SERS Annual Health Care Report

DECEMBER 2005

School Employees Retirement System
Annual Health Care Report

December 2005

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Sec. 3309.49 Employer's contribution rate.

Each employer shall pay annually to the school employees retirement system an amount certified by the secretary that shall be a certain per cent of the earnable compensation of all employees, and shall be known as the "employer contribution." The rate per cent of such contribution shall be fixed by the actuary on the basis of the actuary's evaluation of the liabilities of the school employees retirement system, but shall not exceed fourteen per cent, and shall be approved by the school employees retirement board. The school employees retirement board may raise the rate per cent of the contribution to fourteen per cent of the earnable compensation of all employees. In making such evaluation, the actuary shall use, as the actuarial assumptions, regular interest and such mortality and other tables as are adopted by the school employees retirement board. The actuary shall compute the percentage of such earnable compensation, to be known as the "employer rate," required annually to fund the liability for all allowances, annuities, pensions and other benefits, and any deficiencies in the various funds, provided for in this chapter, after deducting therefrom the annuity and other benefits provided by the contributor's accumulated contributions and deposits or other applicable moneys.

Eff. 4/9/01; Am. Sub. S.B. 270
6/30/91; H.B. 382

3309.491 Employer minimum compensation contribution to fund future health care benefits.

(A) An actuary employed by the school employees retirement board shall annually determine the minimum annual compensation amount for each member that will be needed to fund the cost of providing future health care benefits under section 3309.69 of the Revised Code. The amount determined by the actuary under this division shall be approved by the board and shall be known as the "minimum compensation amount."

(B) (1) The secretary of the school employees retirement board shall annually determine for each employer the "employer minimum compensation contribution."

Subject to division (B)(2) of this section, the amount determined shall be the lesser of the following:

(a) An amount equal to two per cent of the compensation of all members employed by the employer during the prior year;

(b) The total of the amounts determined as follows for each member whose compensation for the prior year was less than the minimum compensation amount:

(i) Subtract the member's compensation for the prior year from the minimum compensation amount;

(ii) Multiply the remainder obtained under division (B)(1)(b)(i) of this section by one, or if the member earned less than a year's service credit for the prior year, by the same fraction as the fraction of a year's service credit credited to the member under section 3309.30 of the Revised Code;

(iii) Multiply the product obtained under division (B)(1)(b)(ii) of this section by the employer contribution rate in effect for the year the service credit was earned.

(2) If the total of the employer minimum contribution amounts determined under division

(B)(1) of this section exceeds one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution, the school employees retirement board shall reduce the amount determined for each employer so that the total amount determined does not exceed one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution. Any reduction shall be applied to each employer in the same proportion as the employer's minimum compensation contribution bears to the total employer minimum compensation contribution.

(C) The secretary shall annually certify to each employer the employer minimum compensation contribution determined under division (B) of this section. In addition to the employer contribution required by section 3309.49 of the Revised Code, each employer shall pay annually to the employers' trust fund the amount certified to the employer under this division.

(D) Annually by the first day of August, the secretary shall submit to the superintendent of public instruction a list of the payments made by each employer under this section during the preceding fiscal year.

Eff. 4/09/2001; S.B. 270
09/09/88; H.B. 290

Sec. 3309.375 Hospital insurance coverage for retirants.

(A) Except as otherwise provided in division (B) of this section, the board of the school employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, "Social Security Amendments of 1965," 79 Stat. 291, 42 U.S.C.A. 1395c, as amended. This coverage shall also be made available to the spouse, widow, or widower of such retirant or disability benefit recipient provided such spouse, widow, or widower has attained age sixty-five and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage only if he or she is the recipient of a monthly allowance or benefit from this system. Not less than twenty-five per cent of the cost for such coverage shall be paid from the appropriate funds of the school employees retirement system and the remainder by the recipient of the allowance or benefit.

The cost of such coverage, paid from the funds of the system, shall be included in the employer's rate provided by sections 3309.49 and 3309.51 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and shall contract for such coverage as provided in section 3309.69 of the Revised Code.

Notwithstanding sections 3309.49 and 3309.51 of the Revised Code, the employer's contribution rate shall not be increased until July 1, 1969, or later to reflect the increased costs created by this section.

(B) The board need not make the hospital insurance coverage described in division (A) of this section available to any person for whom it is prohibited by section 3309.69 of the Revised Code from paying or reimbursing the cost of such insurance.

Eff. 7/29/92; S.B. 346
6/30/91; H.B. 382

Section 3309.69 Group hospitalization coverage; ineligible individuals; service credit; alternative use of health insuring corporation

(A) As used in this section, "ineligible individual" means all of the following:

(1) A former member receiving benefits pursuant to section 3309.34, 3309.35, 3309.36, 3309.38, or 3309.381 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 3309.46 of the Revised Code.

(B) The school employees retirement board 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 retirement or a disability or survivor benefit subscribing to the plan and their eligible dependents.

If all or any portion of the policy or contract premium is to be paid by any individual receiving service retirement or a disability or survivor benefit, the person shall, by written authorization, instruct the board to deduct the premiums agreed to be paid by the individual to the companies, corporations, or agencies.

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 school employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 3309.49 and 3309.491 of the Revised Code. The board shall not pay or reimburse the cost for health care under this section or section 3309.375 of the Revised Code for any ineligible individual.

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.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, make a monthly payment to each recipient of service retirement, or a disability or survivor benefit under the school employees retirement system who is eligible for insurance coverage under part B of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, except that the board shall make no such payment to any ineligible individual. Effective on the first day of the month after April 9, 2001, the amount of the payment shall be the lesser of an amount equal to the basic premium for such coverage, or an amount equal to the basic premium in effect on January 1, 1999.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 3309.375 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, Ohio police and fire pension fund, state teachers retire-

ment system, or state highway patrol retirement system.

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

Eff. 10/1/02; S.B. 247
4/9/01; Am. Sub. S.B. 270
11/2/99; H.B. 222
12/8/98; Sub. H.B. 673
6/4/97; S.B. 67
3/6/97; Am. Sub. S.B. 82
7/29/92; S.B. 346
6/30/91; H.B. 382
5/4/92; H.B. 383

Sec. 3309.691 Long term health care programs.

The school employees retirement board shall establish a program under which members of the retirement system, employers on behalf of members, and persons receiving service, disability or survivor benefits are permitted to participate in contracts for long-term health care insurance. Participation may include dependents and family members. If a participant in a contract for long-term care insurance leaves employment, the participant and the participant's dependents and family members may, at their election, continue to participate in a program established under this section in the same manner as if the participant had not left employment, except that no part of the cost of the insurance shall be paid by the participant's former employer.

Such program may be established independently or jointly with one or more of the other retirement systems. For purposes of this section, "retirement systems" has the same meaning as in division (A) of section 145.581 of the Revised Code.

The board 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 long-term care insurance policy or contract. However, prior to entering into such agreement with an insurance company or health insuring corporation, the board shall request the superintendent of insurance to certify the financial condition of the company or corporation. The board shall not enter into the agreement if, according to that certification, the company or corporation is insolvent, is determined by the superintendent to be potentially unable to fulfill its contractual obligations, or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or under an order of supervision by the superintendent.

The board shall adopt rules in accordance with section 111.15 of the Revised Code governing the program. The rules shall establish methods of payment for participation under this section, which may include establishment of a payroll deduction plan under section 3309.27 of the Revised Code, deduction of the full premium charged from a person's service, disability or survivor benefit, or any other method of payment considered appropriate by the board. If the program is established jointly with one or more of the other retirement systems, the rules also shall establish the terms and conditions of such joint participation.

Eff. 6/4/97; S.B. 67
7/1/93; H.B. 152

10/29/91; H.B. 180

Sec. 3309.70 Overpayment of benefit; recovery.

If a person who is a member, former member, contributor, former contributor, retirant, beneficiary, or alternate payee, as defined in section 3105.80 of the Revised Code, is paid any benefit or payment by the school employees retirement system to which the person is not entitled, the benefit shall be repaid to the retirement system by the person. If the person fails to make the repayment, the retirement system shall withhold the amount due from any benefit due the person or the person's beneficiary under this chapter, or may collect the amount in any other manner provided by law.

Eff. 1/1/02; Sub. H.B. 535
7/29/92; S.B. 346

Section 3305.01 Alternative Retirement Plans-Definitions.

As used in this chapter:

(A) "Public institution of higher education" means a state university as defined in section 3345.011 of the Revised Code, the medical college of Ohio at Toledo, the northeastern Ohio universities college of medicine, or a university branch, technical college, state community college, community college, or municipal university established or operating under Chapter 3345., 3349., 3354., 3355., 3357., or 3358. of the Revised Code.

(B) "State retirement system" means the public employees retirement system created under Chapter 145. of the Revised Code, the state teachers retirement system created under Chapter 3307. of the Revised Code, or the school employees retirement system created under Chapter 3309. of the Revised Code.

(C) "Eligible employee" means any person employed as a full-time employee of a public institution of higher education.

In all cases of doubt, the board of trustees of the public institution of higher education shall determine whether any person is an eligible employee for purposes of this chapter, and the board's decision shall be final.

(D) "Electing employee" means any eligible employee who elects, pursuant to section 3305.05 or 3305.051 of the Revised Code, to participate in an alternative retirement plan provided pursuant to this chapter or an eligible employee who is required to participate in an alternative retirement plan pursuant to division (C)(4) of section 3305.05 or division (F) of section 3305.051 of the Revised Code.

(E) "Compensation," for purposes of an electing employee, has the same meaning as the applicable one of the following:

(1) If the electing employee would be subject to Chapter 145. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "earnable salary" as defined in division (R) of section 145.01 of the Revised Code;

(2) If the electing employee would be subject to Chapter 3307. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "compensation" as defined in division (L) of section 3307.01 of the Revised Code;

(3) If the electing employee would be subject to Chapter 3309. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "compensation" as defined in division (V) of section 3309.01 of the Revised Code.

(F) "Provider" means an entity designated under section 3305.03 of the Revised Code as a provider of investment options for an alternative retirement plan.

Eff. 8/1/05; Sub. S.B. 133
4/01/01; Sub. H.B. 535
3/31/97; Am. Sub. H.B. 586

3309-1-35 Health care and medicare "B" coverage.

(A) Definitions

As used in this rule:

(1) "Ineligible person" has the same meaning as in section 3309.69 of the Revised Code.

(2) "Benefit recipient" means an age and service retirant, disability benefit recipient, or a beneficiary as defined in section 3309.01 of the Revised Code, who is receiving monthly benefits due to the death of a member, age and service retirant or disability benefit recipient.

(3) "Member" has the same meaning as in section 3309.01 of the Revised Code.

(4) "Age and service retirant" means a former member who is receiving a retirement allowance pursuant to section 3309.34, 3309.35, 3309.36 or 3309.381 of the Revised Code.

(5) "Disability benefit recipient" means a member who is receiving a benefit or allowance pursuant to section 3309.35, 3309.40 or 3309.41 of the Revised Code.

(6) "Child" means an unmarried, biological, adopted or step-child of the retirant, member, deceased retirant or deceased member or other child who lives or lived with the retirant, member, deceased retirant or deceased member in a parent-child relationship in which the retirant, member, deceased retirant or deceased member has or had custody of the child.

(7) "Dependent child" means a child who:

(a) (i) Is under age eighteen or under age twenty-two if attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirements of such institution, or

(ii) Regardless of age is physically or mentally incompetent, provided that the incompetence existed prior to the retirant's or member's death and prior to the dependent child reaching age eighteen or age twenty-two if attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirements of such institution, and

(b) During the twelve-month period preceding the application for health care coverage or the member or retirant's death, lived with the member or retirant in a parent-child relationship or received at least one-half of his/her support from the member, retirant, deceased member or deceased retirant.

(8) "Health care coverage" means any plan offered by the system including, but not limited to, the medical plan, and the prescription drug program.

(9) "Premium" means a monthly amount that may be required to be paid by a benefit recipient to continue enrollment for health care coverage for the recipient or the recipient's eligible dependents.

(B) Eligibility

Any person who is not an "ineligible person" as defined in section 3309.69 of the Revised Code, is eligible for health care coverage under the school employees retirement system's

health care plan so long as eligibility has not been terminated as provided in paragraph (D) of this rule and the person qualifies as one of the following:

(1 An age and service retirant or the retirant's spouse or dependent child,

(2) A disability benefit recipient or the recipient's spouse or dependent child,

(3) The spouse or dependent child of a deceased member, age and service retirant or disability benefit recipient, if the spouse or dependent child is receiving a benefit pursuant to section 3309.45 or 3309.46 of the Revised Code,

(4) The dependent child of a deceased member or deceased retirant who is living with the primary recipient of a benefit under section 3309.45 or 3309.46 of the Revised Code in a parent-child relationship in which the primary recipient has custody of the dependent child.

(C) Effective date of coverage

(1 The effective date of health care coverage for persons eligible for health care coverage as set forth in paragraph (B) of this rule shall be as follows, for:

(a) A disability benefit recipient, spouse or dependent child of a disability benefit recipient health care coverage shall be effective on the first of the month following approval of the benefit or the benefit effective date, whichever is later.

(b) An age and service retirant, spouse or dependent child of an age and service retirant health care coverage shall be effective on the first of the month following the date that the retirement application is filed with the retirement system or the benefit effective date, whichever is later.

(c) For an eligible spouse or dependent child of a deceased member or deceased retirant health care coverage shall be effective on the effective date of the benefit if the appropriate application is received within three months of the date of the member's or retirant's death, or the first of the month following the date that the appropriate application is received if not received within three months of the date of the member's or retirant's death.

(2) Eligibility for health care shall terminate when:

(a) The person ceases to qualify as one of the persons listed in paragraph (B) of this rule;

(b) The person's health care coverage is terminated for default as provided in paragraph (D) of this rule; or

(c) The person's coverage is waived as provided in paragraph (E) of this rule.

(D) Premium payment

(1) Payment of premiums for health care coverage shall be by deduction from the benefit recipient's monthly benefit. If the full amount of the monthly premium cannot be deducted from the benefit recipient's monthly benefit, the benefit recipient shall be billed for the portion of the monthly premium due after any deduction from the monthly benefit.

(2) Premium payments billed to a benefit recipient shall be deemed in default after two consecutive months of nonpayment. A benefit recipient who is in default shall be sent notice by certified U.S. mail informing the benefit recipient that payments are in default and

that coverage will be terminated on the first day of the month after the date of the notice unless payment for all months in default is received prior to the termination date. If coverage is terminated due to a recipient's failure to pay premium amounts in default, the recipient shall remain liable for such amounts due for the period prior to termination of coverage.

(3) After termination for default, eligibility for health care coverage can be reestablished and coverage reinstated as provided in paragraph (E)(1)(a) or (E)(1)(b) of this rule, or upon submission of an application for reinstatement supported by medical evidence acceptable to SERS that demonstrates that the default was caused by the benefit recipient's physical or mental incapacity, and payment of all premium amounts in default. "Medical evidence" means documentation provided by a licensed physician of the existence of the mental or physical incapacity causing the default. Health care coverage reinstated after termination for default shall be effective on the first of the month following the date that the application for reinstatement is approved and all payments in default received.

(E) Waiver

(1) Except as otherwise provided in rule 3309-1-55 of the Administrative Code, a benefit recipient may waive health care coverage. Such waiver is effective beginning the first of the month following the later of the retirement system's receipt of the waiver or the effective date of a monthly benefit. The waiver is effective as to both the benefit recipient and the recipient's dependents. A benefit recipient may revoke the waiver by filing a health care enrollment application as follows.

(a) The application is received no later than thirty-one days after reaching age sixty-five. Health care coverage shall be effective the later of the first day of the month after reaching sixty-five or receipt of the enrollment application by the system;

(b) The application is received no later than thirty-one days after involuntary termination of coverage under another group plan with proof of such termination. Health care coverage shall be effective the later of the first day of the month after termination of the other group plan or receipt of proof of termination and the enrollment application by the system.

(2) A benefit recipient retaining health care coverage may remove a spouse or dependent child from health care coverage at any time. An eligible spouse or dependent child may subsequently be enrolled for health care coverage only as provided in paragraph (E)(1)(a) or (E)(1)(b) of this rule.

(F) Medicare part "B"

(1) The effective date of the medicare "B" premium to be paid by the board shall be the later of:

(a) January 1, 1977; or

(b) The first of the month following the date that the school employees retirement system received satisfactory proof of coverage; or

(c) The effective date of SERS health care coverage.

(2) The board shall not:

(a) Pay more than one monthly medicare "B" premium when a retirant or benefit recipient is receiving more than one monthly benefit from this system; nor

(b) Pay a medicare "B" premium to a retirant or benefit recipient who is receiving reimbursement for this premium from the highway patrol retirement system, the police and fire pension fund, the public employees retirement system and/or the state teachers retirement system.

Effective date:	1/2/04
Promulgated under:	R.C. 111.15
Authorized by:	R.C. 3309.04
Rule amplifies:	R.C. 3309.69
Prior effective date:	6/13/03; 11/9/98; 8/10/98;1/2/93; 7/20/89; 3/20/80; 1/1/77
Review date:	2/1/2007; 1/22/03

3309-1-51 Long-term care coverage.

(A) The school employees retirement system may contract directly with an insurer to establish a program that provides contracts for long-term care insurance for members and benefit recipients of the system and members of their families. If the program is established jointly with another retirement system, the contract shall separately establish the terms and conditions for participation through the school employees retirement system.

(B) Members of the school employees retirement system who have contributed to the system during the previous eighteen months may make application to participate in contracts effective on and after July 1, 1994 for long-term care coverage offered pursuant to section 3309.691 of the Revised Code, provided:

(1) Application for coverage shall be made directly to the insurer during enrollment periods specified by the school employees retirement system; and

(2) Determination of eligibility for participation under the terms of any such contract shall be made by the insurer with approval of the school employees retirement system.

(C) The recipient of any monthly benefit may participate in contracts for long-term care coverage, subject to the same conditions as those applicable to members under the terms of paragraph (B) of this rule.

(D) Payment for coverage shall be made by the member or benefit recipient to the insurer in such amounts and by such methods as determined under the contract for long-term care coverage.

(E) A spouse, parent or parent-in-law of any individual who has made application pursuant to paragraph (B) or (C) of this rule may apply for coverage subject to the same terms and conditions as those applicable to members under the terms of paragraph (B) of this rule, provided that in the case of a spouse, the individual participating pursuant to paragraph (B) or (C) of this rule agrees to remit the cost of such coverage along with his or her own payment.

Effective date:	5/3/02
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Authorized by:	R.C. 3309.04
Rule amplifies:	R.C. 3309.691
Review date:	2/1/07; 2/1/02
Prior Effective date:	6/10/94

HEALTH CARE HISTORY

1962, August - Blue Cross/Blue Shield

1968, October - Medicare B (medical) Deduction

Voluntary premium deduction from a benefit recipient's retirement benefit for their and/or their spouse's Medicare B coverage and forwarded monthly to the Medicare Payment Center.

1974, January - Benefit Recipient Cost-Free Blue Cross/Blue Shield

Voluntary enrollment for Blue Cross/Blue Shield coverage paid for by SERS for the benefit recipient. Premium required to cover eligible dependents.

1974, July - Blue Cross/Blue Shield program replaced

Aetna replaced the Blue Cross/Blue Shield Program in July; all benefit recipients enrolled with no cost coverage. Eligible dependents were covered. $20,000 maximum lifetime coverage per covered person for hospital and medical coverage established. Coordination of benefits insures that total claim payment does not exceed total cost when individual is covered by more than one health care plan.

1975, July - Maximum lifetime coverage increased to $250,000

Kaiser HMO offered to benefit recipients and dependents in Cleveland area.

1977, January - Medicare Part B (medical) Reimbursement

SERS begins reimbursing benefit recipients for the cost of Medicare Part B premiums.

1978, January - Filing Date Limitation - Provider Edits

Two-year limitation on liability for health care claims established; Problem Provider edits implemented - edits identify providers who consistently charge in excess of reasonable/ customary amounts.

1980, February - Hospital Audits

On-site hospital billing audit program implemented by Aetna; all hospital bills over $15,000 and bills with ancillary charges greater than 70% of total bill are audited by Aetna staff.

1981, February - Increased Aetna Maximum

Annual lifetime maximum increased to $500,000.

1981, March - Mail Order Drug Plan Introduced

Mail order prescription drug program introduced through National Rx Services, Inc. 90-day supply of prescription drugs for $1 retiree copay.

1981, June - 10 years of Service Credit required for Health Care Eligibility

H.B. 126 establishes 10 years of service credit as minimum required for health care coverage, to become effective June, 1986.

1981, July - Aetna Individual Case Management

Aetna implements individual case management to provide cost-effective alternative treatments.

1981, July - Aetna Split Funded Agreement

Replaced traditional indemnity-type insurance program with Split-Funded program. Split-funded arrangement permits detailed analysis of health care expenses and better control of claim processing costs. Reserves previously held by insurance company transferred to SERS; Health Care Reserve account established to receive funds. Separate accounting insures no commingling of funds accumulated to provide health care coverage with funds accumulated to provide basic retirement benefits.

1982, May - Fraud Investigation

Aetna investigators who review and document potential cases of fraud identified through claim processors, complaints, government agencies, audits, employers and other sources.

1982, December - Disclosure of Health Care Liabilities

SERS becomes first Ohio retirement system to publicly disclose long-term actuarial accrued liabilities of retiree health care. Employer contribution rate required for health care funding is determined by actuary; annual transfer of assets (based on this actuarially-determined rate) to Health Care Reserve account initiated.

1982, December - Health Care Questionnaire

Health care questionnaire mailed to all retirees soliciting ideas for reducing health care costs and opinion regarding six cost containment proposals currently being considered by retirement board.

1983, July - Premiums Established

Premium charges for spouse and dependent insurance coverage implemented; annual program deductible established.

1984, July - Reasonable/Customary Fees Enforced by Aetna

The reasonable and customary fee is the prevailing fee for the same service or supply in the same geographic area, by those of similar professional standing.

1984, September - Special Health Care Task Force

Special Task Force meeting organized by SERS. Representatives from member and employer organizations, Retirement Study Commission, health care providers, actuaries and accountants meet to study SERS' increasing health care costs. Panel members given actuarial estimate of potential tripling of health care costs by 1992 if effective cost containment measures were not implemented.

1985, January - Increase in Deductibles and Copays

50% increase in annual deductible and 100% increase in per-prescription retiree cost of mail order drug program implemented.

1985, July - Hospice Care Coverage provided

Covers charges for services rendered to a terminally ill patient as part of a Hospice Care Program. A terminally ill patient is a person who has received from a physician a medical prognosis of six months or less to live.

1986, March - Warning from Actuary regarding Health Care Financing

Actuary informs retirement board that health care program costs can no longer be funded on a level cost basis with current employer contribution rate; continued level cost funding of basic retirement benefits in peril.

1986, March - Health Care Seminar

Two-day Health Care Seminar, sponsored by Ohio Retirement Systems. The seminar was attended by members of all five retirement boards, the Chairman and members of Ohio Retirement Study Commission, executive directors and key staff members of all retirement systems and actuaries and auditors of some systems. Featured speakers included former chief actuary of the Social Security Administration and CEOs of health insurance and benefits consulting firms.

1986, June - Implementation of Service Credit Requirement

Effective June 13, 1986, Ohio law now requires minimum of 10 years of service to qualify for health care coverage.

1986, July - Hospital Admission Charge introduced

Separate $50 retiree charge for hospital admission instituted.

1986, October - H.B. 1060 introduced

Among other provisions, legislation would freeze Medicare Part "B" reimbursement, change the definition of a "year" of service credit and establish an employer surcharge on low salaries.

1987, September - New HMOs Introduced

Kaiser Plus and United Health Plan HMOs introduced.

1987, December - GASB Statement Number 5 Implemented

Early adoption of Governmental Accounting Standards Board Statement No. 5 - although not required to do so, SERS chooses to disclose health care liabilities as part of Pension Benefit Obligation to draw attention to long-term nature of health care financing problem.

1987, December - Independent Actuarial Review of Health Care

Retirement board authorizes engagement of independent actuarial firm to project health care program costs and propose alternative courses of action to contain future costs.

1987, December - Precertification and Second Surgical Opinions

Hospital pre-certification and second surgical opinions required for retirees and dependents not eligible for Medicare.

1987, December - H.B. 290 introduced

Additional board action promised on passage. Health care provisions of legislation and board action:

a) establish "career" vesting of health care coverage - 25 years of service required for full coverage subsidy. Coverage subsidy established at 25% (10-14 years), 50% (15-19 years) and 75% (20-24 years);

b) 40% reduction of System's subsidy of dependent health care premiums, to be phased-in over five years;

c) freeze Medicare Part "B" reimbursement at current level;

d) establish 80%/20% relationship between System costs and retiree costs of mail order drug program;

e) establish an employer surcharge (additional employer contribution) on members who earn less than an actuarially-determined minimum salary; the surcharge revenues to be used exclusively for funding health care coverage.

1988, June - H.B. 290 becomes law

1988, June - Medicare Direct Program Offered

Medicare-direct program offered to SERS retirees, over 23,000 retirees and dependents enroll in program.

1988, October - Deductibles and Copays Increased

Aetna deductible increased 67%, retiree cost of mail order drug program increased 200%.

1988, November - Prototype Prescription Card Program Tested

Testing of card-based program for dispensing of prescription drugs at retail level begins in Cuyahoga and Richland counties.

1988, December - Actuarial Report confirms effectiveness

Actuary informs SERS that, as a result of H.B. 290 and other cost containment efforts, level-cost funding of health care coverage has been restored.

1989, October - Mail Order Drug Copay Increased

Retiree co-payment for mail order drugs increased 33%, in accordance with 80/20 funding of mail order drug program instituted in 1987.

1989, December - Major Modifications to Mail Order Drug Program Approved

Retirement board approves significant changes to retiree costs under mail order prescription drug program, to be implemented in early 1990.

1990, April - Implementation of Mail Order Drug Program Modifications

Mail order drug program modified to encourage use of lower-cost generic drugs; retiree cost of brand name drugs increased 25%, retiree cost of generic drugs eliminated - projected 1-year savings of modification = $1 million or 6%-7% of total mail order program costs.

1990, March - Health Care Seminar Sponsored

Ohio Retirement Systems sponsors intensive two-day health care seminar. Members of retirement boards, executive directors, senior management and insurance personnel from all five retirement systems and Ohio Retirement Study Commission members and staff in attendance. Featured speakers include actuaries, physicians, insurance company executives, director of pension system outside Ohio and Ohio member of U.S. House of Representatives.

1990, May - Retail Drug Program Introduced

Retail drug program implemented; program permits significant discounts for drugs dispensed at retail level and electronic filing of retirees' prescription drug claims.

1991, March - Health Care Seminar

ORS sponsors another in a series of health care seminars intended to inform O.R.S.C., retirement boards, and key legislators responsible for health care legislation of current and proposed direction of retiree health care programs offered by ORS.

1991, February - Expansion of Medicare Direct Program

Medicare Direct expanded into the state of Florida.

1991, April - Mail-order drug copays to be maintained

Generic drug utilization increased by 33%, as the result of the SERS Board's actions of April, 1990. No retiree increase in overall cost of SERS mail-order drug program is necessary (first time since 1987).

1991, June - General Principles

SERS provides an excellent health care plan to qualified retirees and dependents. To guide the retirement system in the management of health care, the Board adopted the following principles:

1) SERS will use its best efforts within available resources to provide retirees access to quality health care at reasonable cost to retirees.
2) SERS will require its retirees, in turn, to act as reasonable and informed consumers in this process.
3) SERS believes that career public employees should receive greater value due to their longer service, but also recognizes that all eligible retirees should have access to the same health care.
4) The resources to fund the health care program should continue to come primarily from employers.
5) The funding of the program will be premised on concepts of intergenerational equity.
6) Health care coverage is secondary to basic benefits and cannot be paid from assets reserved for basic benefits.
7) Just as the systems are required to disclose the costs of the basic benefit program, so too should the short-term and long-term costs of the health care program be disclosed in a timely and appropriate manner.

1991, August - Expansion of Medicare Direct Program

Medicare Direct expanded into all other participating states.

1991, November - Hospital Discount Program

Aetna (in conjunction with SERS) begins program to negotiate lower rates for hospital confinements of SERS/Aetna health plan participants.

1992, February - Increased utilization of generic drugs permits copay freeze

For the second year in a row, because of increased generic drug utilization, no increase in the retiree's cost of mail-order drugs is necessary.

1992, March - Managed Care Seminar

Other Ohio retirement systems join SERS in sponsoring a managed care workshop.

1992, May - Hospital Discount Program expanded

The Aetna/SERS hospital discount program adds nine more Ohio hospitals granting discounts to SERS retirees and their dependents.

1992, June - Medicare Direct Program Expanded

Medicare Direct expanded to all recipients of Medicare through Railroad Retirement.

1992, October - Health Care Report reviewed by Board

Board is presented report of the future of SERS health care program. Reasons for rising costs are analyzed and short-term solutions to problems are proposed. Board begins work on its' health care cost management strategy.

1993, February - SERS reports Board decision on managed care

Article 'SERS Studies Managed Care' published in February, 1993 issue of Focus on Retirees. Proposed July, 1993 managed care implementation date announced. Numerous comments received from interested retirees.

1993, February - Increased utilization of generic drugs permits copay freeze

For the third year in a row, because of increased generic drug utilization and new contract with National Rx Services, no increase in the retiree's cost of mail-order drugs is necessary.

1993, June - Board makes decision on managed care and new plan design

At its May meeting, the SERS Board adopts plan design changes. Some changes are necessary to properly administer the managed care program, and some are necessary to adjust retiree cost participation (last changed in 1987). Effective January 1, 1994, per-person deductibles are increased from $250 to $275; family deductibles are increased from $500 to $550; out-of-pocket maximums are increased from $500 to $750 (individual) and from $750 to $1500 (family). Inpatient hospital deductible increased from $74 to $100. General differential between PPO and non-PPO deductibles established at 2 times the PPO deductible. Increased first-dollar coverage ($20 physician office charge and $100 annual cancer-screening test) established for PPO participants. Managed care to become effective October 1, 1993 for Aetna participants residing in greater Cincinnati, Cleveland and Columbus areas. Lifetime maximum increased to $1,250,000.

1993, September - Aetna toll-free line established

In order to most effectively administer SERS' health care plan, Aetna agrees to install toll-free phone service for SERS retirees.

1993, October - Managed Care begins - SERS adopts ASC agreement with Aetna

Managed care begins with participants who reside in greater Cincinnati, Cleveland and Columbus areas. Only non-Medicare participants enrolled under managed care; over 3,700 participants enrolled. SERS adopts Administrative Services Only contract with Aetna. Under the ASC arrangement, SERS will be totally self-insured and Aetna will only administer claims; fees paid to Aetna for this service will be limited by contractual agreement. New claim form and explanation of Aetna benefits introduced - claims submission effort by retirees greatly reduced.

1994, February - Change to retail drug program announced

SERS Board adopts new retail drug program. Major feature of new program will result in lower retail prescription drug costs for both SERS and its retirees. First-dollar coverage established with 80/20 copayments [minimum copayments of $2.50 (generic) and $5.00 (brand name)]. Copays of $10.00 (brand) and $0.00 (generic) maintained under mail-order program.

1994, March - Managed Care program expands

SERS/Aetna managed care PPO expands to cover all participants residing in Cincinnati, Cleveland and Columbus areas; over 2,000 additional participants covered by managed care.

1994, January - Managed Care program expands

SERS/Aetna managed care PPO expands to cover all participants residing in Akron, Ohio service area. Over 1,000 additional participants covered by managed care.

1994, March - Managed Care program expands

Expansion of managed care PPO into eastern Ohio.

1994, April - Managed Care program expands

Expansion of managed care PPO into Dayton area.

1994, June - Managed Care program expands

Expansion of managed care PPO into Toledo area.

1994, July - Change in prescription drug coverage announced

SERS Board adopts coordinated prescription drug program. Prescription drug program, both retail and mail-order to be administered by a single vendor, MEDCO. In addition to higher discounts, MAC pricing and additional patient/physician/provider communications, program permits full utilization review to occur on concurrent and prospective basis, rather than only a retroactive basis. Prescription drugs dispensed through rest-home pharmacies continue to be covered by Aetna.

1994, October - Managed Care program expands

Further eastern Ohio PPO expansion; over 8,500 SERS health care participants now under the PPO.

1996, January - Managed Care program expands

76 Ohio counties offer PPO and 12 Ohio counties offer PPO access. Managed care now available for the entire state.

1996, Summer - Board adopts criteria for HMO selection

SERS Board adopts criteria for selecting HMOs to offer as another health care choice. The criteria includes no (Gag orders), no incentive for withholding care, NCQA accreditation, must offer coverage in same geographical area for under and over age 65.

1996, October - Open enrollment meetings

SERS sponsors HMO meetings in 9 cities with over 2300 retirees and dependents attending.

1997, January - Introduction of HMO

27 Counties offer HMO Choice.

1997, October - Open enrollment meetings

SERS sponsors HMO meetings in 12 cities with over 700 retirees and dependents attending.

1998, March - Health Care Policy

The Board adopts statement of Health Care Policy.

1998, July - Mental Health and Substance abuse

The calendar year maximum was removed.

1998, December - H.B. 673 passes

Raises the monthly Medicare Part B premium reimbursement from $24.80 to $31.80. This increase is effective January 1, 1992.

1999, January - SERS offers Aetna National Advantage Program

This program offers discounts from participating hospital and facilities outside of Ohio for our PPO and non-Medicare Indemnity plans.

NOTE: No increase in Aetna premiums since 1993.

1999, January - Board revised reserve level increase from 125% to 150% of projected health care expense

1999, January - HMO Expands

31 Ohio counties, 1 Michigan county and 3 Kentucky counties offer HMO Choice.

1999, March - Health Care Provision Rescinded

SERS Board rescinded the health care provision that applied to members who joined the system after July 1, 1993. The provision required any member who joined SERS after July 1, 1993 to pay the full premium for health care until eligible for Medicare.

1999, April - Change to prescription drug program

SERS Board adopts new drug program. Mail-order generic drug co-payment $3, brand drug co-payment $15 with a 90 day supply limit. Eliminating coverage for over-the-counter drugs, except for diabetic supplies. Exclusion of drugs such as Viagra. Implementing a generic incentive program, and limiting maintenance drugs to only one refill at retail.

1999, August - Change to prescription drug program

SERS worked with Merck Medco to develop a program that coordinates with Medicare to reimburse SERS for prescription drugs covered by Medicare.

1999, October - Open enrollment meetings

31 Ohio counties, 1 Michigan county and 3 Kentucky counties offer HMO Choice. SERS sponsors HMO meetings in 8 cities with over 900 retirees and dependents attending.

2000, January - HMO

SERS offers an additional choice with Anthem HMO.

2000, January - HMO expands

38 Ohio counties, 1 Michigan and 3 Kentucky counties offer HMO choice.

2000, January - PPO/Indemnity

SERS offers Medical Mutual of Ohio as a choice for retirees and dependents who do not desire to enroll in an HMO or Aetna PPO/Indemnity plan.

2000, May - Lifetime maximum

Maximum lifetime coverage increased to $2.5 million.

2000, October - Open enrollment meetings

SERS sponsors HMO/Dental meetings in 11 cities with over 1400 retirees and dependents attending.

2001, January - HMO expands

Non-Medicare HMO offered in all 88 Ohio counties, 4 Indiana and 3 additional Kentucky counties offer HMO choice.

2001, January - Delta Dental

SERS offers retiree pay all premium based optional dental plan to retirees and dependents enrolled in Medical Mutual or Aetna PPO/Indemnity plans. Delta administers the dental programs offered by our HMOs.

2001, April - S.B. 270 Effective

The monthly Medicare Part B reimbursement was raised from $31.80 to $45.50. A lump sum payment was sent to 42,000 retirees for back reimbursement from 1993. The health care surcharge was capped at 2% of payroll per district, and at 1.5% statewide.

2002, January - AultCare PPO

SERS offers AultCare PPO as a choice for retirees and dependents who live in the Akron/Canton area.

2002, December - Stakeholder meeting

SERS sponsors an open meeting with stakeholders to review the system's health care funding status and to share/discuss ideas and changes needed to extend the solvency of the Health Care Stabilization Fund.

2003, January - Change in prescription drug program and co-payments

SERS Board adopts new drug program. Implementing Rx Selections Incentive Open Formulary. Retail co-payment: non-formulary brand-name prescription drug 35%. Mail Order co-payments: generic prescription drug $10, formulary brand-name prescription drug $30, and non-formulary brand-name prescription drug $60. SERS Board also adopts AultCare PPO increased prescription drug co-payments: generic prescription drug $10, formulary brand-name prescription drug $30, and non-formulary brand-name prescription drug $60.

2003, July - Health Care Program Changes

Following months of staff presentations focusing on potential cost-saving modifications to the Health Care Program, the SERS Board adopts changes, effective January, 2004. These changes forestall the projected depletion of the Health Care Stabilization Fund in FY2006, and extend the solvency of the Fund into FY2008.

2003, July - Ohio Association of Public School Employees (OAPSE) lawsuit filed

OAPSE files complaint against SERS in Franklin County Common Pleas Court, alleging breach of fiduciary responsibility and seeking to block the implementation of the January 1, 2004 health care program changes.

2003, September - Open Enrollment Meetings

SERS sponsors 13 medical and dental open enrollment meetings in 11 cities throughout Ohio.

2004, January - Health Care Program Changes

PPO/Indemnity deductible increased from $275 to $340, out-of-pocket from $750 to $1,500, hospital deductible from $100 to $250, PPO office visit co-payment from $20 to $25. Established PPO outside of Ohio for non-Medicare retirees. Medicare Coordination of Benefits ("COB") methodology changed from Government Exclusion to Maintenance of Benefits. HMO plan design: office visit co-payment from $10 to $15, In-patient hospital co-payment $250, Nursing Home co-payment $75 from day 21 to day 100. Two-year medical plan enrollment lock-in.

Deductible carry-over credit (the historical practice of allowing deductible credit from the last three months of the year to be carried-over and applied to the new deductible requirement for the following year) was terminated. SERS offers optional dental plan (retiree pays 100% of premium). Switched dental program administrator from Delta Dental to Aetna Dental with a two-year lock-in premium guarantee.

No Benefit Recipient will pay less than 15% for health care premiums. Prescription drug co-payments increased at Mail-order from $10 to $15 for generic drugs, from $30 to $35 for formulary brand-name drugs, and from $60 to $70 to non-formulary brand-name drugs.

2004, January - Premium Contribution Discount Program introduced

SERS Board approves granting a 50% monthly premium discount to Benefit Recipients who have a qualifying household income equal to or less than the current federal poverty level.

2004, January - SERS' motion to dismiss OAPSE lawsuit granted by the Court

2004, January - OAPSE appeals the Court's decision

2004, June - Premium Contribution Discount Program modified

SERS Board approves revisions to the Premium Discount Program for 2005. Qualifying household income requirement is moderated to include those within 125% of the 2004 federal poverty levels.

2004, July - Health Care Program Changes and Approval of Medco Contract Renewal

SERS Board approves nominal increases to retiree health care premium contributions for CY2005. SERS' subsidization of Rx drug program costs for 2005 remained unchanged at 75%. SERS Board approved a three-year (2005-2007) renewal of its contract with Medco as SERS' PBM provider.

2004, December - Franklin County Court of Appeals Affirms Trial Court's Decision

The Court of Appeals affirmed the dismissal of the five counts that were based solely on the health care changes, but reversed the dismissal of the complaint as to the allegations that the Board wasted system assets by incurring unnecessary expenses for construction of the SERS administration building and in approving unreasonable increases in salary and bonuses for SERS employees.

2005, January-July - Stakeholder Meetings

Various constituencies and stakeholder/interest groups were actively invited/solicited to attend and participate in the Health Care portion of the board meetings held during these seven months. Health care plan design, premium contribution structures, eligibility guidelines, and other ideas/suggestions were posited and discussed.

2005, January - Aetna Compassionate Care Program introduced for a one-year (CY2005) pilot period

SERS authorizes Aetna to introduce its new end-of-life-focused Compassionate Care Program for SERS non-Medicare eligible enrollees in the self-funded plans administered by Aetna.

2005, February - SERS commissions audit of vendors' Patient Management capabilities

SERS joins OPERS, STRS, and OP&F in engaging Mercer Human Resources Consulting to conduct an audit of Aetna's and Medical Mutual's patient management capabilities, and to identify corresponding opportunities for improvement.

2005, March - SERS joins the Health Action Council of Northeast Ohio

SERS becomes the first ORS to join this organization of employers dedicated to affordable, high-quality medical care, and which is committed to reforming the delivery system and rewarding the best in clinical outcomes and efficiencies.

2005, March - SERS spearheads ORS "Hospital Initiative"

SERS organizes and facilitates ORS-wide meeting with executive leadership of Mount Carmel Health System to discuss the systems' efforts to increase patient safety, drive quality, and improve outcomes, as well as to control hospital cost-inflation.

2005, May - Coverage for Non-Sedating Antihistamines eliminated

The Board approved the discontinuation of coverage for non-sedating antihistamines, in view of the availability of acceptable over-the-counter alternatives.

2005, May - Ohio Supreme Court declines to accept OAPSE's discretionary appeal

SUMMARY OF COVERAGE

ELIGIBILITY REQUIREMENTS

The following information is only a general summary of the current SERS health care plan. To the extent resources permit, SERS intends to continue to offer access to health care coverage. However, it reserves the right to change or discontinue any plan or program as necessary. The description below is not a guarantee of the type or amount of coverage, if any, which may be available to retirees, or to members when they retire.

Eligibility for SERS' health insurance coverage is based on service credit. In 1981, H.B. 126 was passed to require ten years of service credit, exclusive of most types of purchased credit, to be able to participate in the health plan. The effective date was June 13, 1986.

Thus, members who retire after June, l986 need ten years of service credit to qualify to participate in SERS' health plan. The following types of credit purchased after January 29, 1981 do not count toward insurance eligibility: military, federal, out of state, municipal, private school, exempted, and early retirement incentive credit.

LEVEL OF COVERAGE

SERS members have a choice of coverage with HMO's in 88 Ohio counties or the basic (PPO/Indemnity) SERS health plan. Retirees under the plan who do not have Medicare are enrolled in a managed care network. Retirees may select an optional dental plan. AultCare PPO is offered in 14 Ohio counties to retirees with or without Medicare.

The following describes the coverage under the basic plan after the yearly deductible and hospital admission charge have been paid by the retiree:

Hospital Charges

The plan pays 80% (or 65% for those in managed care who do not use participating hospitals) for the following charges:

- Room and Board (semi-private charge) and other services and supplies the hospital furnishes while an in-patient.

- Outpatient emergency treatment of an injury or illness severe enough for hospital treatment.

- Outpatient services required because of surgery performed on the date of the service.

Medical Charges

The plan pays 80% (or 65% for those in managed care who do not use participating providers) for the following charges:

- Charges made by a physician and/or surgeon (including office visits, in-hospital visits, and surgery). Routine office visits are subject to a $25 co-pay for managed care enrollees.

- Charges made by a registered nurse that are deemed medically necessary. Not covered are charges by a R.N. who resides in the retiree's home or is a member of the retiree's family.

- Hospital outpatient charges.

- Professional ambulance services or the trip to the first hospital of treatment.

- Durable medical equipment.

Skilled Nursing Facility

The plan will pay 80% coverage for room and board for skilled treatment only. If private accommodations are used, the plan will cover the facility's average daily semi-private room charge.

Also covered are physical therapy, use of special treatment rooms, drugs, casts and dressing.

Expenses listed above will be payable for up to 365 days of confinement in any convalescent period.

Screening Tests

For those under managed care who use participating providers, the plan pays up to $100 each year for preventive tests for cancer: mammogram, PAP smear and PSA test for prostate cancer. Charges above $100 are reimbursed at 90% after the deductible. Managed care enrollees who do not use participating providers are reimbursed 65% after the deductible.

Retirees with Medicare and those not in managed care receive 80% reimbursement for these tests after the deductible.

Outpatient Mental Health and Substance Abuse Treatment

The plan will pay 90% for covered medical services. For those in managed care who do not use participating providers, the plan will pay 50% for covered medical services.

Retirees with Medicare and those not in managed care receive 80% coverage.

Skilled Home Health Care

The plan pays 80% for those under managed care who use participating providers.

Hospice Care

The plan pays 100% for 30 days lifetime of inpatient expenses; 80% up to $5,000 lifetime for outpatient expenses.

Coordination of Benefits

The SERS plan contains a "Coordination of Benefits" provision. Payment on covered expenses will be reduced to the extent of duplicate coverage by any other group carrier determined to be primary insurer under the model COB provisions recommended by the National Association of Insurance Commissioners and adopted by the Trustees of the Ohio Retirement Systems Health Care Plan.

Prevailing Fee

The insurers have established prevailing fees for medically necessary charges and reimburses at the prevailing fee level.

Out-of-pocket Maximum

The maximum out-of-pocket limit under the SERS basic plan is $1,840 per person per calendar year, including the deductible, or $2,090 including the deductible and one hospital admission charge.

The office visit co-pay of $25 for those in the managed care network is not applied against the out-of-pocket limit.

The maximum expense limit for a retiree in the managed care network who does not use participating providers is $3,700 per person, including the deductible.

Lifetime Maximum

The plan will pay up to $2.5 million of covered expenses per person's lifetime.

PRESCRIPTION DRUG COVERAGE

SERS offers a retail and a mail-order prescription drug plan for covered retirees and dependents.

Retail Plan

Retirees receive a card to use at participating pharmacies. Retirees pay 20% of the cost of generic or a formulary brand-name drug or a minimum of $2.50, and 35% for a non-formulary brand-name drug or a minimum of $5.00. Retirees may receive up to a 34-day supply, or 100 units, whichever is less.

If a participating pharmacy is not used, there is no reimbursement, except for nursing home confinements.

Mail-Order Plan

Basic plan enrollees and dependents living in the continental U.S. may receive prescriptions by mail. Most prescriptions can be filled for up to a 90 day supply.

Retirees pay $15 co-payment for a generic prescription drug; $35 co-payment for a formulary brand-name prescription drug; and $70 co-payment for a non-formulary brand-name prescription drug.

DENTAL COVERAGE

Two levels of reimbursement offered depending on the network the retiree chooses to access:

Preventive	100% or 80%	no deductible
Basic	80% or 60%	$50 deductible
Major	50% or 40%	deductible applies

COST SHARING - DEDUCTIBLE, PREMIUMS, CO-PAYMENTS

Deductible

SERS instituted a yearly deductible in 1983. The rate then was $100; it is currently $340 per person. For those in managed care who do not use participating providers, the calendar year deductible is $700 per person. The deductible is indexed to the increase in health care expenses.

Hospital Admission Charge

The retiree is charged $250 for each hospital admission unless readmitted within 60 days. The charge for those in managed care who do not use a participating hospital is $290.

Premiums

Monthly premiums for retiring members are based on years of service:

Years of Service	*Percent of Premium*
10-14.999	100%
15-19.999	50%
20-24.999	25%
25 & over	15%

The percents equate to the following monthly premiums in 2005:

Years of Service	*Percent of Premium*
10-14.999	$687.00
with Medicare	$112.00
15-19.999	$344.00
with Medicare	$ 56.00
20-24.999	$172.00
with Medicare	$ 28.00
25 years & over	$103.00
with Medicare	$ 17.00

The premium rates listed above are for the basic plan - rates under the HMO's are in some cases higher and some cases lower.

Dependent premiums are $301 per month for a spouse under 65, $78 for a spouse with Medicare, and $81/78 a month for children. Dependent premiums are subsidized by SERS at 30%.

All premium rates are indexed to the increase in health care expenses and are subject to change yearly.

Aetna Dental (Retirees may enroll in optional dental plan - monthly premium required. No SERS subsidy.)

Retiree only	$ 21.28
Retiree and one dependent	$ 40.34
Retiree and two or more dependents	$ 61.06

CO-PAYMENTS

Under the basic medical plan, the retiree pays 20% of doctor and other medical charges, up to the maximum yearly limit.

Retirees in the managed care network pay $25 for each doctor office visit.

Those in the managed care network who do not use participating providers pay 35%.

Under the retail prescription drug plan, the retiree pays 20% of the cost of generic or a formulary brand-name drug or a minimum of $2.50, and 35% for a non-formulary brand-name drug or a minimum of $5.00. Mail Order retiree pays $15 co-payment for a generic prescription drug; $35 co-payment for a formulary brand-name prescription drug; and $70 co-payment for a non-formulary brand-name prescription drug.

MEDICARE B REIMBURSEMENT

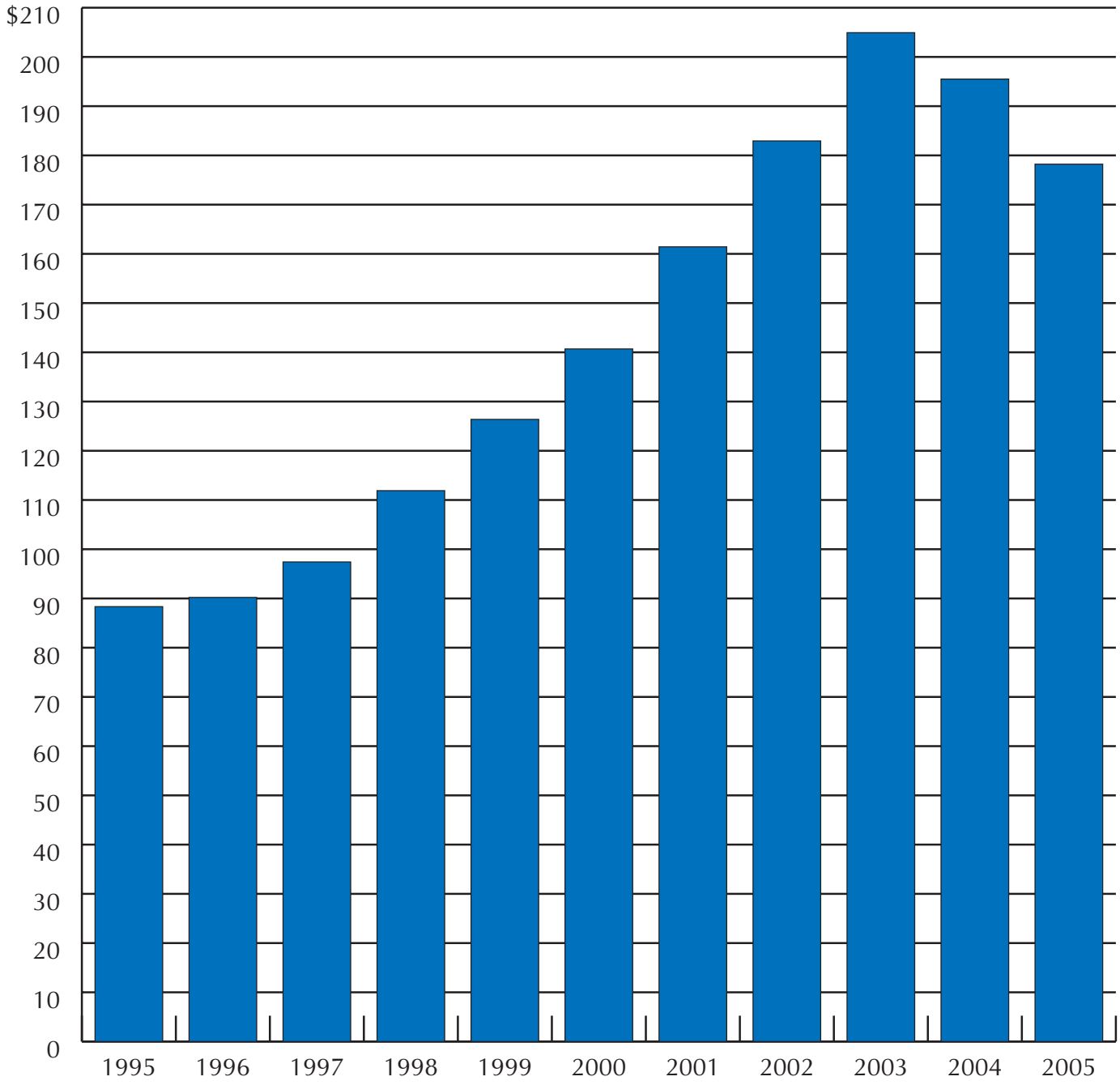
The Medicare Part B reimbursement rate is $45.50 per month. Retirees must pay the difference between the $45.50 and the current Medicare Part B premium, which is $78.20.

Plan Coverage

	Aetna, Medical Mutual and Aultcare*	PPO Out-of-Network	Aetna HMO	Kaiser HMO	Paramount HMO
Deductible	$340/person $700/family	$700/person $1,400/family	—	—	—
Co-Insurance Limit	$1,500/person $3,000 family	$3,000/person $6,000 family	$1,500/single $3,000/family	$2,000/single $6,000/family	$1,500/single $3,000/family
Office visit	80% / $25 PPO	65%	$15 copay	$15 copay	$15 copay
Specialist	80% / $25 PPO	65%	$30 copay	$15 copay	$30 copay
Inpatient Hospital	80% after $250 hospital admit deductible	65% after $290 hospital admit deductible	$250 copay for each stay, 100% thereafter	$250 copay for each stay, 100% thereafter	$250 copay for each stay, 100% thereafter
Emergency Room (for emergency care)	80% after $340 deductible	80% after $340 deductible	$50 copay	$50 copay	$50 copay
Durable Medical Equipment	80%	65%	80%	80%	80%
Nursing Home Skilled Care	80%/365 days	65%/365 days	100% day 1-20, $75 copay per day/21-100	100%/100 days	100% day 1-20, $75 copay per day/21-100
Home Health Care	80%	65%	100%	100%	100%
Prescription Drugs *Aultcare prescriptions are through Scrip Pharmacy. Copays for both retail and mail are $15 Generic; $35 Brand Preferred; and $70 Brand Non-Preferred.	**Medco** Retail 34 days 20% Preferred ($2.50 minimum) 35% Non-Preferred ($5 minimum) Mail Order 90 days $15 Generic, $35 Brand Preferred, $70 Brand Non-Preferred	**Medco** Retail 34 days 20% Preferred ($2.50 minimum) 35% Non-Preferred ($5 minimum) Mail Order 90 days $15 Generic, $35 Brand Preferred, $70 Brand Non-Preferred	**Medco** Retail 34 days 20% Preferred ($2.50 minimum) 35% Non-Preferred ($5 minimum) Mail Order 90 days $15 Generic, $35 Brand Preferred and $70 Brand Non-Preferred	**Kaiser** Retail 34 days $10 copay Mail Order 90 days $25 copay	**Medco** Retail 34 days 20% Preferred ($2.50 minimum) 35% Non-Preferred ($5 minimum) Mail Order 90 days $15 Generic, $35 Brand Preferred and $70 Brand Non-Preferred

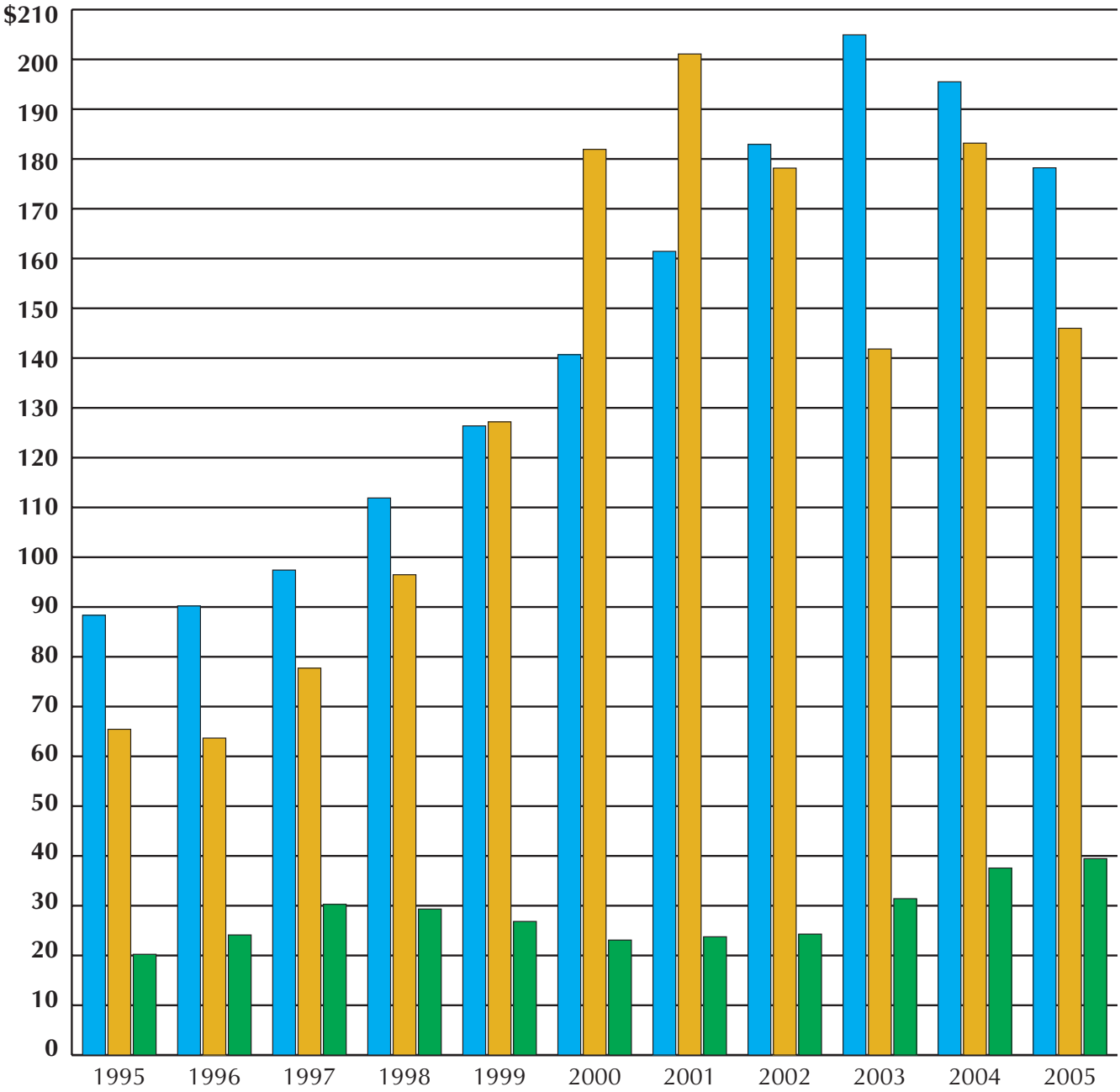
COST AND FUNDING

Health Care Expense - 1995 through 2005 (millions)



Year	Health Care Expense
1995	$ 88,340,780
1996	90,212,211
1997	97,429,197
1998	111,900,575
1999	126,380,984
2000	140,696,340
2001	$161,439,934
2002	182,946,777
2003	204,930,737
2004	195,496,097
2005	178,221,113

Health Care Expense - 1995 through 2005 (millions)



Year	Health Care Expense	Health Care Contributions	Health Care Surcharge	Health Care Fund
1995	$ 88,340,780	$ 65,441,338	$ 20,244,221	$138,209,994
1996	90,212,211	63,675,017	24,131,511	135,804,311
1997	97,429,197	77,720,194	30,288,515	146,383,823
1998	111,900,575	96,488,389	29,336,734	160,308,371
1999	126,380,984	127,195,042	26,847,444	187,969,874
2000	140,696,340	181,930,884	23,103,887	252,308,305
2001	161,439,934	201,081,680	23,763,819	315,713,870
2002	182,946,777	178,161,690	24,304,260	335,233,043
2003	204,930,737	141,830,439	31,423,865	303,556,610
2004	195,496,097	183,181,736	37,566,163	300,860,704
2005	178,221,113	145,991,159	39,446,854	267,482,155

Funding Alternatives and Asset Levels

Funding alternatives for SERS' post-retirement health care program range from pay-as-you-go to level contribution funding.

Level contribution funding (pre-funding) provides for a relatively stable rate of contributions from year to year. However, unlike pensions, health care is not a predictable expense. This method would require SERS to increase contributions to unrealistic levels.

Pay-as-you-go funding requires the minimum amount of revenue necessary to cover disbursements. Only a minimum level of assets would be needed to cover the difference in timing between the contributions and disbursements. The drawback to pay-as-you-go funding, in addition to placing a financial burden on future generations, is that it is highly volatile. Contribution increases or decreases would have to be made frequently and the annual rate of change may vary 0% to 25%, which would create a budgeting problem for the school districts.

The SERS Retirement Board has adopted an alternative method of funding to pay-as-you-go with the establishment of a fund balance that would serve to protect the plan from insolvency in periods when contributions cannot be increased and to smooth the annual rate of change in the contribution level. The amount of assets that should be held in this fund is the level necessary to provide the desired degree of stability and security. This amount is called the target asset level. The target asset level for SERS is 150 percent of annual claims and expenses.

HEALTH CARE POLICY

I. Purpose

The purpose of this Statement of Health Care Benefits Policy is to describe the philosophy and objectives of the Retirement Board of the School Employees Retirement System of Ohio. This Statement sets forth policy and describes the organization and division of responsibilities to prudently implement the Board's philosophy and objectives in accordance with section 3309.69 of the Ohio Revised Code. It also establishes the framework and specific objectives to monitor the systems financing policy and to promote effective communication between the Board, staff, members, retirees, employers and vendors.

II. Background

Beginning in 1974, the Retirement Board provided retirees access to high levels of doctor, hospital, and prescription drug coverage. Over the years, as the cost of this coverage has increased, numerous changes to the program have occurred:

- Mail order prescription drugs
- Deductibles and co-payments increased
- Eligibility increased from 5 to 10 years
- Premiums required
- System subsidy for dependents reduced
- Preferred Providers introduced
- Plan design changes and out-of-pocket maximums increased
- Health Maintenance Organization/Medicare Risk introduced
- Premium Contribution Discount Program introduced

III. Philosophy

The Board realizes the importance of providing retirees access to quality health care programs. The Board further realizes that by statute, section 3309.69 of the Ohio Revised Code, the amount paid by the Board for the health care programs is not guaranteed. The Board:

Will use its best efforts within available resources to provide retirees access to quality health care while achieving the lowest possible cost to retirees and employers.

Will require its retirees, in turn, to act as responsible and informed consumers in this process.

Believes that career public employees should receive greater value due to their longer service, but also recognizes that all eligible retirees should have access to the same health care.

Believes resources to fund the health care program should continue to come primarily from employers.

Recognizes that health care benefits are secondary to basic pension benefits and cannot be paid from assets reserved for basic benefits.

Believes the financial experience of the health care program should be disclosed in a timely and appropriate manner.

IV. Responsibilities

In order to implement the Board's statement of Health Care Benefits Policy the following responsibilities have been assigned:

A. To the Retirement Board:

After consultation with the Board's consultant, the Executive Director and SERS staff, the Retirement Board will determine the system's level of participation in financing the cost of the health care program.

Where possible and when appropriate, the Board will provide Statements of Policy to direct and focus the activities of SERS staff and consultants.

B. To the SERS staff:

In accordance with the Retirement Board's Statement of Policy, the SERS staff will strive to satisfy the Mission of SERS to enhance the well-being and financial security of our members, retirees and beneficiaries through benefit programs and services which are soundly financed, prudently administered and delivered with a focus on understanding and responsiveness.

The SERS staff will periodically report to the Retirement Board on its actions and activities in carrying out the Board's policies and directives. The staff is responsible for monitoring the activity of all health care vendors and reporting to the Board issues of concern or noncompliance with contract terms.

C. To the System Consultant:

In addition to preparing reports required by law, the Consultant will assist the Board and SERS staff by providing education and insight regarding effective health care programs and assist in the strategic planning process by identifying emerging trends in the health care delivery system. The Consultant will provide cost projections based upon SERS experience and demographics.

D. To the Vendors:

It will be the responsibility of the Vendors to provide SERS retirees access to quality health care services.

- Hospital and Doctor Credentialling and Re-credentialling
- Monitor Performance of Providers
- Decisions About Care are being made by Doctors

E. To the Health Care Providers

Health Care Providers, regardless of whether they are contracted with a SERS vendor, are responsible for providing SERS health care program enrollees with the appropriate/necessary care, at the appropriate time, in the most appropriate setting, and for a reasonable level of remuneration. SERS' expectation is that Providers will, at all times, exercise sound judgment that is consistent with accepted standards of care, conduct themselves in a principled, ethical, and professional manner, and always act in the best interest of their patients.

V. Review and Evaluation

In order to establish appropriate and effective policy and to maintain an efficient and affordable healthcare program, the Board will employ the services of a qualified Consultant who will prepare at a minimum, the following reports:

A. Annually

- Report to Legislative Committees on the financial status of the SERS Health Care reserve account
- Cost projections and plan design efficiencies
- Trends and issues in the industry which may have an impact on the health care for retirees.