STATE TEACHERS RETIREMENT SYSTEM OF OHIO

2019 ORSC HEALTH CARE REPORT

(FOR PERIOD JULY 1, 2018 – JUNE 30, 2019)

(Submitted to ORSC December 23, 2019)

As Required by Section 3307.51, Ohio Revised Code

Year in Review-2019

Ohio Revised Code, section 3307.39, allows the State Teachers Retirement Board to offer a cost-sharing, multiple-employer health care plan. STRS Ohio provides access to health care coverage to eligible retirees who participated in the defined benefit or combined plan and their eligible dependents.

Coverage under the current program includes hospitalization, physicians' fees, prescription drugs and partial reimbursement of monthly Medicare Part B premiums. Medicare Part B premium reimbursements will be discontinued effective Jan. 1, 2021. Pursuant to the Ohio Revised Code, the State Teachers Retirement Board has discretionary authority over how much, if any, of the associated health care costs will be absorbed by the plan. All benefit recipients pay a portion of the health care cost in the form of a monthly premium.

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2019, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total pool of STRS Ohio investments.

In December 2018, the Retirement Board adopted a health care plan management policy. The new policy's purpose is to state the board's objectives for the health care plan and to lay out clear criteria for making decisions regarding changes to benefits, as well as when those changes should be considered by the board. The policy indicates the goal is to provide a sustainable long-term health care benefit and to make benefit adjustments as conditions allow or are necessary.

Health Care Fund net position increased 4.1% to $3.9 billion in fiscal 2019 from $3.7 billion in fiscal 2018 as a result of ongoing government reimbursements for Medicare Part D coverage and benefit recipient health care premiums, decreases in health care benefit payments and net positive investment returns. Medicare Part D is a federal program to help cover the costs of prescription drugs for Medicare beneficiaries. This program allows STRS Ohio to recover part of the cost for providing prescription coverage since all eligible STRS Ohio health care plans include creditable prescription drug coverage.

Benefit recipient health care premium income decreased by 5.0% during fiscal 2019 as a result of continued decreases in non-Medicare retiree health care enrollment in 2019. Government reimbursements were $84.8 million in fiscal 2019 compared to $107.2 million in fiscal 2018 due to lower federal direct subsidies and reinsurance for prescription drugs in fiscal 2019. Payments for health care claims and administrative expenses totaled $489.2 million in fiscal 2019, a decrease of 5.5% from

previous fiscal year. The decrease is largely due to lower non-Medicare retiree health care enrollment and offsetting or large prescription rebated and discounts.

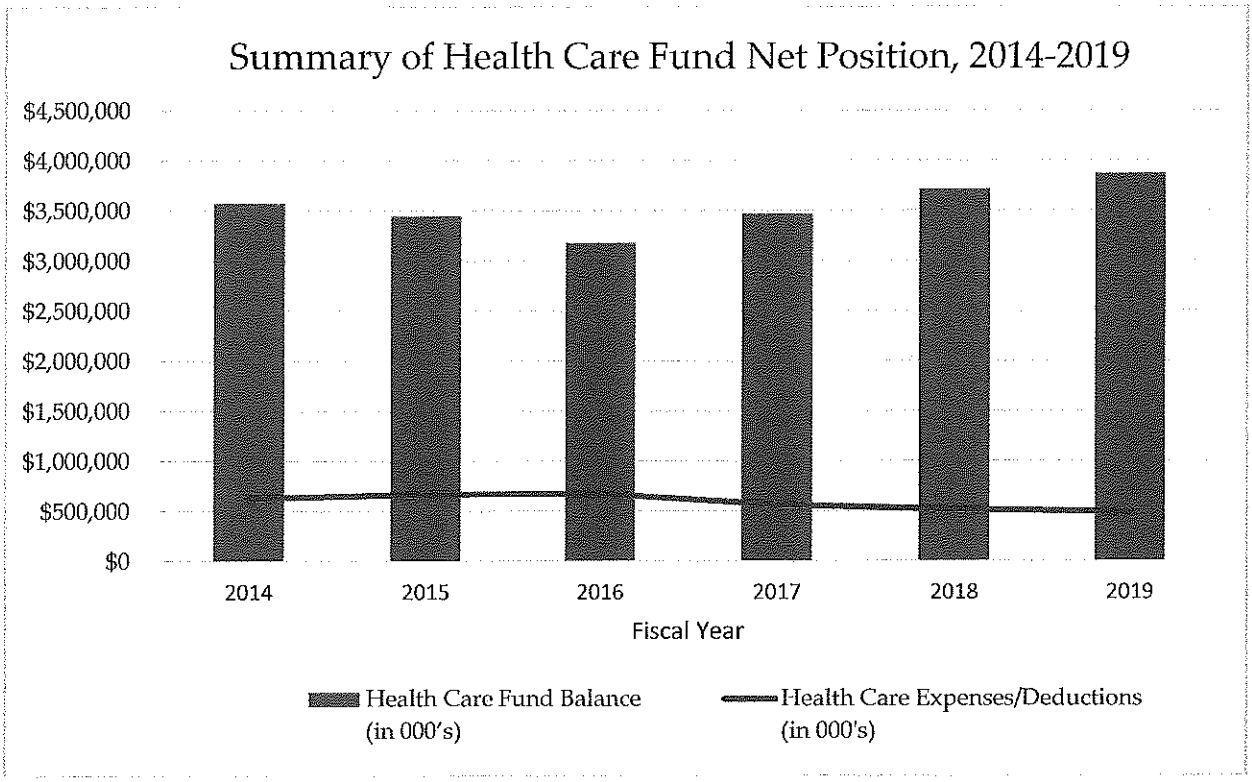
The annual health care actuarial valuation showed that benefit payments for the 12-month period ending June 30, 2019, totaled $489.2 million, an average of about $1.3 million per day. The funded ratio of the plan was 174.7%, meaning if the fund earns 7.45% in all future years and all other plan experience matches assumptions, the fund is projected to remain solvent for all current members. The health care program is susceptible to volatility from investment returns, government reimbursement changes, enrollment fluctuations and health care inflation.

Additionally in 2019, STRS Ohio, in conjunction with Aon Consulting, conducted a competitive bid process for pharmacy benefit manager services, which resulted in nearly a 22% improvement in projected costs over the current contract.

Financial Information

Fiscal Year 2019 (in 000's)

Additions	Deductions	Fund Balance	Solvency Period	Employer Allocation
$642,330	$491,521	$3,872,158	PERPETUAL	0%



Health Care Fund Balance (as graphed above)		
Fiscal Year	**Health Care Fund Balance (in 000's)**	**Health Care Expenses/Deductions (in 000's)**
2014	$3,576,458	$631,960
2015	$3,449,536	$675,184
2016	$3,185,628	$679,648
2017	$3,475,779	$568,459
2018	$3,721,349	$519,897
2019	$3,872,158	$491,521

Average Cost Per Participant
Paid by State Teachers Retirement System
Fiscal Year 2019

Non-Medicare Recipients	Medicare Recipients
$520	$230

Non-Medicare recipients includes all benefit recipients who are not eligible for Medicare.

Medicare recipients includes all benefit recipients who are eligible for Medicare Part A and/or Part B. The enrollee premiums are based on pooling Medicare-eligible individuals together; therefore, the above STRS Ohio subsidies reflect costs averaged across enrollees with Medicare Parts A&B and Medicare Part B-only. Without this pooling, the actual cost for enrollees with Medicare Part B-only would be nearly two times higher than the combined cost.

Population of Benefit Recipients
As of June 30, 2019

Age and Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare A&B	Percent Medicare B-only	Percent Non-Medicare
96,235	3,639	4,498	104,372	76%	11%	13%

Medical Mutual Basic (Non-Medicare)
Aetna Basic (Non-Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	$13,000 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limit one per calendar year (colorectal cancer screening limit one per 24 months if high risk or one per 10 years if not high risk)	

[1] Indemnity and out-of-network payments are based on allowed/non-contracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

AultCare PPO (Non-Medicare)

	In-Network	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee; includes deductible, copayments and coinsurance	$13,000 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%;	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply	

[1] Out-of-network payments are based on allowed/non-contracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Paramount Health Care (Non-Medicare)

	In-Network[1]	Out-of-Network[1]
Deductible[2]	$2,000 per enrollee	
Out-of-Pocket Limit	$4,000 per enrollee; includes deductible, copayments and coinsurance	
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	
Mental Health	Inpatient: Plan pays 80% Outpatient: Enrollee pays $20	
Surgery	Plan pays 80%	
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0%; limited designated services; frequency/age/gender limitations apply	

[1] Enrollee must use HMO network providers. Out-of-network benefits do not apply.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted.

Medical Mutual Health Care Assistance Plan (Non-Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$300 per enrollee	$300 per enrollee
Out-of-Pocket Limit[2]	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150; waived if admitted	
Urgent Care	Enrollee pays $40	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply	

[1] Indemnity and out-of-network payments are based on allowed/non-contracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Aetna Medicare Plan (Medicare)

	In-Network or Extended Service Area[1]	Out-of-Network[1]
Deductible[2]	$150 per enrollee	$500 per enrollee
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	$2,500 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	Plan pays 92%
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $25 (no deductible)	Inpatient: Plan pays 92% Outpatient: Enrollee pays $55 after deductible
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); some limitations may apply	

[1] If providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are combined.

Medical Mutual Basic (Medicare)

	In-Network and Indemnity[1,3]	Out-of-Network[1,3]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee; includes deductible, coinsurance and primary care physician copayments	$13,000 per enrollee; includes deductible and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%[4]	Plan pays 50%[4]
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient: Plan pays 50% Outpatient: Plan pays 80%
Surgery	Plan pays 80%	
Emergency Services		
Emergency Room	Enrollee pays $150; waived if admitted	
Urgent Care	Enrollee pays $40	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limit one per calendar year (colorectal cancer screening limit one per 24 months if high risk or one per 10 years if not high risk)	

[1] Indemnity and out-of-network payments are based on allowed/non-contracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

[3] Benefits are payable after Medicare payments.

[4] Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

AultCare PPO (Medicare)

	In-Network[3]	Out-of-Network[1,3]
Deductible[2]	$150 per enrollee	$500 per enrollee
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	$2,500 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%[4]	Plan pays 92%[4]
Mental Health	Inpatient and Outpatient: Plan pays 96%	Inpatient and Outpatient: Plan pays 92%
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply	

[1] Out-of-network payments are based on allowed/non-contracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

[3] Benefits are payable after Medicare payments.

[4] Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

Paramount Elite (Medicare)

	In-Network[1]	Out-of-Network[1]
Deductible[2]	$150 per enrollee	
Out-of-Pocket Limit	$1,5000 per enrollee; includes deductible, copayments and coinsurance	
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $20	
Surgery	Plan pays 96%	
Emergency Services		
Emergency Room	Enrollee pays $75; waived if admitted	
Urgent Care	Enrollee pays $40	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0%; limited designated services; frequency/age/gender limitations apply	

[1] Enrollee must use HMO network providers. Out-of-network benefits do not apply.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted.

Medical Mutual Health Care Assistance Plan (Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$300 per enrollee	$300 per enrollee
Out-of-Pocket Limit[2]	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%[3]	Plan pays 50%[3]
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150; waived if admitted	
Urgent Care	Enrollee pays $40	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply	

[1] Indemnity and out-of-network payments are based on allowed/non-contracting provider amounts for medically necessary services as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

[2] Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

[3] Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

Express Scripts Prescription Plan (Non-Medicare)

For Medical Mutual Basic, Aetna Basic, AultCare PPO and Paramount Health Care

	Retail Preferred/Home Delivery*
Annual Deductible	$250 per enrollee for covered brand-name drugs, including specialty
Generic	**Retail:** Enrollee pays $10 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $25 for all other generic medications
Formulary	**Retail:** Enrollee pays $30 after deductible **Home Delivery:** Enrollee pays $75 after deductible
Nonformulary Brand	Not covered
Specialty Drugs	Enrollee pays 13% up to a maximum of $550 per fill after deductible
Maximum Annual Expense	If an enrollee pays a total of $5,100 out of pocket in copayments/coinsurance/deductible for generic, covered brand-name and specialty medications, that enrollee pays nothing for covered medications for the remainder of the year.

* Retail Non-Preferred – Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a $10 fee per fill.

Express Scripts Prescription Plan (Non-Medicare)

For Health Care Assistance Program

Retail /Home Delivery	
Annual Deductible	Not applicable
Generic	**Retail:** Enrollee pays $5 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $10 for all other generic medications
Formulary	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40
Nonformulary Brand	Not covered
Specialty Drugs	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40
Maximum Annual Expense	If an enrollee pays a total of $500 out of pocket in copayments for generic and covered brand-name medications, that enrollee pays nothing for covered medications for the remainder of the year.

Express Scripts Medicare Part D Prescription Plan (Medicare)

For Aetna Medicare Plan, Medical Mutual Basic, AultCare PPO and Paramount Elite

	Retail Preferred/Home Delivery*
Annual Deductible	$250 per enrollee for covered brand-name drugs, including specialty
Generic	**Retail:** Enrollee pays $10 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $25 for all other generic medications
Formulary	**Retail:** Enrollee pays $30 after deductible **Home Delivery:** Enrollee pays $75 after deductible
Nonformulary Brand	Not covered
Specialty Drugs	Enrollee pays 13% up to a maximum of $550 per fill after deductible
Maximum Annual Expense	If an enrollee pays a total of $5,100 out of pocket in copayments/coinsurance/deductible for generic, covered brand-name and specialty medications, that enrollee pays nothing for covered medications for the remainder of the year.

* Retail Non-Preferred – Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a $10 fee per fill.

Express Scripts Medicare Part D Prescription Plan (Medicare)

For Health Care Assistance Program

Retail /Home Delivery	
Annual Deductible	Not applicable
Generic	**Retail:** Enrollee pays $5 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $10 for all other generic medications
Formulary	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40
Nonformulary Brand	Not covered
Specialty Drugs	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40
Maximum Annual Expense	If an enrollee pays a total of $500 out of pocket in copayments for generic and covered brand-name medications, that enrollee pays nothing for covered medications for the remainder of the year.

Health Care Future – Fiscal Year 2019

The STRS Ohio Health Care Program is in solid financial position. As of June 30, 2019, the program is nearly 175% funded, meaning there is perpetual solvency for all current retirees and STRS Ohio members upon retirement. The current subsidy strategy calls for pre-Medicare subsidies to be frozen at 2020 levels and for Medicare subsidy increases to be capped at the lesser of 6% or the actual trend. In addition, retirees enrolled in the STRS Ohio Health Care Program and Medicare Part B, receive $29.90 per month as partial premium reimbursement. This reimbursement is scheduled to end Dec. 31, 2020.

Due to the exceptional funding level, the Retirement Board will begin evaluating possible changes to the program for implementation Jan. 1, 2021. In particular, the Board will evaluate providing some level of inflation protection for the pre-Medicare subsidy. The Board will also evaluate continuing the $29.90 monthly Medicare Part B partial premium reimbursement beyond Dec. 31, 2020.

A significant contributor to the solid funding status has been the increasing level of federal government reimbursements resulting from operating a Medicare Advantage and Prescription Part D (MAPD) program and the increasing level of formulary drug rebates. STRS Ohio recognizes these payments are not guaranteed and are subject to significant volatility. Additionally, the system recognizes the investment return volatility associated with the current asset mix. It is also important to note that employer contributions to the Health Care Fund stopped beginning July 1, 2014. As a result of potential funding volatility and lack of employer contributions, any benefit changes will be gradual.

Supplementary Statutory Requirements

The following is provided in accordance with the requirements of Revised Code section 3307.51(E)

(1) A description of the statutory authority for the benefits provided:

Ohio Revised Code, section 3307.39, allows the State Teachers Retirement Board to offer a cost-sharing, multiple-employer health care plan. STRS Ohio provides access to health care coverage to eligible retirees who participated in the defined benefit or combined plan and their eligible dependents.

(2) A summary of coverage for 2019:

A summary of the coverage for calendar year 2019 is provided on pages 5 through 17 in the attached ORSC Health Care Report.

(3) A summary of the eligibility requirements for the benefits:

In general, service retirees are required to have 15 years of qualified service credit to be eligible for the STRS Ohio Health Care Program, and eligibility is extended to disability recipients and some survivor annuitants and survivor benefit recipients.

More details on eligibility requirements for the STRS Ohio Health Care Program are provided in Attachment A on pages 23 and 24.

(4) A statement of the number of participants eligible for the benefits:

As of June 1, 2019, there were 144,692 benefit recipients eligible to participate in the STRS Ohio Health Care Program.

(5) A description of the accounting, asset valuation, and funding method used to provide the benefits:

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2019, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total pool of STRS Ohio investments.

The Actuarially Determined Contribution (ADC) is calculated as the normal cost determined under the Entry Age Normal Actuarial Cost Method, plus the amortization of the unfunded actuarial liability over a 30-year open level percent of pay, plus anticipated administrative

expenses. Currently, the ADC is negative and is projected to remain negative, thus the employer is not expected to make any future contributions to the Health Fund.

(6) A statement of the net assets available for the provision of the benefits as of the last day of the fiscal year:

Post-Employment Health Care
Statement of Fiduciary Net Position
As of June 30, 2019
(In Thousands)

Assets:	
Cash and short-term investments	$ 101,692
Receivables:	
Accrued interest and dividends	12,453
Securities sold	49,425
Medical benefits receivable	27,170
Total receivables	89,048
Investments, at fair value:	
Fixed income	813,993
Domestic equities	1,047,844
International Equities	859,990
Real estate	477,691
Alternative investments	653,181
Total investments	3,852,699
Invested securities lending collateral	23,987
Total assets	4,067,426
Liabilities:	
Securities purchased and other investment liabilities	56,904
Debt on real estate investments	92,913
Accrued expenses and other liabilities	1,649
Medical benefits payable	19,827
Obligations under securities lending program	23,975
Total liabilities	195,268
Fiduciary net position restricted for post-employment health care coverage:	$3,872,158

(7) A statement of any changes in the net assets available for the provision of benefits, including participant and employer contributions, net investment income, administrative expenses, and benefits provided to participants, as of the last day of the fiscal year:

Post-Employment Health Care
Statement of Changes in Fiduciary Net Position
As of June 30, 2019
(In Thousands)

Additions:	
Contributions:	
Employer	$ 0
Government reimbursements	84,789
Benefit recipient health care premiums	312,841
Total contributions	397,630
Investment income from investing activities:	
Net appreciation in fair value of investments	179,855
Interest	22,805
Dividends	43,067
Real estate income	11,976
Investment income	257,703
Less internal investment expenses	(1,964)
Less external asset management fees	(11,379)
Net income from investing activities	244,360
Securities lending income	382
Securities lending expenses	(42)
Net income from securities lending activities	340
Net investment income	244,700
Total additions	642,330
Deductions:	
Health care benefits	489,169
Administrative expenses	2,352
Total deductions	491,521
Net increase in net position	150,809
Fiduciary net position restricted for post-employment health care coverage:	
Beginning of year	3,721,349
End of year	$3,872,158

(8) For the last six consecutive fiscal years, a schedule of the net assets available for the benefits, the annual cost of benefits, administrative expenses incurred, and annual employer contributions allocated for the provision of benefits:

Six-Year History
Fiscal Year Ended (in Thousands)

	2019	2018	2017	2016	2015	2014
Employer contributions	$ 0	$ 0	$ 0	$ 0	$ 0	$ 98,330
Government reimbursements	$ 84,789	$ 107,197	$ 79,357	$ 58,812	$ 61,127	$ 46,132
Benefit recipient premiums	$ 312,841	$ 329,305	$ 339,056	$ 339,927	$ 306,569	$ 277,477
Net investment income	$ 244,700	$ 328,965	$ 440,197	$ 17,001	$ 180,566	$ 524,484
Health care benefits	$ 489,169	$ 517,470	$ 565,962	$ 676,993	$ 672,615	$ 629,465
Administrative expenses	$ 2,352	$ 2,427	$ 2,497	$ 2,655	$ 2,569	$ 2,495
Fiduciary net position available for benefits	$ 3,872,158	$ 3,721,349	$ 3,475,779	$ 3,185,628	$ 3,449,536	$ 3,576,458

(9) A description of any significant changes that affect the comparability of the report required under this division:

There were no significant changes that affect the comparability of the report provided herein.

(10) A statement of the amount paid under division (B) of section 3307.39 of the Revised Code:

In 2018 and 2019, STRS Ohio reimbursed benefit recipients who were enrolled in an STRS Ohio health care plan and Medicare Part B $29.90 per month toward their total Medicare Part B premium. In 2020, the Medicare Part B premium reimbursement will continue at

$29.90 per month for these benefit recipients. The reimbursement from STRS Ohio for Medicare Part B premiums is scheduled to end after calendar year 2020.

Attachment A – Summary of STRS Ohio Eligibility Requirements for the Benefits

3307:1-11-03 Health care services - medical plan.

(A) Eligibility

The following individuals shall be eligible to participate in a medical plan offered by the retirement system:

(1) A service retiree with an effective benefit date:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 and the benefit is based on fifteen or more years of total service credit; or

(c) After July 1, 2023 and the benefit is based on twenty or more years of total service credit.

(2) A service retiree who began receiving service retirement benefits with no break in monthly benefits following the termination of disability benefits, with a disability effective benefit date:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 and the service retiree benefit is based on fifteen or more years of total service credit; or

(c) After July 1, 2023 and the service retiree benefit is based on twenty or more years of total service credit.

(3) A disability benefit recipient.

(4) A survivor annuitant.

(5) A survivor benefit recipient under division (C)(1) of section 3307.66 of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death where the effective date of survivor benefits or the effective date of disability benefits of the deceased member is:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 provided that the deceased member had fifteen or more years of total service credit at the time of death; or

(c) After July 1, 2023 provided the deceased member had twenty or more years of total service credit at the time of death.

(6) A survivor benefit recipient under division (C)(2) of section 3307.66 of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death.

(7) Dependents, to the extent that a medical plan and/or ancillary plan allows for dependent coverage.

(8) Notwithstanding paragraphs (A)(1) to (A)(7) of this rule, an individual not eligible for medicare coverage is not eligible for primary coverage in a medical plan offered by the retirement system if the individual is employed and has access to an entity's medical plan or if similarly situated, non-retired employees have access to an entity's medical plan, provided the medical plan includes prescription coverage and provides equivalent coverage at a cost no more than what is available to full-time employees as defined by the entity. The retirement board may require each enrollee to annually file a verification of employment statement disclosing the availability for enrollment as an employee in an entity's medical plan.

(a) When an individual is enrolled in an entity's medical plan and a medical plan offered by the retirement system, coverage in the retirement system's medical plan will be limited to secondary coverage applied only to those covered medical expenses not paid by the entity's medical plan.

(b) An employed individual not eligible for medicare who does not file a verification of employment statement with the retirement system when requested by the retirement system; does not enroll in the entity's medical plan when eligible to enroll, or is excluded from the entity's medical plan based upon being an enrollee is not eligible to enroll or remain enrolled in a medical plan offered by the retirement system.