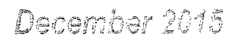
July 1, 2015 Postretirement Benefits Analysis of City of Cranston Public Schools



December 2015

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Section 1 – Overview

Cranston Public Schools ("The Schools") has engaged Buck Consultants, LLC (Buck) to prepare an actuarial valuation of their post-retirement benefits program as of July 1, 2015. This valuation was performed using employee census data, enrollment data, claims, premiums, participant contributions and plan provision information provided by personnel of The Schools. Buck did not audit these data, although they were reviewed for reasonability. The results of the valuation are dependent on the accuracy of the data.

The purposes of the valuation are to analyze the current funded position of The Schools' postretirement benefits program, determine the level of contributions necessary to assure sound funding and provide reporting and disclosure information for financial statements, governmental agencies and other interested parties. This valuation report contains information required for the fiscal year ending June 30, 2016, by the requirements in the Governmental Accounting Standards Board's ("GASB") Statements Nos. 43 and 45, respectively entitled "Financial Reporting for Post-employment Benefit Plans Other Than Pension Plans" and "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions".

The Schools implemented an OPEB Trust effective July 1, 2015. In order to be considered an OPEB Trust for financial reporting purposes, funds contributed to the trust must be irrevocable and must be used for the sole purpose of funding postretirement benefits other than pensions. We understand that The Schools' OPEB Trust meets these criteria and, consequently, our calculations have been based on the existence of a qualified OPEB Trust under GASB 43 and 45. Effective FY2016, The Schools will need to provide financial reporting under GASB 43, in addition to GASB 45.

GASB has since published revisions to GASB 43 and 45 requirements under new GASB Statements Nos. 74 and 75 (GASB 74 will replace GASB 43 and GASB 75 will replace GASB 45). GASB 74 is effective for fiscal years beginning after June 15, 2016, and GASB 75 is effective for fiscal years beginning after June 15, 2017. Therefore, the plan will need to adopt the new standard for its financial statements for the year starting July 1, 2016 and The Schools will need to adopt the new standard for its financial statements for the year starting July 1, 2017. However, earlier adoption is permitted, and it may be desirable for both the plan and the schools to adopt the revised standard for the plan year beginning July 1, 2016 so that financial statements for the plan and for the schools are aligned. We have not evaluated the impact of the new rules on the values presented in this valuation.

Use of this report for any other purposes or by anyone other than The Schools and its auditors may not be appropriate and may result in mistaken conclusions because of failure to understand applicable assumptions, methods, or inapplicability of the report for that purpose. The attached pages should not be provided without a copy of this cover letter. Because of the risk of misinterpretation of actuarial results, you should ask Buck to review any statement you wish to make on the results contained in this report. Buck will not accept any liability for any such statement made without review by Buck.

The valuation results reflect the effect of a change in benefit designs, which was adopted on September 1, 2014. Teachers retiring after this date will receive coverage under the HealthMate 100/80 250 Coinsurance PPO Plan, beginning on January 1, 2016. Administrators who retire on or after January 1, 2016 will receive coverage through the HealthMate 100/80 500 Coinsurance PPO Plan. Teachers retired prior to September 1, 2014 will continue to receive coverage under the old benefit structure (Healthmate Plan with no in-network deductible). Likewise, Administrates who retire prior to January 1, 2016 will have their old benefit structure. Premium information for the revised plans have not yet been provided to The Schools by their medical carrier.. Based on the plan provisions provided in Schedule C, we estimated that the plan changes effective as of 1/1/2016 would not have a significant effect on the teacher premium. Therefore, we assumed that the plan premium for teachers retiring after 9/1/2014 would be the same as the current design. In addition, we estimate a 5% reduction in premiums for administrators. Given that administrators constitute less than 10% of the population, we simplified our calculations by assuming that administrators' plan premium will be the same as the current design.

According to GASB principles, if the benefits are not prefunded, the rate earned by the General Asset Account of the employer must be used to select the discount rate used to measure the plan. To measure on that basis we have used a discount rate of 3.5%. A discount rate of 3.5% represents the long term expectation of the rate earned by the General Asset Account. For plans that are pre-funded through a GASB-qualified OPEB Trust, the discount rate may be based on the long-term expected rate of return based on the assets outlined in the OPEB Trust funding policy. We understand that The Schools' funding policy is to provide funds to the Trust based on annual results of budgetary operations (and not to prefund based on the Annual Required Contribution ("ARC")). Given the lack of commitment to prefunding, along with the fact that Trust assets as of the valuation date are de minimus, we continued to assume that benefits will be paid out of The School's General Asset Account, and therefore we reflect the 3.5% rate of return in our calculations. Section 2 provides a summary of the principal valuation results. Section 7 provides a projection of funding and accounting result amounts.

The economic assumptions other than the discount rate and the demographic assumptions used for financial accounting purposes were chosen by the plan sponsor with our advice. The demographic assumptions were the same as used in the previous valuation except for the changes described below.

Changes from the Prior Valuation

This valuation reflects a number of different actuarial assumptions from the final version of the June 30, 2014 valuation, released in December 2014. In particular:

- We reflected more recent plan premium equivalent rates in developing per capita costs.
- We increased the ultimate trend level from 4.50% to 5.00% to reflect a more explicit assumption about long term expected technology growth and higher long-term real GDP growth. We have also seen an increase in trend in the market in some sectors, and based on that, do not expect that the cost trends will moderate to an ultimate level as quickly as we previously expected.

Fiscal Year Ending	Prior Assumption	**Revised Assumption**
FY2016 → FY2017	7.00%	**7.50%**
FY2017 → FY2018	6.50%	**7.25%**
FY2018 → FY2019	6.00%	**7.00%**
FY2019 → FY2020	5.50%	**6.75%**
FY2020 → FY2021	5.00%	**6.50%**
FY2021 → FY2022	4.50%	**6.25%**
FY2022 → FY2023	4.50%	**6.00%**
FY2023 → FY2024	4.50%	**5.75%**
FY2024 → FY2025	4.50%	**5.50%**
FY2025 → FY2026	4.50%	**5.25%**
FY2026 and later	4.50%	**5.00%**

- We revised our aging assumption based on data from the study, "Health Care Costs - From Birth to Death" prepared by Dale H. Yamamoto and sponsored by the Society of Actuaries. The data behind this assumption is significantly more up to date than data behind our previous age related morbidity assumption. The new aging assumption also reflects difference in cost by gender, which better models varying costs of covering individuals.
- We revised our retirement, termination, disability, and mortality rates to be consistent with those presented in the 2014 Employees' Retirement System of Rhode Island ("ERSRI") Actuarial Experience Study[1]. The decrement rates summarized in Schedule A (e.g. retirement rates, termination rates) were modified to reflect the most recent experience study commissioned by ERSRI. We also reflected updated decrement rates based on an actuarial analysis provided by ERSRI's actuary, Gabriel Roeder & Smith, on June 10, 2015, which suggested modifications to the retirement decrement rates as a result of the revised pension eligibility criteria outlined in the 2015 Settlement Agreement between the State of Rhode Island and most groups representing ERSRI's pensioners. We also refined our calculation of the proportion of retirees electing post-retirement medical coverage.

We believe these assumptions are reasonable for financial accounting purposes. The demographic assumptions used represent a reasonable estimate of future demographic experience of the plan participants. The demographic assumptions reflect the impact of Rhode Island pension reform, and subsequent settlement.

[1] ERSRI Actuarial Experience Investigation for the Six-Year Period Ending June 30, 2013. May 18, 2014. https://d10k7k7mywg42z.cloudfront.net/assets/53b31b93f002ff2dde000019/ExpStudyRpt2014.pdf

Given the assumptions selected, the costs and actuarial exhibits presented in this report have been prepared in accordance with the requirements of GASB 45. While the actuary believes that the assumptions are reasonable for financial reporting purposes, it should be understood that there is a range of assumptions that could be deemed reasonable that would yield different results.

It should be understood that future plan experience may differ considerably from what has been assumed. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. In particular, given that the majority of individuals only receive subsidized coverage prior to age 65, variations in assumed and actual retirement ages can have a dramatic impact on results. Measurement of the sensitivity of these results is outside the scope of our assignment.

Last valuation, we set the amortization period at 17 years so that the ARC would exceed the expected pay-as-you-go cost. While it is not spelled out in GASB 45, we believe that funding levels have to be able to pay benefits when due. This valuation, the amortization period is set equal to 23. Prior to the last valuation, the UAAL was being amortized over a closed 30 year period, which would have had 23 years remaining in Fiscal 2016. Using this closed amortization schedule, if contributions in the amount of the ARC were made each year, the UAAL would be expected to be fully amortized. However, the funding policy providing for contributions to be made to the OPEB Trust only if budgetary constraints allow cannot be guaranteed to accumulate adequate assets to make benefit payments when due.

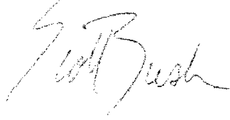
The valuation produces a funded status. This funded status is not appropriate for assessing the sufficiency of plan assets to cover the estimated cost of settling the plan's benefit obligations. The funded status would be appropriate for assessing the need for future actuarially determined contributions if the plan were to be prefunded on a consistent basis as used for measuring the ARC, and if the discount rate were set based on expectations of rate of return of the assets expected to be accumulated.

Our valuation was prepared in accordance with generally accepted actuarial principles and practices, and, to the best of our knowledge, fairly reflects the value of the benefits under the Plan as of July 1, 2015. The valuation was prepared under my supervision. I am an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries and have met the Qualifications Standard of the American Academy of Actuaries to render the actuarial opinions contained herein.

Thank you for this opportunity to be of service. I am available to answer questions about this report.

Respectfully Submitted,

BUCK CONSULTANTS, LLC



Scott Bush, ASA, MAAA
Director, Health Practice

December 7, 2015
Date

Section 2 – Required Information

			Pay-as-You-Go 3.5%
a)	Actuarial valuation date		July 1, 2015
b)	Actuarial Value of Assets	$	0
c)	Actuarial Accrued Liability		
	Active participants	$	10,021,922
	Retired participants		3,309,890
	Total AAL	$	13,331,812
d)	Unfunded Actuarial Liability "UAL" [c - b]	$	13,331,812
e)	Funded ratio [b / c]		0.0%
f)	Annual covered payroll	$	77,648,987
g)	UAL as percentage of covered payroll [d / f]		17.2%
h)	Normal Cost for upcoming fiscal year	$	642,490
i)	Amortization of UAL for upcoming fiscal year	$	824,625
j)	Interest to the middle of the fiscal year	$	25,454
k)	Annual Required Contribution "ARC" for fiscal year 2016 [h + i + j]	$	1,492,569
l)	Expected benefit payments for upcoming fiscal year	$	1,247,922
m)	Increase in Net OPEB Obligation (NOO) [k - l]	$	244,647
n)	UAL amortization period for upcoming fiscal year		23 years

Section 3 – Medical Premiums

Health benefits are available to employees and pre-65 retirees through the Healthmate C2C plan. The School department pays a portion of the medical and dental premium for a retiree only until the retiree reaches age 65. The retiree pays the full premium for post-65 coverage. Costs for dependent coverage are paid for by the retiree.

The following rates were provided by the School department. The rates for medical and dental coverage are the same as were provided last year. These rates are gross of retiree contributions and reflect the average cost of coverage, including administrative fees, for plan participants. It is our understanding that the plan is self-funded and purchases stop-loss insurance to limit its potential losses in a year

Annual Premiums Effective July 1, 2015 – Pre-2016 Plan Design	
Health Mate C2C	
Medical	$7,061
Stop- Loss Insurance Rate	$406
Delta	
Dental	$393

Section 4 – Membership Data

Census data effective July 1, 2015

Number of Employees	**Total**
Actives	
Count	1,035
Average Age	46.5
Average Service	13.6
Retirees*	
Count	125
Average Age	62.7
Total	
Count	1,160

* Only includes members who have elected medical coverage.
Does not include spouses, or post-65 retirees,
who pay the full cost of coverage.

Section 5 – Required Supplementary Information

Schedule of Funding Progress

Actuarial Valuation Date	(a) Actuarial Value of Assets	(b) Actuarial Accrued Liability (AAL)	(b) - (a) Unfunded AAL (UAL)	(a) / (b) Funded Ratio	Covered Payroll	[(b)-(a)] / (c) UAL as Percentage of Covered Payroll
July 1, 2007	0	25,950,366	25,950,366	0.00%	68,573,674	37.84%
July 1, 2008	0	35,821,039	35,821,039	0.00%	69,144,049	51.81%
July 1, 2009	0	31,160,310	31,160,310	0.00%	70,733,606	44.05%
July 1, 2010	0	26,766,553	26,766,553	0.00%	72,135,074	37.11%
July 1, 2011	0	26,287,884	26,287,884	0.00%	73,686,949	35.68%
July 1, 2013	0	13,581,115	13,581,115	0.00%	88,453,767	15.35%
July 1, 2014	0	11,653,717	11,653,717	0.00%	85,987,558	13.55%
July 1, 2015	0	13,331,812	13,331,812	0.00%	77,648,987	17.17%

Section 6 – Net OPEB Obligation

GASB Statement No. 45 requires the development of Annual OPEB Cost and Net OPEB Obligation (NOO). This development is shown in the following table.

Development of OPEB Cost and Net OPEB Obligation (NOO)

Year Ending June 30	Annual Required Contribution	Interest on NOO	Amortization of NOO	Annual OPEB Cost (1) + (2) - (3)	Contribution	Change in NOO (4) - (5)	NOO Balance
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
2008	2,548,187	0	0	2,548,187	2,122,221	425,966	425,966
2009	3,504,375	65,690	65,690	3,504,375	2,288,090	1,216,285	1,642,251
2010	3,119,950	52,609	37,905	3,134,654	2,002,019	1,132,635	2,774,886
2011	2,837,968	111,072	92,884	2,856,156	1,670,995	1,185,161	3,960,047
2012	2,858,098	138,602	229,098	2,767,602	1,377,509	1,390,093	5,350,140
2013	1,270,797	187,255	316,757	1,141,295	1,243,673	(102,378)	5,247,762
2014	1,293,254	183,672	318,403	1,158,523	855,388	303,135	5,550,897
2015	1,391,038	194,281	438,760	1,146,559	447,213	699,346	6,250,243
2016	1,492,569	218,759	400,133	1,311,195			

Note: Fiscal Years Ending 6/30/2008 through 6/30/2014 values are as published in audited financial statements.

Section 7 – Schedule of Employer Contributions

The Governmental Accounting Standards Board's Statement No. 45 "Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions" outlines various requirements of a funding schedule that will amortize the unfunded actuarial liability and cover normal costs. Amortization of the unfunded actuarial liability is to be based on a schedule that extends no longer than 30 years. The contribution towards the amortization of the unfunded actuarial liability may be made in level payments or in payments increasing at the same rate as salary increases. However, there is no requirement to actually fund the Annual Required Contribution.

The amortization schedules shown on the following pages assume amortization to be on a closed basis starting in fiscal year 2016. The normal cost is estimated to increase at the same rate as the assumed ultimate healthcare trend rate. Projected benefit payments/employer contributions reflect only the benefit for those individuals now employed or retired, not any future entrants.

We did not reflect any potential future contributions, since future contributions are based on future budgetary constraints, which we cannot estimate. If benefits were to be regularly pre-funded, the amortization of the UAAL and ARC would be lower.

In the amortization schedules shown on the following page, the projections, based on standard roll forward techniques, assume that The School's funding policy will continue to be based on the current Actuarial Cost Method, the Projected Unit Credit Method, rather than the actuarial cost method, the Entry Age Method, that will be required for calculations under GASB No.'s 74 and 75.

Paragraph 12 of GASB 45 stipulates that valuations must be performed at least biennially. The Schools has traditionally had valuations performed annually. We performed this valuation at the beginning of the fiscal year for this valuation cycle. This valuation is intended for use for the fiscal year ending June 30, 2016.

Section 7 – Schedule of Employer Contributions

Fiscal Year Ending In	Normal Cost	Amortization of UAL	Interest	ARC	Pay-as-You-Go
2015	$ 477,320	$ 889,996	$23,722	$1,391,038	$ 447,213
2016	642,490	824,625	25,454	1,492,569	1,247,922
2017	674,615	840,480	26,286	1,541,381	932,442
2018	708,346	881,203	27,578	1,617,127	837,935
2019	743,763	935,093	29,127	1,707,983	810,191
2020	780,951	999,462	30,889	1,811,302	629,862
2021	819,999	1,087,507	33,094	1,940,600	658,291
2022	860,999	1,187,136	35,534	2,083,669	705,916
2023	904,049	1,299,113	38,224	2,241,386	808,888
2024	949,251	1,421,369	41,129	2,411,749	754,216
2025	996,714	1,570,562	44,541	2,611,817	784,010
2026	1,046,550	1,744,946	48,431	2,839,927	877,868
2027	1,098,878	1,944,525	52,802	3,096,205	897,599
2028	1,153,822	2,184,607	57,920	3,396,349	924,262
2029	1,211,513	2,476,785	63,990	3,752,288	962,744
2030	1,272,089	2,837,206	71,294	4,180,589	1,127,241
2031	1,335,693	3,273,822	79,973	4,689,488	1,202,656
2032	1,402,478	3,834,349	90,856	5,327,683	1,316,896
2033	1,472,602	4,574,211	104,909	6,151,722	1,291,237
2034	1,546,232	5,632,359	124,545	7,303,136	1,494,497
2035	1,623,544	7,186,799	152,855	8,963,198	1,583,312
2036	1,704,721	9,776,011	199,185	11,679,917	1,466,859
2037	1,789,957	15,060,487	292,347	17,142,791	1,382,379
2038	1,879,455	31,094,334	572,079	33,545,868	1,419,681
2039	1,973,428	32,683,560	601,281	35,258,269	1,568,498
2040	2,072,099	34,274,272	630,591	36,976,962	1,624,460

Schedule A – Actuarial Assumptions and Methods

Discount Rate: 3.50% per year, based on the long-term expected rate of return on employer assets expected to be used to pay benefits.

Funding Policy: Benefits are primarily funded on a pay-as-you-go basis, with the possibility of additional benefit pre-funding based on funds available in The Schools' budget. To the extent that funds contributed to the OPEB Trust are lower than the calculated ARC, this funding policy will not produce sufficient assets to satisfy future benefit obligations. The UAAL is not sufficient to cover the estimated cost of settling the plan's benefit obligations, but is appropriate to use to estimate the ARC for the purpose of prefunding the benefit.

Actuarial Cost Method: Projected Unit Credit. Benefits are attributed from date of hire until date of retirement.

Amortization period: Closed period, open basis, level dollar for pay-as-you-go. The amortization period remaining is 23 years for fiscal year 2016.

Participation: It is assumed that 95% of current active employees will elect retiree benefit coverage, based on the portion of the cost paid for by the retiree. Current retirees are assumed to participate in the plan until benefits expire.

Plan Costs: Estimated gross per capita incurred claim cost for 2015-2016 at male age 64 are $12,964 for both teachers and administrators. As noted earlier, we assumed that teachers and administrators would have health care costs consistent with the current design in effect and that accounting for the differing designs would have a de minimus effect for valuation purposes. Per capita costs were developed from the provided School monthly medical and dental costs based on active blended age/sex morbidity rates and associated administrative and stop-loss fees.

Morbidity Factors:

Per capita costs are adjusted to reflect the relative cost of health coverage based on a retiree's age and sex. Representative relative values, relative to a male aged 65 are presented in the table below:

Age	Male	Female
25	0.145	0.298
30	0.180	0.425
35	0.225	0.463
40	0.284	0.464
45	0.352	0.491
50	0.460	0.572
55	0.604	0.667
60	0.778	0.778
65	1.000	0.911

The age/sex health care cost relativities implemented in this valuation reflect associated differences in medical costs are based on data from the recent study, "Health Care Costs - From Birth to Death" prepared by Dale H. Yamamoto and sponsored by the Society of Actuaries.

Healthcare Cost Trend: Applies to stated medical plan premiums and per capita medical costs.

Year	Trend
FY2016 → FY2017	7.50%
FY2017 → FY2018	7.25%
FY2018 → FY2019	7.00%
FY2019 → FY2020	6.75%
FY2020 → FY2021	6.50%
FY2021 → FY2022	6.25%
FY2022 → FY2023	6.00%
FY2023 → FY2024	5.75%
FY2024 → FY2025	5.50%
FY2025 → FY2026	5.25%
FY2026 and later	5.00%

Dental – 5.0% for all years.

The initial trend rates are developed using Buck's National Health Care Trend Survey. The survey gathers information of trend expectations for the coming year from various insurers and PBMs. These trends are broken out by drug and medical, as well type of coverage (e.g. PPO, HMO, POS). We selected plans that most closely match Cranston Schools' benefits and blended the drug trend to the corresponding medical trend to create the composite initial trends. The ultimate trend is developed based on a building block approach which considers CPI, GDP, and Technology growth. The ultimate trend was increased from the previous year to explicitly recognize in the assumption the long term expected technology growth and a higher expected real-GDP growth assumption. We looked at projections published by CMS as well as considering the latest Getzen model as published by the Society of Actuaries to come up with these expectations.

CPI: 3.0% per year, based on Buck's study of capital market assumptions over a 30 year time horizon.

IBNR Claims: The calculations do not reflect Incurred but not Reported (IBNR) claim amounts. We did not explicitly include a reserve for unpaid claims in our valuation.

Separations From Active Service: All employees are assumed to become disabled or withdraw from active service based on the ERS General Employees' rate tables published in the 2014 ERSRI Experience Study.[2]

Employees are assumed to retire at a flat rate of 25% each year once eligible for an unreduced ERSRI pension benefit as determined by the earlier of:

- 65 years of age and 30 years of service;
- 64 years of age and 31 years of service;
- 63 years of age and 32 years of service;
- 62 years of age and 33 years of service;
- The employee's RIRSA date

The 25% becomes 60% in the first year of eligibility if eligibility for an unreduced pension benefit occurs at age 65 or at 25 years of service.

[2] A small portion of the population are administrators that are covered in MERS not ERS. We have assumed that they have the same experience as ERS rather than using separate MERS assumptions for valuation simplicity.

In some cases, the first eligibility date was furnished by ERSRI. In other cases, the RIRSA date was calculated by Buck based on the employee's RIRSA retirement schedule (1-4 for General employees).

Retirement rates are assumed to apply when the employee becomes eligible for both retiree medical coverage and for an unreduced pension. Otherwise, withdrawal rates are assumed to apply.

Pre-Retirement Mortality: 50% of the RP-2000 Combined tables with white-collar adjustment for males and females, consistent with the pre-retirement mortality assumption recommended in the 2014 ERSRI Experience Study. We believe it is reasonable to not apply an explicit mortality improvement scale to the base tables, since doing so would not have a significant effect on the valuation results.

Post-Retirement Mortality: For healthy retirees, 97% of rates contained in a Gabriel Roeder Smith & Company ("GRS") Table based on male teacher experience, projected with Scale AA from 2000, consistent with the post-retirement mortality assumption recommended by 2014 ERSRI Experience Study. 92% of rates contained in a Gabriel Roeder Smith & Company ("GRS") Table based on female teacher experience, projected with Scale AA from 2000, consistent with the post-retirement mortality assumption recommended 2014 ERSRI Experience Study. A sensitivity run using the Tables above projected with Scale BB from 2000, which reflects more recent mortality improvement, impacted the AAL by 0.03%. Therefore, we felt it appropriate to use the same assumption used for the State System.

For disabled retirees, 60% of the PBGC Table Va for disabled males eligible for Social Security disability benefits, consistent with post-retirement mortality assumption recommended by 2014 ERSRI Experience Study. 60% of the PBGC Table VIa for disabled females eligible for Social Security disability benefits, consistent with post-retirement mortality assumption recommended by 2014 ERSRI

Schedule B - Summary of Program Provisions

Medical/Dental Insurance:

Retirees pay a variable portion of their post-retirement medical and dental costs, as outlined below.

Current active employees who are assumed to retire prior to age 65 are valued with the reported medical premium, applicable to both active employees and retirees, with an adjustment based on the aforementioned age/sex morbidity table to adjust to a retiree only rate.

There is no age related premium adjustment for the dental premium.

Current retirees who are under age 65 are assumed to remain in their current medical plan with only individual coverage, until age 65, at which time their school provided cost coverage stops.

There is no school coverage cost for retirees over the age of 65. The retiree pays the total cost of coverage for any elected coverage after the age of 65. Rates for any coverage offered after age 65 are assumed to be self-supporting; the additional cost of covering a spouse would be equal to the cost of family coverage less the cost of single coverage, which we believe is sufficient to cover the additional cost of a retired spouse.

All teachers who retire before 9/1/2014 and administrators who retire prior to 1/1/2016 will continue coverage based on the plan provision in effect prior to 1/1/2016. Teachers and administrators retiring after these dates will be covered under revised plan designs, which will go into effect as of 1/1/ 2016. A summary of plan designs is provided in Schedule C.

Retiree Contributions:

Retirees contribute to the cost of coverage in accordance with the following table:

Retiree Group	Cost Share
Administrators	
Pre 7/1/2005 Retirement	None
7/1/2005 – 6/30/2008	10%
7/1/2008 – 6/30/2010	20%
7/1/2010 – 6/30/2011	22%
Post 7/1/2011 Retirement	25%
Teachers	
Pre 9/1/2005 Retirement	None
9/1/2005 – 8/31/2009	5%
9/1/2009 – 8/31/2011	15%
Post 9/1/2011 Retirement	20%

Dependent Coverage:

No subsidized coverage for beneficiaries. Any coverage for spouses and dependent children is paid for by the retiree and this contribution is assumed to cover all dependent costs.

Retirement Eligibility:

All members with more than 10 years of service as of June 30, 2005 are eligible for retirement on or after age 60 with 10 years of service or age any age with 28 years of service, or after becoming disabled.

All members with less than 10 years of service as of June 30, 2005 are eligible for retirement on or after age 65 with 10 years of service, or on or after age 59 with 29 years of service, or early retirement at age 55 with 20 years of service, or after becoming disabled.

All members must also have completed at least 10 years of service with the City of Cranston, with the exception of disability retirement benefits. To be eligible for disability retirement, the participant must have 5 years of vested service for ordinary disabilities (accidental disability has no service requirement).

Schedule C – Medical Plan Benefit Design

The following table summarizes both the pre-Medicare plan designs in effect for teachers.

	Current Plan In Network/ Out of Network	Plan in effect as of 1/1/2016 In Network/ Out of Network
Group	All teachers retiring prior to 9/1/2014	All teachers retiring on or after 9/1/2014
Deductible • **Individual** • **Family**	No deductible for services with fixed dollar copays $0/ $200 $0/ $600	 $250/ $1,000 $500/ $2,000
Out of Pocket Limits • **Individual** • **Family**	 $6,350/ $6,350 $12,700/ $12,700	 $750/ $3,000 $1,500/ $6,000
Preventative Care	$0/ $25 copay and 20% coinsurance	$0/ 20% coinsurance
Primary Care Office Visits	$15 copay/ $15 copay and 20% coinsurance	$15 copay/ 20% coinsurance
Specialist Office Visits	$25 copay/ $25 copay and 20% coinsurance	$25 copay/ 20% coinsurance
Outpatient Services	$0/ 20% coinsurance	$0/ 20% coinsurance after deductible
Inpatient Services	$0/ 20% coinsurance	0% coinsurance/ 20% coinsurance after deductible
Hospital Emergency Services	$100 copay/ $100 copay	$100 copay/ $100 copay
Urgent Care	$50 copay/ $50 copay and 20% coinsurance	$50 copay/ $50 copay
Ambulance	$50 copay/ $50 copay	$50 copay/ $50 copay
Durable Medical Equipment	20% coinsurance/ 20% coinsurance	20% coinsurance after deductible/ 20% coinsurance after deductible
Prescription Drugs - Retail • **Tier 1 Generic** • **Tier 2 Preferred Brand** • **Tier 3 Non-Preferred Brand** • **Tier 4 Specialty**	 $5 copay/ Not covered $15 copay/ Not covered $30 copay/ Not covered $30 copay/ 50% coinsurance	 $5 copay/ Not covered $15 copay/ Not covered $30 copay/ Not covered $30 copay/ 50% coinsurance
Prescription Drugs – Mail Order • **Tier 1 Generic** • **Tier 2 Preferred Brand** • **Tier 3 Non-Preferred Brand** • **Tier 4 Specialty**	 $12.50 copay/ Not covered $37.50 copay/ Not covered $75 copay/ Not covered N/A	 $10 copay/ Not covered $30 copay/ Not covered $60 copay/ Not covered N/A

The following table summarizes both the pre-Medicare plan designs in effect for administrators.

	Current Plan (In Network/ Out of Network)	Plan in effect as of 1/1/2016 (In Network/ Out of Network)
Group	All administrators retiring prior to 1/1/2016	All administrators retiring after 1/1/2016
Deductible	No deductible for services with fixed dollar copays	
• **Individual**	$0/ $200	$500/ $500
• **Family**	$0/ $600	$1,000/ $1,000
Out of Pocket Limits		
• **Individual**	$6,350/ $6,350	$6,350/ $6,350
• **Family**	$12,700/ $12,700	$12,700/ $12,700
Preventative Care	$0/ $25 copay and 20% coinsurance	$0/ $25 copay and 20% coinsurance
Primary Care Office Visits	$15 copay/ $15 copay and 20% coinsurance	$15 copay/ 20% coinsurance
Specialist Office Visits	$25 copay/ $25 copay and 20% coinsurance	$25 copay/ 20% coinsurance
Outpatient Services	$0/ 20% coinsurance	$0/ 20% coinsurance after deductible
Inpatient Services	$0/ 20% coinsurance	0% coinsurance/ 20% coinsurance after deductible
Hospital Emergency Services	$100 copay/ $100 copay	$100 copay/ $100 copay
Urgent Care	$50 copay/ $50 copay and 20% coinsurance	$50 copay/ $50 copay
Ambulance	$50 copay/ $50 copay	$50 copay/ $50 copay
Durable Medical Equipment	20% coinsurance/ 20% coinsurance	20% coinsurance after deductible/ 20% coinsurance after deductible
Prescription Drugs - Retail		
• **Tier 1 Generic**	$5 copay/ Not covered	$7 copay/ Not covered
• **Tier 2 Preferred Brand**	$15 copay/ Not covered	$30 copay/ Not covered
• **Tier 3 Non-Preferred Brand**	$30 copay/ Not covered	$50 copay/ Not covered
• **Tier 4 Specialty**	$30 copay/ 50% coinsurance	$50 copay/ 50% coinsurance
Prescription Drugs – Mail Order		
• **Tier 1 Generic**	$12.50 copay/ Not covered	$17.50 copay/ Not covered
• **Tier 2 Preferred Brand**	$37.50 copay/ Not covered	$75 copay/ Not covered
• **Tier 3 Non-Preferred Brand**	$75 copay/ Not covered	$125 copay/ Not covered
• **Tier 4 Specialty**	N/A	N/A

Schedule D – Considerations of Health Care Reform

We have not identified any specific provision of health care reform, other than the High Cost Plan Excise Tax ("Cadillac Tax") that would be expected to have a significant impact on the measured obligation. The Cadillac tax will be in effect starting in calendar year 2018. For valuation purposes, we assumed that the value of the tax will be passed back to the employer in higher per capita administrative costs.

The tax is 40% of the excess of a) the cost of coverage over b) the limit. We calculated "a" (the cost of coverage) using the premiums that are the basis of retiree contributions projected with trend, except that we blended the rate for dual coverage and family coverage by actual current enrollment. We calculated "b" (the limit) starting with the statutory limits ($10,200 for single coverage), adjusted for the following:

- Limits will increase from 2018 to 2019 by 4.00% (CPI plus 1%);
- Limits will increase after 2019 by 3.00% (CPI);
- Accumulated non-Medicare eligible medical/drug trend for the period from 2010 through 2018 is compared with the assumed 55% trend increase for the federal standard Blue Cross/Blue Shield option, with trend in excess of 55% applied on the base amount before the additional amount for "early" retirees; and
- For retirees over age 55 but not on Medicare, the limit after adjusting for excess trend is increased by an additional dollar amount of $1,650 for single coverage.