Health Care Report 2004

Presented to the
Ohio Retirement Study Council

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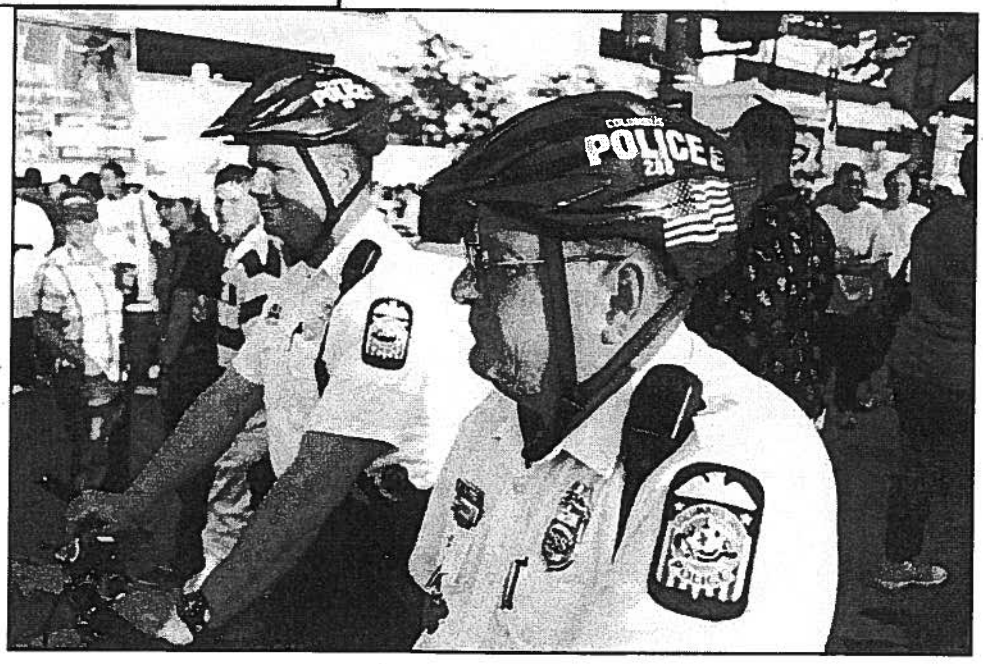

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INTRODUCTION

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. In 2004, a new health care plan was implemented and was designed to ensure that OP&F had the necessary funding to continue to make health care available to current and future retirees for the next 10 years. In 2004, a total of 29,708 retirees, survivors and their eligible dependents were enrolled in health care benefits sponsored by OP&F. The prescription drug plan sponsored by OP&F had 28,831 persons enrolled in 2004.

As required by ORC 742.14(E), OP&F has prepared this report to provide information regarding the health care program offered to OP&F members in 2004. The report also focuses on the methods used by OP&F for funding health care benefits and plans into the future. 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, the report also discusses eligibility, a description of the plans available, and specific OP&F financial information.

30 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, Ohio Revised Code Section (ORC) 742.45). At that time, the plan was offered through Aetna Health Plans.

Beginning 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. In 2004, two Preferred Provider Organization (PPO) Networks, three Health Maintenance Organizations (HMOs) and one Medicare HMO was available. 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, and their surviving spouse(s)/orphans.

HEALTH CARE FUNDING

When OP&F began sponsoring health care benefits in 1974, health care expenditures were approximately $3 million. Thirty years later, in 2004, OP&F health care expenses totaled nearly $158 million. The cost per health care participant rose to $5,313 in 2004, a 12.3 percent increase over 2003. 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.

As required by statute, this report includes the following financial information: *Accounting, Asset Valuation and Funding Methods* (See *Appendix C*), *Plan Net Assets Available for Post employment Health Care Benefits* (See *Appendix D*), and *Statement of Changes in Plan Net Assets Available for Post employment Health Care Benefits* (See *Appendix E*).

Health Care Financing: History

OP&F began to sponsor health care benefits in 1974. The original plan remained relatively unchanged until 1992, when the OP&F Board of Trustees implemented monthly medical expense benefit 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.

Preferred Provider Organizations (PPOs) were also introduced in 1992. 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.

The introduction of 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 had 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. 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 be depleted by 2007 unless changes were made to the funding mix in place at the time. As a result, the Board determined an appropriate mix among the three health care funding

sources—employer contributions, investment income, and benefit recipient contributions—to allow OP&F a solvency period of 10 years to provide health care to eligible members.

Health Care Financing: Current

Effective January 2004, to preserve the Health Care Stabilization Fund, additional changes to the health care programs were implemented. 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. Additionally, a retiree or their surviving spouse/orphan child could opt for health care and/or prescription drugs coverage separately.

As of December 31, 2004, the OP&F Health Care Stabilization Fund had a balance of $293,574,208. This balance was a result of interest generated, along with retiree contributions, rebates and recoveries, and 7.75 percent of employer contributions expressed as a percentage of payroll. This represented an increase in the balance from 2003 of 27 percent ($62.5 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 2004, non-investment earnings generated $188,169,567 in revenue to fund health care. Benefit recipients contributed 35.3 percent toward OP&F's overall health care costs. The remainder, 64.7 percent, was paid from the Health Care Stabilization Fund, which included employer contributions (7.75 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 Preferred Provider Organization (PPO) 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. HMOs are not self-funded and, therefore, assume the risk for claims dollars while OP&F pays a monthly charge. 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 eligible members for the next 10 years.

Health Care Financing: Cost saving measures

The plan changes initiated 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 subsidy levels were established. As a benefit recipient ages, their subsidy level would increase until they reach the highest level available, which is 75 percent for the retired member, and 50 percent for dependents. These levels are shown on the *Subsidy Level Chart* (See *Appendix F*).

Under the plan changes for 2004, 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. Specific contribution amounts and eligibility levels are shown in the *Medical Plan Contributions/Premiums* charts (See *Appendix G*).

OP&F subsidized the cost of Option 1 (the base PPO plan) at 75% for the benefit recipient and 50% for spouses and enrolled dependents (as long as the benefit recipient was not eligible for health care through an employer). To maintain equality from a funding standpoint and fairness to all, benefit recipients selecting a higher cost program (Options 2 and 3) paid the difference in the cost. If this were not the case, OP&F would be providing a higher level of benefits to those selecting these higher cost plans.

Within the prescription drug plan offered in 2004, OP&F employed several cost savings measures, including a prior authorization program that saved money for OP&F and the member. In order to offer more choices, the prescription drug plan featured an open formulary. Under the open formulary, members that chose to do so could obtain non-preferred, brand name drugs in exchange for paying higher co-pays.

Eligibility for enrollment in the OP&F-sponsored health care plan became more selective in 2004, and the opportunities for re-enrollment were significantly reduced. Enrollment opportunities include:

- At the time of the benefit recipient's retirement;
- Three years after the benefit recipient's OP&F retirement, if the benefit recipient retired on or after Jan. 1, 2004;
- 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 are 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 2004. However, they would become responsible for paying the full premium with no OP&F-provided subsidy.

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.

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 who 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.

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 H*) 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.

Because OP&F's Board of Trustees is committed to providing retirees with access to quality, cost effective health care programs, they reaffirmed their policy stating that the Health Care Stabilization Fund would be considered adequate if it is forecasted to be solvent for at least 10 years.

HEALTH CARE ELIGIBILITY

Benefit Recipients & Dependents
In 2004, benefit recipients and their eligible dependents qualified for OP&F's Preferred Provider Organization (PPO) 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. Health care for the eligible surviving spouses 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 father.

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 after 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 Ohio Retirement Systems. 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 another one of the Ohio retirement systems, 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.

Current enrollment figures

As of December 31, 2004, there were 23,167 OP&F benefit recipients. Benefit recipients include both retirees and survivors. Of those, approximately 80 percent participated in the OP&F health care programs at that time. As of December 2004, the breakdown of enrollees and dependents was as follows:

	Number Enrolled in Health Care Program
Benefit recipients	18,462
Dependents	11,246
TOTAL	29,708

Compared to enrollment figures from December 31, 2003, the OP&F-sponsored health care program had fewer enrolled participants. The total enrollment for 2003 was 35,513, or 5,805 more than the 2004 figures above. Specific plan changes were the likely reason for this decrease in enrollment. In 2004, 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) was keeping some 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 any OP&F medical expense benefits program 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, and gives the enrolled benefit recipients the opportunity to change coverage or plans for the upcoming year.

HEALTH CARE COVERAGE OPTIONS

OP&F sponsors health care benefits that include coverage for medical, prescription drug, dental, vision and long-term care. These benefits are described below.

Medical
Based on their area of residence, a choice between two different types of plans for medical coverage are available, a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). Each includes three different options for coverage. Both provide comprehensive coverage for expenses resulting from ordinary diseases, serious or prolonged disabilities, hospitalization and skilled nursing care.

Health Maintenance Organizations (HMOs)
Health Maintenance Organizations (HMOs) provide comprehensive health care coverage, including preventive care services, diagnostic testing, and medical/surgical services. In addition, there are no deductibles to meet, and most services are paid 100 percent after a co-payment. Eligibility for these HMOs depends on a benefit recipient's area of residence. In 2004, OP&F offered HMOs through three different providers—Aetna, Kaiser Permanente and Paramount. (See Appendix I, *Health Maintenance Organizations (HMO)* plan designs).

Medicare HMOs
OP&F also offers a Medicare HMO to Medicare eligibles residing in certain areas through Paramount. Paramount actually administers Medicare benefits, instead of Medicare. Paramount obtains this right by entering into a contract with the Centers for Medicare and Medicaid Services (CMS), an agency of the Federal government. The government then pays a fixed monthly amount for each Medicare plan enrollee to Paramount. The payment made by the government is based primarily on how much it would cost the Medicare program if the Medicare beneficiary received services under the traditional fee-for-service program and the location of the HMO. Benefit recipients and dependents are still Medicare beneficiaries if they enroll in a Medicare HMO. The Medicare HMOs cover all services covered by traditional Medicare.

Preferred Provider Organizations (PPO)
The Preferred Provider Organization (PPO) is a group of independent doctors, hospitals and other health care providers who have agreed to offer their services at set, discounted fees under contract with a network administrator.

In 2004, OP&F benefit recipients were able to select between two different administrators when enrolling in the PPO plan—Aetna and Medical Mutual. Both administrators cover the same types of services and also have the same deductibles and co-payments. The only difference is that different providers may participate in each network.

Anyone who resided in a network area and enrolled in the PPO must utilize participating network providers to receive maximum benefits. Under the PPO, a plan participant simply chooses a doctor or hospital from the administrator's provider listing at the time services are needed.

There were definite advantages for those 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 fee. 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 utilizing a provider outside of the network would incur more out-of-pocket costs. Because special fees had not been negotiated with out-of-network providers, benefit recipients and their enrolled dependents had a lower benefit level and would be responsible for paying any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined.

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 or Medical Mutual 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. When utilizing non-network providers, these benefit recipients and their enrolled dependents had to file their own claim forms, pre-certify themselves and pay any difference between the provider's fee and the usual, customary and reasonable (UCR) allowance determined by the carrier (See *Appendix J* for a chart describing the various PPO benefit levels).

Prescription Drug Coverage

AdvancePCS/Caremark administered prescription drug benefits in 2004. Beginning in 2004, OP&F offered prescription drug coverage as a separate benefit with separate contribution amounts. Prescription drug coverage included a choice of two types of programs and three benefit plan design options (See *Appendix K* for a chart describing the various benefit levels).

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

The AdvancePCS/Caremark retail pharmacy program was for medications that would be taken on a short-term or immediate need basis. Participants realized a savings when utilizing the retail program, however, the co-payments were higher than with the mail service.

AdvancePCS/Caremark's retail program featured a network of quality pharmacies throughout the country. With this program, participants could utilize any pharmacy, although, they 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 L* for a breakdown of dental coverage and contributions, and *Appendix M* 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 then submit a claim form to Aetna. Benefit recipients and their enrolled dependents are then reimbursed for a fixed amount for covered services.

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 DeltaPreferred Option Network because these dentists have agreed to a discounted fee schedule. DeltaPremier dentists have agreed not to charge benefit recipients and their enrolled dependents rates above the usual, customary and reasonable (UCR) 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 DeltaPreferred Option Network and who is not a DeltaPremier 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.

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.

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. 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 have the opportunity to change health care carriers or options and select or 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 plans available in their area of residence.

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 O.R.C. Section 742.45 (B), See Appendix A), if not receiving reimbursement from another source. Reimbursement is made in the monthly benefit payments at the current annual contribution rate, or the rate that the person is being charged, whichever is less. Dependent spouses are not reimbursed for the Medicare Part B premium until such time as they become a benefit recipient. In 2004, OP&F paid out over $8.2 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.

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

	1999-2004					
	1999	2000	2001	2002	2003*	2004 (un-audited)
Additions:						
Employer Contributions	$91,109,660	$101,205,133	$109,036,669	$118,459,642	$120,601,889	$125,183,522
Benefit Rec. Contributions	5,518,098	5,657,431	6,874,699	12,623,875	17,207,506	55,665,341
Investment Income	22,726,931	(3,130,947)	(10,416,465)	(23,046,110)	54,510,471	34,394,433
Recoveries and Rebates	--	--	645,533	2,761,990	3,486,487	7,320,704
TOTAL ADDITIONS	119,354,689	103,731,617	106,140,436	110,799,397	195,806,353	222,564,000
Deductions						
Health care Expenses	100,522,731	111,817,485	129,173,470	153,651,881	168,060,654	157,839,137
Administrative Expenses	2,817,126	3,192,119	3,114,771	2,246,504	2,169,777	2,212,590
TOTAL DEDUCTIONS	103,339,857	115,009,604	132,288,241	155,898,385	170,230,431	160,051,727
Net Increase/Decrease	16,014,832	(11,277,987)	(26,147;805)	(45,098,988)	25,575,922	62,512,273
Net assets held in trust for post employment healthcare benefits:						
Balances						
Beginning of year	271,995,961	288,010,793	276,732,806	250,585,001	205,486,013	231,061,935
End of year	**$288,010,793**	**$276,732,806**	**$250,585,001**	**$205,486,013**	**$231,061,935**	**$293,574,208**

**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 - Member and employer contributions are recorded 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 2003 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 7.75 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, 2004, the balance in the HCSF was $293,574,208.

APPENDIX D

Plan Net Assets Available for Post-Employment Health Care Benefits, as of December 31, 2004 (un-audited)

Assets:	Cash and Short-term Investments	$14,388,362
Receivables:	Employers' Contributions	32,339,360
	Members' Contributions	-
	Accrued Investment Income	776,624
	Investment Sales Proceeds	1,012,983
	Local Funds Receivable	-
	Total Receivables	**34,128,967**
Investments, at fair value:	Bonds	37,600,028
	Mortgage & Asset Backed Securities	10,111,904
	Stocks	135,582,635
	Real Estate	15,818,683
	Commercial Mortgage Funds	2,776,725
	Venture Capital	5,393,116
	International Securities	60,321,790
	Total Investments	**267,604,881**
	Collateral on Loaned Securities	57,796,607
Capital Assets:	Land	90,969
	Building and Improvements	602,323
	Furniture and Equipment	127,480
	Computer Software and Hardware	186,411
	Accumulated Depreciation	(229,916)
	Total Capital Assets, Net	777,267
	Prepaid Expenses and Other	6,379
	TOTAL ASSETS	**374,702,462**
Liabilities:	Medical Benefits Payable	14,028,550
	Investment Commitments Payable	4,495,929
	Accrued Administrative Expenses	273,185
	Death Benefit Fund	---
	Other Liabilities	325,579
	DROP Liabilities	4,208,404
	Obligations Under Securities Lending	57,796,607
	TOTAL LIABILITIES	**81,128,254**
Net assets held in trust for Post-employment healthcare benefits:		**$ 293,574,208**

APPENDIX E

Statement of Changes in Plan Net Assets Available for Post-Employment Health Care Benefits (Year ending December 31, 2004).

Additions:	*From Contributions:*	
	Employers'	$ 125,183,522
	Members'	-
	State of Ohio – Subsidies	-
	Health Care	55,665,341
	Total Contributions	**180,848,863**
	From Investment Income:	
	Net Appreciation (Depreciation) of Fair Value of Investments	29,662,642
	Bond Interest	2,716,215
	Dividends	1,965,795
	Real Estate Operating Income, net	546,300
	Foreign Securities	5,644
	Other	206,169
	Less Investment Expenses	(806,937)
	Net Investment Income (Loss)	**34,295,828**
	From Securities Lending Activities:	
	Securities Lending Income	900,341
	Securities Lending Expense:	
	Borrower Rebates	(770,716)
	Management Fees	(31,020)
	Total Securities Lending Expense	(801,736)
	Net Income from Securities Lending	98,605
	Interest on Local Funds Receivable	
	Other Income	7,320,704
	TOTAL ADDITIONS	**222,564,000**
Deductions:	Benefits:	
	Retirement	-
	DROP	-
	Disability	-
	Health Care	157,839,137
	Survivor	-
	Death Benefit Fund	-
	Contribution Refunds	-
	Administrative Expenses	2,212,590
	Other Expenses	-
	TOTAL DEDUCTIONS	**160,051,727**
	Net Increase (Decrease)	62,512,273
Net assets held in trust for post-employment healthcare benefits:		
	Balance, Beginning of year	231,061,935
	Balance, End of year	**$ 293,574,208**

APPENDIX F

2004 Contribution Levels

The amount of the full premium for each health care option that OP&F subsidizes for members who retired on or after January 1, 2004, depends upon when they retire, as well as their age and years of service at retirement. OP&F's Health Care Plan phases in subsidy level changes over a five-year period, as shown on the chart. As members age, their subsidy will increase until they eventually reach the full level of subsidy, which is 75% for the retiree and 50% for dependents. Benefit recipients will automatically move to the next level five years after their date of retirement. OP&F does not subsidize health care costs for retirees who are employed and eligible for health care through their employer.

Charts on the following pages indicate the actual monthly contributions rates in 2004 for benefit recipients who are eligible for these levels.

Subsidy Level Chart

	Level 1	Level 2	Level 3*
If your Age at Retirement + Years of Service at Retirement =	**77 and below**	**78-82**	**83 or higher**
And you retire in:	**You will pay this much of the full premium:**		
2004			
Benefit Recipient	62.5%	43.75%	25%
Spouse & Child(ren)	75%	62.5%	50%
2005			
Benefit Recipient	70%	47.5%	25%
Spouse & Child(ren)	80%	65%	50%
2006			
Benefit Recipient	77.5%	51.25%	25%
Spouse & Child(ren)	85%	67.5%	50%
2007			
Benefit Recipient	85%	55%	25%
Spouse & Child(ren)	90%	70%	50%
2008			
Benefit Recipient	92.5%	58.75%	25%
Spouse & Child(ren)	95%	72.5%	50%
2009			
Benefit Recipient	100%	62.5%	25%
Spouse & Child(ren)	100%	75%	50%

** The following are automatically eligible for the Level 3 subsidy: disability recipients, regardless of their retirement date; Medicare eligibles; all members who retired prior to January 1, 2004; and all surviving spouses and children, regardless of the member's date of death or retirement.*

APPENDIX G

Medical Plan contributions and premiums

Level 1 contributions chart, 2004

These are the actual monthly contribution rates for benefit recipients who retired under a service retirement in 2004 and whose age, plus years of service at retirement is below 77:

	Option 1			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$257.66	$231.84	$229.55	$228.58
Spouse	$214.01	$194.75	$190.67	$189.86
Child(ren)	$109.50	$141.76	$97.55	$97.14

	Option 2			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$288.36	$251.91	$234.71	$251.85
Spouse	$235.02	$208.79	$194.24	$205.96
Child(ren)	$119.87	$151.41	$99.38	$105.38

	Option 3			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$318.63	$265.34	$248.74	$267.37
Spouse	$255.73	$218.20	$203.95	$216.70
Child(ren)	$130.09	$157.86	$104.35	$110.88

Level 2 contributions chart, 2004

These are the actual monthly contribution rates for benefit recipients who retired under a service retirement in 2004 and whose age, plus years of service at retirement is between 78-82:

	Option 1			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$180.36	$162.29	$160.69	$160.01
Spouse	$178.34	$162.29	$158.89	$158.22
Child(ren)	$91.25	$123.51	$81.29	$80.95

	Option 2			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$211.06	$182.36	$165.85	$183.28
Spouse	$199.35	$176.33	$162.46	$174.32
Child(ren)	$101.62	$133.16	$83.12	$89.19

	Option 3			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$241.33	$195.79	$179.88	$198.80
Spouse	$220.06	$185.74	$172.17	$185.06
Child(ren)	$111.84	$139.61	$88.09	$94.69

Level 3 contributions chart, 2004

These are the actual monthly contribution rates for benefit recipients who retired under a service retirement in 2004 and whose age, plus years of service at retirement is 83 or more. In addition, the following are automatically eligible for the Level 3 subsidy: disability recipients, regardless of their retirement date; Medicare eligibles; all members who retired prior to Jan. 1, 2004; and all surviving spouses and children, regardless of the member's date of death or retirement date.

	Option 1			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$103.07	$92.74	$91.82	$91.43
Spouse	$142.68	$129.84	$127.11	$126.58
Child(ren)	$73.00	$105.26	$65.04	$64.76
Eligible For Medicare				
Benefit Recipient	$26.21	$128.37	$76.29	$62.35
Spouse	$44.30	$142.01	$110.63	$96.69
Child(ren)	$44.30	$142.01	$110.63	$83.10

	Option 2			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$133.77	$112.81	$96.98	$114.70
Spouse	$163.69	$143.88	$130.68	$142.68
Child(ren)	$83.37	$114.91	$66.87	$73.00
Eligible For Medicare				
Benefit Recipient	$40.32	$144.22	$76.29	$71.32
Spouse	$55.99	$156.27	$110.63	$105.66
Child(ren)	$55.99	$156.27	$110.63	$91.20

	Option 3			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$164.04	$126.24	$111.01	$130.22
Spouse	$184.40	$153.29	$140.39	$153.42
Child(ren)	$93.59	$121.36	$71.84	$78.50
Eligible For Medicare				
Benefit Recipient	$73.60	$154.12	$109.57	$77.31
Spouse	$83.55	$165.18	$143.91	$111.65
Child(ren)	$83.55	$165.18	$143.91	$96.61

*If the Medicare eligible benefit recipient and/or dependent resides in a county where Paramount offers a Medicare HMO, the rates were different (Lucas and Wood Counties in Ohio and Monroe County in Michigan). The monthly rates for Medicare eligibles who reside in these counties will be - LEVEL 3: Options 1 & 2, Benefit Recipient: $20.25 and Spouse/ Dependent: $40.51; and Option 3, Benefit Recipient: $39.07 and Spouse/Dependent: $59.33. Full Premiums: Options 1 & 2, Benefit Recipient: $81.01 and Spouse/ Dependent: $81.01; and Option 3, Benefit Recipient: $99.83 and Spouse/ Dependent: $99.83. The rates for Options 1 and 2 of the Medicare HMO plan are the same since the benefit levels are the same.

Full Premiums & Re-Employed Benefit Recipients

These are the actual full monthly contributions rates for each plan, which OP&F subsidizes for most benefit recipients and their dependents. The only benefit recipients who paid these rates in 2004 are benefit recipients (including survivors) who were employed and eligible for health care through their employer—OP&F no longer subsidized health care for these individuals in 2004. Re-employed benefit recipients who waive OP&F coverage are permitted to enroll in OP&F coverage when they are no longer eligible for coverage through their employer. OP&F subsidizes coverage for these individuals upon receipt of proper documentation stating they are no longer eligible for employer-sponsored coverage. When applying for health care benefits sponsored by OP&F, benefit recipients must indicate on their enrollment form if they are employed and eligible for health care coverage through their employer.

	Option 1			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$412.26	$370.95	$367.28	$365.73
Spouse	$285.35	$259.67	$254.22	$253.15
Child(ren)	$146.00	$178.26	$130.07	$129.52
Eligible For Medicare				
Benefit Recipient	$104.85	$207.01	$154.93	$140.99
Spouse	$88.60	$186.31	$154.93	$140.99
Child(ren)	$88.60	$186.31	$154.93	$127.40

	Option 2			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$442.96	$391.02	$372.44	$389.00
Spouse	$306.36	$273.71	$257.79	$269.25
Child(ren)	$156.37	$187.91	$131.90	$137.76
Eligible For Medicare				
Benefit Recipient	$118.96	$222.86	$154.93	$149.96
Spouse	$100.29	$200.57	$154.93	$149.96
Child(ren)	$100.29	$200.57	$154.93	$135.50

	Option 3			
	Aetna or Medical Mutual PPO	*Aetna HMO*	*Kaiser HMO*	*Paramount HMO*
Not Eligible For Medicare				
Benefit Recipient	$473.23	$404.45	$386.47	$404.52
Spouse	$327.07	$283.12	$267.50	$279.99
Child(ren)	$166.59	$194.36	$136.87	$143.26
Eligible For Medicare				
Benefit Recipient	$152.24	$232.76	$188.21	$155.95
Spouse	$127.85	$209.48	$188.21	$155.95
Child(ren)	$127.85	$209.48	$188.21	$140.91

Contribution Discount Program

OP&F's Contribution Discount Program offers a contribution reduction to benefit recipients with total annual "household income" under an amount established annually by the Board of Trustees, which in 2004 was 30 percent in each coverage category.

Annually, benefit recipients must apply for the contribution discount. Benefit recipients who enroll in medical expense benefits 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.

APPENDIX H

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 by 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 I

Health Maintenance Organization (HMO) Plan Designs

	Option 1	Option 2	Option 3
Aetna			
Office visit co-pay	$25	$15	$10
Coverage percentage	100%	100%	100%
Emergency room co-pay	$100	$50	$35
Hospital admit co-pay	$400	$200	--
Kaiser—for enrollees NOT eligible for Medicare			
Office visit co-pay	$25	$15	$10
Coverage percentage	100%	100%	100%
Emergency room co-pay	$100	$50	$25
Hospital admit co-pay	$250	$200	--
Kaiser Medicare—for enrollees eligible for Medicare			
Office visit co-pay	$15	$15	$10
Coverage percentage	100%	100%	100%
Emergency room co-pay	$50	$50	$25
Hospital admit co-pay	$250	$250	--
Paramount—for enrollees NOT eligible for Medicare			
Office visit co-pay	$20 PCP $25 specialist	$10 PCP $15 specialist	$5 PCP $10 specialist
Durable medical equipment/prosthetics	20% member co-insurance	20% member co-insurance	20% member co-insurance
Emergency room co-pay	$100	$50	$35
Hospital admit co-pay	$400	$200	--
Paramount Prestige—for enrollees eligible for Medicare who do NOT reside in a county where a Medicare HMO is offered*			
Office visit co-pay	$20 PCP $25 specialist	$10 PCP $15 specialist	$5 PCP $10 specialist
Durable medical equipment/prosthetics	20% member co-insurance	20% member co-insurance	20% member co-insurance
Emergency room co-pay	$100	$50	$35
Hospital admit co-pay	$400	$200	--
Paramount Elite—for enrollees eligible for Medicare who reside in a county where a Medicare HMO is offered*			
Office visit co-pay	$10 PCP $15 specialist	$10 PCP $15 specialist	$5 PCP $10 specialist
Durable medical equipment/prosthetics	20% member co-insurance	20% member co-insurance	20% member co-insurance
Emergency room co-pay	$50	$50	$35
Hospital admit co-pay	$200	$200	--

APPENDIX J

Preferred Provider Organization (PPO) Plan Designs

The benefit coverage for benefit recipients residing in areas considered "in-network" and "non-network" are explained in the charts below. Routine health check-ups and claims that the insurance company determines are for maintenance care are not covered under the PPO Network. This chart describes coverage for both the Aetna and Medical Mutual plans.

	Option 1	Option 2	Option 3
***In-Network:** Member & Dependents assigned to a PPO network and using network providers*			
Office visits	$25 co-pay	$15 co-pay	$10 co-pay
Coverage percentage	80% hospital 80% all other services	80% hospital 80% all other services	100% hospital 80% all other services
Emergency room co-pay	$100	$75	$50
Hospital admission deductible	$250	$250	$100
Deductible: single/family	$400/800	$200/400	$100/200
Out-of-pocket: single/family	$1,200/2,400	$1,000/2,000	$500/750
***Out-of-Network:** Member & Dependents assigned to a PPO network, but NOT using network providers*			
Office visits	70%	70%	70%
Coverage percentage	70% hospital 70% all other services	70% hospital 70% all other services	70% hospital 70% all other services
Emergency room co-pay	$100	$75	$50
Hospital admission deductible	$250	$250	$100
Deductible: single/family	$750/1,500	$500/1,000	$250/500
Out-of-pocket: single/family	$5,000/10,000	$3,000/4,000	$1,500/2,250
Non-Network: Medicare A&B eligible or permanent residents of an area without a PPO network			
Office visits	80%	80%	80%
Coverage percentage	80% hospital 80% all other services	80% hospital 80% all other services	100% hospital 80% all other services
Emergency room co-pay	$100	$75	$50
Hospital admission deductible	$250	$250	$100
Deductible: single/family	$400/800	$200/400	$100/200
Out-of-pocket: single/family	$1,200/2,400	$1,000/2,000	$500/750

APPENDIX K

Prescription Drug Plan Design/Contribution Amounts

The chart below lists the benefits available through the prescription drug program in 2004.

	Option 1	Option 2	Option 3
Retail--for short-term or immediate need			
Days Supply (as prescribed)	30	30	60
Generic	$5	$5	$5
Brand Name:			
Preferred	$10	$10	$10
Non-Preferred	$15	$10	$10
Mail Order--for long-term or ongoing use			
Days Supply (as prescribed)	90	90	60
Generic	$10	$10	$1
Brand Name:			
Preferred	$20	$20	$5
Non-Preferred	$30	$20	$5

Prescription Drug 2004 Contribution Chart

LEVEL 1	Option 1	Option 2	Option 3
Not Eligible for Medicare			
Benefit Recipient	$85.04	$96.62	$112.04
Spouse	$93.77	$104.44	$118.66
Child(ren)	$26.84	$30.17	$34.60

LEVEL 2	Option 1	Option 2	Option 3
Not Eligible for Medicare			
Benefit Recipient	$59.53	$71.11	$86.53
Spouse	$78.14	$88.81	$103.03
Child(ren)	$22.37	$25.70	$30.13

LEVEL 3	Option 1	Option 2	Option 3
Not Eligible for Medicare			
Benefit Recipient	$34.02	$45.60	$61.02
Spouse	$62.52	$73.19	$87.41
Child(ren)	$17.90	$21.23	$25.66
Eligible for Medicare			
Benefit Recipient	$49.89	$66.68	$89.07
Spouse	$101.67	$118.78	$141.58
Child(ren)	$101.67	$118.78	$141.58

Full Premiums	Option 1	Option 2	Option 3
Not Eligible for Medicare			
Benefit Recipient	$136.06	$147.64	$163.06
Spouse	$125.03	$135.70	$149.92
Child(ren)	$35.79	$39.12	$43.55
Eligible for Medicare			
Benefit Recipient	$199.55	$216.34	$238.73
Spouse	$203.33	$220.44	$243.24
Child(ren)	$203.33	$220.44	$243.24

APPENDIX L

Supplemental Dental Plan Design/Premium Amounts

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

	DeltaPreferred Option Utilizing DeltaPreferred Option Network Dentist	**DeltaPremier** Utilizing DeltaPremier Dentist/Pays up to usual, customary & reasonable fees	**Non-network Dentist*** Utilizing dentist who does NOT participate in DeltaPreferred Option & is NOT DeltaPremier
Deductible	$50 single/$150 family	$100 single/$300 family	$100 single/$300 family
Calendar Year Max.	$1,500 per person	$750 per person	$750 per person
Class I Benefits	***Delta Dental Pays:***	***Delta Dental Pays:***	***Delta Dental Pays:***
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	***Delta Dental Pays:***	***Delta Dental Pays:***	***Delta Dental Pays:***
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	***Delta Dental Pays:***	***Delta Dental Pays:***	***Delta Dental Pays:***
Prosthodontics	50% after deductible	30% after deductible	30% after deductible
Major Restorative	50% after deductible	30% after deductible	30% after deductible

**When utilizing a dentist who does not participate in the DeltaPreferred Option Network and who is not a DeltaPremier dentist, benefit recipients and dependents will be responsible for paying directly to the dentist any amount above the average fee charged for that service.*

Note: Orthodontia services are not covered. Other exclusions and limitations may apply.

Supplemental Dental Plan Premuim Amounts

	Delta Dental
Benefit Recipient (including survivors)	$19.90
Benefit Recipient & Spouse	$38.85
Benefit Recipient & Child(ren)	$33.70
Benefit Recipient, Spouse & Child(ren)	$59.86

APPENDIX M

Supplemental Vision Plan Design/Premium Amounts

	Plan Pays
Eye Exam*	$50 for one exam very 12 months
Frames	$20 for one pair every 24 months
Lenses, every 24 months	
Single Vision	$30
Bifocals	$40
Trifocals	$60
Lenticular	$100
Contact Lenses	$160

**This is for a 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.), then the claim will not be paid under this vision plan. The claim may be paid, however, under the major medical plan, subject to the deductibles of that plan.*

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