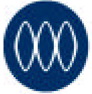

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REVIEW OF CONTRIBUTION RATES NECESSARY TO ACTUARIALLY FUND POST-RETIREMENT HEALTHCARE BENEFITS FOR HPRS, OP&F, PERS, SERS AND STRS

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February 11, 2004

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I. Introduction

Pursuant to the request of the Ohio Retirement Study Council, “ORSC”, the purpose of this report is to roughly estimate the magnitude of the contribution rates that would be necessary to actuarially fund the post-retirement healthcare benefits provided by:

- the Ohio Highway Patrol Retirement System, “HPRS”;
- the Ohio Police & Fire Pension Fund, “OP&F”;
- the Ohio Public Employees Retirement System, “PERS”;
- the School Employees’ Retirement System of Ohio, “SERS”; and,
- the State Teachers’ Retirement System of Ohio, “STRS”.

All five systems provide post-retirement healthcare benefits. Since these benefits are typically updated annually, we have based these cost projections on the package of benefits and cost-sharing arrangements in effect during 2004 for each of the systems. (The costs shown would have been higher for OP&F, SERS and STRS if we had based these projections on the package of benefits and cost-sharing arrangements in effect during 2003, due to the significant changes they made in their healthcare plans effective 2004.)

In this report, we have estimated the actuarial cost of the portion of the total premium for these benefits that is paid by the systems from employer contributions. Retirees pay the balance of the total premium for these benefits. (We will sometimes refer to the portion of the premium paid by the systems from employer contributions as the subsidy provided by the system for these benefits.)

While there is more than one possible approach to “actuarial funding” of post-retirement benefits, the contribution rates set forth in this report are based on the Entry Age Normal Actuarial Cost Method. (This is the actuarial cost method used by all of the systems to prepare their annual actuarial valuations.) Unfunded actuarial liabilities were amortized as a level percent of payroll over a period of 30 years.

The analysis that follows addresses discretionary healthcare benefits only. As Medicare Part B premium reimbursements are mandated by Ohio statute, we have included the cost of the mandated Medicare Part B premium reimbursements with retirement benefits in the two separate reports that examined mandated benefits, “Review of the Adequacy of the Contribution Rates to OP&F, SERS and STRS” dated November 5, 2003, and “Review of the Adequacy of the Contribution Rates to HPRS and PERS” dated February 11, 2004.

In general, this review is based on participant data and actuarial assumptions provided by the systems and their consulting actuaries for our use in the above mentioned contribution rate adequacy studies. Except where we indicate that some change was made, we used those assumptions without modification throughout this review.

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Additionally, the systems provided us with updated enrollment counts for the post-retirement healthcare plans. We want to thank them for their cooperation and prompt responses to our requests and questions.

For purposes of this report, we used the premium rates provided by OP&F, PERS, SERS and STRS for 2004, net of any participant contributions, without any other adjustments as the initial per capita claims costs. Weighted-average per capita claim costs were developed based on the enrollments in the current options provided by the system. For HPRS, we adjusted the 2003 rates in the December 31, 2002 actuarial valuation based on the 2003 actual paid claims, and increased these adjusted rates by 10% to determine initial per capita claims costs for 2004. We have not reviewed these initial per capita claims costs for reasonableness with the underlying plan benefits.

In performing this analysis, we relied on the data and other information provided by the systems and their consulting actuaries. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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II. Summary

The major findings and recommendations from this review are summarized below.

- Healthcare fund balances have generally been declining in recent years due to a combination of investment losses and negative cash flow (e.g. – contributions allocated to healthcare benefits were less than benefits and administrative expenses).

- Current contribution rates allocated to discretionary healthcare benefits are on the order of 1/10 to 1/3 of the contribution rates needed to actuarially fund the plans so that the portion of the total cost of healthcare subsidized by the systems could be maintained.

- If the current healthcare contribution rates persist, or if the contribution rates allocated to healthcare are further decreased to shift funding back to mandated benefits, discretionary healthcare benefits would have to be significantly reduced.

- At a minimum, discretionary healthcare benefits could be offered to retirees with the retiree required to pay the full cost. This latter alternative would at least allow retirees to retain their coverage if they choose to pay for it.

- Medicare Part D reimbursements from the federal government beginning in 2006 will help defray the overall cost of prescription drugs somewhat, but are estimated to have a minimal effect on helping the systems move toward actuarial funding of post-retirement healthcare benefits. Alternatively, some, or all, of those reimbursements could be applied to reduce the portion of the premiums paid by retirees.

- Changes to post-retirement healthcare plan designs in response to increasing healthcare costs may reduce enrollments, and may also affect retirement patterns. We have not attempted to estimate the potential effect of shifts in enrollment patterns or retirement patterns in preparing this report. To the extent that fewer/(more) retirees enroll for healthcare benefits than assumed or delay/(accelerate) retirement from the assumed ages, the contribution rates shown in this report would decrease/(increase).

III. Magnitude of Healthcare Funds

Currently, none of Ohio's five statewide retirement systems actuarially fund the discretionary post-retirement healthcare benefits. Rather, contributions allocated to healthcare are derived from the excess of the total statutory contribution above the amount required to actuarially fund the mandated pension benefits. The fund balances have been generally declining due to current healthcare allocations that are smaller than the "pay-as-you-go" costs (annual benefit payments plus expenses) and adverse investment returns.

The table below shows the healthcare fund balances in recent years. Market values are shown for all five systems. The healthcare funds would be exhausted within a few years if contributions were to cease.

Market Value of Healthcare Funds
(in millions of dollars)

Valuation Year	HPRS (1/1)	OP&F (1/1)	PERS (1/1)	SERS (7/1)	STRS (7/1)
2000	94.0	288.0	11,163.2	252.3	3,419.1
2001	89.4	276.7	10,965.4	315.7	3,255.9
2002	83.7	250.6	9,936.4	335.2	3,010.5
2003	73.7	205.5	8,886.3	303.6	2,797.7
2004 (estimated)	85.9	187.1	10,763.2	254.9	2,719.3

Since HPRS, OP&F, PERS and STRS pay mandated Medicare Part B premium reimbursements from their Healthcare Funds, all or a portion of those funds need to be allocated to these mandated benefits before determining the assets available to provide discretionary healthcare benefits. We estimated the net assets available for discretionary healthcare benefits and summarized the results in the table below.

Estimated Market Value of Healthcare Funds Net of the Actuarial Accrued Liability for Medicare Part B Reimbursements
(in millions of dollars)

	HPRS (1/1/2004)	OP&F (1/1/2004)	PERS (1/1/2004)	SERS (7/1/2004)	STRS (7/1/2004)
Total Assets	85.9	187.1	10,763.2	254.9	2,719.3
Medicare B	(35.1)	(517.9)	(4,254.2)	N/A	(888.4)
Net Assets	50.8	0.0 *	6,509.0	254.9	1,830.9

* Negative amount set to zero as unfunded liability for Medicare Part B reimbursement for OP&F is reflected in the November 5, 2003 report discussed above in Section I.

IV. 2004 Per Capita Costs and System Subsidies

The tables below show the monthly gross premiums and retired member and spouse contributions for the most popular plans offered by each system. In performing the valuations, gross premiums and retired member and spouse contributions for all of the plans offered by a system were taken into consideration. The subsidy provided by the system is the difference between the gross premium for coverage and the retiree contribution.

UNIFORMED SYSTEMS – MONTHLY GROSS PREMIUMS and RETIRED MEMBER CONTRIBUTIONS

		HPRS		OP&F		PERS Law	
		Member	**Spouse**	**Member**	**Spouse**	**Member**	**Spouse**
Under Age 65	**Popular Option**	Aetna PPO		Aetna PPO		Med Mutual PPO	
	Gross Premium	$382	$382	$548	$410	$687	$687
	Maximum Contribution	0	70	343	308	0	80
	Minimum Contribution	0	70	137	205	0	80
Age 65 and over	**Popular Option**	Aetna PPO		Aetna PPO		Aetna PPO	
	Gross Premium	293	293	304	292	295	295
	Maximum Contribution	0	0	190	219	0	40
	Minimum Contribution	0	0	76	146	0	40
Overall System Subsidy (approx.)		100%	85%	75%	50%	99%	85%
Average Salary		$51,000		$57,000		$44,000	

As HPRS does not develop premiums, the premiums listed above were estimated as described in the Introduction, and include the HPRS subsidy for post-retirement dental and vision benefits.

The contributions listed above are for OP&F members who select Option 1, and are current retirees as of January 1, 2004. OP&F members can choose among three options for medical and prescription drug coverage, with Option 1 being the lowest premium / highest out-of-pocket cost option, and Option 3 being the highest premium /

lowest out-of-pocket cost option. Regardless of the option elected, OP&F subsidizes 75% of the total Option 1 cost for members and 50% of the total Option 1 cost for spouses and children. Members who choose to buy up to a higher option pay the full premium differential. OP&F members who retire in 2004 or later may pay a larger portion of the total cost, depending on age and service at retirement. For more detail please see the brochures available at www.op-f.org in the "Health Care Plan 2004" section. The approximate overall system subsidy shown for OP&F is based on the current retiree population as of January 1, 2004, and will decrease over time as active members retire on the new lower benefit schedule.

NON-UNIFORMED SYSTEMS – MONTHLY GROSS PREMIUMS and RETIRED MEMBER CONTRIBUTIONS

		PERS State & Local		SERS		STRS	
		Member	**Spouse**	**Member**	**Spouse**	**Member**	**Spouse**
Under Age 65	**Popular Option**	Med Mutual PPO		Aetna PPO		Med Mutual PPO	
	Gross Premium	687	687	736	588	541	427
	Maximum Contribution	0	80	602	274	541	427
	Minimum Contribution	0	80	90	274	135	427
Age 65 and over	**Popular Option**	Aetna PPO		Aetna PPO		Aetna PPO	
	Gross Premium	295	295	234	232	228	238
	Maximum Contribution	0	40	107	74	228	238
	Minimum Contribution	0	40	16	74	57	238
Overall System Subsidy (approx.)		99%	85%	75%	65%	60%	0%
Average Salary		$30,000		$19,000		$47,000	

In addition to the premiums shown above, PERS provides a subsidy for post-retirement dental and vision benefits to retired members.

Please see Appendix B for a description of how member premiums for SERS and STRS vary by length of service.

V. Indicators of the ability of each System to subsidize Discretionary Healthcare Benefits

The systems all follow modified Pay-as-you-go funding of discretionary healthcare benefits. As a result, they have to rely on either assets accumulated to date or future contributions made on behalf of active members to fund these discretionary retiree benefits.

We have developed two very rough indicators of the financing resources available to each of the systems relative to their current number of retirees and beneficiaries. These rough indicators are:

1. The amount of healthcare assets per retired member and beneficiary (referred to as the "assets per retiree"), and,

2. The active member payroll per retired member and beneficiary (referred to as the "payroll per retiree").

We will discuss each of these rough indicators below.

Healthcare assets per retired member and beneficiary

On average, the five Ohio Retirement Systems had accumulated roughly $37,000 per retiree as of the last actuarial valuation of the systems. PERS – Law had by far the largest amount of assets with over $109,000 per retiree. SERS and OP&F had the two lowest amounts of assets with slightly more than $5,000 and $8,500 per retiree, respectively.

The greater the assets per retiree, the less in current contributions are needed to provide a given level of healthcare coverage to a current retiree. In general, PERS and HPRS have assets accumulated well above the average for all five systems and OP&F, SERS and STRS have significantly less than average.

Active member payroll per retired member and beneficiary

On average, the five Ohio Retirement Systems had $70,000 of active member payroll per retiree as of the last actuarial valuation of the system. PERS – Law had by far the largest amount of payroll per retiree with over $141,000 per current retiree. SERS had the lowest amount of active payroll per retiree with only slightly more than $38,000 per retiree.

The greater the active payroll per retiree, the lower the current contribution rate needs to be to generate a given subsidy per retiree. In general, HPRS, OP&F, PERS (with the exception of PERS – Law) and STRS have payrolls per retiree fairly close to the average – they range from a low of $64,000 in the case of HPRS to $82,500 in the case

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of PERS – State. SERS is well below the average figure with only slightly more than 50% of the average system. PERS – Law has roughly twice the average payroll per retiree.

Combined effect of indicators

SERS has the most difficult problem in funding healthcare benefits since it needs to charge employers a contribution rate roughly twice the rate that the other four systems can charge employers to fund a equal subsidy per retiree. Note that the maximum statutory limitations on employer and member contribution rates are the same for PERS – State, PERS – Local, SERS and STRS. SERS has the authority to assess an employer surcharge, which none of the other systems can assess employers, but that surcharge is limited to 1.5% or total system payroll.

PERS – Law has the most resources to fund healthcare benefits, with both the highest payroll per retiree (roughly 2X the average) and the highest assets per retiree (roughly 3X the average).

These rough indicators are summarized on the following table for each of the Retirement Systems.

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Summary Statistics regarding the five Ohio Retirement Systems
Data relevant to the financing of healthcare benefits for retired members and beneficiaries
(Data shown is as of the most recent actuarial valuation)

	Public Safety Systems				Non-uniformed Systems					Grand Total
	HPRS	OP&F	PERS Law	Total	PERS State	PERS Local	SERS	STRS	Total	
Number of:										
(1) Active members	1,548	28,343	8,030	37,921	110,017	247,377	122,315	179,944	659,653	697,574
(2) Retired members and beneficiaries	1,231	23,923	2,525	27,679	50,011	88,483	59,999	108,294	306,787	334,466
(3) Inactive members	6	2,069	331	2,406	22,081	40,334	8,796	131,600	202,811	205,217
(4) Total	2,785	54,335	10,886	68,006	182,109	376,194	191,110	419,838	1,169,251	1,237,257
(5) Ratio of active members to retired members and beneficiaries	1.26	1.18	3.18	1.37	2.20	2.80	2.04	1.66	2.15	2.09
(6) Total active member payroll (in thousands)	$78,997	$1,606,274	$356,694	$2,041,966	$4,129,049	$6,721,385	$2,302,289	$8,425,838	$21,578,561	$23,620,526
(7) Active member payroll per retired member and beneficiary	$64,173	$67,144	$141,265	$73,773	$82,563	$75,962	$38,372	$77,805	$70,337	$70,622
(8) Ratio of line (7) to average	0.91	0.95	2.00	1.04	1.17	1.08	0.54	1.10	1.00	1.00
(9) Healthcare Fund (in thousands)	$73,746	$205,486	$276,173	$555,405	$3,198,614	$5,471,595	$303,557	$2,797,704	$11,771,469	$12,326,874
(10) Healthcare Fund per retired member and beneficiary	$59,907	$8,589	$109,375	$20,066	$63,958	$61,838	$5,059	$25,834	$38,370	$36,855
(11) Ratio of line (9) to average	1.63	0.23	2.97	0.54	1.74	1.68	0.14	0.70	1.04	1.00

The ratio on line (8) is an index of the base for future contributions relative to the average for all of the systems.

The ratio on line (11) is an index of the assets accumulated in the past for healthcare benefits relative to the average for all of the systems.

Note: Healthcare Funds of HPRS, OP&F, PERS (all divisions) and STRS include assets available to pay Medicare Part B premium reimbursements. The comparable assets for SERS are included in the SERS assets allocated to pension and other mandated benefit.

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VI. Contribution Rates Necessary for Actuarial Funding

Premiums for healthcare benefits have been growing much faster than inflation for decades. It is likely that the cost of these benefits will continue to grow faster than inflation for a number of years, but the rate of that growth is subject to a great deal of uncertainty. As a result, we decided to provide two estimates of these costs based on two alternative scenarios regarding future rates of healthcare premium inflation, or "trend". These scenarios are:

- "Trend = Payroll Growth" – In this scenario, it is assumed that in all future years the systems will provide a subsidy per retiree that increases at the same rate as the rate of wage inflation. In the past, healthcare costs have increased at a much higher rate than payroll growth. Since the rate of payroll growth is likely to be much less than the increase in healthcare costs, this scenario implicitly assumes that members will bear the majority of cost increases beyond the current levels, and the percentage of total costs subsidized by the systems would decrease.

- "Trend = Estimated Rate of Healthcare Inflation" – In this scenario, it is assumed that in all future years the systems would continue subsidizing the same percentage of overall healthcare costs as they are currently. We assumed that healthcare cost inflation would continue over the near term at rates roughly consistent with recent past experience – roughly 10% per year higher than the rate of wage inflation – and then gradually decrease over the next 25 years to a rate of increase only 1% higher than wage inflation.

The table below sets forth the contribution rates necessary to achieve actuarial funding of the post-retirement discretionary healthcare benefits provided by the systems, using the 2004 provisions as a starting point. We have also shown the current allocation to healthcare benefits for comparison purposes.

Contribution Rates Required to Actuarially Fund Discretionary Healthcare Benefits
(as a percentage of payroll)

Trend:	Payroll Growth	Healthcare Growth	Current Allocation
System/Valuation Date			
HPRS - 1/1/2004	12.4%	39.7%	3.50%
OP&F - 1/1/2004	8.7	22.3	7.75
PERS - 1/1/2004	10.0	32.2	4.00
SERS - 7/1/2004	12.1	32.4	4.91
STRS - 7/1/2004	3.0	9.8	1.00

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As indicated in the table, the contributions allocated to discretionary healthcare benefits would have to be increased significantly in order to actuarially fund these benefits, even on the more favorable assumption that the subsidies would only grow at the rate of payroll growth. In the absence of such increases, significant continued cutbacks to benefits will be required. (Note that for SERS, the healthcare surcharge may provide up to 1.5% of payroll in addition to the current allocation.)

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VII. Potential Impact of Medicare Part D Reimbursements

Beginning in 2006, Medicare Part D will be the primary payor for covered prescription drug benefits for individuals who enroll. Employers that sponsor post-retirement healthcare plans that provide prescription drug benefits that are "actuarially equivalent" to Medicare Part D will receive a federal subsidy for members who do not enroll in Part D.

The plan sponsor reimbursement formula in 2006 will be:

{ lesser of (employer + member cost, $5,000), minus $250} * 28%

These limits are expected to increase with healthcare inflation. As individual member's prescription drug costs will have a wide distribution, we have assumed that 20% of the total cost of prescription drugs for Medicare eligible retirees and covered dependents will be reimbursed. (Note that the federal reimbursement is based on the total cost for prescription drug benefits. For example, while STRS does not currently provide any subsidy to a spouse that elects medical coverage, our understanding is that a spouse's prescription drug costs would still give rise to a federal reimbursement to STRS, subject to the limits in the formula above.)

Due to this additional source of funding from the federal government, the employer subsidy plus the retired member contributions will total less than 100% of the gross premiums. Assuming that each of the system's post-retirement prescription drug plans is actuarially equivalent to Medicare Part D, we have estimated the potential impact on each system of these federal reimbursements. ***(It is important to note that no regulations have been issued at this time so these estimates should be viewed as very preliminary. We included them here only to provide ORSC with a rough, order-of-magnitude estimate of the potential value of the reimbursements from this recently enacted legislation.)***

The table below illustrates estimated costs under three possible treatments of the federal reimbursements:

- "Reduce Retired Member Contributions" – Under this scenario, the systems continue to pay the same percentage of overall costs that they are currently paying, and all federal reimbursements are applied toward reducing retired member contributions.

- "Split 50-50" – Under this scenario, the systems allocate half of the federal reimbursements toward reducing retired member contributions, and half toward reducing system subsidies.

- "Reduce System Subsidy" – Under this scenario, retired members would continue to contribute the same percentage of overall costs as they currently pay,

and all federal reimbursements would be applied toward helping to pay for the system subsidies.

Contribution Rates Required for Actuarial Funding
Alternative treatments of the Medicare Part D Reimbursements
(as a percentage of payroll)

System/ Valuation Date	Reduce Retiree Contributions only	Split 50-50	Reduce Cost of System Subsidy	Current Allocation
HPRS - 1/1/2004	N/A	N/A	36.8% *	3.50%
OP&F - 1/1/2004	22.3%	21.1%	19.8	7.75
PERS - 1/1/2004	N/A	N/A	29.3 *	4.00
SERS - 7/1/2004	32.4	30.6	28.7	4.91
STRS - 7/1/2004	9.8	9.3	8.7	1.00

* As HPRS and PERS currently fund almost the entire cost of discretionary healthcare benefits, it is expected that these two systems would apply the Medicare Part D reimbursements toward reducing the system subsidies rather than totally eliminating the retired member contributions.

The healthcare trend assumption reflected in the table above is the "Estimated Rate of Healthcare Inflation" scenario described in Section VI.

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APPENDIX A

Actuarial Assumptions

In order to value the discretionary healthcare benefits, several assumptions were made regarding election percentages. We developed election percentages for current retirees and estimated election percentages for future retirees based on enrollment counts as discussed below.

HPRS

Based on December 2002 enrollment counts, 100% of future retirees are assumed to elect coverage. Additionally, 75% of retired members are assumed to elect spouse coverage. Pre-Medicare spouse per capita claims costs were increased by 20% of the child's rate to account for the probability of covering a child. One hundred percent of disabled retirees and 100% of survivors are assumed to elect coverage.

OP&F

Based on January 2004 enrollment counts, 90% of future retirees are assumed to elect coverage. Additionally, 65% of electing retired members are assumed to also elect spouse coverage. Pre-Medicare spouse per capita claims costs were increased by 20% of the child's rate to account for the probability of covering a child. Ninety percent of disabled retirees and 90% of survivors are assumed to elect coverage.

PERS

Based on November 2003 enrollment counts, 100% of future retirees are assumed to elect coverage. Additionally, 40% of electing retired members are assumed to also elect spouse coverage. Pre-Medicare spouse per capita claims costs were increased by 60% of the child's rate to account for the probability of covering a child. One hundred percent of disabled retirees and 100% of survivors are assumed to elect coverage.

SERS

Based on January 2004 enrollment counts, the following election percentages are assumed for future retirees:

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- Retiree with 10 years of service: 60%
- Retiree with 15 years of service: 70%
- Retiree with 20 years of service: 80%
- Retiree with 25 years of service, or pre-1989 retiree: 95%

Additionally, 30% of electing retired members are also assumed to elect spouse coverage. Pre-Medicare spouse per capita claims costs were increased by 35% of the child's rate to account for the probability of covering a child. Ninety percent of disabled retirees and 80% of survivors are assumed to elect coverage.

STRS

Based on January 2004 enrollment counts, the following election percentages are assumed for future retirees:

- Current retirees as of January 1, 2004 with less than 15 years of service: 50%
- Retirees with 15 years of service: 80%
- Retirees with 20 years of service: 85%
- Retirees with 25 years of service: 90%

Additionally, 35% of electing retired members are also assumed to elect spouse coverage (affects Medicare Part D reimbursement valuation only). Eighty-five percent of disabled retirees and 60% of survivors are assumed to elect coverage.

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APPENDIX B

General Overview of System Subsidies

HPRS

Medical and prescription drug coverage is completely subsidized for retired members and for Medicare eligible spouses. The monthly contribution level for non-Medicare eligible spouses is $70, and the monthly contribution level for one or more children is $25. For more detail please follow the links under "Health Benefits" at www.ohprs.org.

Dental and vision coverage is available on a subsidized basis.

OP&F

Members currently retired as of January 1, 2004 can choose among three options for medical and prescription drug coverage, with Option 1 being the lowest premium / highest out-of-pocket cost option, and Option 3 being the highest premium / lowest out-of-pocket cost option. Regardless of which option is elected, OP&F subsidizes 75% of the total Option 1 cost for members, and 50% of the total Option 1 cost for spouses and children. Members who choose to buy up to a higher option pay the full premium differential.

Members retiring on or after January 1, 2004 also can choose among three options for medical and prescription drug coverage, as described above. Additionally, member, spouse and child contributions are a function of age and service at retirement, calendar year of retirement, and elapsed time from date of retirement. For more detail please see the brochures available at www.op-f.org in the "Health Care Plan 2004" section.

Dental and vision coverage is available on a member-pay-all basis.

PERS

Ten years of service is required to receive post-retirement medical and prescription drug coverage. Member contributions as a percent of total cost varies according to the plan selected, but in general, members contribute about 1% of the total cost, spouses contribute about 15% of the total cost and children contribute about 10% of the total cost. For more detail please see the "2004 Health Care Coverage" brochure available at www.opers.org in the "Retirees" section.

Dental and vision coverage is available on a subsidized basis.

SERS

Ten years of service is required to receive post-retirement medical and prescription drug coverage. SERS subsidizes 75% of the prescription drug cost for all participants. The total plan cost less this subsidy is referred to as the "contribution setting rate". Members contribute a varying percentage of the contribution setting rate depending on their service. Members with 10 years of service contribute 100%, members with 15 years of service contribute 50%, members with 20 years of service contribute 25% and members with 25 or more years of service contribute 15%. Members who retired prior to 1989 contribute 15% regardless of years of service.

Spouse and child contributions as a percentage of the contribution setting rate do not vary with service. Spouses contribute roughly 50% to 70% depending on the plan selected, and children contribute 70%. For more detail please follow the "Health Care" link in the "Retirees" section of www.ohsers.org.

Dental and vision coverage is available on a member-pay-all basis.

STRS

Defined Benefit and Combined Plan

Members retiring on or after January 1, 2004 need 15 years of service to be eligible for post-retirement medical and prescription drug coverage. Current retirees as of January 1, 2004 who have less than 15 years of service are eligible, but pay the entire cost. Member contributions as a percent of total cost vary linearly with service. Members with 15 years contribute 62.5%, decreasing by 2.5% for each additional year of service, up through members with 30 or more years of service who contribute 25%. Spouses and children contribute 100% of the total cost. For more detail please follow the "Health Care" link at www.strsoh.org.

Dental and vision coverage is available on a member-pay-all basis.

Defined Contribution Plan

Members are not eligible for post-retirement healthcare.

Milliman does not intend to benefit and assumes no duty or liability to any parties other than the ORSC who receive this report.