ULSTER COUNTY COMPTROLLER'S OFFICE

Elliott Auerbach, Comptroller

February 5, 2018

Audit of Internal Controls over Ulster County's Health Benefit Plan and Related Reporting

The mission of the Ulster County Comptroller's Office is to serve as an independent agency of the people, to protect the public interest by monitoring County government and to assess and report on the degree to which its operation is economical, efficient and its financial condition sound.

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February 5, 2018

Dear County Officials:

Following is our report on the internal controls over the administration of the Ulster County health benefit plan ("Plan"). Our review sought to determine whether controls in place are adequate to ensure that the Plan and the administration of health benefits in general are being appropriately estimated, financially supported, and properly overseen.

We encountered many difficulties in regard to obtaining information from third-parties during our audit. Moreover, at the time this report was released, all testing could not be completed. Therefore, we will issue an update to this report when requested information is received and all testing is capable of being concluded.

Generally, the estimation of costs and administration of health benefits for the Plan appear to be adequate despite gaps in communication and review. Our investigation showed that there was no mechanism in place – either internally by the County or externally by one of our third-party providers – to monitor the submission and reimbursement of stop-loss insurance claims. Due to this omission, the Comptroller's Office identified up to $188,000 in stop-loss reimbursements that were denied without substantiation and appear to represent monies owed to the County as part of the 2016 plan year but were never received. As a result of our audit, the County should be able to recoup much, if not all, of these monies due once they are approved. Further, internal controls regarding claims processing are lacking, as it appears that no third-party actually reviews claims that are processed and paid. Accordingly, we suggest that County Management and/or the County Legislature engage a specialized third-party firm to conduct a review of the claims processed by Blue Cross Blue Shield, as well as the general administration of the Plan, to ensure that the County is receiving the best value in terms of service provision and that claims have been appropriately processed and paid.

The reports issued by this Office are an important component in accomplishing the development and promotion of short and long-term strategies to achieve reduced costs, to improve service delivery, and to account for and protect the County's assets. These reports are expected to be a resource and are designed to identify currently emerging fiscally related problems and provide recommendations for improvement.

The Office of the Ulster County Comptroller conducted this audit and produced this Report in accordance with the Comptroller's authority as set forth in Article IX, Section 57, first paragraph, and Sections 57(A) and (G) of the Ulster County Charter, as well as applicable State laws, rules, and regulations.

If we can be of assistance to you, or if you have any questions concerning this Report, please feel free to contact us.

Respectfully submitted,

Ulster County Comptroller

Background

Self-funding is a financing mechanism in which an employer directly funds health care claims as opposed to contracting with an insurance company to purchase premium based coverage. In most cases, self-funded benefit plans are managed by an independent Third-Party Administrator ("TPA") who is typically responsible for the day-to-day operations of the plan, including the coordination of benefits and claims processing.

In 2016, Ulster County paid Rose & Kiernan $126,072 to operate as the County's broker for health benefits. As the County's broker, Rose & Kiernan was responsible for a number of administrative duties, including assisting Blue Cross Blue Shield with the preparation of the plan document that "serves as the foundation for plan operations."[1] Rose & Kiernan aided the County in choosing a TPA by shopping the market for insurance providers to find the best possible value for the County as a whole. To accomplish this goal, Rose & Kiernan took the hundred most commonly used "medical billing codes" and acquired price estimates for these services from insurance providers. These costs provided a basis for them to make a price/coverage comparison, as it is impossible to know at the onset what type and quantity of claims will be submitted by members throughout the year.

The County also paid Blue Cross Blue Shield ("BCBS") $660,180 to provide TPA services and has continued to contract with this provider for medical benefit coverage. In a self-funded benefit plan, the TPA functions as an independent firm that is particularly skilled in the operation of a health plan. As Ulster County's TPA, BCBS is responsible for the majority of the Plan's functions, including the processing of claims, preapprovals, denials, and related activities. Primary duties also include assisting with claims management, plan enrollment, and offering support with reporting requirements, as well as plan document coordination. BCBS bills the County monthly for this service. Self-funded plan enrollees accordingly pay a "premium equivalent," which encompasses "the cost per covered employee, or the amount the [employer] would expect to reflect the [sum total] cost of claims paid, administrative costs, and stop-loss premiums" distributed among covered individuals.[2] In theory, these fees allow the County to "rent" the BCBS network, as BCBS is responsible for negotiating the payment price for services that are paid directly by the County each month.

[1] *See gen* "Understanding Your Fiduciary Responsibilities Under A Group Health Plan," by the Employee Benefits Security Administration, United States Department of Labor (September 2015). Available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf

[2] *See gen* "Definitions of Health Insurance Terms," by the United States Department of Labor (Bureau of Labor Statistics) (citing "the Federal Government's Interdepartmental Committee on Employment-based Health Insurance Surveys approved […] set of definitions for use in Federal surveys collecting employer-based health insurance data"). Available at https://www.bls.gov/ncs/ebs/sp/healthterms.pdf

Moreover, Ulster County paid $663,003 in premiums for stop-loss insurance benefits provided by Sun Life Financial for 2016. Designed to guard against catastrophic claims, this type of coverage is a "form of reinsurance for self-funded employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit)."[3] Stop-loss insurance essentially kicks in when claims exceed certain limits, providing "back-up" coverage for the County.

2016 Plan Enrollment

During the 2016 enrollment period, the County had 1249 contracts with participants for medical coverage across two Plan offerings. Generally, individuals pay less if they use providers that belong to the Plan's network. The first is considered a Preferred Provider Organization ("PPO") Plan, which contracts with medical professionals to create a "network" of participating providers. In 2016, there were 484 County enrollees in the PPO plan. A second plan, known as a Point of Service ("POS") Plan, offers coverage at a reduced "premium equivalent" rate, but out-of-network costs will be higher due to an increased deductible for services that are not provided in-network. Enrollment in the POS Plan was 765 contracts during the November 2015 enrollment period for the 2016 calendar year. For applicable "premium equivalent" rates for the 2016 plan year by employee type, please see **Appendix.**

In order to determine participants' contributions for the year – which are applied as "premium equivalents" and deducted from participants' paychecks – the County first projects overall health insurance costs with the assistance of its broker. This amount provides a basis to calculate the portion paid by all members of the Plan. Employment contracts stipulate what share of this "premium equivalent" will be attributed to the covered employee and what share is owed by the County; as a whole, members contribute approximately 13.5% of the total medical coverage cost. However, actual participant contribution percentages may vary because "premium equivalents" are based on estimated costs. Contribution rates for covered employees range from 0-20% based on applicable employment contracts.

Cost-Benefit Assumptions

Generally, self-funded plans offer many benefits to employers, including the ability to self-tailor the plan. Additionally, self-funded plans typically offer increased savings because "profits" are retained by the employer (e.g. the County) rather than an insurance company. However, some studies suggest that when utilizing a TPA, employers are not achieving the same level of success as compared to a traditional insurance plan.[4] Small brokers may not have the sophistication or resources necessary

[3] *See gen* id.
[4] *See gen* "What your broker isn't telling you about self-insurance," by Michael Turpin (August 5, 2011). Available at www.businessinsurance.com

to effectively unbundle and manage self-funded health benefit plans. Additionally, errors arising out of claims processing and stop-loss reimbursements can limit economic benefits achieved. When using a TPA for these types of services, it is important that there is a monitoring process in place and a considerable amount of involvement from County Management to ensure that the County is receiving the best value possible.

At the time of our audit, there was no historical data available to determine what a fully-insured health plan would have cost the County; therefore, we were unable to do a cost-benefit comparison of the County's choice to self-fund over a historical period. Currently, the Personnel Department is in the process of collecting this historical data from both the County's previous and current brokers to enable the Comptroller's Office, as well as other stakeholders, to conduct a meaningful analysis of the cost-benefit assumptions related to the County's overall choice to self-fund health benefits.

2016 Estimated and Actual Costs

In 2016, with the help of Rose & Kiernan, the County estimated that actual health insurance costs would total $26,700,119 for all medical coverage, including retiree premiums, dental, and vision. Of this amount, $23,636,376 was estimated to cover the cost of medical coverage solely provided by the Plan, which is broken down as follows:

2016 Estimated Plan Costs	
Blue Cross Blue Shield ("BCBS") Claims	$17,038,958
ESI RX Claims	$4,450,237
CanaRX Claims	$174,011
Stop Loss Insurance Premiums	$669,814
BCBS Admin PPO Plan	$258,863
BCBS Admin POS Plan	$409,153
Rose & Kiernan Broker Fee	$157,374
ACA Fees & Taxes	$477,967
Total	**$23,636,376**[5]

Using these estimated costs, the County determines a "premium equivalent" for coverage with the assistance of its broker, Rose & Kiernan. These "premium equivalents" are then applied to the applicable contribution rate depending on the employment contract for each covered enrollee.

[5] The primary source of this data was a year-to-date summary report created by Rose & Kiernan (dated January 25, 2017) and furnished to our office by the Personnel Department for our review. We chose these numbers for our report in order to isolate costs for the 2016 Plan year because numbers reflected within the County's financial system may include payments made for claims incurred in years other than 2016.

Actual results exceeded expectations for 2016. According to Management, several high dollar value claims helped cause this delta, including 134 claimants that exceeded $25,000. Of these claims, seven individuals surpassed the $275,000 stop-loss claim threshold, and the County received a total of $1,901,134 in stop-loss reimbursements as a result. As noted, stop-loss insurance premiums cost the County $663,003 for the 2016 Plan year.

In 2016, the County estimated $3,190,911 in collections from County enrollees (including non-Medicare retirees) for medical coverage. Total medical expense payments were $26,814,109 for the year before considering contributions made by both active employees and retirees covered by the Plan.

Total estimated and actual costs of the Plan for 2016 are reflected in the following chart:

2016 Estimated vs. Actual Plan Costs			
	Estimate	**Actual**	**Difference**
Blue Cross Blue Shield ("BCBS") Claims	$17,038,958	$19,989,663	$2,950,705
ESI RX Claims	$4,450,237	$4,985,549	$535,312
CanaRX Claims	$174,011	$141,850	-$32,161
Stop Loss Insurance Premiums	$669,814	$663,003	-$6,810
BCBS Admin PPO Plan	$258,863	$236,896	-$21,967
BCBS Admin POS Plan	$409,153	$423,285	$14,132
Rose & Kiernan Broker Fee	$157,374	$126,072	-$31,302
ACA Fees & Taxes	$477,967	$247,792	-$230,175
Stop Loss Reimbursements*	$0	-$1,901,134	-$1,901,134
Prescription Rebates*	$0	-$754,940	-$754,940
Totals*	**$23,636,376**	**$24,158,035**	**$521,660**
* No stop-loss reimbursements were included in the 2016 projected costs because no stop-loss claims occurred in the 2015 claim period; RX rebate credits were not used in 2016 pharmacy plan projected costs but anticipated rebates for 2016 were $440,000; Amounts presented do not include Dental, Vision, or Medicare Retiree Insurance			

[6]

After taking stop-loss reimbursements received and prescription rebates into consideration, the County's actual medical insurance expenses for the year were $521,660 higher than anticipated, which does not include differences resulting from Medicare retiree premiums, dental, and vision costs.

[6] *See* id (Rose & Kiernan Summary Report).

Objectives

The objectives of this audit were to evaluate the process by which the County administers its health benefit plan and to evaluate the working relationships among the County, its broker (Rose & Kiernan, during the audit period), its TPA (Blue Cross Blue Shield), and its stop-loss carrier (Sun Life Financial) in relation to the delivery of health benefits and overall provision of services. Specifically, our audit sought:

- To evaluate the effectiveness of internal controls over the administration of the County's health benefit plan for the period of January 1, 2016, to December 31, 2016;
- To review all available reports for mathematical accuracy and completeness during the audit period;
- To review the administration, determination, and reconciliation of participants' contributions to the Plan for the audit period; and
- To review compliance with Schedule A contract requirements, regarding services provided in relation to the administration of health benefits

Findings & Recommendations

1. **Finding** – Contract deliverables not achieved

   There is no independent audit of claims paid to the provider.

   During our audit, we discovered that no third party has verified paid claims for covered individuals, reasonableness, or duplication. Although external auditors are permitted to examine claim information, it is our understanding that neither Rose & Kiernan nor the County Personnel Department actively review claim data. After examining the contract between Rose & Kiernan and the County, we determined that one "Schedule A" provision called for "a medical review by an independent auditor of all claims paid." To date, it appears no such review has taken place despite the Schedule A requirement.

   Recommendation – As past contractual provisions have not been performed, we recommend that greater oversight should be applied by Personnel to ensure that vendors are supplying required services. If this provision is included in future contracts then perhaps a penalty should be stipulated for non-performance.

2. **Finding –** Inadequate controls regarding review of claims paid

   No independent review of claims has been completed.

   As noted in the previous finding, our audit revealed that there is no detailed claim information provided to, and examined by, the County. Currently, the sole claims processing review is conducted by BCBS, which means that no entity other than BCBS actively monitors claims for their validity. As BCBS essentially acts as a "middleman" – collecting and remitting payments on behalf of the County – it is important that County management is directly able to determine that claims paid were legitimate. Further, due to the fact that BCBS is acting on behalf of the County rather than its own "bottom line," there may not be as much incentive for BCBS to scrutinize claims activity as would be the case if BCBS had a greater (i.e. personal) financial stake in the process. Therefore, the County should engage an industry specific review to determine that services provided on behalf of the County are of sufficient quality based on industry standards. At present, the County is only provided a bill that shows the total dollar amount to be paid by plan type. While BCBS has an internal "claims review process," the County currently pays BCBS based on a summary bill with no detailed data and no review outside of BCBS.

   Recommendation – The County or its present broker, Relph Benefit Advisors, should be regularly reviewing claims paid. Further, we recommend that the County engage an outside firm – with expertise in the administration and delivery of health care benefits – to do a thorough examination of the processing behind paid claims, as the current contract with our current broker does not speak to an independent audit. This analysis should extend to all administrative services relating to the Plan to ensure that the County is getting the greatest possible value.

3. **Finding** – Availability of information and timeliness of response

   Information was not available within a reasonable timeframe.

   During our audit, several questions arose regarding the submissions of claims, the calculation of overpayments, and the process by which both items are handled. After requests were made by the Personnel Department for Rose & Kiernan, BCBS, and Sun Life to provide the information related to our questions, multiple follow-up requests were required. Over two months elapsed before documents and partial explanations were delivered. In terms of stop-loss insurance information requested, explanations and documentation were still outstanding as of the release date of this report. When the County must use third-party providers to handle aspects of County business, it is imperative that Management is able to clearly determine in a timely manner that services were adequately provided on the County's behalf. The responses received – and the protracted timeframe required – were unacceptable, leaving Management incapable of verifying that processes were completed correctly.

Recommendation – Management should include timeliness provisions in future contracts, outlining their expectations regarding the prompt access of information to prevent future problems. Future contracts should expressly address what information will be proactively provided to management, what information will be otherwise available upon request, and a timeframe that is acceptable for response.

4. **Finding** – Denied claims not substantiated

   Claims submitted to our stop-loss insurance provider ("Sun Life") were denied without proper substantiation to verify the denial was appropriate.

   Our stop-loss testing revealed claims for one participant that had been denied. In all other instances, denied claims were resubmitted and paid. We requested a detailed accounting of these denials to verify if the claims had been resubmitted and paid in a later period or whether the denial in total was legitimate. This inquiry as to the reason for each denial and the status of each claim eventually led us to uncover that these questionable denials represented up to $188,315.17 in monies that should be eligible for reimbursement to the County. The Personnel Department contacted both BCBS and Sun Life in regard to these claims, which confirmed that the County will soon be in receipt of monies owed to it as discovered by our audit (pending final approval).

   Recommendation – Management should strive to improve the flow of information between service providers and County personnel responsible for the administration of health benefit related services. While the responsibility of submitting stop-loss claims is contractual between BCBS and Sun Life, it is important that County Management be able to review the detail behind services provided. Further, County Management should continually oversee and review the submission of these claims to ensure that the County is fully in receipt of all funds due. As we have already noted, it is important that services provided on behalf of the County are still being actively scrutinized to ensure that the County's best interests are preserved.

5. **Finding** – Offset amounts not substantiated

   Several amounts that offset stop-loss reimbursements were not substantiated with proper documentation.

   During our stop-loss testing, there were several claim reimbursements that were reduced by "offset" amounts. These offset amounts could relate to many things, including overpayments made or reimbursement received from other entities (e.g. Worker's Compensation). During our audit, we requested that Sun Life provide proper documentation to verify that $127,521 in offset amounts were appropriate and substantiated. The response received was not adequate to verify that the offset amounts were for overpayments or funds already received. After numerous attempts to receive proper documentation, we were unable to verify any of these amounts.

Recommendation – Per our previous recommendation, we feel that communications between County Management and service providers need to be greatly improved. It is extremely important that the County is able to verify that third-party administrators have adequately provided services on behalf of the County and that information regarding payments due to the County is readily available. We also reiterate our suggestion that a third-party should be engaged to conduct a thorough review of the services provided on behalf of the County against agreed upon policies, procedures, and industry standards in general.

6. **Finding** – Cost-benefit analysis not possible at the time of our audit

We are unable to determine the cost-benefit of self-funding as compared to a fully-insured plan with premium payments to a carrier.

We originally sought to include in our review an analysis of the County's decision-making to provide health benefits via a self-funded plan. To conduct this comparison, we requested the cost of providing health insurance via a traditional premium based plan through an insurer. However, this information was not available, as the County was not provided comparative costs by their broker in any of the years under review. As the calculation of insurance premium rates uses many variables specific to an employer's population and other factors, we are unable to determine what the cost would have been had the County provided fully-insured benefits through a carrier. Further, as health benefit expenses represent a significant and fluctuating yearly cost to the County, the ability to monitor the fiscal effect of this decision is important to policymakers and should be readily available for review.

Recommendation – In future years, the County should request that its broker annually collect, analyze, and retain information regarding the cost to the County to provide true premium-based insurance. Collecting this information will allow taxpayers and policymakers to determine the impact of the County's decision to utilize self-funding.

Note: At the time this report was released in draft form for departmental review and commentary, the Personnel Department was in the process of collecting historical costs for a traditional premium based insurance plan. This information will be collected going forward so that management and policymakers will have the data needed to conduct a meaningful cost-benefit analysis on an annual basis since the inception of the Plan. Once this information has been provided to our Office, we will issue an addendum to this report representing inclusion of the analysis.

Scope

Stop-Loss Insurance Testing:

- To verify that all eligible claims were submitted for reimbursement and such reimbursement was received by the County;
- To verify that amounts owed for reimbursement were correctly determined by reviewing calculations made;
- To verify that the County was charged the correct deductible for each stop-loss claim submitted;
- To review back-up documentation to support "offset amounts" applied to reimbursements*[7];
- No sample population was used during testing because all stop loss claims were reviewed

Health Benefit Administration Testing:

- To review claims processed to determine that all claims paid were for covered participants*;
- To review payments made for proper back-up documentation*;
- To review the methodology behind the "premium equivalent" determination;
- To review the methodology by which processed claims are audited in order to evaluate the effectiveness of internal controls;
- To determine if contract deliverables were achieved by Rose & Kiernan

***Scope Limitation**: Due to previously established confidentiality and information sharing agreements, as well as the unavailability of information requested, we were unable to obtain documents needed to complete this phase of testing and suggest a third-party review. If documents are received to allow for additional testing, we will update this report to include any findings or recommendations as a result.

Conclusion

Our audit revealed the possibility for several improvements to internal controls, specifically in relation to the review of processed claims information and the availability of information to County Management.

Throughout the audit, we encountered many issues when requesting information from third-parties providing services to the County. Requests of Rose & Kiernan, Sun Life, and BCBS required numerous instances of follow-up and further clarification. Given that the County is immensely reliant on these parties to provide a large number of services at significantly high costs to the County, it is imperative that inquiries

[7] Offset amounts are reimbursements received from other funding sources (e.g. Worker's Compensation Fund) and therefore are not reimbursable under the stop-loss insurance policy.

regarding the administration of the Plan are timely and responded to in full so that Management receives assurance as to the correct and effective oversight of the program. At the time our initial report was drafted, our audit testing could not be completed because requested information pertaining to rejected stop-loss claims and offset amounts had not been provided to our Office.[8] During our review and comment phase, we were notified by the Personnel Department that the denied stop-loss claims in question should have been resubmitted and paid based on the Department's communication with both BCBS and Sun Life. Therefore, a lack of effective oversight allowed for up to $188,000 in 2016 stop-loss reimbursements that were due to the County to remain undetected and unpaid. As an outcome of this audit, Ulster County will rightfully receive those stop-loss reimbursements owed.

The testing we did complete allowed us to determine that enrollee contributions were correctly calculated and applied. Also, estimated amounts for the Plan appeared reasonable for the audit period. However, our testing of internal controls revealed that greater controls are needed to determine that contracted services are being adequately provided and that claims paid are appropriately reviewed. Further, our stop-loss testing could not be completed in terms of determining whether offset amounts were appropriately applied to reimbursable claims to verify if the County received all reimbursements due. As a result, we suggest that County Management or the County Legislature hire a specialized firm to conduct an in-depth analysis of the services offered by the TPA, broker, and stop-loss carrier due to the financial magnitude of the cost of providing health benefits.

***Management's Response*:** It is the practice of the Office of the Comptroller to share a draft of the audit with the auditee prior to its release in order to make any necessary corrections, clarify ambiguities, and incorporate the auditee's response to any findings. This audit was provided to the auditee on February 6, 2018, for review and commentary. Minor concerns and edits were provided to this Office by the Director of Personnel on February 13th and immediately included in the report thereafter. The final draft, inclusive of the auditee's suggested edits, was returned back to the Personnel Department as a courtesy and with the understanding that the Department's opportunity for formal comment would only extend until the report was finalized on February 23rd. To date, no formal response to the report has been memorialized by the Department that can be included as part of this audit.

[8] The request for this information was initiated on December 6, 2017.

APPENDIX: 2016 PREMIUM EQUIVALENTS AND SUMMARY OF BENEFITS

2016 ULSTER COUNTY EMPLOYEE HEALTH INSURANCE RATES EFFECTIVE JANUARY 1, 2016	TIER STATUS	EMPLOYEE SHARE				MONTHLY COUNTY COSTS		MONTHLY TOTAL COSTS	
		MONTHLY		BI WEEKLY		COUNTY COSTS		TOTAL COSTS	
		POS	PPO	POS	PPO	POS	PPO	POS	PPO
CSEA HIRED BEFORE 1/1/1994	INDIVIDUAL W/ DENTAL AND VISION	$8.00	$8.00	$4.00	$4.00	$731.49	$1,086.56	$739.49	$1,094.56
(fixed contributions)	2 PERSON W/ DENTAL AND VISION	$36.06	$36.06	$18.03	$18.03	$1,344.45	$2,028.11	$1,380.51	$2,064.17
	FAMILY W/ DENTAL AND VISION	$36.06	$36.06	$18.03	$18.03	$1,921.89	$2,934.69	$1,957.95	$2,970.75
	INDIVIDUAL DENTAL AND VISION ONLY	$0.00		$0.00		$40.25		$40.25	$0.00
	FAMILY DENTAL AND VISION ONLY	$0.00		$0.00		$103.88		$103.88	$0.00
		MONTHLY		BI WEEKLY		COUNTY COSTS		TOTAL COSTS	
		POS	PPO	POS	PPO	POS	PPO	POS	PPO
PBA HIRED BEFORE 7/1/1994	INDIVIDUAL W/ DENTAL AND VISION	$0.00	$0.00	$0.00	$0.00	$739.49	$1,094.56	$739.49	$1,094.56
UCSEA HIRED BEFORE 7/1/1994	2 PERSON W/ DENTAL AND VISION	$15.06	$15.06	$7.53	$7.53	$1,365.45	$2,049.11	$1,380.51	$2,064.17
(fixed contributions)	FAMILY W/ DENTAL AND VISION	$15.06	$15.06	$7.53	$7.53	$1,942.89	$2,955.69	$1,957.95	$2,970.75
	INDIVIDUAL DENTAL AND VISION ONLY	$0.00	$0.00	$0.00	$0.00	$40.25		$40.25	$0.00
	FAMILY DENTAL AND VISION ONLY	$0.00	$0.00	$0.00	$0.00	$103.88		$103.88	$0.00
		MONTHLY		BI WEEKLY		COUNTY COSTS		TOTAL COSTS	
		POS	PPO	POS	PPO	POS	PPO	POS	PPO
PBA HIRED 7/1/1994 - 9/1/2015	INDIVIDUAL W/ DENTAL AND VISION	$110.92	$164.18	$55.46	$82.09	$628.57	$930.38	$739.49	$1,094.56
CSEA HIRED 1/1/1994- 9/19/2012	2 PERSON W/ DENTAL AND VISION	$207.08	$309.64	$103.54	$154.82	$1,173.43	$1,754.53	$1,380.51	$2,064.17
UCSA HIRED 5/19/2010- 2/20/2013	FAMILY W/ DENTAL AND VISION	$293.70	$445.62	$146.85	$222.81	$1,664.25	$2,525.13	$1,957.95	$2,970.75
UCSEA HIRED 7/1/1994- 8/18/2014									
(15% of total premium)	INDIVIDUAL DENTAL AND VISION ONLY	$6.04		$3.02		$34.21		$40.25	$0.00
	FAMILY DENTAL AND VISION ONLY	$15.58		$7.79		$88.30		$103.88	$0.00
		MONTHLY		BI WEEKLY		COUNTY COSTS		TOTAL COSTS	
PBA HIRED AFTER 9/1/2015		POS	PPO	POS	PPO	POS	PPO	POS	PPO
CSEA HIRED AFTER 9/19/2012	INDIVIDUAL W/ DENTAL AND VISION	$147.90	$218.92	$73.95	$109.46	$591.59	$875.64	$739.49	$1,094.56
UCSA HIRED AFTER 2/20/2013	2 PERSON W/ DENTAL AND VISION	$276.10	$412.84	$138.05	$206.42	$1,104.41	$1,651.33	$1,380.51	$2,064.17
UCSEA HIRED AFTER 8/18/14	FAMILY W/ DENTAL AND VISION	$391.60	$594.16	$195.80	$297.08	$1,566.35	$2,376.59	$1,957.95	$2,970.75
(20% of total premium)									
	INDIVIDUAL DENTAL AND VISION ONLY	$8.06		$4.03		$32.19		$40.25	$0.00
	FAMILY DENTAL AND VISION ONLY	$20.78		$10.39		$83.10		$103.88	$0.00
		MONTHLY		BI WEEKLY		COUNTY COSTS		TOTAL COSTS	
		POS	PPO	POS	PPO	POS	PPO	POS	PPO
MANAGEMENT NON-UNION	INDIVIDUAL W/ DENTAL AND VISION	$73.96	$109.46	$36.98	$54.73	$665.53	$985.10	$739.49	$1,094.56
LEGISLATORS	2 PERSON W/ DENTAL AND VISION	$138.06	$206.42	$69.03	$103.21	$1,242.45	$1,857.75	$1,380.51	$2,064.17
UCSA HIRED BEFORE 5/18/2010	FAMILY W/ DENTAL AND VISION	$195.80	$297.08	$97.90	$148.54	$1,762.16	$2,673.68	$1,957.95	$2,970.75
SUPERIOR OFFICERS UNION									
(10% of total premium)	INDIVIDUAL DENTAL AND VISION ONLY	$4.04		$2.02		$36.21		$40.25	$0.00
	FAMILY DENTAL AND VISION ONLY	$10.40		$5.20		$93.48		$103.88	$0.00
ROUNDING OF PREMIUM CONTRIBUTIONS MAY LEAD TO SLIGHT DIFFERENCES									

POS vs. PPO: The local area networks for both plans are virtually the same, and neither plan requires a referral. When staying in-network, both plans offer similar co-pays and coverage, including regional emergency room coverage and around the world. However, out-of-pocket costs for out-of-network expenses will vary substantially between the plans.[9]

[9] *See gen* "2016 Summary of Benefits and Coverage," by the Ulster County Personnel Department (for Benefit Plan Year January 1-December 31, 2016). Available at http://ulstercountyny.gov/sites/default/files/2016%20SBC%20and%20Federal%20Notices.pdf