Ohio Police & Fire Pension Fund

2017 HEALTH CARE REPORT

Presented to the Ohio Retirement Study Council, July 2018

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This report is a historical review of the Ohio Police & Fire Pension Fund health care program and does not supersede OP&F's Health care Plan Document, Medical Plan Document or the Member's Guide to Health Care Coverage.

Executive Summary

Since 1974, the Ohio Police & Fire Pension Fund (OP&F) Board of Trustees has been committed to providing a subsidized health care plan as part of its benefits for retirees. The Board, along with OP&F staff, has made it a priority to provide secure health care benefits, and to preserve the group-sponsored health care program model that has been in place for many years, albeit with some changes along the way.

These changes were designed to help keep the cost of the plan affordable while also creating solutions to improve quality, increase member compliance and adherence, and reduce fraud and waste. OP&F has also managed costs by choosing a single national plan administrator, UnitedHealthcare (UHC), to take advantage of the economies of scale, and the focus and leverage offered by one plan to positively influence claims costs, drug ingredient costs, and administrative fees.

These cost savings measures and efficiencies have helped to extend the life of the health care stabilization fund (HCSF). However, economic pressures continue to challenge OP&F despite our best efforts to reduce costs and maintain the ability to provide access to health care benefits for our members. The value of the HCSF was less than $906 as of March 2018 million and, at the current spending level, the fund is estimated to be depleted in less than 10 years. With the HCSF solvency period quickly eroding, the Board of Trustees hired Gabriel Roeder Smith & Company (GRS) to make short and long term recommendations designed to stabilize the health care fund. The consideration of change to any plan design element requires thorough analysis by the Board its actuarial advisors and OP&F staff to determine potential impacts and probable effects. At this point, the recommendations are still being discussed, however, some important changes were implemented in the 2017 health care plan year and more significant changes will be implemented in future years.

The year in review: 2017

2017 marks the 50th year of operations for OP&F. Staff, the Board of Trustees and its health care consultant, GRS, celebrated this milestone while working toward a major transition from a group-sponsored health care plan to a new consumer-driven model. Three finalists emerged from the search and presented their ideas to the Board in September. Aon was selected to be OP&F's vendor partner to establish a framework for the new retiree health care plan scheduled to be implemented on Jan. 1, 2019. Although the self-insured model will be ending, the structure of the old plan will tentatively serve as a guideline for the new plan design.

Aon will work directly with retirees and assist them in choosing an appropriate health care plan from the marketplace to fit their needs. A fixed-cost monthly stipend will be provided to eligible members to assist in paying associated costs. It is the desire of the Board to create stipend levels that will provide meaningful financial support for Medicare and non- Medicare retirees. The current health care plan will be in place throughout 2017 and in 2018. OP&F will continue to provide retirees with access to a quality health care plan while also accomplishing OP&F's goal to extend the life of the HCSF and available funding for health care to approximately 15 years.

As of Dec. 31, 2017, the HCSF balance was $932,087,789, which represents an increase in the balance from 2016 of three percent or $30,434,074. This was a result of interest generated on the balance of the HCSF along with retiree contributions, rebates and recoveries, and employer contributions, expressed as a percentage of payroll (0.5 percent from Jan. 1, 2017 to Dec. 31, 2017). Non-investment earnings generated $109,427,728 in revenue to fund health care. Benefit recipients contributed 38 percent toward OP&F's overall health care costs. The remaining 62 percent was paid from the HCSF. The specific breakdown of the HCSF over the last six years is shown on the Schedule of Changes in Net Assets Available for Post-Employment Health Care Benefits (See Appendix B).

The medical plan for OP&F members not eligible for Medicare, along with the retiree, prescription drug plan, is self-funded. OP&F pays the full cost of claims dollars for this program plus an administrative fee to a third party administrator. Members over the age of 65 are offered a fully insured premium based Medicare Supplement program. OP&F's actuary sets rates for the self-funded medical and prescription drug plans and reports annually on the solvency of the HCSF, but performs a full review of all assumptions and methods every five years. The structure of this plan includes a self-insured medical plan for the under 65 population, a Medicare supplement plan for Medicare eligible retirees, and a self-insured pharmacy plan. Funding for the plan comes through a portion of the employer contributions earmarked for health care – currently 0.50 percent. Investment returns and contributions from those enrolled in the plan are the only other sources that make up the HCSF.

Enrollments and Cost per Covered Life

As of Dec. 31, 2017, OP&F had 27,751 benefit recipients whom were eligible for health care coverage. Benefit recipients include retirees, orphans and survivors. Of those, approximately 70 percent participated in the OP&F medical program and 65 percent participated in the OP&F prescription drug program. As of Dec. 2017, the breakdown of enrollees and dependents (spouses and dependent children) enrolled in OP&F-sponsored health care plan was as follows (see Appendix H for network, non-network and out-of-area benefits):

Number Enrolled in Health Care Program

Benefit Recipients, Medical	Benefit Recipients, Rx	Dependents, medical	Dependents, Rx
18,913	17,292	7,694	6,292

Average cost per covered life

UHC	Prescription	AARP
$7,769	$2,846	$2,009

Compared to enrollment figures from Dec. 31, 2016, the OP&F-sponsored health care program had a decrease in enrolled participants. The total covered lives enrolled for 2017 was 27,048 or 312 less than the 2016 figures.

In 2017, re-employed retirees and dependents that had a health care plan available to them from an employer were not eligible for the OP&F-sponsored plan and were not eligible to receive an OP&F subsidy. As a result, eligible members with spouses who are eligible for health care coverage through another employer may choose not to enroll in the OP&F plan. Members participating in DROP are not eligible for the OP&F-sponsored health care plan.

Significant Changes that affect the comparability of the report

For Non AARP medical plans

- New copays, deductibles, out of pocket maximums;
- Prior authorization following principles of medical necessity for certain services for non-Medicare participants living in a network area is now required;
- Preventative care covered at 100 percent; and
- Preventative care benefits for woman at 100 percent which include prenatal visits, voluntary sterilization and certain contraceptives

Prescriptions

- New copays and new 4th Tier for medications;
- New Value Network of participating pharmacies;
- Plan will now follow principles of medical necessity;
- Certain preventive medications will be covered at 100 percent;
- New annual prescription out of pocket maximum; and
- Addition of external review for appeals

Eligibility

- Dependent children now covered to age 26 and stepchildren no longer eligible unless covered under OP&F-sponsored plan prior to Jan. 1, 2017;
- Retirees and dependents no longer eligible if covered under another plan offering health care benefits unless covered with OP&F-sponsored plan prior to Jan. 1, 2017

Future of OP&F Health Care

In the spring of 2017, OP&F announced with health care costs continuing to escalate, offering a plan, as we previously have in the past was no longer prudent. With the market conditions and our own demographics, OP&F was being forced out of the group-sponsored model. Without change, the health care plan will exhaust the health care fund in a matter of years. Even with these significant changes, current trends in health care and prescription drug costs, health care support beyond a 15-year projection was not foreseeable without a new income stream.

In recognition of the declining funds available for retiree health care, the Board looked for a more efficient use of the funds still available in an effort to extend solvency of the trust from nine years to 15 years.

Conveying that the current health care plan would be in place throughout 2018, the OP&F Board of Trustees, staff and our outside partners were all dedicated to searching for a firm to assist OP&F in the transition from a group-sponsored health care plan to a new consumer-driven model. Due to their extensive experience in assisting these type of transitions, at the Nov. 15, 2017 Board Meeting, the OP&F trustees directed staff to begin contract discussions with Aon to provide health care exchange services for our membership.

OP&F announced at the Dec. 2017 meeting of the Board of Trustees, a decision to collaborate with Aon to develop the framework for the new plan design, most importantly the eligibility requirements and stipend levels members can expect.

The Board made the decision to restructure how OP&F offers retiree health care and efficiently use the estimated $900 million in assets held in the Health Care Stabilization Fund targeted to transition in Jan. 1, 2019.

On March 27, 2018, the OP&F Board of Trustees unanimously approved the implementation date and framework for a new health care model. The cornerstone of this new strategy is a fixed cap stipend earmarked to pay a portion of the member's health care.

Although the self-insured health care plan will be ending, the structure of the old plan will tentatively serve as a guideline for the new plan design. The new plan will assist retirees in selecting a health care plan from the marketplace and include a fixed-cost monthly stipend to assist in paying associated costs.

The current eligibility structure is expected to be adopted for the new plan, meaning that to receive a stipend a retiree must not have access to another group health care plan. In addition, if a retiree has waived OP&F coverage in the past, they would not be eligible for the stipend unless a qualifying event occurs (marriage, death, divorce, the involuntary loss of group coverage, or the date of Medicare eligibility).

OP&F's health care partner, Aon, has already been working with OP&F staff in anticipation of the new plan design, which will allow OP&F retirees to use the monthly stipend amount to select a health care plan that best fits the specific needs of their family.

OP&F and Aon continue to develop the eligibility rules and options for enrolling in the new health care plan model. However, OP&F anticipates that these rules should be similar to the eligibility rules that are in place for the sponsored retiree health care plan design currently in place.

OP&F has also adopted a similar poverty-level subsidy, to give assistance to families who qualify. Aon will assist retirees in choosing an appropriate health care plan for their needs. Access to Aon's services will be for all retired members and dependents, whether they are eligible for the stipend or not.

With these decisions now made, Aon and OP&F are moving forward with a plan to notify retirees of the process of selecting a health care plan for 2019. In mid-June 2018, Aon anticipates mailing detailed information to retirees on the new health care plan model. Concurrently, Aon will also launch a dedicated website for OP&F members and have a toll free phone number available to answer any questions members may have. The OP&F website will have a link on its home page to the new Aon page set up for OP&F members.

2017 Health Care Eligibility

Retirees, survivors who are receiving the statutory survivor benefit, and dependents, may qualify to participate in the OP&F-sponsored health care coverage if they are determined to be eligible according to the terms of the health care plan.

Benefit recipient eligibility guidelines

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

Retiree

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

Surviving spouse

Upon the effective date of the statutory survivor benefits, a surviving spouse who receives a statutory survivor benefit from OP&F is eligible to participate in the OP&F-sponsored health care plan except when the following apply.

- The surviving spouse is participating in or waived health care coverage through another Ohio retirement system;
- The surviving spouse has access to another group health care plan;
- The surviving spouse was not legally separated from an OP&F member on or after Jan. 1, 2004, unless they have access to another group health care plan; or
- OP&F does not receive The Survivor Health Care Eligibility and Enrollment form within 90 days.

Once enrolled, the health care coverage for an eligible surviving spouse continues without interruption. If the surviving spouse remarries, the new spouse and any child born to the surviving spouse after the OP&F member's death are not eligible for coverage, unless the OP&F member is the child's parent.

Surviving child/orphan

A child who is eligible and is receiving a statutory survivor benefit from OP&F is eligible for the OP&F-sponsored health care coverage unless the statutory survivor has access to another group health care plan. Children may be covered on their own or under the surviving spouse as a dependent.

Dependent Eligibility Guidelines

Spouse

A spouse who is not eligible for health care coverage through another Ohio retirement system is eligible as a dependent under the OP&F-sponsored health care coverage unless they have access to another group health care plan, but a spouse who is legally separated on or after Jan. 1, 2004 is not an eligible dependent.

Child

A dependent child is eligible to participate if he or she meets the following criteria:

- The benefit recipient must be the child's natural parent or have legally adopted the child in order for the child to be eligible for the OP&F-sponsored health care coverage (the legal adoption provision does not apply to children added to coverage prior to Jan. 1, 2004 and has had continuous coverage);
- Stepchildren if they were covered under the OP&F-sponsored health care coverage prior to Jan. 1, 2017; or
- A dependent child who is 18 up to 26 years of age, who is not eligible to enroll in an employer-sponsored health plan (as described by law) is eligible to enroll in the OP&F-sponsored health care coverage. A dependent application must be completed and approved by UnitedHealth and the following criteria are met:
  - -The child is the natural child or adopted child of the Benefit Recipient.
  - -The child is not employed by an employer offering any health benefit plan under which the child is eligible for coverage. (Please note that being offered any type of health care through an employer makes the dependent ineligible for participation in any health care through OP&F).

Dependent parent

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

Dependent only eligibility

If the member did not enroll in the OP&F-sponsored health care plan, his or her dependents cannot enroll unless the member enrolls in other group coverage and the dependents are not eligible and have no access to coverage on their own. Written proof that the dependents do not have access to coverage is required. Dependent-only coverage may be required by a qualified medical child support order.

2017 Health Care Coverage Options

In 2017, OP&F sponsored health care benefits included coverage for medical, prescription drug, and voluntary dental and vision coverage. Below is a description of these optional health care coverages.

Medical

The 2017 health care plan offered one plan design through one carrier, UnitedHealthcare (UHC), for all non-Medicare eligible benefit recipients and dependents, early Medicare recipients, Medicare A only recipients, Medicare B only recipients, or OP&F retirees residing outside of the U.S.

OP&F benefit recipients and dependents age 65 and over that are Medicare eligible and enrolled in both Medicare Parts A and B are eligible to enroll in AARP Medicare Supplement Plans B, F, or L offered through AARP Health Care Options. OP&F's subsidy is based on the Ohio Plan L premium.

Anyone who was not Medicare-eligible, resided in a network area and enrolled should have utilized participating network providers to receive maximum benefits. A plan participant simply chooses a doctor or hospital from the administrator's provider listing at the time of services.

There are definite advantages for members who utilize network providers. Negotiations allowed for special, reduced fees with all network providers so that benefit recipients and their enrolled dependents would not be responsible for paying the difference between the provider's normal charge and specially negotiated fees. In addition, when using network providers, there were no claim forms to file and deductibles and the maximum yearly out-of-pocket cost was lower.

Benefit recipients and their enrolled dependents that chose to utilize a provider outside of the network, even though network providers were available, incurred higher out-of-pocket costs. Benefit recipients and their enrolled dependents were responsible for paying any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined by UHC because special fees had not been negotiated with non-network providers.

The UHC plan does not have networks in all areas of the country. Benefit recipients and their enrolled dependents who resided in one of these out-of-network areas could still choose UHC as their claims administrator. These benefit recipients and their enrolled dependents could then use any provider or hospital and still receive most benefits at the network benefit level. However, when utilizing out-of-area providers, the benefit recipients may need to file their own claim forms and notify UHC themselves for procedures that needed to be pre-certified. The benefit recipient would pre-certify procedures with UHC and pay any difference between the provider's fee and the UCR allowance determined by UHC (See Appendix H for a chart describing the various benefit levels).

Prescription drug coverage

In 2017, OP&F offered one prescription drug plan through OptumRx Pharmacy, as a separate coverage, with separate contribution amounts.

The mail service pharmacy program

Beginning June 1, 2013, OP&F chose OptumRx Pharmacy for the distribution of mail order prescriptions. For the greatest savings, benefit recipients and their enrolled dependents could order medications through the mail and could order refills over the phone or internet. With the mail service program, there were no deductibles and no claim forms to file.

The retail pharmacy program

The OptumRx Value Network Pharmacy program, consisting of 35,000 participating pharmacies, is best used to purchase medications that would be taken on a short-term or immediate need basis and features a network of quality pharmacies throughout the country. With this program, participants could utilize any pharmacy, although members would save more when visiting a network pharmacy. When using a network pharmacy, there were no deductibles or claim forms to file.

Specialty pharmacies

UnitedHealthcare has a designated network of specialty pharmacies that serve members taking specialty medications often used to treat complex conditions.

Prescription Drug co-pays

The Chart below compares the copays for the OP&F-sponsored prescription drug plan between retail and OptumRx Mail Service Pharmacy. Limited coverage is available at non-network pharmacies.

Presciption drug co-pays

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

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

4th Tier added for 2017

The medications on Tier 4 include many high-cost brand name, specialist and some generic medications used to treat complex conditions. Many Tier 4 drugs have lower cost options available in Tiers 1, 2, or 3.

Voluntary vision and dental plans

For the 2017 plan year, OP&F continued to sponsor voluntary dental coverage through UHC. The voluntary vision coverage was offered through UHC Vision, underwritten by UnitedHealthcare Insurance Company.

Routine vision and dental services are not covered under OP&F's medical plans. Therefore, OP&F does not subsidize the cost of these plans. These plans are offered in addition to the medical and prescription drug programs and have separate contribution amounts.

Enrollment in supplemental vision and dental plans is permitted with a qualifying event and once every year during the Annual Change Period. Once enrolled, benefit recipients and their eligible dependents must remain enrolled for the remainder of the calendar year, unless there is a valid change in family status.

UnitedHealthcare vision coverage

Under the vision plan, benefit recipients and their enrolled dependents may visit any UHC vision provider. Benefit recipients and their enrolled dependents have minimal copayments for the exam, lenses and frames at the time of service. In 2017, OP&F had 10,296 benefit recipients enrolled in the UHC Vision plan.

UnitedHealthcare dental coverage

Under the UHC dental plan, benefit recipients and their enrolled dependents may choose any dentist in the country. The maximum benefit level is achieved by utilizing UHC's network of participating dentists, as these dentists have agreed to a discounted fee schedule. When utilizing a dentist who does not participate in UHC's

Network, benefit recipients and their enrolled dependents are responsible for paying directly to the dentist any amount above the usual and customary rates prevailing in the geographic area in which the expense is incurred.

In 2017, OP&F had 11,844 benefit recipients enrolled in UHC dental coverage. The UHC dental plan offers a consumer-driven feature, Consumer Max Multiplier, which allows members to carry forward a portion of their unused annual dental maximum into an account for future use based on specific plan guidelines.

Annual Change Period

In the fall of every year, plan participants will receive the Member's Guide to Health Care Coverage and personalized Annual Change Period form that provides more details about the upcoming OP&F-sponsored health care coverage, describes the Annual Change Period process, and announces any changes to the plan or contribution rates. The form can be used to verify or waive current enrollment, ensures that any pre-printed information contained on the form is accurate, as well as waiving or enrolling in the voluntary dental and vision coverage. This major project involves creating a customized form for health care participants and a booklet specifically outlining the available health care plans.

Health Care and Prescription Drug Discount Program

In 2017, OP&F may provide a 30 percent discount on the monthly contributions for health care and prescription drug coverage if participants are enrolled in the OP&F-sponsored health care and prescription drug coverages and have a low household income.

Eligibility

To be eligible for the contribution discount for 2017, the total household income must be less than 225 percent of the poverty level established annually by the Department of Health and Human Services. As a result, the gross income levels that OP&F will use for the 2017 discount period are indicated in the following chart. For example, if there were a total of two individuals residing in a household in 2015 and your combined income was less than or equal to $36,045, they would be eligible for the discount.

Discount program income levels

Size of family unit	Household income less than, or equal to:
1	$26,730
2	$36,045
3	$45,360
4	$54,675
5	$63,990
6	$73,305
7	$82,642
8	$92,002
9	$101,362
10	$110,722
For each additional person, add $9,630	

Household income

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

The benefit recipient and eligible dependents who are primarily dependent on the benefit recipient

OP&F and Medicare

Part A

Individuals must have earned a pre-determined quantity of eligible quarters of employment to become eligible for enrollment in Medicare Part A, which is hospital insurance. If an individual is not eligible for the AARP Medicare Supplement insurance and chooses to enroll in the OP&F-sponsored health care coverage, UHC will pay a percentage of covered hospital expenses not paid by Medicare Part A after the individual's deductible is met.

Part B

Members are eligible to enroll in Medicare Part B once they turn 65 years of age (or have a qualifying illness or disability prior to age 65.) OP&F requires members to enroll in Medicare Part B as soon as they are eligible. If members do not sign up, refuse or stop Medicare Part B enrollment, UHC will estimate what Medicare Part B would pay and deduct that amount from the charges before making payment. The Member is then responsible for what Medicare Part B would have paid.

Part B Reimbursements

Upon eligibility for Medicare Part B, benefit recipients are eligible for reimbursement of the Medicare Part B premium through OP&F (as required by ORC Section 742.45 (B), See Appendix A), if they are not receiving reimbursement from another source.

In 2017, OP&F paid more than $18.9 million in Medicare B reimbursements.

Part D Subsidy

In 2017, OP&F received a slightly more than $8.02 million in Part D subsidy dollars for deposit into the HSCF.

APPENDIX A

Statutory Authority for Health Care Benefits

§ 742.45. Deduction from benefit payment for group health insurance

(A) The Board of Trustees of the Ohio police and fire pension fund may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving service or disability pensions or survivor benefits subscribing to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the eligible individual's sponsored dependents as the Board considers appropriate.

If all or any portion of the policy or contract premium is to be paid by any individual receiving a service, disability, or survivor pension or benefit, the individual shall, by written authorization, instruct the Board to deduct from the individual's benefit the premium agreed to be paid by the individual to the company, corporation, or agency.

The Board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the Ohio police and fire pension fund. The cost paid from the funds of the Ohio police and fire pension fund shall be included in the employer's contribution rates provided by sections 742.33 and 742.34 of the Revised Code.

The Board may provide for self-insurance of risk or level of risk as set forth in the contract with the companies, corporations, or agencies, and may provide through the self-insurance method specific benefits as authorized by the rules of the Board.

(B) Except as otherwise provided in this division, the Board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service, disability, or survivor benefits under the Ohio police and fire pension fund who is eligible for coverage under part B of the medicare program established under Title XVIII of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, an amount specified by the Board or determined pursuant to a formula established by the Board that is not less than ninety-six dollars and forty cents, for such coverage, except that the Board shall not pay an amount that exceeds the amount paid by the recipient for the coverage.

The Board shall pay not more than one monthly premium under this division to an eligible benefit recipient even if the recipient is receiving more than one monthly benefit from the fund. The Board shall not pay a monthly premium under this division to an eligible benefit recipient who is receiving reimbursement for the premium from any other source.

(C) The Board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

(D) The Board shall make all other necessary rules pursuant to the purpose and intent of this section.

APPENDIX B

Schedule of Changes in Net Assets Available for Post Employment Health Care Benefits

2012–2017

	2012	2013	2014	2015	2016	2017
Additions:						
Employer Contributions	$130,285,935	$69,426,521	$9,895,274	$10,211,723	$10,708,739	$10,871,479
Benefit Rec. Contributions	65,066,253	66,564,696	69,965,747	71,187,555	73,161,967	$74,450,891
Investment Income	126,894,129	158,418,556	80,862,561	6,673,634	84,898,902	$115,417,359
Recoveries and Rebates	21,226,179	15,565,560	18,009,774	23,266,521	27,855,788	$24,105,358
TOTAL ADDITIONS	343,472,496	309,975,333	178,733,356	111,339,433	196,625,396	$224,845,087
Deductions:						
Health Care Expenses	187,445,986	191,335,860	199,594,201	213,235,336	223,535,753	$193,595,036
Administrative Expenses	562,689	710,855	732,022	682,917	798,310	$815,977
TOTAL DEDUCTIONS	188,008,675	192,046,715	200,326,223	213,918,253	224,334,063	$194,411,013
NET INCREASE/(DECREASE)	$155,463,821	$117,928,618	($21,592,867)	($102,578,820)	($27,708,667)	$30,434,074

Net assets held in trust for post employment health care benefits:

Balances						
Beginning of Year	$780,141,630	$935,605,451	$1,053,534,069	$1,031,941,202	$929,362,382	$901,653,715
END OF YEAR	$935,605,451	$1,053,534,069	$1,031,941,202	$929,362,382	$901,653,715	$932,087,789

APPENDIX C

Accounting, Asset Valuation and Funding Methods

1. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by OP&F.

Basis of Accounting:

OP&F's financial statements have been prepared using the accrual basis of accounting. Revenues are recognized when earned and expenses are recorded when a liability is incurred.

Investments:

Investment purchases and sales are recorded on a trade date basis. Dividend income is recognized on the dividend date, while interest and rental income is recognized when earned. Investments are reported at fair value. Securities traded on a national or international exchange, are valued at the last reported sales price at current exchange rates. Mortgages are valued on the basis of future principal payments discounted at prevailing interest rates for similar instruments. The fair value of real estate and timber are based on independent appraisals and internal valuations. Investments that do not have an established market are reported at estimated fair value. Private equity limited partnership interest is based on values established by each partnership's valuation committees.

Net appreciation is determined by calculating the change in the fair value of investments between the end of the year and the beginning of the year, less the cost of investments purchased, plus sales of investments at fair value. Investment expense consists of administrative expenses directly related to OP&F's investment operations and a proportional amount of all other administrative expenses allocated based on the ratio of OP&F's investment staff to total OP&F staff. OP&F has no individual investment that exceeds five percent of net assets available for benefits.

Federal Income Tax Status:

OP&F was determined to be a trust under section 401(a) of the Internal Revenue Code that is exempt from federal income taxes under section 501(a) of the Internal Revenue Code. OP&F's DROP plan was also determined to be part of the 401(a) trust.

Property and Equipment:

Property and equipment are recorded at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets. The range of estimated useful lives
is as follows:
Buildings and improvements ..... 40 years
Furniture and equipment..... 3 to 10 years
Computer software and hardware ..... 2 to 10 years

Contributions and Benefits:

Employer and Member contributions are recognized when due or in the period the related member salaries are earned. Benefits and refunds are recognized when due and payable in accordance with the terms of the plan.

2. Asset Valuation Method

The difference between actual market value and expected market value is recognized over five years (20 percent per year). The actuarial value is the market value adjusted by the total unrecognized gains or losses incurred during the five year period.

3. Funding Method

Health care benefits are funded on a pay-as-you-go basis. This fund is credited with a portion of employer contributions equal to 0.5 percent of active member payroll from Jan. 1, 2016 to Dec. 31, 2016; all benefit recipient health care contributions, as well as an equal share of investment income to the balance of the HCSF. The HCSF is charged with all health care expenses and administrative costs. As of Dec. 31, 2017, the balance in the HCSF was $932,087,789.

APPENDIX D

Plan Net Assets Available for Post-Employment Health Care Benefits

as of Dec. 31, 2017 (un-audited)

Assets:	Cash and Short-term Investments	**$56,777,996**
Receivables:	Employers' Contributions	1,203,350
	Accrued Investment Income	2,253,915
	Investment Sales Proceeds	4,834,321
	TOTAL RECEIVABLES	**$8,291,586**
Investments, at fair value:	Bonds – Domestic	$206,797,450
	Bonds – International	206,600
	Mortgage and Asset Backed Securities	25,597,920
	Stocks – Domestic	191,760,123
	Stocks – International	188,899,810
	Real Estate	105,332,631
	Commercial Mortgage Funds	2,200,001
	Private Debt	24,883,884
	Private Equity	66,524,379
	Timber	20,154,646
	Master Limited Partnerships	60,917,189
	Derivatives – Domestic	-372
	Derivatives – International	-52,835
	TOTAL INVESTMENTS	**$893,221,426**
	Collateral on Loaned Securities	$57,434,419
	TOTAL ASSETS	**$1,015,725,427**
Liabilities:	Health Care Payable	$18,013,257
	Investment Commitments Payable	8,189,962
	Obligations Under Securities Lending	57,434,419
	TOTAL LIABILITIES	**$83,637,638**
NET ASSETS HELD IN TRUST FOR POST-EMPLOYMENT HEALTH CARE BENEFITS:		**$932,087,789**

APPENDIX E

Statement of Changes in Plan Net Assets Available for Post-Employment Health Care Benefits

(Year ending Dec. 31, 2017)

Additions:	*From Contributions:*	
	Employers	$10,871,479
	Member Health Care Premiums	74,450,891
	TOTAL CONTRIBUTIONS	**$85,322,370**
	From Investment Income:	
	Net Appreciation (Depreciation) of Fair Value of Investments	$95,022,365
	Bond Interest	7,707,070
	Dividends	5,918,711
	Alternative Investment Income	5,349,010
	Repurchase Agreement Interest	0
	Master Limited Partnerships Income	3,801,884
	Other Investment Income (Loss)	449,018
	Less Investment Expenses	-3,084,284
	NET INVESTMENT INCOME/(LOSS)	**$115,163,774**
	From Securities Lending Activities:	
	Securities Lending Income	$751,553
	Securities Lending Expense:	-497,968
	NET INCOME FROM SECURITIES LENDING	**$253,585**
	Other Income	$24,105,358
	TOTAL ADDITIONS	**$224,845,087**
	Benefits:	
Deductions:	Health Care	$193,595,036
	Administrative Expenses	815,977
	TOTAL DEDUCTIONS	**$194,411,013**
	NET INCREASE (DECREASE)	**$30,434,074**
NET ASSETS HELD IN TRUST FOR POST-EMPLOYMENT HEALTH CARE BENEFITS:		
BALANCE, BEGINNING OF YEAR		$901,653,715
BALANCE, END OF YEAR		**$932,087,789**

APPENDIX F

Health Care Funding Policy

The OP&F Board of Trustees recognizes the limitations imposed by law on the cost of health care benefits. OP&F will manage the terms of the health care benefits program in a manner that, over the long-term, ensures the solvency of OP&F with respect to providing pension and disability benefits.

To determine the affordable level of health care costs, the Board will utilize forecast studies prepared by the actuary on at least a quinquennial basis (every five years) or other studies commissioned by the Board on an ad-hoc basis. The forecast studies will be prepared following each quinquennial experience study, so as to best reflect current expectations of OP&F pension and health care liabilities.

The cost of health benefits is funded through benefit recipient paid contributions and through contributions that employers pay on behalf of active members. OP&F understands that the employer's contribution for all benefits, both pension and health care has been set by statute as a percentage of payroll. The assumed level percentage of active member payroll was determined in 1991, via a forecast study, to be the long-term affordable level to be devoted to health care based on actuarial experience at that time. OP&F will adjust the percentage of active member payroll used for health care benefits at least every five years to the maximum level consistent with OP&F's primary obligation to pay pension benefits.

Based on the projected health care costs included as part of the forecast studies and after paying costs covered by the current percentage of active member payroll and the amount of HCSF deemed prudent by the Board, the monthly contributions for benefit recipients and dependents will be adjusted to pay all remaining health care costs. When adjusting contributions paid by the benefit recipients, the Board will apportion the contributions among the benefit recipient and dependent population after considering many factors.

If changes in benefit recipient monthly contributions and active member payroll contributions fail to offset rising health care costs, the Board will consider changes to health care benefit levels.

OP&F will ensure that this funding policy is effectively communicated to OP&F's membership and will work toward improving member understanding of the issues surrounding the funding of health care benefits.

APPENDIX G

2017 Health Care Contributions

For benefit recipients and eligible dependents who are non-Medicare eligible, early Medicare A & B, early Medicare A only, Medicare B only or OP&F benefit recipients residing outside of the United States and who began receiving OP&F benefits on or prior to July 24, 1986. This chart outlines the monthly contributions that they are responsible for paying and the subsidized portion that OP&F pays for coverage.

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

Contribution rates for benefit recipients and eligible dependents who are non-Medicare eligible, early Medicare A & B, early Medicare A only, Medicare B only or a OP&F benefit recipient residing outside of the United States and who began receiving OP&F benefits on or after July 25, 1986. This chart outlines the monthly contributions they are responsible for paying and the subsidized portion that OP&F pays for coverage.

	Not eligible for Medicare			Non-AARP Medicare Supplemental Insurance Plan		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage
Benefit Recipients	$226.28	$678.84	$905.12	$73.34	$220.00	$293.34
Spouse	$499.39	$149.80	$599.19	$165.45	$61.82	$247.27
Child(ren)	$234.88	$78.29	$313.17	$185.45	$61.82	$247.27

Not eligible for Medicare

Benefit recipients and their eligible dependents who have not reached age 65.

Non-AARP

Benefit recipients and eligible dependents who are early Medicare, early Medicare A, early Medicare B, early Medicare A and B, age 65 and older and Medicare A only, age 65 and older and Medicare B only or reside outside the United States.

Prescription Drug Contributions

This chart outlines the monthly contributors that benefit recipients are responsible for paying and the subsidized portion that OP&F pays for coverage.

	Not eligible for Medicare			Non-AARP Medicare Supplemental Insurance Plan		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage
Benefit Recipients	$74.30	$222.92	$297.22	$74.30	$222.92	$297.22
Spouse	$139.99	$139.99	$279.98	$139.99	$139.99	$279.98
Child(ren)	$41.61	$41.61	$83.22	$41.61	$41.61	$83.22

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

	Not eligible for Medicare			Non-AARP Medicare Supplemental Insurance Plan		
	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage	Benefit recipient's monthly contribution	OP&F's monthly amount	Full premium for health care coverage
Benefit Recipients	$74.30	$222.92	$297.22	$74.30	$222.92	$297.22
Spouse	$209.99	$69.99	$279.98	$209.99	$69.99	$279.98
Child(ren)	$62.41	$20.81	$83.22	$62.41	$20.81	$83.22

Voluntary dental and vision coverage contribution rates

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

	UnitedHealthcare dental	UnitedHealthcare vision
Benefit recipients (including survivors)	$34.71	$7.18
Benefit recipient and spouse	$65.48	$13.48
Benefit recipient and child(ren)*	$68.22	$13.22
Benefit recipient, spouse and child(ren)*	$114.02	$20.47

* Contribution rates remain the same regardless of the number of children enrolled.

APPENDIX H

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

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

A non-Medicare participant living in a network area

Members enrolled in this plan are subject to medical necessity, which requires prior authorization of certain services.

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

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

** If no prior authorization and service is medically necessary, then a $200 penalty applies

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

A participant eligible for Medicare Part B only and living in a network area

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

	Network ▼	Non-Network ▼
Annual Deductible		
Individual / family	$750 / $1,500	$2,250 / $4,500
Co-Insurance limit	$2,000 / $4,000	$10,000 / $20,000
Co-Insurance	80%	80% or 50%
Physician Services		
Office visit	$30 / 100%	50%
Emergency Care		
Emergency department*	$200 / 80%	$200 / 80%**
Non-emergency services rendered in emergency room*	$200 / 50%	$200 / 50%**
Urgent care	80%	80%
Hospital In-Patient Services		
Prior admission testing	80%	80%
Scheduled in-patient admit	$400 / 80%	$400 / 50% **
Emergency in-patient admit *	$400 / 80%	$400 / 80%
Ambulatory Services		
Diagnostic lab / x-ray	80%	80%
Ambulatory surgery center	$150 / 80%	$150 / 80%**
Mental Health and Substance Abuse		
Scheduled in-patient admit	$400 / 80%	$400 / 50% **
Emergency in-patient admit *	$400 / 80%	$400 / 80%
Out-patient	100%	
Out-patient mental / drug /alcohol	100%	80%
Preventive Care		
Physician office visit	100%	50%
Other Services		
Rehab therapies	80%	80%
Chiropractor	80%	80%
Durable medical equipment	80%	80%**
Home health care services	80%	80%**
Private duty nursing	80%	80%**
Skilled nursing facility	$400 / 80%	$400 / 80%**
Sub-acute rehabilitation center	$400 / 80%	$400 / 80%**
Ambulance	80%	80%**
Hospice (in-patient/out-patient)	100%	100%

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

** If no prior authorization and service is medically necessary, then a $200 penalty applies

APPENDIX I

Voluntary Dental Plan Design/Premium Amounts

As shown below, enrolled members would have less out-of-pocket expenses by using a network dentist.

	UnitedHealthcare	Voluntary dental
	Network	***Non-network***
Deductible	$50 single/$150 family	$100 single/$300 family
Class I Benefits		
Calendar year maximum per person	$1,500 per person	$750 per person
Diagnostic services	100% (with no deductible)	75% (with no deductible)
Preventive services	100% (with no deductible)	75% (with no deductible)
Fluoride treatment	100% (with no deductible)	75% (with no deductible)
Emergency palliative	100% (with no deductible)	75% (with no deductible)
Radiographs	100% (with no deductible)	75% (with no deductible)
Class II Benefits		
Oral surgery	80% (after deductible)	50% (after deductible)
Minor restorative	80% (after deductible)	50% (after deductible)
Periodontics	80% (after deductible)	50% (after deductible)
Endodontics	80% (after deductible)	50% (after deductible)
Class III Benefits		
Prothodontics	50% (after deductible)	30% (after deductible)
Major restorative	50% (after deductible)	30% (after deductible)
New dental implances	50% (after deductible)	0% (after deductible)

APPENDIX J

Voluntary Vision Plan Design/Premium Amounts

	UnitedHealthcare Vision	
Vision Features:	**Network Providers**	**Non-Network Providers**
Plan Frequency	Pair of lenses for eyeglasses: once every 12 months; Contact lenses in lieu of eyeglasses: once every 12 months; frames: once every 24 months	Pair of lenses for eyeglasses: once every 12 months; Contact lenses in lieu of eyeglasses: once every 12 months; frames: once every 24 months
Exam co-pay	$10, one per year	Up to $50 reimbursement
Materials co-pay	$0 co-pay	Not applicable
Single vision lenses	$0 co-pay	Up to $60 reimbursement
Lined bifocal lenses	$0 co-pay	Up to $80 reimbursement
Lined trifocal lenses	$0 co-pay	Up to $120 reimbursement
Lined lenticular lenses	$0 co-pay	Up to $200 reimbursement
Polycarbonate lenses	$0 co-pay	Not applicable
New standard progressive	$0 co-pay	Not applicable
New deluxe progressive	$0 co-pay	Not applicable
New platinum progressive	$0 co-pay	Not applicable
Scratch coating	$0 co-pay	Not applicable
Frames	*$0 co-pay; $130 allowance plus up to 50% over allowable at discretion of provider	Up to $78.00 reimbursement
Contact Lens Fitting and Evaluation	$0 co-pay under UnitedHealthcare Vision's contact lenses package	Elective contacts in lieu of eye glasses: $200; Necessary contacts in lieu of eye glasses $210

- A benefit recipient's individual provider may offer discounts in addition to the vision coverage offered through UHC
- Underwritten by UnitedHealthcare Insurance Company

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