Ohio Police & Fire Pension Fund

2008 Health Care Report

Presented to the Ohio Retirement Study Council, **June 2009**

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Respectfully submitted by
William J. Estabrook, Executive Director

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140 E. Town Street
Columbus, Ohio 43215
(614) 228-2975
www.op-f.org

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.

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

Executive Summary

The Ohio Police & Fire Pension Fund Board of Trustees recognizes the importance in providing a health care option for our retirees. The Board, along with OP&F staff, has strived to offer secure health care benefits; including medical, prescription drug, dental and vision coverage. While health care costs have continued to rise rapidly, OP&F has managed to control costs by cutting administrative expenditures, outsourcing, and actively managing the plan design. OP&F is committed to working with our vendors to implement recommendations that allow OP&F to continue to offer a dependable and cost effective plan.

In 2008, OP&F moved their eligibility and enrollment administration to a single national plan administrator, in a strategy to take advantage of the economies of scale offered by the OP&F retiree population located across the country. The partnership with one provider affords leverage, which results in a focused plan design and the ability to positively influence claim costs and administration fees. This customized plan better meets the needs of the retired police officers and fire fighters of Ohio today and it affords controls that will benefit future plan designs. A focused plan from one provider also allows creative solutions to such important areas as educating members on the importance of consumer driven health care and controlling health care costs, which ultimately secures the stability of the health care trust.

OP&F has developed a trust fund (the Health Care Stabilization Fund, or HCSF) that seeks to ensure the integrity of pension benefits and seeks to minimize the impact of market conditions on the ability to provide health care. Even with the unprecedented year of low investment returns, the OP&F HCSF solvency was maintained at 20 years at calendar year end. The solvency of the HCSF maintained while having no increase in the percentage rate of employer contributions throughout this period.

2008 Highlights include:

- Outsourcing the over-65 Medicare population to an AARP Medicare Supplement plan eliminated the claims risk involved with a self insured plan for this group.
- AARP offered members a plan that paid the claims more beneficially to the retiree than the 2007 plan offered to similar retirees.
- OP&F health care costs only increased 3.0 percent overall in 2008, while the industry experienced a 4.3 percent increase in medical costs and 11 percent increase in prescription drug costs.
- Outsourcing the eligibility and enrollment portion of the health care process cut administrative expenses by over $1 million dollars in 2008 and reduced the liability exposure for OP&F
- Offered improved consumer-driven options, such as “roll-over” plans of unused portion of annual maximum dental benefit to subsequent years.
- In order to reduce costs, plan design changes were made that limited the quantity limits on lifestyle drugs, and formularies were developed with a continued focus on the use of generic equivalents.
- The relationship with OP&F’s new vendor resulted in better negotiated rebates and recoveries.
- Programs that control the rapidly rising costs of specialty drugs through case management and initial quantity limits were introduced by the new vendor.
- OP&F medical and prescription drug cost trends continue to beat the national averages for percent increases.

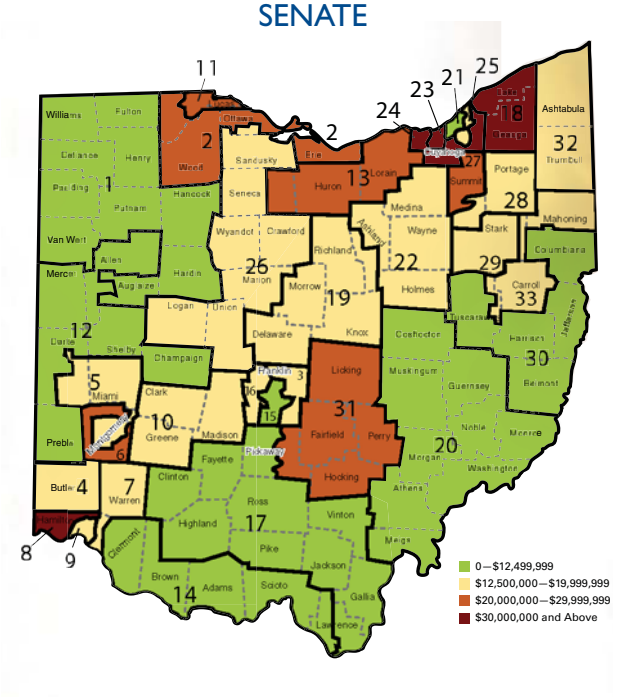
Cost benefits studies are part of a continuing effort to provide secure future health care programs that meet member expectations. OP&F is evaluating alternative prescription drug programs offered by the Centers for Medicare and Medicaid (CMS) as part of the Retiree Drug Subsidy (RDS) program such as The Employer Group Waiver Plan. Other cost containment studies include partnering with a large retailer to provide lower-cost prescription drugs and bypassing the third party provider. Programs such as this have the flexibility to eliminate copayments and offer retirees a plan they can depend on in the future.

The OP&F Board of Trustees and staff are committed to maintaining and improving a health care plan for an expanding membership. OP&F continues to preserve the solvency of the Health care Stabilization Fund by looking at best practices and alternatives to a traditional plan.

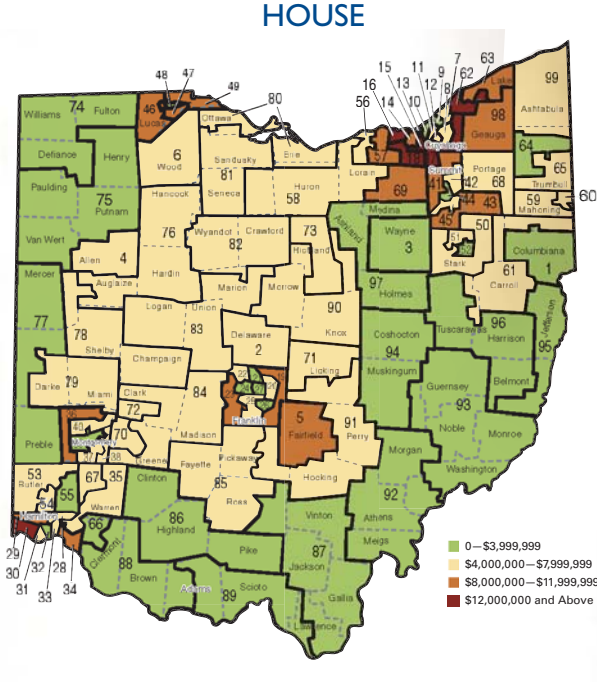
Economic impact

As a major economic impact to Ohio, OP&F strives to provide economic solutions that benefit OP&F members and the state of Ohio. The charts below illustrate OP&F's direct economic impact to Ohio Senate and House Districts according to a 2006 study.

SENATE



HOUSE



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 2008, a total of 25,653 retirees, survivors and their dependents were enrolled in health care benefits sponsored by OP&F. The prescription drug plan sponsored by OP&F had 24,565 covered lives enrolled in 2008.

When OP&F began sponsoring health care benefits in 1974, health care expenditures were approximately $3 million. Thirty-four years later, in 2008, OP&F health care expenses totaled over $153 million. The cost per health care participant in 2008 was $5,981, a six percent increase from 2007. The following sections will chronicle the OP&F health care program from a historical perspective, detail the current health care funding structure and describe how OP&F anticipates addressing funding of these benefits into the future.

Health Care Financing: Current

As of December 31, 2008, the OP&F Health Care Stabilization Fund had a balance of $438,658,131. 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 a decrease in the balance from 2007 of nearly 17 percent or $88 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 2008, non-investment earnings generated $201,805,224 in revenue to fund health care. Benefit recipients contributed 37 percent toward OP&F's overall health care costs. The remainder, 63 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 for members under age 65. OP&F pays the full cost of claims dollars for this program. The over age 65 members are offered a fully insured premium based program. OP&F's actuary reviews all assumptions and methods every five years and reports annually on the solvency of the Health Care Stabilization Fund.

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.

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).

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.

For the 2008 health care plan year, the OP&F Board of Trustees approved a health care program with one provider. Effective January 1, 2008, UnitedHealthcare became the OP&F third party administrator and administers all healthcare benefits relating to medical, prescription drug, voluntary dental and vision for eligible benefit recipients and dependents. UnitedHealthcare administers a self-insured plan for members who are not eligible for Medicare Parts A and B and a premium-based AARP plan for members who are eligible for Medicare Parts A and B.

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 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 Financing: Chronology of Progress

1974
- OP&F begins sponsoring health care benefits (See Appendix A for statutory authority)
  - Blue Cross & Blue Shield offered (fully insured) from February to June
  - Move to self-insured coverage with Aetna indemnity on July 1, 1974
  - Expenditures total $3 million

1977 to 1990
- The years between 1977 and 1990 saw very few health care changes
- Medicare Part B reimbursement mandated,
  - $7.20 in 1977
  - $33.90 in 1990 (reduced to $28.60 March 1, 1990)

1981
- National mail service added for prescription drugs

1986
- Members required to contribute to Medicare tax of 1.45% in April
  - Hire dates prior are grandfathered and did not pay a contribution toward Medicare tax

1990's
- HMO's and Medicare HMO's added to the OP&F-sponsored health care plan
  - Implemented to save money for both OP&F and benefit recipient

1992
- Board of Trustees implemented monthly contributions from benefit recipient
  - Benefit recipients contributed 8 percent of the cost of health care
  - OP&F subsidized 92 percent of the cost
- PPO's were introduced
  - Encouraged participants to utilize participating network providers
    - Pay less out of pocket for health care expenses

1993
- Retail prescription drug network introduced, as well as an established mail-order plan

1995
- Long term care was offered through Aetna

2000
- Health care costs increased to $111.8 million
- OP&F covered 34,499 lives

2001
- Board of Trustees changed the contribution structure for health care
  - Benefit Recipients contributed 6 percent of projected costs
  - OP&F began giving a 30% discount on health care and Rx premiums for qualified members in July
  - Health care costs went up to $129.1 million
  - OP&F covered 35,290 lives

2002
- Board of Trustees, again, changed the contribution structure for health care
  - Health Care Contributions Increased
    - Single $41.20, 2-Party $82.40, Family $123.60
- Total health care costs totaled $153.6 million
- 35,452 Covered lives

2004
- Additional changes to the health care program
  - Three-pronged approach
    1. Plan Design
    2. Contributions/ OP&F subsidy levels
    3. Eligibility

2005
- OP&F joins the Ohio Retirement Systems in the Irrevocable Waiver Program
  - Allows members to select which system their medical costs will be covered under
- Health care costs continue to rise, but covered lives are decreased because of members enrolling in their employer sponsored coverage

2006
- In December, OP&F terminated the last of our HMO plans
  - (Aetna, Kaiser, Paramount)

2007
- The irrevocable waiver program through the ORS is discontinued
  - Members or dependents were grandfathered into the system if an irrevocable waiver was executed on or before December 31, 2007
- A new health care plan design introduced: One Plan, 2 Vendors (Aetna, Medical Mutual)

2008
- OP&F outsources to UnitedHealthCare to administer program
  - Reduces administrative costs

Health Care Eligibility

In 2008, 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 2008, 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 voluntary 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 in the next column.

- **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 if their OP&F commencement of benefits is prior to the other ORS.
- **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

The irrevocable waiver program through the ORS has been discontinued. Members or dependents who had executed an irrevocable waiver on or before December 31, 2007, were grandfathered into the program on the date in which the system discontinued the waiver program.

Current enrollment figures

As of December 31, 2008, there were 23,846 OP&F benefit recipients. Benefit recipients include both retirees and survivors. Of those, approximately 59 percent participated in the OP&F health care programs at that time. As of December 2008, the breakdown of enrollees and dependents (spouses and dependent children) was as follows:

Number Enrolled in Health Care Program	
Benefit Recipients	13,975
Dependents	11,678
TOTAL	**25,653**

Compared to enrollment figures from December 31, 2007, the OP&F-sponsored health care program had fewer enrolled participants. The total enrollment for 2007 was 26,601, or 948 more than the 2008 figures above. Specific plan changes were the likely reason for this decrease in enrollment. In 2008, 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 3,499 public safety officers on the job longer. Members participating in DROP are not eligible for 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

In 2008, OP&F sponsored health care benefits that include coverage for medical, prescription drug, voluntary dental, vision, and long-term care. Each of these optional health care benefits is described below.

Medical

The 2008 health care plan offered one plan design through one carrier, UnitedHealthcare, for all non-medicare eligible benefit recipients and dependents, early Medicare recipients, Medicare A only recipients, Medicare B only recipients, or OP&F retirees residing outside of the U.S.

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

Anyone who 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 non-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 determined by UnitedHealthcare.

The UnitedHealthcare plan did not have networks in all areas of the country. Benefit recipients and their enrolled dependents who resided in one of these out-of-network areas could still choose UnitedHealthcare as their claims administrator. These benefit recipients and their enrolled dependents could then use any provider or hospital and still receive most benefits at the network benefit level. However, when utilizing out-of-area providers, these benefit recipients may need to file their own claims forms, notify UnitedHealthcare themselves for procedures that needed to be pre-certified 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 UnitedHealthcare (See Appendix H for a chart describing the various benefit levels).

Prescription Drug Coverage

In 2008, OP&F offers one prescription drug plan through UnitedHealthcare Pharmacy, as a separate coverage, with separate contribution amounts. (See Appendix G for a chart describing the various contributions & co-pays).

The Mail Service Pharmacy Program

UnitedHealthcare Pharmacy uses Medco for the distribution of the mail order prescriptions in 2008. 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 UnitedHealthcare 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. Beginning in 2008, UnitedHealthcare Pharmacy prescription medications are no longer categorized by generic, preferred and non-preferred. Prescriptions will now be categorized by tiers:

- **Tier 1 drugs** have the lowest co-payment which includes predominately generic drugs. However, there may be generic drugs which fall into other Tier levels.
- **Tier 2 drugs** have the middle co-payment level which includes many brand name drugs.
- **Tier 3 drugs** have the highest co-payment level which includes several products with a Tier 1 or Tier 2 alternative.

Voluntary Vision & Dental Plans

For the 2008 plan year, OP&F will continue to sponsor voluntary dental coverage through UnitedHealthcare. The voluntary vision coverage was offered through UnitedHealthcare Vision, underwritten by United-Healthcare Ins. Co. 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. 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.

UnitedHealthcare Vision Coverage

UnitedHealthcare vision coverage 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 UnitedHealthcare vision provider. Benefit recipients and their enrolled

dependents have minimal co-payments for the exam, lenses and frames at the time of service. In 2008, OP&F had 5,845 benefit recipients enrolled in the UnitedHealthcare Vision.

UnitedHealthcare Dental Coverage

The UnitedHealthcare 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 UnitedHealthcare dental plan, benefit recipients and their enrolled dependents may choose any dentist in the country; however, the maximum benefit level is achieved by utilizing UnitedHealthcare's network of participating dentists, because these dentists have agreed to a discounted fee schedule. When utilizing a dentist who does not participate in UnitedHealthcare's Network, benefit recipients and their enrolled dependents will be responsible for paying directly to the dentist any amount above the usual and customary rates prevailing in the geographic area in which the expense is incurred. In 2008, OP&F had 7,401 benefit recipients enrolled in UnitedHealthcare dental coverage. The UnitedHealthcare dental plan offers a consumer-driven feature, Consumer Max Multiplier, that allows members to carry forward a portion of their unused annual dental maximum into an account for future use.

Coordination of Dental & Vision Benefits

Benefits under the vision and dental plans will be coordinated with those of another dental and vision plans 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. 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 2008, OP&F had 190 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. 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 was handled by Aetna. Monthly premiums for 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 will receive an Annual Change Period Guide and form that provides more details about the upcoming OP&F –sponsored health care coverage, describes the Annual Change Period process, and announces any changes to the plan or contribution rates. The form can be used to verify or waive current enrollment and ensures that any preprinted information contained on the form is accurate; as well as waiving or enrolling in the voluntary dental and vision coverage. This major project involves creating a customized form for health care participants and a booklet specifically outlining the available health care plans.

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 payment at the current basic contribution rate. Dependent spouses are not reimbursed for the Medicare Part B premium until such time as they become a benefit recipient. In 2008, OP&F paid over $13.4 million in Medicare B reimbursements.

When becoming eligible for Medicare Part B, benefit recipients must send UnitedHealthcare a copy of their Medicare card (or a letter from Medicare) and a properly completed Medicare Part B Reimbursement Statement in a UnitedHealthcare-approved format or Medicare billing statement. UnitedHealthcare 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 2008.

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, a 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 2008, OP&F received $7.8 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 2008 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

2003-2008

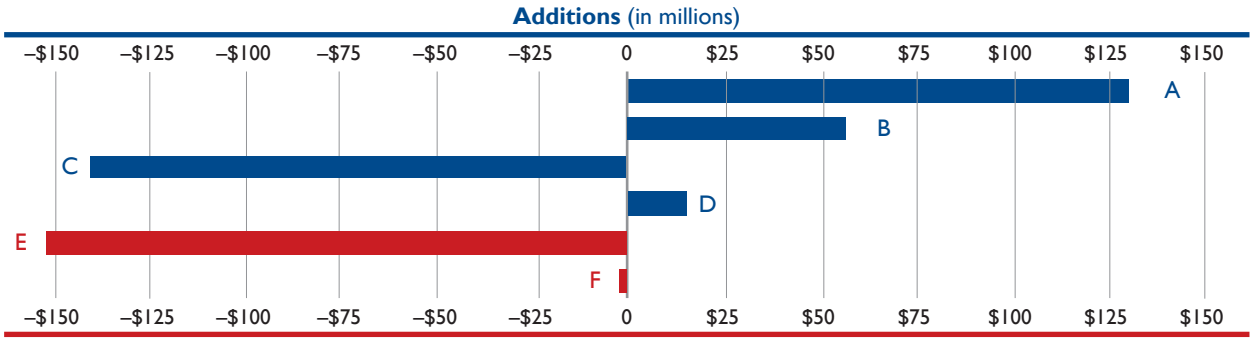
	2003*	2004	2005	2006	2007	2008
Additions:						
Employer Contributions	$120,601,889	$125,183,522	$128,183,051	$138,940,502	$121,721,828	$129,544,343
Benefit Rec. Contributions	17,207,506	55,665,341	55,271,881	58,532,848	56,031,875	56,948,977
Investment Income	54,510,471	34,394,433	27,984,135	62,735,803	49,938,228	(136,005,249)
Recoveries and Rebates	3,486,487	7,320,704	3,873,264	14,648,983	13,629,565	15,311,904
TOTAL ADDITIONS	**$195,806,353**	**$222,564,000**	**$215,312,331**	**$274,858,136**	**$241,321,496**	**$66,021,909**
Deductions						
Health care Expenses	168,060,654	157,839,137	163,311,330	178,906,570	149,237,194	153,421,375
Administrative Expenses	2,169,777	2,212,590	2,535,171	2,393,497	1,683,560	941,252
TOTAL DEDUCTIONS	**$170,230,431**	**$160,051,727**	**$165,846,501**	**$181,300,067**	**$150,920,754**	**$154,362,627**
Net Increase/Decrease	**$25,575,922**	**$62,512,273**	**$49,465,830**	**$93,558,069**	**$90,400,742**	**($88,340,719)**

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

Balances						
Beginning of year	205,486,013	231,061,935	293,574,208	343,040,038	436,598,107	526,998,849
End of year	$231,061,935	$293,574,208	$343,040,038	$436,598,107	$526,998,849	$438,658,131

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

2008 Additions and Deductions



Additions:

A: Employer contributions $129,544,343
B: Benefit recipient contributions 56,948,977
C: Investment income ..... (135,783,316)
D: Recoveries and rebates 15,311,904
TOTAL: $66,021,908

Deductions:

E: Health care expenses $153,421,375
F: Administrative expenses 941,252
TOTAL: $154,362,627

2008 Net Increase/Decrease: ($88,340,719)

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 markets 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 a trust under section 401(a) of the Internal Revenue Code that is exempt from federal income taxes under section 501(a) of the Internal Revenue Code.

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, 2008, the balance in the HCSF was $438,658,131.

Appendix D

Plan Net Assets Available for Post-Employment Health Care Benefits

as of December 31, 2008 (un-audited)

Assets:	Cash and Short-term Investments	$21,405,397
Receivables:	Employers' Contributions	36,174,243
	Accrued Investment Income	1,663,589
	Investment Sales Proceeds	3,595,356
	Total Receivables	**41,433,188**
Investments, at fair value:	Bonds	53,503,495
	Mortgage & Asset Backed Securities	33,512,441
	Stocks	158,752,973
	Real Estate	41,140,595
	Commercial Mortgage Funds	2,258,249
	Venture Capital	14,980,440
	International Securities	97,652,766
	Total Investments	**401,800,959**
	Collateral on Loaned Securities	45,630,099
	TOTAL ASSETS	**510,269,643**
Liabilities:	Health Care Payable	13,490,207
	Investment Commitments Payable	12,491,206
	Obligations Under Securities Lending	45,630,099
	TOTAL LIABILITIES	**71,611,512**
Net assets held in trust for Post-employment health care benefits:		**$ 438,658,131**

Appendix E

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

(Year ending December 31, 2008)

Additions:	*From Contributions:*	
	Employers	$ 129,544,343
	Member Health Care Premiums	56,948,977
	Total Contributions	**186,493,320**
	From Investment Income:	
	Net Appreciation (Depreciation) of Fair Value of Investments	(144,855,134)
	Bond Interest	4,730,866
	Dividends	3,742,493
	Real Estate Operating Income, net	990,240
	Foreign Securities	38,293
	Other	399,442
	Less Investment Expenses	(1,051,449)
	Net Investment Income (Loss)	**(136,005,249)**
	From Securities Lending Activities:	
	Securities Lending Income	1,405,260
	Securities Lending Expense:	
	Borrower Rebates	(1,115,619)
	Management Fees	(67,707)
	Total Securities Lending Expense	(1,183,326)
	Net Income from Securities Lending	221,934
	Interest on Local Funds Receivable	
	Other Income	15,311,904
	TOTAL ADDITIONS	**66,021,909**
Deductions:	Benefits:	
	Health Care	153,421,375
	Administrative Expenses	941,252
	TOTAL DEDUCTIONS	**154,362,627**
	NET INCREASE (DECREASE)	$ (88,340,718)
Net assets held in trust for Post-employment health care benefits:		
	Balance, beginning of year	$ 526,998,849
	Balance, end of year	**$ 438,658,131**

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

2008 Premiums & Contributions

If a member or their spouse is employed and eligible for medical or prescription drug coverage through their 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 UnitedHealthcare and AARP medical and prescription drug coverage for 2008. 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 Recipients	$609.02	$226.44	See AARP Plan	$226.44
Spouse	$403.17	$213.31	See AARP Plan	$213.31
Child(ren)	$210.72	$63.40	See AARP Plan	$63.40

	Non-AARP eligible	
	Full premium for medical coverage	**Full premium for prescription drug coverage**
Benefit Recipients	$197.36	$197.36
Spouse	$166.37	$166.37
Child(ren)	$166.37	$166.37

Contribution rates for the 2008 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 before 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 & Prescription contribution rates

The charts on the nexgt page outline the monthly contribution amounts that benefit recipients are responsible for and the subsidized portion OP&F pays for coverage of both the UnitedHealthcare and the AARP Medicare Supplement Plans for 2008. Figures shown may vary slightly due to rounding.

Began receiving OP&F benefits on or before July 24, 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 Recipients	$152.26	$456.76	$49.34	$148.02
Spouse	$201.59	$201.58	$83.18	$83.19
Child(ren)	$105.36	$105.36	$83.18	$83.19

Began receiving OP&F benefits on or after July 25, 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 Recipients	$152.26	$456.76	$49.34	$148.02
Spouse	$302.38	$100.79	$124.78	$41.59
Child(ren)	$158.04	$52.68	$124.78	$41.59

AARP Medicare Supplement Plan – Benefit Recipients (Ohio residents) Plan L

Time from your Medicare Part B effective date	**Total monthly premium**	**OP&F's monthly subsidized amount**	**Benefit recipient's monthly contribution**
Less than 3 years	$ 78.40	$58.80	$19.60
3-6 years	$ 112.00	$84.00	$28.00
More than 6 years	$123.20	$92.40	$30.80

Dependents with 50% subsidy (Ohio Residents) Plan L

Time from your Medicare Part B effective date	**Total monthly premium**	**OP&F's monthly subsidized amount**	**Benefit recipient's monthly contribution**
Less than 3 years	$ 78.40	$39.20	$39.20
3-6 years	$ 112.00	$56.00	$56.00
More than 6 years	$123.20	$61.60	$61.60

Dependents with 25% subsidy (Ohio Residents) Plan L

Time from your Medicare Part B effective date	**Total monthly premium**	**OP&F's monthly subsidized amount**	**Benefit recipient's monthly contribution**
Less than 3 years	$ 78.40	$19.60	$58.80
3-6 years	$ 112.00	$28.00	$84.00
More than 6 years	$123.20	$30.80	$92.40

Prescription Drug contribution rates

Began receiving OP&F benefits on or before July 24, 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 Recipients	$56.61	$169.83	$56.61	$169.83
Spouse	$106.66	$106.65	$106.66	$106.65
Child(ren)	$31.70	$31.70	$31.70	$31.70

Began receiving OP&F benefits on or after July 25, 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 Recipients	$56.61	$169.83	$56.61	$169.83
Spouse	$159.98	$53.33	$159.98	$53.33
Child(ren)	$47.55	$15.85	$47.55	$15.83

Prescription Drug co-pays:

	Retail pharmacy co-pay Up to a 30-day supply	**Mail order pharmacy co-pay Up to a 90-day supply**
Tier 1	$5 co-pay	$10 co-pay
Tier 2	$20 co-pay	$40 co-pay
Tier 3	$40 co-pay	$60 co-pay

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 2008 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 2008, 541 benefit recipients received the contribution discount for health care and 522 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 UnitedHealthcare during 2008 may have experienced a difference in coverage between in–network, non–network and out-of-area providers as outlined in the below chart.

	In Network ▼	Non-Network ▼	Out-of-Area ▼
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%
Hoime 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 a non–network hospital; emergency department co–pay not applied if admitted to hospital.*

** *Office visit co-pay when applicable; vaccines for travel are not covered*

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

Appendix I

Voluntary Dental Plan Design/Premium Amounts

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

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

Voluntary 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

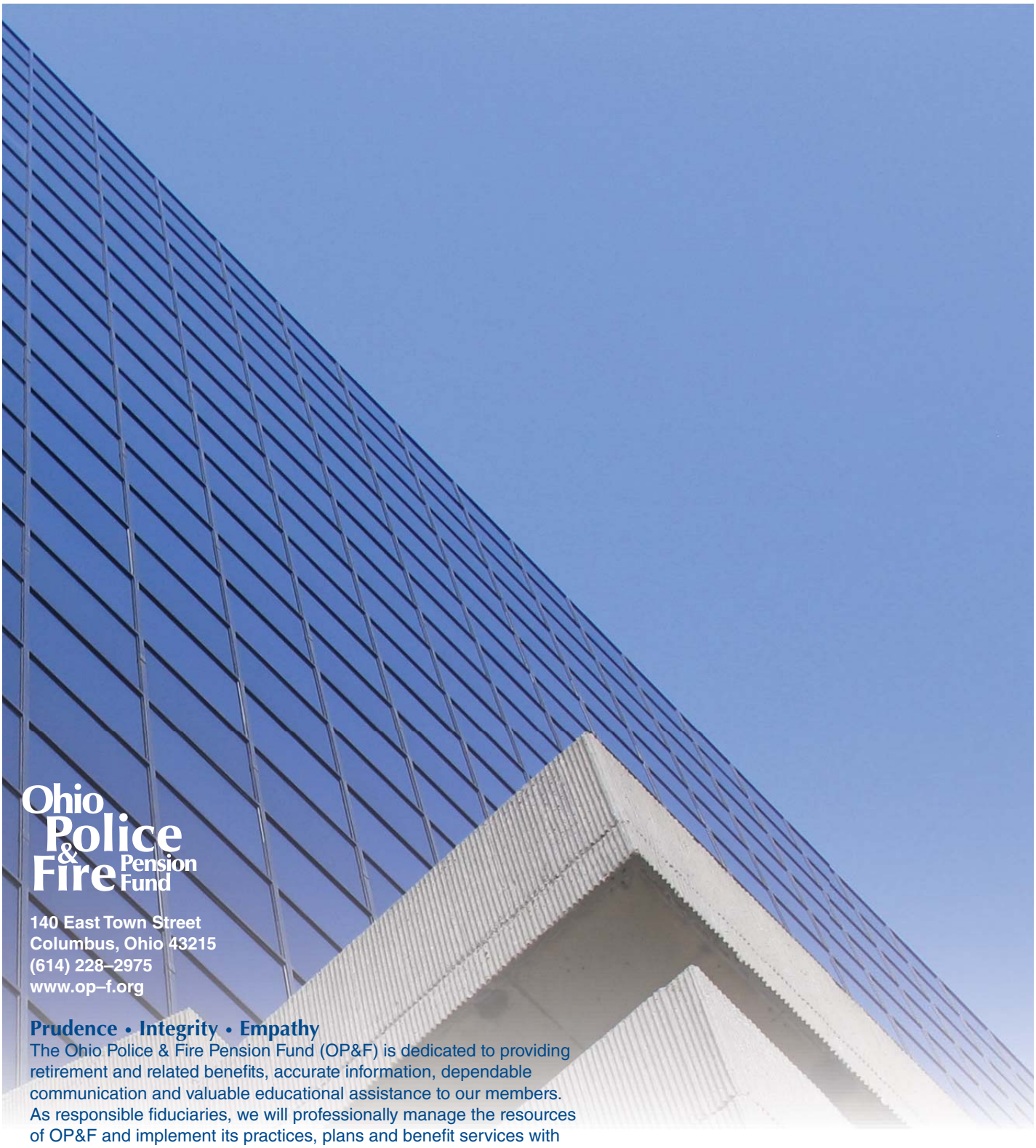
Appendix J

Voluntary Vision Plan Design/Premium Amounts

Voluntary Vision Features:	UnitedHealthcare Vision
Plan Frequency	Pair of lenses for eyeglasses: once every 12 months; Contact lenses in lieu of eyeglasses: once every 12 months; Frames: once every 24 months
Exam Co-pay	$10
Materials Co-pay	$0
Single Vision Lenses	$0 co-pay
Lined Bifocal Lenses	$0 co-pay
Lined Trifocal Lenses	$0 co-pay
Lined Lenticular Lenses	$0 co-pay
Scratch Coating	$0 co-pay
Frames	$0 co-pay plus up to 50% over $130 allowance
Contact Lens Fitting and Evaluation	$0 co-pay under UnitedHealthcare's Contact Lenses Package

Voluntary Vision Plan Premium Amounts

	Aetna Vision
Benefit Recipient (including survivors)	$5.48
Benefit Recipient & Spouse	$10.29
Benefit Recipient & Child(ren)	$10.09
Benefit Recipient, Spouse & Child(ren)	$15.63



Ohio Police & Fire Pension Fund

140 East Town Street
Columbus, Ohio 43215
(614) 228–2975
www.op–f.org

Prudence • Integrity • Empathy

The Ohio Police & Fire Pension Fund (OP&F) 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.