 1-800-383-4278

NEVADA – Medicaid; Medicaid Website: <http://dwss.nv.gov>; Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid; Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>; Phone: 603-271-5218”

NEW JERSEY – Medicaid and CHIP; Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid>; Medicaid Phone: 609-631-2392; CHIP Website: <http://www.njfamilycare.org/index.html>; CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid; Website: http://www.nyhealth.gov/health_care/medicaid; Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid; Website: <http://www.ncdhhs.gov/dma>; Phone: 919-855-4100

NORTH DAKOTA – Medicaid; Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid>; Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP; Website: <http://www.insureoklahoma.org>; Phone: 1-888-365-3742

OREGON – Medicaid and CHIP; Website: <http://www.oregonhealthykids.gov>; <http://www.hijossaludablesoregon.gov>; Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid; Website: <http://www.dpw.state.pa.us/hipp>; Phone: 1-800-692-7462

RHODE ISLAND – Medicaid; Website: www.ohhs.ri.gov; Phone: 401-462-5300

SOUTH CAROLINA – Medicaid; Website: <http://www.scdhhs.gov>; Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid; Website: <http://dss.sd.gov>; Phone: 1-888-828-0059

TEXAS – Medicaid; Website: <https://www.gethipptexas.com>; Phone: 1-800-440-0493

UTAH – Medicaid and CHIP; Website: <http://health.utah.gov/upp>; Phone: 1-866-435-7414

VERMONT– Medicaid; Website: <http://www.greenmountaincare.org>; Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP; Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>; Medicaid Phone: 1-800-432-5924; CHIP Website: <http://www.famis.org>; CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid; Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtml>; Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid; Website: www.dhhr.wv.gov/bms; Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid; Website: <http://www.badgercareplus.org/pubs/p-10095.htm>; Phone: 1-800-362-3002

WYOMING – Medicaid; Website: <http://health.wyo.gov/healthcarefin/equalitycare>; Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Financial information privacy notice

This notice describes how financial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective January 1, 2016

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and nonfinancial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please call the member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446.

Your rights regarding your protected health information

Visit myuhc.com/uhcrights to view the Annual Rights & Resource Disclosure.

The Annual Rights & Resource Disclosure will inform you about:

- Finding a doctor, hospital or other network provider on myuhc.com®. To request a printed directory, call the member phone number on your health plan ID card
- Obtaining routine, preventive and specialty care; urgent, ER and hospital care; after-hours, out-of-state/area and behavioral health care*
- Notification requirements and medical services, financial incentives and evaluation of new technology
- Case and Disease Specific Management
- Benefit coverage, exclusions, restrictions, and costs of care; Pharmacy notification procedures and benefits*
- Looking up claims/Obtaining an ID card
- How to voice a complaint or submit an appeal
- Quality improvement program results
- Your rights and responsibilities as a member
- Women's Health and Cancer Rights Act; Newborns' and Mothers' Health Protection Act
- Health Plan Notices of Privacy Practices
- Language assistance services

* If applicable

Log in to myuhc.com/uhcrights to view a complete copy of the Annual Rights & Resource Disclosure. No further action is required unless you wish to receive a printed copy of the disclosure.

To request a paper copy, send a request by mail to UnitedHealthcare, 9200 Worthington Rd., Westerville, OH 43082.

For United Behavioral Health, additional information is available at liveandworkwell.com/newsletter. To request a paper copy, call the mental health phone number on your health plan ID card.

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

Medical

UnitedHealthcare
Attn: Claims Unit
P.O. Box 30555
Salt Lake City, UT 84130
1-888-496-3984
www.myuhc.com

AARP Medicare Supplement Insurance Plans

1-800-392-7537 To Change Plans
1-800-523-5800 General Information
www.aarpmedsuppretirees.com

Prescription Drug

OptumRx
Attn: Claims Department
P.O. Box 29077
Hot Springs, AR 71903
1-888-496-3984
www.myuhc.com

OptumRx® Mail Service Pharmacy:
OptumRx
P.O. Box 2975
Mission, KS 66201
1-888-496-3984

Voluntary Dental

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

Voluntary Vision

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

Long-Term Care

Prudential: 1-800-732-0416
Aetna: 1-800-537-8521

Medicare

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

Bureau of Worker's Compensation

1-800-644-6292
www.ohiobwc.com



UnitedHealthcare
9200 Worthington Rd
Westerville OH 43082
Phone: (888) 832-0964
Fax: (866) 459-0518