Ohio Public Employees Retirement System
2019 ORSC Health Care Report
(For period January 1, 2019-December 31, 2019)

Submitted to ORSC June 30, 2020

Year in Review-2019

As of year-end 2019, with a net asset base of $106.3 billion, OPERS is the largest pension system in Ohio and the 12th largest public pension system in the nation. For more than half of our history, OPERS has provided access to health care coverage for retirees which, although not mandated, we believe is an important part of a secure retirement.

Review of the OPERS Health Care Program

On January 15, 2020, the OPERS Board of Trustees voted to adopt changes to health care coverage for Medicare and pre-Medicare retirees. These changes will preserve health care coverage for current and future retirees. During 2019, OPERS spent considerable time researching and evaluating options and sharing potential changes with retirees and active members. Staff members and leadership traveled the state to communicate and engage with members and retirees about potential solutions and invite feedback. Collectively, feedback indicated that health care is an important component of retirement security and our membership was willing to accept changes in the interest of preserving health care.

The overall goal was to design a flexible health care program that can provide access to coverage based on available funding. Implementing the approved package of changes will achieve this goal. As designed, the new program extends our ability to provide access to health care coverage for eligible retirees. Changes to the OPERS health care program are effective January 1, 2022.

OPERS Medicare Connector

Throughout 2019, OPERS continued efforts to ensure all eligible participants enrolled in individual Medicare plans via the OPERS Medicare Connector were successfully using their Health Reimbursement Arrangement (HRA) account if they so desired. These

efforts included in-person seminars, hands-on workshops and personal outreach to retirees with little or no HRA activity.

From 2015 to 2018, Medicare-eligible retirees received an annual $300 lump sum HRA deposit to help support additional out-of-pocket expenses. OPERS did not extend this $300 deposit into 2019, keeping to the original, approved decision to provide the subsidy from 2015 through 2018.

OPERS Pre-Medicare Health Plan

OPERS continues to implement annual adjustments to plan design and premiums for the OPERS pre-Medicare plan to keep pace with rising costs. For the 2019 plan year, adjustments to deductibles, copays and co-insurance amounts were implemented to more closely align with plans available in the insurance market. Increased medical and prescription costs, primarily from specialty drugs, and high utilization of medical services increased the full monthly premium for participants.

2019 Financial Highlights

OPERS finished 2019 with one of our strongest investment returns in history with gains of 17.23% for our Defined Benefit portfolio. The Health Care portfolio reported an investment gain of 19.59% in 2019, compared to a loss of 5.76% in 2018. The overall 115 Health Care Trust (115 Trust) net asset balance increased to $12.6 billion in 2019 from $11.3 billion in 2018.

Funded Status

Health care coverage is not statutorily guaranteed and can only be funded if pension funding is adequate. That said, retirees continue to inform us of the importance of meaningful access to health care. OPERS continues its goal of ensuring financial stability of both the pension and health care funds and will continue to evaluate plan and product designs to encourage sustainability.

On January 15, 2020, the Board approved several changes to the health care plan offered to Medicare and pre-Medicare retirees in efforts to decrease costs and increase the solvency of the health care plan. These changes are effective January 1, 2022 and include changes to base allowances for Medicare retirees, as well as replacing OPERS-sponsored medical plans for pre-Medicare retirees with monthly allowances, similar to the

program for Medicare retirees. Program eligibility will change for new pre-Medicare retiree beginning January 1, 2022. These changes are not reflected in the current year financial statements but are expected to decrease the associated OPEB (Other Post-Employment Benefits) liability.

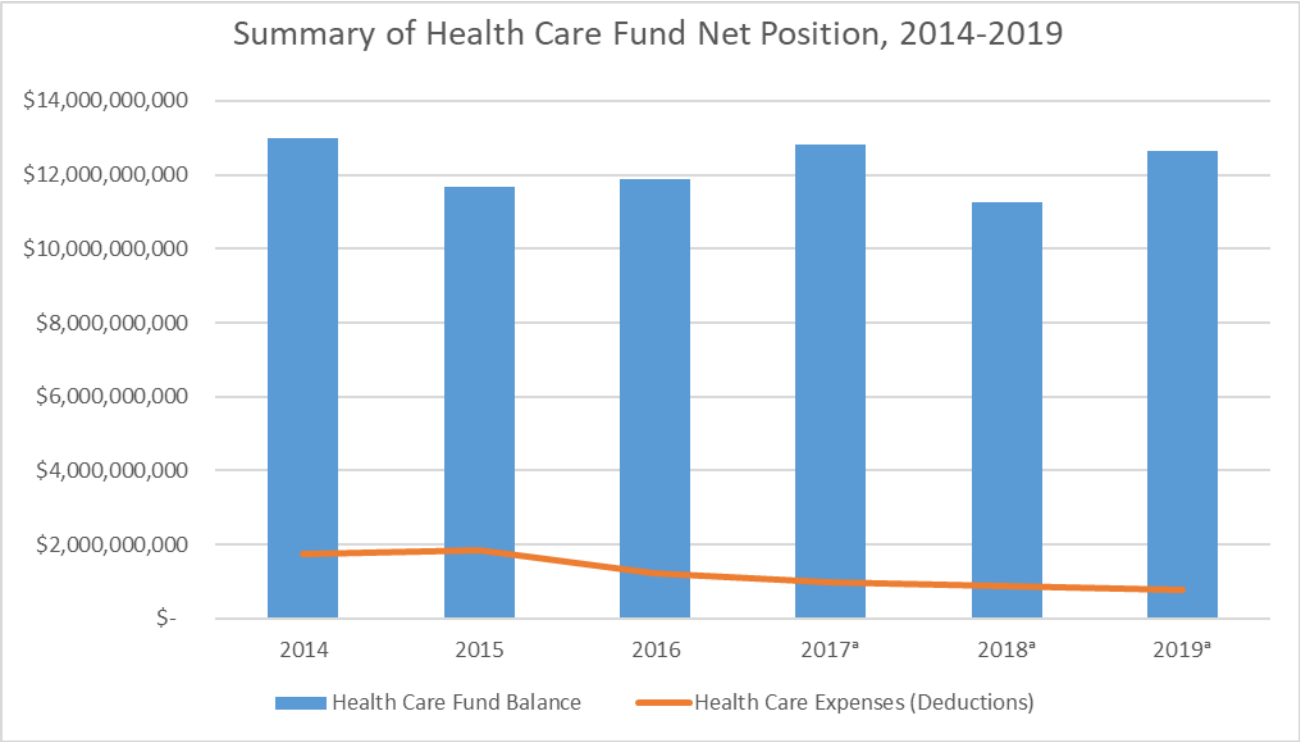
In 2016, the Board adopted changes to the pension and health care actuarial assumptions based on the results of an experience study for the period 2011 through 2015. The experience study incorporates both a historical review and forward-looking projections to determine the appropriate assumptions to maintain the pension plan on a path toward full funding. As reported in 2016, the most notable changes included a reduction in the long-term pension investment return assumption from 8.0% to 7.5% and a change in mortality tables for both pension benefits and health care coverage.

In addition to the experience studies, conditions are monitored, and assumptions are reviewed annually to ensure that the assumptions remain reasonable until the next scheduled experience study. If conditions change materially, it may become necessary to review and update assumptions in advance of the next scheduled experience study. In 2018, the Board adopted changes to further reduce the long-term pension investment return assumption from 7.5% to 7.2% and the long-term health care investment return assumption from 6.5% to 6.0%.

The funding objective is to meet long-term pension benefit obligations and, to the extent possible, fund post-employment health care. As of December 31, 2018, the date of the latest health care actuarial valuation, the actuarial liability for health care was $17.8 billion and the System had accumulated assets of $11.6 billion for that obligation, leaving an unfunded actuarial accrued liability of $6.2 billion. The $6.2 billion unfunded actuarial accrued liability is a decrease from the 2017 unfunded accrued actuarial liability of $6.4 billion. The decrease results from continued savings from the 2013 plan design changes. The funded ratio declined slightly from 65.4% at the end of 2017 to 65.3% in 2018.

Financial Information

Additions	Deductions	Fund Balance	Solvency Period	Employer Allocation[1]
$ 2,179,918,645	$ 785,846,596	$ 12,647,057,751	11	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance	Health Care Expenses (Deductions)
2014	$ 13,002,142,126	$ 1,760,320,053
2015	$ 11,678,627,027	$ 1,851,680,887
2016	$ 11,880,487,863	$ 1,220,424,124
2017ª	$ 12,818,833,665	$ 971,410,051
2018ª	$ 11,252,985,702	$ 889,891,322
2019ª	$ 12,647,057,751	$ 785,846,596

ª GASB Statement No. 74 requires health care expenses be reported net of certain health care receipts. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy and formulary rebates included in Contract and Other Receipts has been revised and is now included in Health Care Expenses, starting in 2017 upon implementation of this standard.

[1] No employer contributions were allocated to health care in 2017 through 2019 for the Traditional Pension and Combined plans. The contributions for the Member-Directed RMAs for 2019 remained at 4%.

Average Annual Cost Per Participant Paid by OPERS

Pre-Medicare Recipients	Re-employed Pre-Medicare Recipients	Medicare Recipients
$13,462	$9,974	$4,050

Pre-Medicare Recipients include OPERS benefit recipients who meet OPERS health care eligibility requirements, have not yet reached age 65 and do not qualify for any type of early Medicare eligibility.

Re-employed Pre-Medicare Recipients include OPERS benefit recipients who are not yet eligible for Medicare, meet OPERS health care eligibility requirements and have returned to work in an OPERS-covered position. OPERS requires these recipients to enroll in their employer's health plan, provided the employer offers coverage to other employees in similar positions, allowing the OPERS pre-Medicare plan to be a secondary payer.

Medicare Recipients include OPERS benefit recipients who meet OPERS health care eligibility requirements, are Medicare-eligible, are enrolled in Medicare Parts A and B and are enrolled in an individual Medicare plan through the OPERS Medicare Connector. This group also includes re-employed Medicare-eligible recipients who are enrolled in the Medical Mutual Medicare Secondary Plan and receive an allowance toward their premium based on their years of qualified health care service credit and age. There are also some retirees under age 65 who qualify for Medicare due to specific conditions.

Population of Recipients

Age-and-Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare
139,768	18,818	130	158,716	81%

2019 Medical Mutual PPO Plan for OPERS Pre-Medicare and Pre-Medicare Re-Employed Participants

	In-Network	Out-of-Network	Out of Area
Deductible	$1,200	$2,400	$1,200
Out-of-Pocket limit	$4,250	$5,700	$4,250
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Medical Services (% covered by plan)			
Outpatient	75%	60%	75%
Mental health	75%	60%	75%
Surgery	75%	60%	75%
Emergency Services			
Emergency Room	$150* copay (emergency) $250 copay (non-emergency) 75% facility 75% all other charges	$150* copay (emergency) $250 copay (non-emergency) 75% facility 75% all other charges	$150* copay (emergency) $250 copay (non-emergency) 75% facility 75% all other charges
Urgent Care	$45 copay	60%	$45 copay
Preventive Services			
Annual physical	100%**	60%***	100%**
Flu vaccines	100%**	60%***	100%
PAP, Mammography, Colonoscopy, Sigmoidoscopy, Bone Density Testing†	100%**	60%***	100%

All services are subject to medical necessity. After a participant meets the annual deductible and the out-of-pocket limit in a calendar year, all medically necessary services are covered at 100% with the exception of lab services subject to coverage maximums.

**Waived if admitted **Not subject to co-insurance or deductible ***Subject to annual deductible*

† Subject to age and frequency limitations

2019 Prescription Drug Plan for Pre-Medicare and Pre-Medicare Re-Employed Participants

	Retail Preferred/Home Delivery	Retail/Non-Preferred Network
Annual deductible	$100 (generics) $300 (brands)	$100 (generics) $300 (brands)
Generic	20% co-insurance $8 max retail $20 max mail	25% co-insurance $11 max
Formulary	30% co-insurance $60 max retail $150 max mail	35% co-insurance $65 max
Non-formulary Brand	Not Covered	Not Covered
Specialty Drugs – Biosimilar/Generic	40% co-insurance $150 max	40% co-insurance $150 max
Specialty Drugs - Brand	40% co-insurance $300 max	40% co-insurance $300 max

Supplemental Drug List (by request)

No requests for 2019

OPERS Health Care Coverage for Medicare-eligible Retirees

OPERS Medicare Connector Health Reimbursement Arrangement (HRA)

During 2019, Medicare-eligible retirees selected an individual medical or prescription drug plan (or both) through the OPERS Medicare Connector. They were also eligible for a monthly allowance, deposited into an HRA, to be used for reimbursement of qualifying medical expenses. Any remaining allowance can be used to reimburse the cost of any of the following:

- Medicare Part B premium,
- Vision and dental premiums,
- Deductibles, co-insurance and other out-of-pocket medical expenses,
- Medical expenses for a spouse,
- Future health care expenses, including premium increases as the member ages.

Medical Mutual Medicare Secondary Plan

The Medical Mutual Medicare Secondary Plan is the plan OPERS provides for Medicare-eligible retirees who are not eligible to participate in the OPERS Medicare Connector and receive an HRA allowance during re-employment. These retirees include Medicare-eligible, re-employed retirees and their eligible Medicare dependents as well as Medicare–eligible retirees under age 65 with specific conditions.

Medical Mutual PPO Plan for OPERS Medicare-eligible Participants

Deductible	$500* (not included in out-of-pocket limit)
Out-of-Pocket limit	$1,000* (excluding deductible)
Medical Services (% covered by plan)	
Outpatient Hospice	100% (covered by Medicare at a certified hospice agency)
Mental health	80%
Surgery	80%
Emergency Services	
Emergency Room	$50 copay (waived if admitted)
Urgent Care	$50 copay
Preventive Services	
Annual physical	100%
Flu vaccines	100%
PAP, Mammography, Colonoscopy, Sigmoidoscopy, Bone Density Testing	100%

Coverage as shown includes combined payments through Original Medicare (Parts A and B) and the Medical Mutual Medicare Plan. After a participant meets the annual deductible and the out-of-pocket maximum in a calendar year, all medically necessary services are covered at 100%.

Prescription drug coverage is the same as the Pre-Medicare Prescription Drug Plan found on page 7.

**Annual out-of-pocket maximum equals $1,500 ($500 deductible plus $1,000 out-of-pocket limit per year).*

A look ahead – working together toward a solution

Although health care is neither mandated nor guaranteed, the OPERS Board, leadership and staff recognize the importance to our members of providing access to health care coverage as it is a significant component of a secure retirement. This dedication to maintaining access to coverage has become increasingly expensive as OPERS retirees, like national trends, have increased in number and have longer life expectancies. In addition, health care costs continue to increase significantly faster than inflation.

Two major issues combined to create the immediate health care challenge. First, we anticipate that health care expenses will continue to grow as the number—and life expectancies—of our retirees continues to grow. Second, the funding status of the pension fund requires that all contributions be allocated to improve pension funding. Thus, until pension funding improves, there is no funding source for health care.

As of December 31, 2018, the date of the most recent health care valuation, health care liabilities exceeded the assets accumulated to fund the liabilities by $6.2 billion. We must be realistic: The combination of existing and projected health care expenditures, coupled with the current restriction that OPERS cannot actively contribute to the health care fund, means that the current health care trust fund is expected to last only approximately 11 years.

To address the lack of health care funding, the OPERS Board initiated a review of the health care program beginning in 2018. This project, referred to as Health Care Preservation Plan 3.1, culminated in a defined package of recommendations in 2019, and subsequent approval in the first quarter of 2020.

Changes to the OPERS health care program, effective January 1, 2022, will eliminate the current group plan for pre-Medicare retirees and replace it with a health reimbursement arrangement plan (HRA) augmented by the assistance from a vendor to help retirees select a plan on the open market. The amount of the HRA allowance will vary based on the retiree's age at which they first enrolled in OPERS health care and years of service. The HRA model was put in place for the Medicare retirees in 2015 and has been

successful. Changes will also include a reduced monthly base allowance amount for Medicare retirees, beginning in 2022.

Although OPERS will no longer administer a group health plan, we are committed to assisting retirees through each phase of this transition and continuing our support even after the changes have been implemented. Between now and 2022, OPERS will provide extensive communications and educational opportunities to ensure pre-Medicare retirees understand their options and are prepared to enroll in a plan outside of the OPERS pre-Medicare group plan and successfully begin using their health reimbursement arrangement.

Supplementary Statutory Requirements

Pursuant to Sections 145.58 and 145.584 of the Ohio Revised Code (ORC), the OPERS Board of Trustees (Board) is required to prepare annually a report giving a full accounting of the revenues and costs relating to the provision of health coverage. The report must be as of December 31. Section 10 of ORC 145.22 (E) requires OPERS to submit the report by June 30 of the following year to the Ohio Retirement Study Council, director of Budget and Management, and the standing committees of the Ohio House of Representatives and Ohio Senate.

The following information fulfills the requirements of OPERS as outlined in ORC Section 145.22(E). The requirements and the System's responses follow:

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

Appendices A and B are copies of ORC Section 145.58 (group hospitalization coverage; ineligible individuals; service credit; alternate use of Health Maintenance Organization) and ORC Section 145.584 (Medicare-equivalent benefits for members ineligible for Medicare), as they existed during 2019. Both sections were amended by Substitute Senate Bill 343, effective January 7, 2013.

(2) A summary of coverage for 2019:

The following is an outline of OPERS health care coverage in 2019:

The 2019 OPERS Retiree Health Plan for Pre-Medicare Recipients

The 2019 OPERS health care plan administrator, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our pre-Medicare participants. Doctors and medical facilities that belong to the PPO network agree to perform services at agreed-upon contract rates. While participants were able to choose any provider and still receive coverage, they had lower out-of-pocket costs if they chose a network provider. Pre-Medicare re-employed retirees were in a separate plan with identical coverage. **A more detailed explanation of coverage can be found on page 6.**

Prescription Drug Coverage

Retirees enrolled in the OPERS retiree health care plan (Medical Mutual) or the Medical Mutual Pre-Medicare Re-Employed Plan received prescription drug coverage through Express Scripts.

OPERS Pre-Medicare Prescription Drug Coverage

In 2019, plan participants could receive up to a 30-day supply of medication, plus refills, as prescribed by their physician at a retail pharmacy. Plan participants could receive up to a 90-day supply of medication, plus refills, as prescribed by their physician, through the Express Scripts home delivery program. Cost share for prescriptions differs based on the delivery method, whether a drug is a generic or a name brand and its formulary status. **A more detailed explanation of coverage can be found on page 7.**

Wellness Retiree Medical Account (RMA)

Prior to 2017, pre-Medicare plan participants also had the opportunity to earn modest wellness incentives that were deposited in a Wellness RMA. The Wellness RMA also contained excess retiree health care premium allowances. In plan year 2018, Wellness RMA participants were notified of account balances and a transition campaign was implemented with the goal of encouraging participants to seek reimbursement from their remaining balances with the intent to close these accounts. No additional deposits were made to the Wellness RMA accounts in 2019. Account funds can be used to reimburse the retiree's qualified medical expenses.

Member-Directed Retiree Medical Account (RMA)

Upon termination from OPERS=covered employment and a distribution from the Member-Directed Plan, a participant may use the vested funds in their Member-Directed RMA to reimburse qualified health care expenses. Vesting requirements for the Member-Directed RMA have changed over the life of the plan. The Member-Directed RMA originally required 10 years of participation to fully vest in the contributions and interest earned on the account. Effective January 1, 2009, participants were required to participate for a five-year period to become fully vested. Effective July 1, 2015, new participants to the Member-Directed RMA are required to participate for 15 years to become fully vested.

OPERS Medicare Connector Health Reimbursement Arrangement (HRA)

During 2019, Medicare-eligible retirees selected an individual medical or prescription drug plan (or both) through the OPERS Medicare Connector. The Connector is administered by a vendor selected by OPERS. The vendor assists retirees, spouses and dependents with selecting a medical and pharmacy plan. They were also eligible for a monthly allowance, deposited into an HRA account, to be used for reimbursement of qualifying medical expenses. The allowance can be used toward the reimbursement of the premium of an individual Medicare plan. Any remaining allowance can be used to reimburse the cost of any of the following:

- Medicare Part B premium,
- Vision and dental premiums,
- Deductibles, co-insurance and other out-of-pocket medical expenses,
- Medical expenses for a spouse,
- Future health care expenses, including premium increases as the retiree ages.

The Internal Revenue Service defines qualifying medical expenses. Claims filed through the HRA are reimbursed for qualifying medical expenses retirees and their dependents incur. Reimbursements of qualifying medical expenses are not taxable income and are not reported on any tax form. The amount of the HRA monthly allowance depends on years of qualifying service and age when first enrolled in the OPERS health care plan. HRA balances roll over from month-to-month and year-to-year.

Medical Mutual Medicare Secondary Plan

The Medical Mutual Medicare Secondary Plan is the plan OPERS provides for Medicare-eligible retirees who are not eligible to participate in the OPERS Medicare Connector and receive an HRA allowance during re-employment. These retirees include Medicare-eligible, re-employed retirees and their eligible Medicare dependents as well as Medicare–eligible retirees under age 65 with end-stage renal disease.

Medicare Part A Reimbursement

Ohio law allows OPERS to provide premium reimbursement to those who are not eligible for premium-free Medicare Part A. Medicare-eligible OPERS retirees are required to enroll in, and pay, the monthly premium for Medicare Part A coverage through the Centers for Medicare and Medicaid Services. OPERS provides a monthly reimbursement for the Medicare Part A premium cost and provides a 50% Medicare Part A premium reimbursement to eligible spouses. With enrollment in both Medicare Parts A and B, retirees and eligible spouses can make a plan selection through the Connector and retirees may receive an HRA allowance.

The Dental Plan

During 2019, voluntary dental coverage was available to all OPERS retirees, and their eligible dependents, regardless of their participation in OPERS health care. The dental plan, administered by MetLife, is intended to help defray the costs of dental care, including oral examinations, diagnostic services and extractions, as well as crowns, bridges and dentures. If a

retiree chooses coverage under the dental plan, a premium payment is deducted from each monthly benefit payment. OPERS does not subsidize this plan.

The Vision Plan

Voluntary vision coverage is offered to all OPERS retirees and their eligible dependents, regardless of their participation in OPERS health care. The vision plan, administered by Aetna, covers services provided by ophthalmologists, optometrists or opticians for examinations, frames and lenses. A premium payment is deducted from each monthly benefit payment for those recipients who choose to participate. OPERS does not subsidize this plan.

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

Eligibility requirements for 2019 OPERS health care plans are as follows:

Age-and-Service Retirement

All OPERS members are in one of three retirement groups: Group A, Group B or Group C. The retirement group determines pension eligibility and benefit calculation. The group also affects when members will be eligible for health care coverage through OPERS. In 2019, a benefit recipient must be age 60 and have 20 years of qualifying health care service credit or have 30 years of qualifying health care service credit at any age under Group A; 31 years of qualifying health care service credit at any age under Group B; and 32 years of qualifying health care service credit at any age under Group C to be eligible for OPERS retiree health care.

For retirement benefits effective on and after January 1, 2014, OPERS limited the types of service credit counted toward health care eligibility to the following:

- Contributing service
- Service transfers from other Ohio retirement systems
- Service purchased under USERRA (military service that interrupts public service)
- Restored service credit
- Unreported service

Once a retiree voluntarily withdraws from OPERS health care on or after January 1, 2014, they cannot reenroll absent proof of creditable coverage or a recent involuntary termination under another plan.

As of January 1, 2014, contributing service credit for health care accumulated only if the member's earnable salary was at least $1,000 per month. Partial health care credit was not granted for months in which earnable salary is less than $1,000. Credit earned prior to January 2014 is not affected by this requirement.

Disability Benefit Recipients

Recipients of disability benefits prior to January 1, 2014, have continued access to health care coverage while the disability benefit continues and will not be subject to the five-year rule described below. The allowance will be determined in the same way as an age-and-service retiree. If the recipient does not meet minimum age-and-service requirements, the minimum allowance will be used.

Recipients with an initial disability effective date on or after January 1, 2014, will have coverage during the first five years of disability benefits. After five years, the recipient must meet minimum age-and-service health care eligibility requirements or be enrolled in Medicare due to disability status to remain enrolled in OPERS health care. If enrolled, the allowance will be determined in the same way as an age-and-service retiree.

Coverage for Surviving Spouses

If a member retired, chose a joint life or multiple life annuity plan of payment and passes away, their surviving spouse will have access to the OPERS health care plans. Surviving spouses do not receive an allowance and are responsible for the full cost of coverage for the pre-Medicare health plan. However, OPERS does provide limited HRA funding to Medicare-enrolled surviving spouses meeting a low-income requirement.

Eligible Dependents

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code (IRC), retirees receiving a monthly age-and-service or disability benefit may enroll their legal spouse and any eligible children under the age of 26.

- The member or retiree's eligible children are a biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, un-emancipated minor child and ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.
- For a child to be eligible for coverage, the child must be under the age of 26 (regardless of enrollment as a full-time student or marital status). Coverage may be extended if the child is permanently and totally disabled prior to age 22. This means that the child is not

able to work in any substantial gainful activity because of a physical or mental impairment which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

Participants in OPERS health care receiving a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member may only enroll those dependents that would have been eligible dependents of the deceased retiree or member as defined on this page.

Coverage Options

In 2019, OPERS continued to provide monthly allowances for health care coverage for Traditional Pension Plan and Combined Plan retirees and their eligible dependents in various OPERS-sponsored plans. For those retiring on or after January 1, 2015, the allowance (subsidy) provided by OPERS is based on age and years of qualifying service credit when a recipient first enrolls in OPERS health care.

In 2019, OPERS offered medical and pharmacy plans for recipients yet to enroll in Medicare. Monthly allowances were used to offset the monthly premium for the coverage provided. Traditional Pension Plan and Combined Plan retirees enrolled in Medicare Parts A and B received an allowance credited to an HRA to be used to reimburse qualifying medical expenses associated with the coverage in which the retiree is enrolled through the Connector. If the retiree is living, the retiree may use their HRA to reimburse the cost of a spouse's coverage. Spouses eligible for Medicare began to have access to the Connector in 2016; spouses not yet eligible for Medicare have access to OPERS coverage at full cost. If the retiree has at least 20 years of qualifying service and is enrolled in OPERS health care, children (up to age 26) receive half of the retiree's allowance percentage. If the recipient has less than 20 years of qualifying service, children (up to age 26) have access to OPERS coverage at the full cost until 2020.

Member-Directed Retiree Medical Account (RMA)

Member-Directed Plan participants are provided with a Member-Directed RMA. The plan holds the portion of employer contributions of the Member-Directed Plan participants that are set aside for funding retiree health care. Upon separation or retirement, the participant may use the vested funds in their Member-Directed RMA to reimburse qualified health care expenses. Members with an account prior to July 1, 2015 become vested in the account at a rate of 20% for each year of participation until the member is fully vested at the end of five years. For members establishing accounts on or after July 1, 2015, the member is fully vested after 15 years at a rate of 10% for each year starting in the sixth year of participation. The account earns a fixed annual interest rate established by the Board. Interest on the RMA accrues only if the investment portfolio containing the RMA assets earns a return greater than zero in the prior year.

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

As of December 31, 2019, there were 177,363 OPERS retirees and primary beneficiaries eligible to participate in OPERS health care. In addition to a retiree, a primary benefit recipient could be a survivor of a deceased retiree continuing to receive coverage on the retiree's account, which is representative of the OPERS contributing membership.

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

OPERS financial statements are prepared using the accrual basis of accounting under which deductions are recorded when the liability is incurred, and revenues are recognized when earned. Health care payments are considered a liability and recognized when a present obligation exists and a condition that requires the event creating the liability has taken place. Therefore, OPERS estimates health care claims which have been incurred at year-end, but which have not yet been reported to the System as of fiscal year end. Health care reimbursements are recognized when they become measurable and due to OPERS based on contractual requirements. Therefore, health care reimbursements contain estimates based on information received from health care vendors and other sources.

Investment purchases and sales are recorded as of the trade date. All investments are generally reported at fair value. Fair value is the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. All investments, with the exception of real estate, private equity and hedge funds, are valued based on closing market prices or broker quotes. Securities not having a quoted market price have been valued based on yields currently available on comparable securities of issuers with similar credit ratings. The fair value of real estate investments, private equity and hedge funds is based on a net asset value, which is established by the fund or by the fund's third-party administrator.

Employer contributions and investment earnings are used to fund health care expenses. No portion of the employer contributions for the Traditional Pension and Combined plan members were credited to the 115 Health Care Trust (115 Trust) for the year ended December 31, 2019. The health care contribution rate allocation for the Member-Directed Plan retiree medical accounts (RMAs) for 2019 remained at 4%. In 2017, OPERS implemented Governmental Accounting Standards Board Statement No. 74 (GASB 74), *Financial Reporting for Post-Employment Benefit Plans Other Than Pension Plans (OPEB)*. GASB 74 requires that certain health care receipts, or payments, from retirees and health care vendors to OPERS, to offset the related health care expenses reported in the Health Care Expenses category in the Statement of Changes in Fiduciary Net Position. The presentation of Retiree-Paid Health Care Premiums,

Federal Subsidy and rebates, rebates previously reported in Contract and Other Receipts, has been revised and these health care receipts are now included in health care expenses.

The 115 Trust was established in 2014. The 401(h) Health Care Trust and Voluntary Employees' Beneficiary Association Trust were closed as of June 30, 2016 and the net positions transferred to the 115 Trust on July 1, 2016. From 2016 forward, the 115 Trust pre-funds and holds the portion of employer contributions of the Traditional Pension, Combined and Member-Directed plans set aside for funding retiree health care.

The funded status of health care as of December 31, 2018, the most recent actuarial valuation, was 65.3%. The funding progress of health care is measured in terms of solvency years, or the number of years that funds are projected to be available to pay health care expenses under the current plan design before health care would be reduced to a pay-as-you-go basis. The fund is expected to become insolvent after 11 years as of the December 31, 2018 valuation. The health care stabilization fund is intended to somewhat mitigate this risk. The Board approved changes to the OPERS health care plans in 2012. The ultimate goal of the health care changes was to match the income to the health care trust (assumed to be 4%) and disbursements from the health care trust (also assumed to be 4%). Additionally, the Board established a health care stabilization fund to hold income in excess of 4%. The balance of the stabilization fund will supplement income to the health care core (operating) fund when employer contributions or investment income of 4% was not available during the year or disbursements from the trust exceed 4% during the year. The stabilization fund is an accounting function only and not listed separately in the combining financial statements. Health care valuations are prepared using total health care fund assets.

On January 15, 2020, the Board approved several changes to the health care plan offered to Medicare and pre-Medicare retirees in efforts to decrease costs and increase the solvency of the health care plan. These changes are effective January 1, 2022 and include changes to base allowances and eligibility for Medicare retirees, as well as replacing OPERS-sponsored medical plans for pre-Medicare retirees with monthly allowances, similar to the program for Medicare retirees. These changes are not reflected in the current year financial statements but are expected to decrease the associated OPEB liability.

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

Please see Appendix C, "Statements of Fiduciary Net Position - Health Care."

(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:

Please see Appendix D, "Statements of Changes in Fiduciary Net Position - Health Care."

(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:

Please see Appendix C, "Statements of Fiduciary Net Position - Health Care" and, Appendix D, "Statements of Changes in Fiduciary Net Position - Health Care."

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

In conjunction with the implementation of Governmental Accounting Standards Board Statement No. 74 (GASB 74), *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, in 2017, health care receipts, or payments, from retirees and health care vendors to OPERS are required to offset the related health care expenses incurred by OPERS during the year. As a result, health care expenses were reduced by $251.2 million and $250.0 million in 2019 and 2018, respectively, for retiree-paid health care premiums, prescription rebates and federal subsidies.

(10) A statement of the amount paid under division (C) of section 145.58 of the Revised Code:

OPERS discontinued reimbursement of Medicare Part B premiums as of December 31, 2016. However, in accordance with section 145.584 of the Revised Code, OPERS reimburses retirees who do not have premium-free Medicare Part A for their Part A premiums as well as any applicable surcharges (late-enrollment fees).

Appendix A – Ohio Revised Code Sec. 145.58

(A) The public employees retirement board shall adopt rules establishing eligibility for any coverage provided under this section. The rules shall base eligibility on years and types of service credit earned by members. Eligibility determinations shall be made in accordance with the rules, except that an individual who, as a result of making a false statement in an attempt to secure a benefit under this section, is convicted of violating section 2921.13 of the Revised Code is ineligible for coverage.

(B) The board may enter into agreements 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 coverage, or any combination thereof, for eligible individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage in accordance with division (D)(2) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the eligible individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to individuals who are not eligible under the rules adopted under division (A) of this section if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.584 of the Revised Code for any such 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 coverage as authorized by rules of the board.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or

survivor benefit under the public employees retirement system who is eligible for coverage under part B of the Medicare program established under Title XVIII of "The Social Security Act Amendments of 1965," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended, an amount determined by the board for such coverage, except that the board shall make no such payment to any individual who is not eligible for coverage under the rules adopted under division (A) of this section or pay an amount that exceeds the amount paid by the recipient for the coverage.

At the request of the board, the recipient shall certify to the retirement system the amount paid by the recipient for coverage described in this division.

(D) The board shall establish by rule requirements for the coordination of any coverage or payment provided under this section or section 145.584 of the Revised Code with any similar coverage or payment made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement 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.

Amended by 130th General Assembly File No. TBD, SB 42, §1, eff. 3/23/2015.

Amended by 129th General Assembly File No.148, SB 343, §1, eff. 1/7/2013.

Effective Date: 10-01-2002; 2008 SB267 03-24-2009

Appendix B – Ohio Revised Code Sec. 145.584

(A) Except as otherwise provided in division (B) of this section, the board of the public 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 without payment of premiums, one of the following:

(1) 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;

(2) An amount, determined by the board, to reimburse the retirant or disability benefit recipient for payment of premiums for federal hospital insurance benefits described in this division, which amount shall not exceed the premiums paid.

This coverage or amount 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 without payment of premiums. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage or amount only if he or she is the recipient of a monthly allowance or benefit from this system. A portion of the cost of the premium or amount for the spouse may be paid from the appropriate funds of the system. The remainder of the cost shall be paid by the recipient of the allowance or benefit.

The cost of such coverage or amount, paid from the funds of the system, shall be included in the employer's rate provided by section 145.48 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and may contract for such coverage as provided in section 145.58 of the Revised Code.

At the request of the board, the recipient of reimbursement under this section shall certify to the retirement system the premium paid for the federal insurance benefits described in division (A) of this section. Payment of the amount described in division (A)(2) of this section shall begin for the first month that the recipient is participating in both the federal hospital insurance benefits and a health care arrangement offered by the system.

(B) The board need not make the hospital insurance coverage or amount described in division (A) of this section available to any person for whom it is prohibited by section 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance.

Amended by 130th General Assembly File No. TBD, SB 42, §1, eff. 3/23/2015.

Renumbered from § 145.325 and amended by 129th General Assembly File No.148, SB 343, §1, eff. 1/7/2013.

Appendix C – Statements of Fiduciary Net Position – Health Care

	2019	2018	2017	2016	2015	2014
115 Health Care Trust[1]						
Assets						
Cash and Cash Equivalents	**$818,204,587**	**$595,183,342**	**$823,866,242**	**$874,632,840**	**$228,930,728**	**$7,797,254**
Receivables						
Members and Employers	1,892,495	2,016,190	17,310,993	28,954,270	31,146,407	20,597,780
Vendor and Other	12,585,164	12,173,150	10,325,432	67,090,996	140,747,042	175,326,214
Investment Sales Proceeds	52,212,702	38,943,225	58,028,023	70,760,106	744,048	988,589
Accrued Interest and Dividends	46,169,385	44,840,466	44,801,284	41,092,533	1,246,089	728,607
Total Receivables	**112,859,746**	**97,973,031**	**130,465,732**	**207,897,905**	**173,883,586**	**197,641,190**
Investments						
Fixed Income	4,855,122,000	4,117,147,799	4,348,639,837	4,087,785,698	296,365,386	66,380,103
Domestic Equities	3,183,847,864	2,911,258,188	3,403,242,732	3,071,759,733	82,245,096	50,172,724
International Equities	2,674,811,901	2,240,589,009	2,645,509,612	2,265,107,975	58,142,626	41,687,272
Other Investments	1,237,576,242	1,495,996,430	1,654,750,270	1,534,240,696	48,222,156	24,508,856
Total Investments	**11,951,358,007**	**10,764,991,426**	**12,052,142,451**	**10,958,894,102**	**484,975,264**	**182,748,955**
Capital Assets						
Land	942,728	942,728	942,728	942,728		
Building and Building Improvements	27,971,184	27,986,068	27,998,673	28,004,098		
Furniture and Equipment	34,246,182	32,854,966	33,676,485	32,759,796	1,441,984	
Total Capital Assets	63,160,094	61,783,762	62,617,886	61,706,622	1,441,984	0
Accumulated Depreciation	(41,103,250)	(38,171,032)	(36,873,343)	(33,678,510)		
Net Capital Assets	**22,056,844**	**23,612,730**	**25,744,543**	**28,028,112**	**1,441,984**	**0**
TOTAL ASSETS	**12,904,479,184**	**11,481,760,529**	**13,032,218,968**	**12,069,452,959**	**889,231,562**	**388,187,399**
Liabilities						
Undistributed Deposits	196,350	214,798	230,367	287,413	10,021	
Benefits Payable	115,181,776	119,532,084	114,643,770	109,142,271	1,634,811	
Investment Commitments Payable	142,043,307	109,027,945	98,511,166	79,535,412	1,789,658	1,803,774
Accounts Payable and Other Liabilities					44,685,032	303,453
TOTAL LIABILITIES	**257,421,433**	**228,774,827**	**213,385,303**	**188,965,096**	**48,119,522**	**2,107,227**
Net Position Restricted for OPEB	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**	**$11,880,487,863**	**$841,112,040**	**$386,080,172**

Source: 2014-2019 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016.

Appendix C – Statements of Fiduciary Net Position – Health Care

	2015	2014
401(h) Health Care Trust[1]		
Assets		
Cash and Cash Equivalents	**$437,888,805**	**$503,893,407**
Receivables		
Members and Employers		12,096,566
Early Retirement Incentive Plan		6,062
Vendor and Other	677,725	1,309,906
Investment Sales Proceeds	43,193,263	64,470,004
Accrued Interest and Dividends	39,359,404	47,590,193
Total Receivables	**83,230,392**	**125,472,731**
Investments		
Fixed Income	3,733,008,136	4,434,483,598
Domestic Equities	2,969,522,823	3,296,381,497
International Equities	2,221,451,642	2,661,469,316
Other Investments	1,390,445,167	1,615,807,236
Total Investments	**10,314,427,768**	**12,008,141,647**
Capital Assets		
Land	916,220	916,220
Building and Building Improvements	27,256,121	27,261,277
Furniture and Equipment	29,358,536	28,536,399
Total Capital Assets	57,530,877	56,713,896
Accumulated Depreciation	(30,510,198)	(28,082,475)
Net Capital Assets	**27,020,679**	**28,631,421**
TOTAL ASSETS	**10,862,567,644**	**12,666,139,206**
Liabilities		
Undistributed Deposits	243,005	183,002
Benefits Payable	91,451,759	99,279,185
Investment Commitments Payable	76,923,764	113,120,724
Accounts Payable and Other Liabilities	22,880,935	13,033,505
TOTAL LIABILITIES	**191,499,463**	**225,616,416**
Net Position Restricted for OPEB	**$10,671,068,181**	**$12,440,522,790**

Source: 2014-2015 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. No activity exists for 2016 through 2019.

Appendix C – Statements of Fiduciary Net Position – Health Care

	2015	2014
Voluntary Employees' Beneficiary Association Trust[1]		
Assets		
Cash and Cash Equivalents	**$4,675,584**	**$4,148,957**
Receivables		
Members and Employers	13,932,389	11,647,166
Investment Sales Proceeds	532,305	628,545
Accrued Interest and Dividends	437,722	465,050
Total Receivables	**14,902,416**	**12,740,761**
Investments		
Fixed Income	37,189,326	38,408,780
Domestic Equities	27,429,090	28,230,500
Real Estate	17,627,759	16,410,600
Private Equity	19,309,205	19,895,505
International Equities	28,135,488	31,447,388
Other Investments	23,392,047	24,639,714
Total Investments	**153,082,915**	**159,032,487**
Collateral on Loaned Securities	**18,887,694**	**17,067,184**
Capital Assets		
Land	26,508	26,508
Building and Building Improvements	788,568	788,717
Furniture and Equipment	2,196,905	2,171,989
Total Capital Assets	3,011,981	2,987,214
Accumulated Depreciation	(2,180,336)	(2,101,775)
Net Capital Assets	**831,645**	**885,439**
TOTAL ASSETS	**192,380,254**	**193,874,828**
Liabilities		
Benefits Payable	208,449	254,216
Investment Commitments Payable	843,360	1,017,665
Due to Other Plans	5,992,744	
Obligations Under Securities Lending	18,888,895	17,063,783
TOTAL LIABILITIES	**25,933,448**	**18,335,664**
Net Position Restricted for OPEB	**$166,446,806**	**$175,539,164**

Source: 2014-2015 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. No activity exists for 2016 through 2019.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2019	2018	2017	2016	2015	2014
115 Health Care Trust[1]						
Additions						
Employer Contributions	$24,318,141	$23,441,668	$157,417,888	$274,419,455	$253,673,333	$111,561,319
Contract and Other Receipts[2]	540,809	279,178	857,541	93,306,585	95,860,582	143,813,190
Retiree-Paid Health Care Premiums[2]				184,368,783		
Federal Subsidy[2]				4,065,058	175,930,875	131,904,250
Other Income, net	1,724	732,193	117,882	15,715	10	76,970
Interplan Activity				6,036,782		
Total Non-investment Income	**24,860,674**	**24,453,039**	**158,393,311**	**562,212,378**	**525,464,800**	**387,355,729**
Income/(Loss) From Investing Activities						
Net Increase/(Decrease) in the Fair Value of Investments	1,600,900,770	(862,731,054)	1,303,745,052	160,473,865	(17,539,101)	(2,660,677)
Bond Interest	162,002,938	108,077,693	162,929,606	92,284,043	6,517,201	535,544
Dividends	428,602,794	88,148,545	325,553,345	130,678,719	(9,556,397)	1,019,374
International Income/(Loss)	227,029	398,457	248,369	(1,998)	(1,178)	223
Other Investment Income/(Loss)	2,172,948	293,975	396,299	(282,340)	(43,576)	
External Asset Management Fees	(33,296,008)	(28,772,749)	(36,062,800)	(27,669,191)	(2,147,433)	(61,239)
Net Investment Income/(Loss)	**2,160,610,471**	**(694,585,133)**	**1,756,809,871**	**355,483,098**	**(22,770,484)**	**(1,166,775)**
Investment Administrative Expenses	(5,552,500)	(5,824,547)	(5,447,329)	(2,853,560)	(302,871)	(26,581)
Net Income/(Loss) from Investing Activity	**2,155,057,971**	**(700,409,680)**	**1,751,362,542**	**352,629,538**	**(23,073,355)**	**(1,193,356)**
TOTAL ADDITIONS	**2,179,918,645**	**(675,956,641)**	**1,909,755,853**	**914,841,916**	**502,391,445**	**386,162,373**
Deductions						
Health Care Expenses[2]	767,888,929	870,284,919	952,001,573	1,195,956,899	45,184,620	
Administrative Expenses	17,957,667	19,606,403	19,408,478	21,693,387	2,174,957	82,201
TOTAL DEDUCTIONS	**785,846,596**	**889,891,322**	**971,410,051**	**1,217,650,286**	**47,359,577**	**82,201**
Special Item[1]						
Interplan Activity—Trust Closures				**11,342,184,193**		
Net Increase/(Decrease)	1,394,072,049	(1,565,847,963)	938,345,802	11,039,375,823	455,031,868	386,080,172
Net Position Restricted for OPEB						
Balance, Beginning of Year	11,252,985,702	12,818,833,665	11,880,487,863	841,112,040	386,080,172	
Balance, End of Year	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**	**$11,880,487,863**	**$841,112,040**	**$386,080,172**

Source: 2014-2019 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation.

[2] GASB Statement No. 74 requires health care expenses be reported net of certain health care receipts. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy and formulary rebates included in Contracts and Other Receipts, has been revised and is now included in Health Care Expenses, beginning in 2017 upon implementation of this standard.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2016	2015	2014
401(h) Health Care Trust[1]			
Additions			
Employer Contributions			$135,522,351
Contract and Other Receipts		$9,435	10,950,386
Retiree-Paid Health Care Premiums		248,601,375	238,406,380
Federal Subsidy			44,715,641
Other Income, net			7,601,841
Total Non-investment Income		**248,610,810**	**437,196,599**
Income/(Loss) From Investing Activities			
Net Increase/(Decrease) in the Fair Value of Investments	$428,632,525	(453,577,747)	209,726,745
Bond Interest	(60,085,563)	157,207,141	284,087,239
Dividends	131,736,664	105,609,193	186,495,341
International Income/(Loss)	3,751	(11,506)	18,941
Other Investment Income	14,158	652,343	4,302,396
External Asset Management Fees	(7,012,448)	(27,988,205)	(30,811,500)
Net Investment Income/(Loss)	**493,289,087**	**(218,108,781)**	**653,819,162**
Investment Administrative Expenses	(3,080,517)	(5,355,603)	(5,252,268)
Net Income/(Loss) from Investing Activity	**490,208,570**	**(223,464,384)**	**648,566,894**
TOTAL ADDITIONS	**490,208,570**	**25,146,426**	**1,085,763,493**
Deductions			
Health Care Expenses		1,774,989,836	1,738,596,173
Administrative Expenses		19,611,199	18,329,337
TOTAL DEDUCTIONS		**1,794,601,035**	**1,756,925,510**
Special Item[1]			
Interplan Activity—Trust Closures	**(11,161,276,751)**		
Net Decrease	(10,671,068,181)	(1,769,454,609)	(671,162,017)
Net Position Restricted for OPEB			
Balance, Beginning of Year	10,671,068,181	12,440,522,790	13,111,684,807
Balance, End of Year	**$0**	**$10,671,068,181**	**$12,440,522,790**

Source: 2014-2016 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this inter-plan activity and nets to zero in consolidation. No activity exists for years ended December 31, 2017 through 2019.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2016	2015	2014
Voluntary Employees' Beneficiary Association Trust[1]			
Additions			
Employer Contributions[2]	$10,483,804		$14,702,198
Contract and Other Receipts	22,722		20,484
Total Non-investment Income	**10,506,526**		**14,722,682**
Income/(Loss) From Investing Activities			
Net Increase/(Decrease) in the Fair Value of Investments	2,277,759	($5,883,465)	958,805
Bond Interest	1,222,858	1,902,518	1,625,463
Dividends	1,738,911	826,237	2,547,764
Real Estate Operating Income	1,026,057	2,959,962	3,017,022
International Income	79	371	240
Other Investment Income	517,933	1,724,353	3,584,241
External Asset Management Fees	(92,819)	(907,438)	(692,565)
Net Investment Income	**6,690,778**	**622,538**	**11,040,970**
From Securities Lending			
Securities Lending Income	92,902	106,312	77,985
Securities Lending Expense	(41,106)	(23,811)	(6,747)
Net Securities Lending Income	51,796	82,501	71,238
Unrealized Gains/(Losses)	4,152	(1,202)	3,401
Net Income from Securities Lending	**55,948**	**81,299**	**74,639**
Investment Administrative Expenses	(40,192)	(75,920)	(71,081)
Net Income from Investing Activity	**6,706,534**	**627,917**	**11,044,528**
TOTAL ADDITIONS	**17,213,060**	**627,917**	**25,767,210**
Deductions			
Health Care Expenses	1,417,445	2,396,972	2,217,933
Administrative Expenses	629,201	1,330,559	1,094,409
Interplan Activity	727,192	5,992,744	
TOTAL DEDUCTIONS	**2,773,838**	**9,720,275**	**3,312,342**
Special Item[1]			
Interplan Activity—Trust Closures	**(180,886,028)**		
Net Increase/(Decrease)	(166,446,806)	(9,092,358)	22,454,868
Net Position Restricted for OPEB			
Balance, Beginning of Year	166,446,806	175,539,164	153,084,296
Balance, End of Year	**$0**	**$166,446,806**	**$175,539,164**

Source: 2014-2016 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this inter-plan activity and nets to zero in consolidation. No activity exists for years ended December 31, 2017 through 2019.

[2] Beginning in October 2014, the Board approved the funding of the VEBA Trust participant accounts using the reserves in the VEBA Trust rather than the allocation of employer contributions. Instead, employer contributions were allocated to the Member-Directed Plan to repay the original plan start-up and administrative costs.