Ohio Police & Fire Pension Fund

2007 **Health Care Report**

Presented to the:

Ohio Retirement Study Council

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Prudence • Integrity • Empathy

The Ohio Police & Fire Pension Fund is dedicated to providing retirement and related benefits, accurate information, dependable communication and valuable educational assistance to our members. As responsible fiduciaries, we will professionally manage the resources of OP&F and implement its practices, plans and benefit services with the highest ethical standards.

Introduction

The Ohio Police & Fire Pension Fund (OP&F) sponsors a health care benefits program including coverage for medical, prescription drugs, dental, vision and long-term care for its eligible members and dependents. In 2007, a total of 26,601 retirees, survivors and their dependents were enrolled in health care benefits sponsored by OP&F. The prescription drug plan sponsored by OP&F had 25,300 covered lives enrolled in 2007.

As required by Ohio Revised Code (ORC) Section 742.14(E), OP&F has prepared this report to provide information regarding the health care program offered to OP&F members in 2007. The report also focuses on the methods used by OP&F for funding health care benefits and future plans. The OP&F Board of Trustees realizes that one of the greatest and most difficult issues it must face is funding the rising cost of health care benefits without jeopardizing future pension, disability and survivor benefits. In addition to health care funding, this report also discusses eligibility, a description of the available plans, and OP&F financial information regarding funding of these costs.

33 years of offering health care benefits

In 1974, OP&F began to offer medical expense benefits to all retired members, survivors and eligible dependents as an optional benefit, as long as the cost of funding those benefits did not jeopardize funding of pension, survivor, and disability benefits (See *Appendix A* for the statutory authority for health care benefits, ORC Section 742.45). At that time, the plan was offered through Aetna Health Plans.

In July 1992, contributions were required for most benefit recipients* due to the rising costs of health care. Additional cost saving plan design measures have been introduced since that time. The 2007 health care plan offered one plan design and a choice between two health care carriers: Aetna POS II and Medical Mutual PPO.

Effective January 1, 2007, Aetna PPO – which was the name of the 2006 health care carrier – was called the Aetna Choice POS II network. This change in the network name did not impact the benefits or services provided by Aetna. Aetna POS II offered the same flexibility as a PPO. Also, beginning January 1, 2007, OP&F no longer sponsored medical coverage through Health Maintenance Organizations (HMOs) including Medicare HMOs. A separate program was available for prescription drugs, as well as supplemental dental, vision and long-term care plans.

** "Benefit recipients" are defined as OP&F members who are receiving either service or disability pension benefits, their surviving spouse(s), orphans and children receiving statutory benefit from OP&F.*

Health Care Funding

When OP&F began sponsoring health care benefits in 1974, health care expenditures were approximately $3 million. Thirty-three years later, in 2007, OP&F health care expenses totaled over $149 million. The cost per health care participant in 2007 was $5,623, a thirteen percent decrease from 2006. This section details the historical perspective of OP&F's health care program, the current health care funding structure and how OP&F anticipates addressing funding of these benefits into the future.

Health Care Financing: History

The original plan remained relatively unchanged until 1992 when the OP&F Board of Trustees implemented monthly contributions from benefit recipients. In 1992, member contributions were developed and implemented based upon benefit recipients contributing eight percent of the cost of health care and OP&F subsidizing 92 percent of the costs.

Also introduced in 1992 were PPOs. Under these plans, participants were encouraged to utilize participating network providers in order to pay less out of pocket for their health care expenses. Participating network providers had contractually agreed to charge less for their services, a savings which was then to be passed on to participants and to OP&F, as the plan sponsor.

HMOs and Medicare HMOs were added to the OP&F-sponsored health care plan in the 1990s and were implemented to save money for both OP&F and benefit recipients.

A stand-alone prescription drug program has been a part of OP&F-sponsored health care benefits since the 1970s. However, plan changes in 1993 introduced a retail prescription drug network in addition to an established mail-order plan.

While the contribution by benefit recipients remained flat, the cost of health care continued to rise. By 2001, the eight percent that contributions covered in 1992 had dwindled to the equivalent of five percent. In 2001, the Board of Trustees changed the contribution structure from the flat contribution rate first introduced in 1992, to benefit recipients contributing six percent of projected costs. In 2002, this percentage reached 12 percent. Contribution rates were then updated each year based on projected costs.

A study prepared by OP&F actuaries in 2002 projected that OP&F's Health Care Stabilization Fund would deplete rapidly, unless changes were made to the funding mix in place at the time. As a result, the OP&F Board of Trustees determined an appropriate mix among the three health care funding sources—employer contributions, investment income, and benefit recipient contributions—to allow OP&F the ability to provide health care to eligible participants.

Effective January 2004 additional changes to the health care programs were

implemented to preserve the Health Care Stabilization Fund. The strategy was a three-pronged approach with changes to plan designs, contributions/OP&F subsidy levels for both non-Medicare and Medicare individuals, and eligibility. This strategy remained unchanged in 2005 and 2006. Additionally, a retiree or their surviving spouse/orphan child could opt for health care and/or prescription drugs coverage separately.

Health Care Financing: Current

As of December 31, 2007, the OP&F Health Care Stabilization Fund had a balance of $526,998,849. This balance was a result of interest generated on the balance of the Health Care Stabilization Fund, along with retiree contributions, rebates and recoveries, and 6.75 percent of employer contributions expressed as a percentage of payroll. This represented an increase in the balance from 2006 of nearly 21 percent or $90.4 million. The specific breakdown of the Health Care Stabilization Fund 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*).

In 2007, non-investment earnings generated $191,383,268 in revenue to fund health care. Benefit recipients contributed 38 percent toward OP&F's overall health care costs. The remainder, 62 percent, was paid from the Health Care Stabilization Fund, which included employer contributions (6.75 percent of payroll) and investment income on the balance of the Health Care Stabilization Fund. Deductions from that fund included actual health care expenses and administrative expenses related to health care. Health care expenses included medical and prescription drug claims payments, premiums, administrative fees, and Medicare Part B reimbursements.

Currently, the medical and prescription drug coverage sponsored by OP&F are self-funded, meaning that OP&F pays the full cost of claims dollars for these programs' plans. OP&F's actuary reviews all assumptions and methods every five years and reports annually on the solvency of the Health Care Stabilization Fund. OP&F uses this information to determine the adequacy of retiree contributions and employer contributions. The Board of Trustees annually addresses the issues surrounding rising health care costs and explores viable funding options to secure a health care option for all eligible members.

Health Care Financing: Cost saving measures

The plan changes in 2004 changed the amount OP&F would subsidize. The amount of the subsidy depended on when the benefit recipient retired, as well as their age and years of service at retirement. Three (3) subsidy levels were established. As a benefit recipient aged, their subsidy level would increase until they reach the highest level available, which was 75 percent for the retired member, and 50 percent for dependents.

Under the plan for 2006, benefit recipients paid a set percentage of the full cost of benefits. Contribution rates ranged from 25 percent to 100 percent, depending on the level for which a benefit recipient qualified. To maintain equality from a funding standpoint, benefit recipients selecting a higher cost program paid the difference in the cost.

Contribution rates for the 2007 OP&F–sponsored medical and prescription drug

plans were based on when the member retired or began receiving OP&F benefits. If the member began receiving OP&F benefits on or prior to July 24, 1986, OP&F would subsidize the health care premium 75 percent for the benefit recipient and 50 percent for the benefit recipient's eligible dependents. If the OP&F member began receiving benefits on or after July 25, 1986, OP&F would subsidize 75 percent of the benefit recipient's premium and 25 percent for the benefit recipient's eligible dependents' premium.

Eligibility for enrollment in the OP&F-sponsored health care plan was selective in 2007, and the opportunities for re-enrollment were significantly reduced. Enrollment opportunities include:

- At the time of the benefit recipient's retirement;
- Three (3) years after the benefit recipient's OP&F retirement or commencement of OP&F benefits;
- With proof of change in family status (i.e., marriage, death, divorce);
- With proof of loss of group coverage; or
- At the time of Medicare eligibility.

OP&F benefit recipients who were re-employed and eligible for health care through their employer still had the option of enrolling in the OP&F-sponsored health care plan in 2007. However, they were responsible for paying the full premium with no OP&F-provided subsidy (See *Appendix G*).

Additionally, the Board of Trustees determined that there would be an enrollment period in 2007, allowing those who waived coverage prior to January 1, 2004, an opportunity to enroll in the OP&F-sponsored plan. As a result of that opportunity, 97 members chose to enroll in OP&F's medical plan and 121 members chose to enroll in OP&F's prescription drug plan.

If benefit recipients or their enrolled dependents do not enroll in Medicare Parts A or B when eligible, OP&F's health care carriers process claims as if the individual was enrolled and the benefit recipient is responsible for all fees and expenses incurred that Medicare would have paid. In addition, OP&F seeks to recover any reimbursements that were erroneously processed for these individuals by the carriers.

Whether eligible for both Medicare Parts A and B, or only Medicare Part B, OP&F's medical plans were designed to supplement Medicare coverage for benefit recipients and their enrolled dependents. As a result, OP&F plans become secondary coverage for benefit recipients and their enrolled dependents that are eligible for Medicare. All medical expenses covered under the OP&F plans are reduced by the Medicare benefits available for those expenses. This is done before the medical benefits of the selected OP&F plan are calculated.

In 2005, OP&F evaluated the impact of the new Medicare Part D program being implemented effective January 1, 2006. OP&F decided to continue offering prescription drug coverage to Medicare eligible individuals and seek the 28 percent subsidy offered by the Centers for Medicare and Medicaid Services (CMS).

Funding strategies

OP&F's Board of Trustees continually confronts the challenge of funding the rising cost of health care benefits without

jeopardizing future pension, survivor, and disability benefits. In addition to the fact that the costs for health care services across the country keep rising, other factors affecting OP&F benefit funding include continuing increases in Medicare premiums and deductibles and the extended life span of retirees.

As part of the *Health Care Funding Policy* (See *Appendix F*) adopted by the OP&F Board in December 1997, 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 to determine the affordable level of health care. The forecast studies will be prepared following each quinquennial experience study, so as to best assess current and expected OP&F pension and health care liabilities.

Beginning with a Health Care Summit in 2005 and continuing into 2006 with two additional summits, the OP&F Board of Trustees, along with staff and consultants, are committed to building a health care plan that looks at the limited resources available and yet provides an appropriate level of access to quality health care programs, including prescription drugs.

In April 2006, the OP&F Board of Trustees recommended and approved several changes to the OP&F-sponsored health care plan for the 2007. These changes included the following:

- HMOs discontinued effective December 31, 2006.
- Establishment of a lifetime maximum of $2.5 million per covered person.
- Offering a single health care plan.
- Co-pays, deductibles and out-of – pocket expenses for medical and prescription drug coverage increased.
- The OP&F subsidized health care premium methodology was changed.

Health Care Eligibility

In 2007 OP&F continued to offer a health care plan to eligible retired members and their eligible dependents. Eligibility guidelines for all benefit recipients,

including surviving spouses, along with dependents and students are described below. Enrollment information is also included in this section

Benefit Recipients & Dependents

In 2007, new benefit recipients and their eligible dependents qualified for OP&F's medical plan and prescription drug benefits on the effective date of their retirement.

Surviving Spouses

Surviving spouses who receive a statutory survivor pension through OP&F are eligible for participation in the OP&F-sponsored health care program unless they are eligible for health care through another Ohio Retirement System or they were legally separated from the member on or after January 1, 2004, but are subject to limited waivers. Health care for the eligible survivors of retirants continues without interruption upon a retiree's death. Survivors of active members become eligible for OP&F's health care program on the effective date of their statutory survivor pension.

Surviving spouses who remarry are still eligible for OP&F health care as long as they are not eligible for health care through another Ohio Retirement System; however, the new spouse cannot be covered. Children born to the survivor after the member's death are also not eligible for coverage, unless the deceased member is the child's parent.

Dependents

With limited exceptions, benefit recipients must be enrolled in an individual plan in order to enroll their dependents in that plan. Effective January 1, 2004, the dependents eligible to participate in the OP&F-sponsored health care program included:

- The retiree's spouse, excluding a spouse who is eligible for health care coverage through another Ohio Retirement System or from whom the benefit recipient was legally separated on or after January 1, 2004;
- Unmarried child(ren) under 18 years of age, or under 23 if attending school and financially dependent upon the benefit recipient for support, provided the benefit recipient is the child's natural parent or the benefit recipient has legally adopted the child (the legal adoption provision does not apply to children added to coverage prior to January 1, 2004). Stepchildren who have not been legally adopted can be added to coverage on or after January 1, 2004 if the benefit recipient certifies to OP&F that coverage is not available through another parent and they meet all other eligibility guidelines; and
- A dependent child who is financially dependent upon the benefit recipient for support, regardless of age, who is unable to earn a living because of a physical or mental handicap, but only if the child became incapacitated prior to attaining age 18 (age 23 if then attending school). A disabled child over age 23 may only apply for OP&F health care at the time the benefit recipient is first eligible for OP&F health care; however, the disabled child must have met the regulations listed above prior to attaining age 23. The benefit recipient must be the child's natural parent or have legally adopted the child. The health care administrator will determine if the

child has met the requirements for eligibility and may also periodically require proof of continued disability and dependency. Benefit recipients and their enrolled dependents have the right to appeal any provider determinations.

Student Eligibility (ages 18-23)

Children 18 to 23 years of age are eligible for OP&F coverage if primarily dependent upon the benefit recipient for support, and attending an accredited institution, and enrolled for at least two-thirds of the minimum number of credit hours required to be considered a full-time student. *(NOTE: home schooling is covered if it meets applicable requirements).*

In order to verify eligibility for dependent children between these ages, benefit recipients are required to complete a Student Eligibility Form for each child for every semester or quarter and file the completed form in the time prescribed by OP&F.

Other Ohio Retirement Systems

Individuals who are eligible for medical, prescription drug or supplemental dental and vision coverage through one of the other Ohio Retirement Systems (ORS) may not be eligible for the OP&F Health Care Plan. These other systems include: Ohio Public Employees Retirement System (OPERS), School Employees Retirement System (SERS), State Highway Patrol Retirement System (SHPRS), and State Teachers Retirement System (STRS). There is no coordination of benefits between the ORS. The specific impact to members, survivors and dependent spouses is indicated below.

- *OP&F Retirees*—Benefit recipients who receive a service or disability pension from OP&F and an additional one (1) from another ORS, can participate in the OP&F-sponsored health care plan if they have more service credit with OP&F. If they have the same amount of service credit with OP&F and the other system, they can choose to participate in OP&F's Health Care Plan. Retirees cannot receive health care benefits from more than one retirement system.
- *Surviving Spouses*—If survivors receive a statutory survivor benefit from OP&F and are receiving a service or disability pension from another retirement system, they cannot participate in the OP&F Health Care Plan. If they are receiving only statutory survivor benefits from more than one system, they can enroll in the OP&F Plan.
- *Surviving Children*—Surviving children will always have primary medical coverage under the surviving spouse; however, children cannot be a dependent of more than one system. A child who is receiving a statutory survivor benefit from OP&F can participate in OP&F coverage.
- *Dependent spouses*—Dependent spouses who are active members of another Ohio Retirement System can participate in the OP&F Health Care Plan until they retire and become eligible for health care through that retirement system.
- *Dependent children*—If a child has one parent who is eligible for coverage through OP&F and another parent who is eligible for coverage through another system, the parent may select OP&F or the other system for the child's health care; however, the child cannot be a dependent of more than one system.

Waiving coverage with the intent to participate in health care sponsored by another ORS

Effective January 1, 2005, an OP&F benefit recipient who is also a benefit recipient (or a dependent of a benefit recipient) of another Ohio Retirement System may irrevocably waive OP&F health care benefits with intent to participate in the other system's health care plan.

Individuals may request to irrevocably waive OP&F sponsored coverage at any time. To do this, the individual must first obtain a written confirmation from the other Ohio Retirement System, stating that health care benefits will be offered upon enrollment. A written confirmation from the other system must then be forwarded to OP&F and an OP&F *Waiver of Health Care Benefits* form must be completed.

OP&F cannot accept postdated requests for irrevocable waivers; therefore, coverage terminates on the first of the month following OP&F's receipt of the written request if received prior to the 15th day of the month. Otherwise, it is effective the first day of the second month following its receipt. Under the current health care eligibility guidelines, any future loss of group coverage would afford an opportunity for re–enrollment into the OP&F, sponsored health care plans, provided written notification of such circumstance is received by OP&F within 60 days of the qualifying event.
Conversely, individuals who have irrevocably waived health care coverage with another Ohio Retirement System with intent to participate in the health care plan sponsored by OP&F must provide documentation of such decision. Enrollment is then limited to the established guidelines.

The arrangement between OP&F and the other Ohio Retirement Systems has changed to provide that the waiver program will continue between OP&F and STRS through December 31, 2007, but will be discontinued with STRS for the plan year beginning on January 1, 2008. In addition, OPERS has discontinued the program effective April 6, 2007 and SERS has discontinued the program effective March 1, 2007. In the future, waivers will be covered under the coordination of benefits section in OP&F's health care plan.

Current enrollment figures

As of December 31, 2007, there were 23,611 OP&F benefit recipients. Benefit recipients include both retirees and survivors. Of those, approximately 74 percent participated in the OP&F health care programs at that time. As of December 2007, the breakdown of enrollees and dependents (spouses and dependent children) was as follows:

	Number Enrolled in Health Care Program
Benefit Recipients	17,582
Dependents	9,019
TOTAL	**26,601**

Compared to enrollment figures from December 31, 2006, the OP&F-sponsored health care program had fewer enrolled participants. The total enrollment for 2006 was 28,100, or 1,499 more than the 2007 figures above. Specific plan changes were the likely reason for this decrease in enrollment. In 2007, re-employed retirees who had a health care plan available to them from an employer were eligible for the OP&F-sponsored plan. However, they

did not receive an OP&F subsidy. Also, changes in 2004 have made the cost of the OP&F-sponsored plan more closely associated with other retirement systems' plans. 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. Another reason for the decrease was that OP&F's Deferred Retirement Option Plan (DROP) kept 3,227 public safety officers on the job longer and, therefore, out of the OP&F-sponsored health care plan.

Ensuring accuracy of eligibility information

To keep OP&F files accurate, all benefit recipients enrolled in the health care plan sponsored by OP&F receives an Annual Change Period Form in the fall of each year. This form requests updates to current information, including address, covered dependents and Workers' Compensation information, Medicare Part B reimbursement information and gives the enrolled benefit recipients the opportunity to change coverage for the upcoming year.

Health Care Coverage Options

Again in 2007, OP&F sponsored health care benefits that include coverage for medical, prescription drug, dental, vision, and long-term care. Each of these optional health care benefits is described below.

Medical

In 2007, OP&F benefit recipients were able to select between two different plan administrators—Aetna POS II and Medical Mutual PPO. Both administrators covered the same types of services and also have the same deductibles and co-payments. The only difference was that different providers could participate in each network.

Anyone who resided in a network area and enrolled had to utilize 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 services were needed.

There were definite advantages for members who utilized network providers. Special, reduced fees had been negotiated with all network providers, and 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 was lower.

Benefit recipients and their enrolled dependents who utilized a provider outside of the network incurred more out-of-pocket costs. Because special fees had not been negotiated with out-of-network providers, 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.

The carriers did not have networks in all areas of the country. Benefit recipients and their enrolled dependents who resided in one of these non-network areas could still choose either Aetna POS II or Medical Mutual PPO 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 non-network providers, these benefit recipients had to file their own claim forms, pre-certify procedures and pay any difference between the provider's fee and the usual, customary and reasonable (UCR) allowance determined by the carrier (See *Appendix H* for a chart describing the various benefit levels).

Prescription Drug Coverage

Medco Health Solutions was OP&F's Pharmacy Benefit Manager (PBM) in 2007, administering the prescription drug benefits. Beginning in 2004, OP&F offered prescription drug coverage as a separate benefit with separate contribution amounts (See *Appendix G* for a chart describing the various contributions and co-pays).

The Mail Service Pharmacy Program

For the greatest savings, benefit recipients and their enrolled dependents could order

medications through the mail. The mail service program was ideal for medications taken on a regular or long-term basis. With the mail service program, there were no deductibles and no claim forms to file. Plan participants simply mailed their prescription and co-payment directly to the mail pharmacy, which then promptly processed and mailed the filled prescription. Refills could also be ordered over the phone or via the Internet.

The Retail Pharmacy Program

Medco's retail pharmacy program is designed for 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.

Supplemental Vision & Dental Plans

Routine vision and dental services are not covered under OP&F's medical plans. To supplement medical coverage, benefit recipients annually have the option of enrolling in a separate vision and dental plan. Benefit recipients and their eligible dependents may enroll in either one or both types of coverage, regardless of the administrator chosen for their medical coverage. These plans are offered in addition to the medical and prescription drug programs and have separate contribution amounts. Benefit recipients may also enroll in these plans if they do not elect to enroll in an OP&F-sponsored health care plan. Eligible dependents may only enroll in the plan(s) in which the benefit recipient is enrolled (Please see *Appendix I* for a breakdown of dental coverage and contributions, and *Appendix J* for vision coverage and contributions).

Enrollment in supplemental vision and dental plans is only permitted once every year during the Annual Change Period with coverage taking effect on January 1st of the following year. Once enrolled, benefit recipients and their eligible dependents must remain enrolled for 12 consecutive months. Appropriate deductions will be taken for that period unless there is a valid change in family status. OP&F does not subsidize the cost of these plans; therefore, those enrolled pay the full premium.

Aetna Vision Coverage

Aetna's vision plan helps pay the costs of an annual eye exam, eyeglasses, contact lenses and frames. All eligible benefit recipients and their dependents may enroll in this plan regardless of their area of residence.

Under the vision plan, benefit recipients and their enrolled dependents may visit any licensed eye care provider. Benefit recipients and their enrolled dependents pay for the vision service at the time it is received and submit a claim form to Aetna. Benefit recipients and their enrolled dependents are reimbursed for a fixed amount for covered services. In 2007, OP&F had 5,243 benefit recipients enrolled in the Aetna Vision.

Delta Dental Coverage

The Delta Dental plan provides coverage for preventive, diagnostic and basic restorative care. All benefit recipients and their eligible dependents can enroll in the dental plan, regardless of their area of residence.

Under the Delta Dental plan, benefit recipients and their enrolled dependents may choose any dentist in the country; however, the maximum benefit level is achieved by utilizing the Delta Preferred Option Network because these dentists have agreed to a discounted fee schedule. Delta Premier dentists have agreed not to charge benefit recipients and their enrolled dependents rates above the usual, customary and reasonable fees for their area, which is based on the prevailing rate charged by most dentists in the area. When utilizing a dentist who does not participate in the Delta Preferred Option Network and who is not a Delta Premier dentist, benefit recipients and their enrolled dependents will be responsible for paying directly to the dentist any amount above the average fee charged for that service. In 2007, OP&F had 7,078 benefit recipients enrolled in Delta Dental.

Coordination of Dental & Vision Benefits

Benefits under the vision and dental plans will be coordinated with those of another dental and vision plan in which a benefit recipient or eligible dependent is enrolled.

Long Term Care Coverage

To help pay the cost of long term care, OP&F offers a separate Long Term Care Plan through Aetna. This plan is available to active OP&F members, their spouses and parents; as well as current OP&F benefit recipients and their dependents. In 2007, OP&F had 205 members and/or Benefit Recipients enrolled in Long Term Care Coverage.

Long Term Care refers to a wide range of personal health care services for people of all ages who need custodial care because of a chronic illness or long-lasting disability. This does not include acute medical care, which helps people recover from an illness or injury. The OP&F-sponsored plans do not cover custodial care, and Medicaid only covers long-term care for people living at or below the poverty level. Aetna Long Term Care enrollees are eligible for benefits toward custodial nursing home expenses, home care, adult day care or other long-term care expenses with no subsidy provided by OP&F. Enrollment for this plan is handled by Aetna. Monthly premiums for Aetna's long term care are determined by a person's age at the time of enrollment and do not increase as the enrollee ages.

Annual Change Period

In the fall of every year, plan participants had the opportunity to change health care carriers or select /waive optional dental and vision coverage during the Annual Change Period. This major project involves creating a customized form for health care participants and a booklet specifically outlining the available health care plans.

Medicare 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.

Reimbursement is made in the monthly benefit payments at the current annual contribution rate. Dependent spouses are not reimbursed for the Medicare Part B premium until such time as they become a benefit recipient. In 2007, OP&F paid over $12.7 million in Medicare B reimbursements.

When becoming eligible for Medicare Part B, benefit recipients must send OP&F a copy of their Medicare card (or a letter from Medicare) and a properly completed Medicare Part B Reimbursement Statement in an OP&F-approved format or Medicare billing statement. OP&F typically sends the Medicare Part B Reimbursement Statement to benefit recipients three months prior to their 65th birthday. Upon notification of a retiree's death, the surviving spouse will receive instructions regarding applying for the Medicare Part B reimbursement. Reimbursement will begin when OP&F receives the information indicated above. The Board of Trustees has determined that OP&F will not make retroactive reimbursements.

Medicare Part D Subsidy

The Centers for Medicare & Medicaid Services began offering a new prescription drug plan (Medicare Part D) to Medicare eligible retirees to be effective January 1, 2006. The OP&F Board of Trustees reviewed the prescription drug options for Medicare Part D and decided to file for the 28 percent subsidy offered to plan sponsors such as OP&F for prescription drug expenses incurred in 2007.

The 28 percent subsidy is only allowed for prescription drug expenses incurred by retirees who chose to stay with the OP&F-sponsored prescription drug plan. If a retiree is eligible for Medicare Part D, they must decide to enroll in either Medicare Part D or stay with the OP&F-sponsored prescription drug plan. The retiree cannot be enrolled in both.

The application process began in September 1, 2005 to be completed by September 30, 2005. However, CMS granted a one-time extension until October 31, 2005. Among the qualifications for subsidy is that a qualified actuary submits attestation to CMS that the OP&F plan's actuarial value is at least equal to the actuarial value of the defined standard prescription drug plan under Medicare Part D. The actuary, member of the American Academy of Actuaries, certified that OP&F was actuarially equivalent. Therefore, a Notice of Creditable Coverage was provided to all OP&F retirees within the Annual Change Period communications.

In 2007, OP&F received $9.1 million in subsidy dollars to be deposited into the Health Care Stabilization Fund. However, CMS requires a reconciliation of cost reporting for the subsidy within 15 months of the 2007 plan year. The final subsidy amount may fluctuate slightly once the reconciliation is complete due to year-end cost adjustments.

Appendix A

Statutory Authority for Health Care Benefits

§ 742.45. Deduction 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) 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 medical insurance coverage under part B of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, an amount equal to the basic premiums for such coverage.

(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

	2002-2007					
	2002	**2003***	**2004**	**2005**	**2006**	**2007**
Additions:						
Employer Contributions	$118,459,642	$120,601,889	$125,183,522	$128,183,051	$138,940,502	$121,721,828
Benefit Rec. Contributions	12,623,875	17,207,506	55,665,341	55,271,881	58,532,848	56,031,875
Investment Income	(23,046,110)	54,510,471	34,394,433	27,984,135	62,735,803	49,938,228
Recoveries and Rebates	2,761,990	3,486,487	7,320,704	3,873,264	14,648,983	13,629,565
TOTAL ADDITIONS	110,799,397	195,806,353	222,564,000	215,312,331	274,858,136	241,321,496
Deductions						
Health care Expenses	153,651,881	168,060,654	157,839,137	163,311,330	178,906,570	149,237,194
Administrative Expenses	2,246,504	2,169,777	2,212,590	2,535,171	2,393,497	1,683,560
TOTAL DEDUCTIONS	155,898,385	170,230,431	160,051,727	165,846,501	181,300,067	150,920,754
Net Increase/Decrease	(45,098,988)	25,575,922	62,512,273	49,465,830	93,558,069	90,400,742
Net assets held in trust for post employment health care benefits:						
Balances						
Beginning of year	250,585,001	205,486,013	231,061,935	293,574,208	343,040,038	436,598,107
End of year	**$205,486,013**	**$231,061,935**	**$293,574,208**	**$343,040,038**	**$436,598,107**	**$526,998,849**

**As a result of an audit adjustment, the 2003 financial figures were amended.*

Appendix C

Accounting, Asset Valuation and Funding Methods

1. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by the Ohio Police & Fire Pension Fund (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. Short-term investments are valued at cost, which approximates 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 is 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 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 exempt from federal income taxes under Section 501(a) of the Internal Revenue Code.

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, further adjusted if necessary, to be within 10 percent of the market value for 2005 and 20 percent of the market value thereafter.

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 6.75 percent of active member payroll; all benefit recipient health care contributions, as well as an equal share of investment income to the balance of the Health Care Stabilization Fund (HCSF). The HCSF is charged with all health care expenses and administrative costs. As of December 31, 2007, the balance in the HCSF was $526,998,849.

Appendix D

Plan Net Assets Available for Post-Employment Health Care Benefits, as of December 31, 2007 (un-audited)

Assets:	Cash and Short-term Investments	$19,153,766
Receivables:	Employers' Contributions	35,136,963
	Accrued Investment Income	1,484,861
	Investment Sales Proceeds	1,537,901
	Total Receivables	**38,159,725**
Investments, at fair value:	Bonds	61,420,999
	Mortgage & Asset Backed Securities	42,530,231
	Stocks	210,115,734
	Real Estate	40,597,805
	Commercial Mortgage Funds	2,474,102
	Venture Capital	14,108,608
	International Securities	127,241,324
	Total Investments	**498,488,803**
	Collateral on Loaned Securities	60,411,031
	TOTAL ASSETS	**616,213,325**
Liabilities:	Health Care Payable	15,723,911
	Investment Commitments Payable	13,079,534
	Obligations Under Securities Lending	60,411,031
	TOTAL LIABILITIES	**89,214,476**
Net assets held in trust for Post-employment healthcare benefits:		**$ 526,998,849**

Appendix E

Statement of Changes in Plan Net Assets Available for Post-Employment Health Care Benefits (Year ending December 31, 2007)

Additions:	*From Contributions:*	
	Employers'	$ 121,721,828
	Member Health Care Premiums	56,031,875
	Total Contributions	**177,753,703**
	From Investment Income:	
	Net Appreciation (Depreciation) of Fair Value of Investments	38,151,152
	Bond Interest	5,514,027
	Dividends	4,334,248
	Real Estate Operating Income, net	1,497,117
	Foreign Securities	72,343
	Other	1,523,760
	Less Investment Expenses	(1,358,468)
	Net Investment Income (Loss)	**49,734,179**
	From Securities Lending Activities:	
	Securities Lending Income	4,292,714
	Securities Lending Expense:	
	Borrower Rebates	(4,026,168)
	Management Fees	(62,497)
	Total Securities Lending Expense	(4,088,665)
	Net Income from Securities Lending	204,049
	Interest on Local Funds Receivable	
	Other Income	13,629,565
	TOTAL ADDITIONS	**241,321,496**
Deductions:	Benefits:	
	Health Care	149,237,194
	Administrative Expenses	1,683,560
	TOTAL DEDUCTIONS	**150,920,754**
	Net Increase (Decrease)	$ 90,400,742

Net assets held in trust for post-employment healthcare benefits:	
Balance, Beginning of year	$ 436,598,107
Balance, End of year	**$ 526,998,849**

Appendix F

Health Care Funding Policy

The Ohio Police & Fire Pension Fund 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 Health Care Stabilization Funds 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 the membership's understanding of the issues surrounding the funding of health care benefits.

Appendix G

2007 Premiums & Contributions

If a member or their spouse is employed and eligible for medical or prescription drug coverage through the employer, they can participate in the OP&F–sponsored health care plan. However, OP&F will not subsidize the health care contributions. Also, if a member's spouse is eligible for medical or prescription drug coverage though his or her retirement system, as long as it is not another Ohio retirement system (ORS), he or she will be eligible for the OP&F–sponsored health care plan but will be responsible for paying the full premium.

Full premiums for OP&F–sponsored medical and prescription drug coverage

The chart below outlines the full premiums paid by the benefit recipient for both the Aetna and Medical Mutual medical coverage and Medco prescription drug coverage for 2007. Figures shown may vary slightly due to rounding.

	Not eligible for Medicare		*Medicare eligible*	
	Full premium for medical coverage	**Full premium for prescription drug coverage**	**Full premium for medical coverage**	**Full premium for prescription drug coverage**
Benefit Recipient	$575.66	$218.25	$110.33	$218.25
Spouse	$381.09	$205.58	$93.03	$205.58
Child(ren)	$199.18	$61.11	$93.03	$61.11

Contribution rates for the 2007 OP&F–sponsored medical and prescription drug plans will be based on when the member retired or began receiving OP&F benefits. If the member began receiving OP&F benefits on or prior to July 24, 1986, OP&F will subsidize the health care premium 75 percent for the benefit recipient and 50 percent for the benefit recipient's eligible dependents. If the OP&F member began receiving benefits on or after July 25, 1986, OP&F will subsidize 75 percent of the benefit recipient's premium and 25 percent for the benefit recipient's eligible dependents' premium.

Medical contribution rates

The chart below outlines the monthly contribution amounts that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage of both the Aetna and Medical Mutual plans for 2007. Figures shown may vary slightly due to rounding.

	Not eligible for Medicare		*Medicare eligible*	
	Benefit recipient's monthly contribution	**OP&F's monthly subsidized amount**	**Benefit recipient's monthly contribution**	**OP&F's monthly subsidized amount**
Benefit Recipient	$143.92	$431.74	$27.58	$82.77
Spouse	$190.55	$190.54	$46.52	$46.51
Child(ren)	$99.59	$99.59	$46.52	$46.51

Prescription Drug co-pays

Formulary	Co-pay for retail (up to a 30-day supply)	Co-pay for retail (up to a 90-day supply)
Generic	$5 co-pay	$10 co-pay
Preferred	$20 co-pay	$40 co-pay
Non-Preferred	$30 co-pay	$60 co-pay

Prescription Drug contribution rates
Began receiving benefits PRIOR to July 23, 1986:

	Not eligible for Medicare		*Medicare eligible*	
	Benefit recipient's monthly contribution	**OP&F's monthly subsidized amount**	**Benefit recipient's monthly contribution**	**OP&F's monthly subsidized amount**
Benefit Recipient	$54.56	$163.69	$54.56	$163.69
Spouse	$102.79	$102.80	$102.79	$102.80
Child(ren)	$30.56	$30.55	$30.56	$30.55

Began receiving benefits AFTER to July 23, 1986:

	Not eligible for Medicare		*Medicare eligible*	
	Benefit recipient's monthly contribution	**OP&F's monthly subsidized amount**	**Benefit recipient's monthly contribution**	**OP&F's monthly subsidized amount**
Benefit Recipient	$54.56	$163.69	$54.56	$163.69
Spouse	$154.19	$51.40	$154.19	$51.40
Child(ren)	$45.83	$15.28	$45.83	$15.28

Contribution Discount Program

OP&F's Contribution Discount Program offers a reduction in the contribution level for benefit recipients with total annual "household income" under an amount established annually by the Board of Trustees, which in 2007 was 30 percent in each coverage category.

Annually, benefit recipients must apply for the contribution discount. Benefit recipients who enroll in health care and prescription drug benefits sponsored by OP&F throughout the year may apply for the discount when they enroll. However, to qualify OP&F must receive a completed *Application for Health Care Contribution Discount* within 90 days from the date that OP&F sent the application. In 2007, 426 benefit recipients received the contribution discount for health care and 402 received the contribution discount for prescription drugs.

Appendix H

Comparing in–network, out–of–network and non–network benefits

Benefit recipients and dependents enrolled in Aetna or Medical Mutual in 2007 may have experienced a difference in coverage between in–network, out–of–network and non–network providers as outlined in the below chart.

	In-Network ▼	Out-of-Network ▼	Non-Network ▼
Annual Deductible ($2.5 million lifetime maximum per person) ****			
Individual / family	$500 / $1,000	$1,000 / $2,000	$500 / $1,000
Co-Insurance limit	$1,500 / $3,000	$5,000 / $10,000	$1,500 / $3,000
Co-Insurance	80%	50%	80%
Physician Services			
Office visit	$30 / 100%	50%	80%
Emergency Care			
Emergency department	$100 / 80%	$100 / 80%	$100 / 80%
Non-emergency services rendered in emergency room	$100 / 50%	$100 / 50%	$100 / 50%
Urgent care	$50 / 80%	50%	80%
Hospital In-Patient Services			
Prior admission testing	80%	50%	80%
Scheduled in-patient admit	$250 / 80%	$250 / 50% ***	$250 / 80%
Emergency in-patient admit *	$250 / 80%	$250 / 80%	$250 / 80%
Ambulatory Services			
Diagnostic lab / x-ray	80%	50%	80%
Ambulatory surgery center	$150 / 80%	50%	$150 / 80%
Mental Health (No annual maximum) and Substance Abuse ($3,100 annual maximum)			
Scheduled in-patient admit	$250 / 80%	$250 / 50% ***	$250 / 80%
Emergency in-patient admit *	$250 / 80%	$250 / 80%	$250 / 80%
Out-patient	$30 co-pay/visit/80%	50%	$30 co-pay/visit/80%
Out-patient mental / drug	$30 co-pay/visit/80%	50%	$30 co-pay/visit/80%
Out-patient alcohol	$30 co-pay/visit/80%	50%	$30 co-pay/visit/80%
Preventive Care			
Carrier Standard	Office visit co-pay/100%	50%	80% office visit/100% lab
Other Services			
Therapies	$30 co-pay/visit/80%	50%	$30 co-pay/visit/80%
Chiropractor	$30 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% (120 hours/year)	50% (120 hours/year)	80% (120 hours/year)
Skilled nursing facility	$250 / 80%	$250 / 50%***	$250 / 80%
Sub-acute rehabilitation center	$250 / 80%	$250 / 50%***	$250 / 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.*

**** $200 penalty applied if scheduled admission to non–participating hospital is not pre–certified through the carrier.*

***** The most that will be paid under the health care plan for any person during his or her lifetime commencing on Jan. 1, 2007, which excludes previous claims prior to Jan. 1, 2007.*

Appendix I

Supplemental Dental Plan Design/Premium Amounts

As shown below, enrolled members receive the maximum benefit level when utilizing the Delta Preferred Option Network.

	DeltaPreferred Option	DeltaPremier	Non-network Dentist
Deductible*	$50 single/$150 family	$100 single/$300 family	$100 single/$300 family
Calendar Year maximum per person**	$1,500 per person	$750 per person	$750 per person
Class I Benefits			
Diagnostic Services	100% (with no deductible)	75% (with no deductible)	75% (with no deductible)
Preventive Services	100% (with no deductible)	75% (with no deductible)	75% (with no deductible)
Emergency Palliative	100% (with no deductible)	75% (with no deductible)	75% (with no deductible)
Radiographs	100% (with no deductible)	75% (with no deductible)	75% (with no deductible)
Class II Benefits			
Oral Surgery	80% (after deductible)	50% (after deductible)	50% (after deductible)
Minor Restorative	80% (after deductible)	50% (after deductible)	50% (after deductible)
Periodontics	80% (after deductible)	50% (after deductible)	50% (after deductible)
Endodontics	80% (after deductible)	50% (after deductible)	50% (after deductible)
Class III Benefits			
Prosthodontics	50% (after deductible)	30% (after deductible)	30% (after deductible)
Major Restorative	50% (after deductible)	30% (after deductible)	30% (after deductible)

** These are not separate deductibles by type of dentist. Once the lowest deductible has been met, only the additional amount required under the higher deductible must be met.*

*** These are not separate maximums by type of dentist. Once the lowest maximum payment has been met, only the additional amount under the higher maximum payment is available by seeking treatment from a Delta Preferred Option dentist.*

Supplemental Dental Plan Premium Amounts

	Delta Dental
Benefit Recipient (including survivors)	$23.21
Benefit Recipient & Spouse	$43.78
Benefit Recipient & Child(ren)	$45.60
Benefit Recipient, Spouse & Child(ren)	$76.21

Appendix J

Supplemental Vision Plan Design/Premium Amounts

	Aetna	EyeMed Vision Care**
Supplemental vision coverage pays:		
Routine eye exam (every 12 months)*	$50	$0
Frames (one pair every 24 months)	$78 for one pair every 24 months	$5 co-pay (covers up to a regular retail value of $130)
Lenses		
Single vision	$35	$5 co-pay
Bifocals	$55	$5 co-pay
Trifocals	$75	$5 co-pay
Lenticular	$100	$5 co-pay
Contact lenses	$180	$10 co-pay (covers up to a retail value of up to $200 and is instead of eyeglass lenses and frames)

** Routine eye exam only. If the doctor determines that there is a related medical condition at the time of the exam, (i.e. glaucoma, cataracts, etc.) the claim will not be paid under this supplemental vision plan. The claim may be paid, however, under medical coverage, subject to the deductibles of that plan.*

*** Exam and prescription for eyeglass lenses are covered. If receiving a contact lens exam, the member is responsible for paying the fees associated with fitting and follow–up. Dilated fundus exams are also included, if required.*

Supplemental Vision Plan Premium Amounts

	Aetna Vision
Benefit Recipient (including survivors)	$3.71
Benefit Recipient & Spouse	$7.42
Benefit Recipient & Child(ren)	$6.29
Benefit Recipient, Spouse & Child(ren)	$10.00

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