Ohio Police & Fire Pension Fund

Health Care Report 2002

Presented to:
Ohio Retirement Study Council
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Respectfully submitted by:
William J. Estabrook,
Executive Director
Ohio Police & Fire Pension Fund
140 E. Town St.
Columbus, OH 43215
(614) 228-2975

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Introduction

(Please note that this report reflects the Ohio Police & Fire Pension Fund's health care program for the year 2002. Substantial changes are being made to the health care program for an effective date of 1/1/2004.)

Introduction

The Ohio Police & Fire Pension Fund (OP&F) offers an excellent medical expense benefits program including coverage for major medical, prescription drug, dental, vision and long-term care. In 2002, almost 35,500 retirees, survivors and their eligible dependents were enrolled in OP&F 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, O.R.C. 742.45). At that time, only one plan was offered through Aetna Health Plans.

Due to rising health care costs, contributions were required for most benefit recipients beginning in July of 1992. In addition, cost saving plan design measures have been introduced since that time as well. In 2002, two Preferred Provider Organization (PPO) Networks, three Health Maintenance Organizations (HMOs) and two Medicare HMOs were available, as well as a separate prescription drug program. Supplemental dental, vision and long term care plans were also available. Long term care is the only OP&F-sponsored benefit that is also offered to active members.

As required by Ohio Revised Code Section 742.14 (E), OP&F has prepared the enclosed report to provide information regarding the health care program offered to OP&F members in 2002. 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 funding, the report also discusses eligibility, a description of the plans available, and financial information.

Health Care Funding

Health Care Funding

When OP&F took on the responsibility of health care benefits in 1974, health care expenditures were approximately $3 million, compared to $153,651,881 million spent 28 years later in 2002. The health care expenses in 2002 increased 18.95 percent over 2001. In addition, the cost per health care participant rose to $4,334 in 2002, an 18.41 percent increase over 2001. This section addresses the current health care funding structure and how OP&F anticipates addressing funding of these benefits into the future.

Current health care financing

In 1992, the OP&F Board of Trustees implemented monthly medical expense benefit contributions from benefit recipients. The Health Care Stabilization Fund had a balance of $205,486,013 as of December 31, 2002 as a result of the interest generated, along with retiree contributions, rebates and recoveries, and 7.75 percent of employer contributions expressed as a percentage of payroll. This represents a decrease in the balance from 2001 of 18 percent ($45.1 million), primarily due to an increase in gross health care costs.

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). Deductions from that fund include actual health care expenses and administrative expenses related to health care. Health care expenses include major medical and prescription drug claims payments, premiums, administrative fees, and Medicare B reimbursements.

In 2002, non-investment earnings generated $133,845,507 in revenue to fund health care. Benefit recipients contributed 8.22 percent toward OP&F's overall health care costs. The remainder, 91.78 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.

Currently, OP&F is self-funded for the PPO and prescription drug plans, meaning that OP&F pays the full cost of claims dollars for these plans. HMOs are not self-funded and, therefore, are paid on a premium basis. 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's Health Care Committee is actively addressing the issues surrounding rising health care costs and is exploring viable long-term health care funding options.

As required by statute, this report also includes other financial information including Accounting, Asset Valuation and Funding Methods (See Appendix C), Plan Net Assets Available for Postemployment Health Care Benefits (See Appendix D), and Statement of Changes in Plan Net Assets Available for Postemployment Health Care Benefits (See Appendix E).

Cost saving measures

OP&F has established several measures within the last several years to reduce health care costs. First, benefit recipients began contributing toward the cost of their health care in 1992. This contribution schedule changed on July 1, 2002 (See Appendix F). Secondly, Preferred Provider Organizations (PPOs) were introduced in 1992. Under these plans, participants are encouraged to utilize participating network providers in order to pay less out of pocket for their health care expenses. Participating network providers have contractually agreed to charge less for their services, a savings which can then be passed on to the participants and to OP&F. In addition, the introduction of a stand-alone prescription drug program, as well as HMOs and Medicare HMOs, saves money for both OP&F and plan participants.

Future funding strategies

The OP&F Trustees continually confront the challenge of funding the rising cost of health care benefits without jeopardizing future pension, survivor, and disability benefits. In 2002, OP&F health care costs rose 18.95 percent. Besides 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 G) 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.

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 current funding mix. As a result, the Board must determine an appropriate mix among the three health care funding sources—employer contributions, investment income, and benefit recipient contributions—to allow OP&F to provide health care well into the future. The Board's Health Care Committee continues to actively address the issues surrounding rising health care costs and continues to explore viable long-term health care funding options.

After carefully examining health care funding issues over the past few years, the Board voted to implement a new health care contribution schedule for benefit recipients effective July 1, 2001. This schedule will be adjusted annually based on OP&F's overall annual health care costs so that benefit recipients will collectively contribute a Board approved percentage of OP&F's overall costs. On July 1, 2002, the percentage was adjusted to 12 percent.

Because OP&F's Trustees are 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. Therefore, beginning in January 2004, to preserve the Health Care Stabilization Fund, additional changes to the health care program will be implemented. The strategy is 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 may opt for health care and/or prescription drugs coverage separately.

Health Care Eligibility

Health Care Eligibility

Retirant and survivor eligibility
OP&F members are eligible for health care benefits through OP&F the first day after they are taken off their employer's payroll. In addition, health care coverage for eligible surviving spouses starts from the member's date of death and when survivor benefits begin. There are no pre-existing condition clauses.

Dependent eligibility
Benefit recipients must be enrolled in an individual plan in order to enroll their dependents in that plan. Dependents eligible for the OP&F Medical Expense Benefits Program include:

- The benefit recipient's spouse;
- Unmarried child(ren) at least 14 days of age, but under 18 years of age, or under 22 if attending school* on a full-time basis (or at least a two-thirds basis) and primarily dependent upon the benefit recipient for support. Primarily dependent means that the child is validly claimed as an exemption for income tax (FITR) purposes by the benefit recipient in the year that medical expenses are incurred;
- A dependent child (validly claimed as an exemption on FITR), regardless of age, who is unable to earn a living because of a physical or mental handicap, but only if such child became incapacitated prior to attaining age 18 (age 22 if then attending school on a full-time or at least a two-thirds basis). A disabled child over age 22 may only apply for OP&F medical expense benefits at the time the benefit recipient is FIRST eligible for OP&F medical expense benefits. However, the disabled child must have met the regulations listed above prior to attaining age 22. The medical expense benefits 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 do have the right to appeal any carrier determinations; and
- Unmarried step-children, grandchildren or other children at least 14 days of age, but under 18 years of age, or under 22 if attending school on a full-time basis (or at least a two-thirds basis) for whom the benefit recipient is the legal guardian required to provide health care coverage. Step-children, grandchildren or other children must be financially dependent upon the benefit recipient for support and live with the benefit recipient in a regular parent-child relationship.

  Under the guidelines specified above, financially dependent shall be demonstrated by any of the following:
  1. The benefit recipient validly claims the child as an exemption for federal income tax return (FITR) purposes;
  2. A divorce decree or separation agreement that went into effect after 1984 stating that the member can claim the child as the member's dependent without regard to any condition, such as payment of support, by filing with OP&F a certified copy of certain pages from the decree or agreement specified by OP&F**;

3. A decree or agreement that was executed before 1985 stating that the non custodial parent is entitled to the exemption and he or she provides at least $600 for the child's support during the year (this provision cannot have been modified by the parties after 1984), by filing with OP&F a certified copy of certain pages from the divorce or judgment specified by OP&F** and an affidavit that certifies that the member provided support to the child in accordance with applicable Internal Revenue Code provision; and
4. The child is treated as having received over half of his or her total support from a person under a multiple support agreement.

**Must be enrolled for at least two thirds of the minimum number of credit hours required to be considered a full time student at an accredited institution. An institution is considered a school if it: offers a regular schedule of courses on an annual or more frequent basis; has a full-time faculty and permanent administration; and includes some formal classroom sessions rather than just on-the-job training.*
*** Includes cover page, the page that states that the benefit recipient can claim the child as his or her dependent, and the signature page with the other parent's signature and the date of the agreement.*

Current enrollment figures

As of December 31, 2002, there were 23,413 OP&F benefit recipients. Benefit recipients include both retirees and survivors. Of those, approximately 89 percent participated in the OP&F health care programs at that time. As of December, the breakdown of enrollees and dependents was as follows:

	Number Enrolled
Benefit recipients	20,838
Dependents	14,614
TOTAL	35,452

Ensuring accuracy of eligibility information

To keep OP&F files accurate, all benefit recipients enrolled in OP&F's Medical Expense Benefits Program are required to complete and return an Annual Health Care Eligibility Form (AHCEF) once every year. This form requests current information regarding address, covered dependents, Workers' Compensation information, etc. It is mailed in the fall of every year. Benefit recipients who do not comply after several requests face termination of coverage.

Health Care Program Options

Health Care Program Options

The Ohio Police & Fire Pension Fund offers an excellent medical expense benefits program which includes coverage for major medical, prescription drug, dental, vision and long term care. This section describes these benefits in more detail.

Major medical

Based on their area of residence, benefit recipients have the choice between two different types of plans for major medical coverage, a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). Both plan types provide excellent coverage for expenses resulting from ordinary injuries or diseases, serious or prolonged disabilities, hospitalization and skilled nursing care.

HMOs—OP&F offers HMOs through three different carriers–**Aetna, Kaiser Permanente,** and **Paramount**. Eligibility for these plans is based on area of residence as determined by the carriers. The Kaiser HMO is restricted to the Akron/Cleveland area and requires the utilization of primary care physicians in participating Kaiser facilities only. The other HMOs offer participants the choice of primary care physicians who are independent practicing physicians located throughout the state. Health Maintenance Organizations (HMOs) provide comprehensive health care coverage, including preventive care services, diagnostic testing, inpatient medical/surgical services and more. In addition, there are no deductibles to meet and most services are paid 100 percent after a co-payment (See Appendix H). Eligibility for these HMOs is limited to residents who live in specific counties of Ohio and certain contiguous states.

Medicare HMOs—OP&F also offers two Medicare HMOs to Medicare eligibles who live in eligible areas (through **Kaiser** and **Paramount**). The Medicare HMO carriers actually administer Medicare benefits, instead of Medicare. The carriers obtain this right by entering into a contract with the Center for Medicare and Medicaid Services (CMS), an agency of the federal government. The government then pays a fixed monthly amount for each Medicare plan member to the carrier. The payment made by the government is based 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 are still Medicare beneficiaries if they enroll in a Medicare HMO. The Medicare HMOs cover all services covered by traditional Medicare, plus much more such as routine vision, hearing and dental care–all at no additional cost (See Appendix H).

Preferred Provider Organizations (PPOs)—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. Currently, OP&F benefit recipients may choose 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 between these carriers is that different providers participate in each network, although many providers overlap.

Anyone who resides in a network area and enrolls in the PPO Network must utilize participating PPO providers to receive maximum benefits. Under the PPO plans, a plan participant simply chooses a doctor or hospital from the administrator's provider listing at the time services are needed. Plan participants are not required to utilize network providers, however, there are definite advantages for participants who do. Special, reduced fees have been negotiated with all network providers, and plan participants will not be responsible for paying the difference between the provider's normal charge and the specially negotiated fee. In addition, when using network providers, there are no claim forms to file, deductibles are lower and the maximum yearly out-of-pocket is lower.

Plan participants who utilize a provider outside of the network will incur more out-of-pocket costs. Because special fees have not been negotiated with non-network providers, participants have a lower benefit level and will be responsible for paying any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined.

The carriers do not have networks in all areas of the country. Benefit recipients who reside in one of these non-network areas still choose either Aetna or MMO as their claims administrator. These individuals can then use any provider or hospital and still receive most benefits at the "network" benefit level. When utilizing non-network providers, however, these benefit recipients must still file their own claim forms, pre-certify themselves and pay any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined by the carrier.

Please see Appendix I for a chart describing the various benefit levels.

Prescription drugs

Prescription drug coverage is administered by AdvancePCS, regardless of which carrier or plan a benefit recipient chooses for major medical coverage. All benefit recipients and their dependents who enroll in major medical coverage are also automatically enrolled in prescription drug coverage at the same time. Benefit recipients receive a separate card for prescription drugs, which contains the AdvancePCS logo. The prescription drug program allows participants to purchase their medications at discounted rates at either a retail location or, for the greatest savings, through the mail (See Appendix J).

Supplemental dental and vision

Most of the HMO plans cover routine dental and vision services, however, the PPO plans do not. To supplement their medical coverage, benefit recipients have the option to enroll in separate dental and vision plans. These plans are offered in addition to the medical expense benefit plans, and have separate contribution amounts. Benefit recipients may also enroll in these plans if they do not elect to enroll in a OP&F-sponsored medical expense benefit plan. Enrollment in these plans is only permitted once every year during the fall open enrollment period. The terms require that the covered persons participate for twelve months with no earlier right to terminate coverage. OP&F does not subsidize the cost of these plans—enrollees pick up the full premium. Please see Appendix K for a breakdown of dental coverage, Appendix L for a breakdown of vision coverage and Appendix M for contribution amounts for both plans.

Long term care

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. OP&F's major medical plans do not cover custodial care and Medicaid only covers long term care for people living at or below the poverty level.

To help pay the cost of long term care, OP&F offers a separate long term care policy through Aetna. Enrollees are eligible for a benefit of $50 to $250 per day toward custodial nursing home expenses, and half of the covered amount toward home care, adult day care, or other long term care expenses. This is not an OP&F subsidized benefit and premiums, based on the person's age at the time of enrollment, are paid directly to Aetna by enrollees. This plan is available to active OP&F members, their spouses and parents, as well as current OP&F benefit recipients and their dependents.

Open Enrollment

Every year, plan participants have the opportunity to change plans during the open enrollment period. This major project involves creating a customized booklet for health care participants, which specifically outlines the plans available in their area of residence.

Medicare Part B Reimbursements

Medicare Part B Reimbursements

Upon eligibility for Medicare Part B, benefit recipients and surviving spouses are eligible for reimbursement of the Medicare Part B premium through OP&F (as required by O.R.C. 742.45, Section B, See Appendix A), if not receiving reimbursement from another source. The 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. In 2002, OP&F paid out over $6.1 million in Medicare B reimbursements.

When becoming eligible for Medicare Part B, benefit recipients should submit a copy of their Medicare card and Medicare Part B Reimbursement Statement as soon as possible. Upon notification of a benefit recipient's death, the surviving spouse will be sent instructions regarding applying for the Medicare Part B reimbursement. Retirees and surviving spouses who are eligible to receive the Medicare B reimbursement from another Ohio Retirement System or from another source are not eligible for the OP&F reimbursement. Reimbursement will not begin until the proper information is received. No retroactive reimbursements are made.

Appendices

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

1997 - 2002

	1997	1998	1999	2000	2001	2002
Additions:						
Employer Contributions	$75,277,682	$79,553,768	$91,109,660	$101,205,133	$109,036,669	$118,459,642
Retirant Contribution	5,251,898	5,331,515	5,518,098	5,657,431	6,874,699	12,623,875
Investment Income	20,647,822	23,034,445	22,726,931	(3,130,947)	(10,416,465)	(23,046,110)
Recoveries and Rebates	979,352	979,352	-	-	645,533	2,761,990
TOTAL ADDITIONS	102,156,754	108,899,080	119,354,689	103,731,617	106,140,436	110,799,397
Deductions:						
Health care Expenses	76,459,832	83,928,305	100,522,731	111,817,485	129,173,470	153,651,881
Administrative Expenses	3,048,819	2,396,457	2,817,126	3,192,119	3,114,771	2,246,504
TOTAL DEDUCTIONS	79,508,651	86,324,762	103,339,857	115,009,604	132,288,241	155,898,385
Net Increase/Decrease	22,648,103	22,574,318	16,014,832	(11,277,987)	(26,147,805)	(45,098,988)
Net assets held in trust for postemployment healthcare benefits:						
Balance, Beginning of year	226,773,540	249,421,643	271,995,961	288,010,793	276,732,806	250,585,001
Balance, End of year	$249,421,643	$271,995,961	$288,010,793	$276,732,806	$250,585,001	$205,486,013

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 ex-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 5 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	40 years
Furniture, fixtures, equipment and software	3 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% 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% of the market value for 2002 and 20% 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 HCSF. The HCSF is charged with all health care expenses and administrative costs. As of December 31, 2002, the balance in the HCSF was $205,486,013.

APPENDIX D

Plan Net Assets Available for Postemployment Health Care Benefits as of December 31, 2002

Assets	
Cash and Short-term Investments	$ 10,619,850
Receivables:	
Employers' Contributions	30,086,258
Accrued Investment Income	850,381
Investment Sales Proceeds	655,268
Total Receivables	31,591,907
Investments, at fair value:	
Bonds	27,899,830
Mortgage & Asset Backed Securities	20,989,646
Stocks	84,661,495
Real Estate	16,040,864
Commercial Mortgage Funds	3,162,622
Private Equity	2,472,606
International Securities	33,639,031
Total Investments	188,866,094
Collateral on Loaned Securities	30,987,039
Capital Assets:	
Building, Furniture and Equipment	801,515
Accumulated Depreciation	(154,788)
Total Capital Assets	646,727
Prepaid Expenses and Other	10,892
TOTAL ASSETS	262,722,509
Liabilities	
Medical Benefits Payable	16,754,185
Investment Commitments Payable	9,034,924
Accrued Administrative Expenses	171,030
Other Liabilities	289,318
Obligations Under Securities Lending	30,987,039
TOTAL LIABILITIES	57,236,496
Net assets held in trust for postemployment healthcare benefits	**$205,486,013**

APPENDIX E

Statement of Changes in Plan Net Assets Available for Postemployment Health Care Benefits Year Ending December 31, 2002

Additions:	
Contributions:	
Employers	$118,459,642
Retirants	12,623,875
Total Contributions	131,083,517
Investment Income:	
Net Appreciation of Fair Value of Investments	(42,621,006)
Bond Interest	3,856,002
Dividends	783,303
Real Estate Operating Income, net	1,190,748
Foreign Securities	14,017,295
Other	174,336
Less Investment Expenses	(515,078)
Net Investment Income	(23,114,400)
From Securities Lending Activities:	
Securities Lending Income	606,903
Securities Lending Expense:	
Borrower Rebates	(509,360)
Management Fees	(29,253)
Total Securities Lending Expense	(538,613)
Net Income from Securities Lending	68,290
Other Income	2,761,990
TOTAL ADDITIONS	110,799,397
Deductions:	
Health Care Benefits	153,651,881
Administrative Expenses	2,246,504
TOTAL DEDUCTIONS	155,898,385
Net Increase (Decrease)	(45,098,988)
Net assets held in trust for postemployment health care benefits:	
Balance, Beginning of year	250,585,001
Balance, End of year	$205,486,013

APPENDIX F

Major Medical Plan Premiums

Contributions for major medical and prescription drug coverage are deducted monthly from the benefit recipient's check. All benefit recipients and their eligible dependents are charged a monthly premium for major medical coverage. The contributions required for participation in all parts of the OP&F Medical Expense Benefits Program are indicated below.

January 1 to June 30, 2002
Monthly Major Medical*

Coverage Category	Category Definition	Monthly Contribution 7/1/01 through 6/30/02
Single	Benefit recipient** is the only enrollee.	$25.35
Two-Party	Benefit recipient** plus one eligible family member enrolled.	$35.49
Family	Benefit recipient** plus two or more eligible family members enrolled.	$45.63

July 1, 2002 to December 31, 2003
Monthly Major Medical*

Coverage Category	Category Definition	Monthly Contribution 7/1/02 through 12/31/03
Single	Benefit recipient** is the only enrollee.	$41.20
Two-Party	Benefit recipient** plus one eligible family member enrolled.	$82.40
Family	Benefit recipient** plus two or more eligible family members enrolled.	$123.60

**Please note that these rates are subject to change at any time.*
***"Benefit recipient" includes retirees and surviving spouses.*

Under the contribution schedule, originally implemented on July 1, 2001, there are three categories of premiums – single, two-party, and family. The amount of these contributions is simply based on the number of family members enrolled in the program. The Board will review medical benefit expenses annually to determine the premiums and the discount program that will be effective each year.

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 2002 was 30% in each coverage category. To be considered for this discount, benefit recipients must annually request an *Application for Health Care Discount* form from OP&F and submit the properly completed application to OP&F by April 30th. OP&F will send benefit recipients notification by May 30th as to whether or not they qualify for the discount. For those

who qualify, the discount will then begin on July 1st and run through June 30th of the following year. Benefit recipients who receive the discount must reapply for the discount each year.

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 ninety (90) days from the date that OP&F sent the application.

APPENDIX G

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 employers contribution for all benefits, both pension and health care, has been set by statute as a percentage of payroll. The assumed level percentage of 6.5 percent 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 H

Health Maintenance Organization (HMO) Coverage

Description	Aetna	Kaiser	Paramount
PHYSICIAN SERVICES			
Office Visit with PCP	$10 copay	$10 copay	$10 copay
Specialist			
Consultation	$10 copay	$10 copay	$10 copay
Treatment	100%	$10 copay	$10 copay
Immunizations & Inoculations	100%	100%	100%
Allergy Treatment/Testing	$10 copay	100%	$10 copay
Diagnostic x-ray & lab testing	100%	100%	100%
Podiatrists	$10 copay (if med. necessary)	$10 copay (if med. necessary)	$10 copay if medically necessary/2 preventive visits per year
Chiropractors	$10 copay (unlimited)	$10 copay: 20 visits per yr, then 50% per visit	Subluxation: $10 copay for 20 visits then 50% unlimited
PREVENTIVE SERVICES (one per year)			
Physical Exams	$10 copay	$10 copay	$10 copay
Routine PSA Test	100%	$10 copay	$10 copay
Routine Mammogram	100%	$10 copay	100%
Routine PAP Smear	100%	$10 copay	$10 copay
Routine Eye Exam	$10 copay 1/yr.	$10 copay	$10 copay
Routine Hearing Exam	$10 copay	$10 copay	$10 copay
**one gynecological exam per year covered with participating GYN, without PCP referral*			
HOSPITAL SERVICES			
Hospital Confinement	100%	100%	100%
Inpatient Physician Visit	100%	100%	100%
Surgical Procedures (inpatient and out-patient)	100%	100%	100%
EMERGENCY ROOM			
Hospital Charges	$25 copay waived if admitted	$25 copay waived if admitted	$25 copay waived if admitted
Ambulance	100%	100%	100%
MENTAL HEALTH			
Inpatient Confinement	100% (unlimited)	100% (unlimited)	100%
Outpatient Care	$10 copay (unlimited)	$10 copay (unlimited)	$5 copay (unlimited)
ALCOHOL & SUBSTANCE ABUSE			
Inpatient Confinement	100% (unlimited)	100%	100%
Outpatient Care	$10 copay (unlimited)	$10 copay	$5 copay (unlimited)

Health Maintenance Organization (HMO) Coverage (cont'd)

Description	Aetna	Kaiser	Paramount
OTHER SERVICES			
Skilled Care Facility	100% (unlimited)	100%, 100 days/ calendar year or benefit period	100%, up to 100 days/ benefit period
Home Health Care	100% (unlimited)	100%	100%
Hospice Services	100%	100%	100%
Outpatient Therapy Services	$10 copay (unlimited)	$10 copay	100%
Durable Medical Equipment	100%	100%	100%
Hearing Aid Allowance	$700 every 36 mos.	100% every 3 years	$700 every 3 years
Vision—Glasses & Contacts (Covered 100% under all plans if in conjunction with cataract surgery)	$300 every 24 mos.	$300 every 24 mos. Use United Optical for exam & hardware	$500 every 2 years
DENTAL COVERAGE	**Advantage Dental**	**Delta Dental**	**Delta Dental**
Deductible	None	None	$50 per person, $150 family maximum
Annual Maximum	None	None	$1500 per year
Preventive Care	$2 copay 2 visits/yr	100%	100%, no deductible
Basic Care	Discounted fees	Discounted copays	80% after deductible
Major Restorative Care	Discounted fees	Discounted copays	50% after deductible
Network Providers Required	Yes	Yes	Yes

Primary Care Physicians must provide and/or arrange for all health care. All benefits subject to medical necessity requirements and/or prior approval by the HMO.

APPENDIX I

Preferred Provider Organization (PPO) Benefits Chart

The benefit coverage for benefit recipients residing in areas considered "in-network" and "non-network" are explained in the Network PPO Comparison Chart below. Please note that routine check-ups and claims that the insurance company determines are for maintenance care are NOT covered under the Preferred Provider Organization (PPO) plans.

Description	Non-Network *Medicare A & B eligible/Permanent residents of non-network area*	Network *Member & dependents assigned to a PPO network and using network providers*	Out-of-Network *Member & dependents assigned to a PPO network, but using non-network providers*
GENERAL INFORMATION			
Major Plan Features	Use any provider	Use network provider	Use any provider
Deductible (per plan year):			
Benefit recipient	$100.00	$100.00	$250.00
Family	$200.00	$200.00	$500.00
(no carryover)			
Max. Annual Out-of-Pocket:	Excludes deductible	Excludes deductible	Excludes deductible
Benefit recipient	$500.00	$500.00	$1,500.00
Family	$750.00	$750.00	$2,250.00
Lifetime Maximum	$1,000,000.00	$1,000,000.00	$1,000,000.00
Claim Forms	Yes	No	Yes
Pre-certification/ Utilization review	Patient responsible	Provider responsible	Patient responsible
Pre-certification penalty:			
Inpatient (per admission)	$200.00	None	$200.00
Outpatient	$100.00	None	$100.00
Managed Second Opinion			
Surgery	$100.00	None	$100.00
PHYSICIAN SERVICES			
Office visits	80%	$10.00 copay	70%
Surgeon/Consultant fees	80%	80%	70%
Services not available in network	80%	80%	80%
Surgeons/Surgery fees	80%	80%	70%
OB/Maternity visits & delivery	80%	80%	70%
Diagnostic, x-ray & lab fee	80%	80%	70%
HOSPITAL SERVICES			
Per admission deductible	None	None	$100.00
Inpatient coinsurance	100%	100%	70%
Outpatient			
Pre-admission testing	100%	100%	70%
Surgery	100%	100%	70%
All other	80%	80%	70%
EMERGENCY ROOM			
Hospital Emergency Care* (includes associated tests & physician charges)	$50 copay for facility (waived if admitted); 80% other charges	$50 copay for facility (waived if admitted); 80% other charges	$50 copay for facility (waived if admitted); 80% other charges

Preferred Provider Organization Benefits Comparison Chart, cont'd.

Description	Non-Network	Network	Out-of-Network
MENTAL HEALTH**			
Inpatient & partial hospitalization coinsur. (includes drug abuse)	100%	100%	70%
Mental/Nervous & Drug Abuse outpatient coinsur.	80%	80%	70%
Alcoholism inpatient coins.	100%	100%	70%
Alcoholism outpatient coinsurance	80%; annual maximum benefit = $550.00	80%; annual maximum benefit = $550.00	70%; annual maximum benefit = $550.00
PREVENTIVE CARE***			
Well baby/child care	Age 0-1 = 80%; $500/yr Age 1-9 = 80%; $150/yr	Age 0-1 = 80%; $500/yr Age 1-9 = 80%; $150/yr	Age 0-1 = 70%; $500/yr Age 1-9 = 70%; $150/yr
Routine PAP Smear Max. one per calendar yr.	80%	$10 copay for physician services; 80% for lab	70%
Routine Mammogram Max. $85 annual benefit	80%	$10 copay for physician services; 80% for lab	70%
Routine PSA Max. $85 annual benefit	80%	$10 copay for physician services; 80% for lab	70%
OTHER COVERED EXPENSES			
Skilled nursing facility	100%; up to 365 days	100%; up to 365 days	70%; up to 365 days
Chiropractors & physical therapists**, durable medical equipment & ambulance**	80%	80%	70%; limit of 24 chiropractic visits
Acupuncturist (in lieu of anesthesiologist)	80%	80%	70%
Private duty nurse home health care	80%; private duty limit of 120 8-hr shifts per calendar year	80%; private duty limit of 120 8-hr shifts per calendar year	70%; private duty limit of 120 8-hr shifts per calendar year
Hospice care Inpatient Outpatient	*Lifetime maximum* = 100%; up to 30 days 80%; limited to benefit of $3,000.00	*Lifetime maximum* = 100%; up to 30 days 80%; limited to benefit of $3,000.00	*Lifetime maximum* = 80%; up to 30 days 70%; limited to benefit of $2,000.00

**Must be on same day as injury or illness*

***Covered for alcohol or drug abuse treatment only if treatment is for underlying causes leading to rehabilitation from such addiction. Detoxification alone is not covered.*

****Routine health check-ups and claims that the insurance company determines are for maintenance care are NOT covered under the PPO plans. The HMOs do cover these services.*

*****Chiropractic care must be non-maintenance care, and physical therapy treatments must be performed by registered therapist and recommended by physician.*

APPENDIX J

Prescription Drug Benefits

Prescription Drug Benefits Chart

The chart below lists the benefits available through the Prescription Drug Program. Benefit recipients should consult their Prescription Drug Program brochure for more information on using the retail and mail prescription services.

Description	Retail Program	Mail Program
When to use	Short-term or immediate need	Long-term or ongoing use
You pay	**Participating Pharmacies:** $5.00 for generic $10.00 for brand names **Non-Participating Pharmacies:** $7.50* for generic $15.00* for brand name **After deductible is satisfied*	$1.00 for generic $5.00 for brand names
Drug supply per Rx (as prescribed by physician)	Up to 60 days	Up to 60 days
Drug deductible	**Participating Pharmacies:** None **Non-Participating Pharmacies & when claim forms filed:** $50.00 per person $100.00 family maximum	None
Claim form required	**Participating Pharmacies:** No **Non-Participating Pharmacies:** Yes	No

APPENDIX K

Supplemental Dental Coverage

ONE PLAN WITH THREE NETWORKS. This dental plan consists of two networks–the DeltaPreferred Option Plus and the DeltaPremier. As shown below, benefit recipients and their enrolled dependents receive the maximum benefit level when utilizing the DeltaPreferred Network.

DESCRIPTION OF PROCEDURE	***DeltaPreferred Option Plus Utilizing DeltaPreferred Option Plus Network dentist***	***Delta Premier Utilizing Premier Network Dentist***	***Non Network Dentist (pays up to usual, customary & reasonable limits)***
Deductible	50/150 family	100/300 family	100/300 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 (minor)	80% after deductible	50% after deductible	50% after deductible
Minor Restorative	80% after deductible	50% after deductible	50% after deductible
Periodontics (minor)	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
Orthodontia services are not covered. Other exlcusions & limitations may apply.			

APPENDIX L

Supplemental Vision Coverage

DESCRIPTION	PLAN PAYS
Eye Exams*	$50 for one exam every 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 every 24 months

**This is for routine eye exams 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 benefit recipient's major medical benefits and subject to the deductibles of the medical plan.*

APPENDIX M

Supplemental Dental and Vision Plan Premiums

Who's Covered	Aetna Vision	Delta Dental
Benefit Recipient (including survivors)	$3.71	$17.05
Benefit Recipient & Spouse	7.42	33.25
Benefit Recipient & Child(ren)	6.29	29.02
Benefit Recipient, Spouse & Child(ren)	10.00	51.62