2021 Health Care Report

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OPERS

Ohio Public Employees Retirement System
2021 ORSC Health Care Report
(For period January 1, 2021-December 31, 2021)

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Year in Review-2021

As of year-end 2021, Ohio Public Employees Retirement System (OPERS) serves approximately 1,210,000 members, including more than 219,000 retirees and beneficiaries. In addition, OPERS partners with approximately 3,700 public employers. With a net asset base of $127.0 billion, OPERS is the largest public pension system in Ohio and the 13th 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.

Changes to the OPERS Health Care Program

In 2020, the OPERS Board of Trustees voted to adopt changes to health care coverage for Medicare and Pre-Medicare retirees. These changes, referred to as the Health Care Preservation Plan (HCPP 3.1), will preserve access to health care coverage for current and future retirees. 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 make great progress toward 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.

The new changes to the health care program eliminate the group medical plan for Pre-Medicare retirees and replaces it with a Health Reimbursement Arrangement (HRA). The amount of the retiree's HRA allowance varies based on the retiree's age at which they first enrolled in the OPERS health care program and their years of service at retirement. The HRA model was put in place for Medicare-eligible retirees in 2015 and has been successful. Other changes to the program include a reduced monthly base allowance amount for Medicare retirees (from $450 to $350), and modifications to eligibility, effective January 1, 2022.

OPERS selected Via Benefits, offered by Willis Towers Watson, to administer the OPERS Pre-Medicare Connector for eligible Pre-Medicare retirees beginning in 2022. If they so desire, Via Benefits will assist participating Pre-Medicare retirees with the transition to a new medical plan they choose from the open market. Via Benefits also administers the process by which participants can be reimbursed for qualifying medical expenses, using an HRA that OPERS provides. Via Benefits has administered the OPERS Medicare Connector, a similar service available to OPERS Medicare-eligible retirees since its inception in 2015. Unlike the Pre-Medicare plan, the OPERS Medicare Connector is a closed HRA, which necessitates retirees enrolling through Via Benefits to select a plan.

Throughout 2021, OPERS worked to implement the technology and resources necessary to execute the 2022 health care changes. OPERS also carried out a robust communication and education strategy aimed at preparing Pre-Medicare retirees to make the transition from an OPERS-sponsored group medical plan to an HRA model. OPERS is committed to assisting retirees through each phase of this transition and we'll continue offering support after the changes are implemented.

In 2021, OPERS experienced a continuation of many of the challenges experienced in 2020, as well as the addition of some new ones. The pandemic continued, resulting in the need for continued flexibility in the delivery of service. OPERS maintained online educational opportunities and enhanced these offerings further to meet the needs of Pre-Medicare retirees transitioning to a new medical plan.

Also, like other companies and organizations across the country, OPERS is experiencing the impact of a labor shortage. We have been preparing for the large volume of retirements of the baby boomer generation by investing in technology to allow more efficient use of staff. However, no one anticipated the labor shortage following the pandemic which has impacted our staffing levels and those of the vendors who provide service to our members. We felt the strain of this shortage during the open enrollment period in the fall of 2021. Retirees requiring assistance with the health care program transition ultimately received the help they needed but some experienced longer than normal wait times. In an effort to alleviate similar concerns in the future, OPERS

continues to collaborate with our vendors to develop new strategies in response to the ongoing labor shortage.

OPERS Medicare Connector

Throughout 2021, OPERS sustained efforts to ensure all eligible participants enrolled in individual Medicare plans via the OPERS Connector were successfully using their HRA account if they so desired. These efforts included interactive webinars and personal outreach to retirees with little or no HRA activity. OPERS works constantly with Via Benefits, the OPERS Connector administrator, to refine and improve the HRA reimbursement experience for Medicare-eligible participants in the OPERS Connector.

OPERS Pre-Medicare Health Plan

Before the OPERS Pre-Medicare medical plan was closed at the end of 2021, OPERS continued to implement annual adjustments to plan design and premiums for the plan to keep pace with rising costs. For the 2021 plan year, premiums amounts were not changed. The prescription drug out-of-pocket maximum was increased by $400 from $2,400 to $2,800. The increase aligned OPERS with the ACA guideline for overall maximum allowable out-of-pocket costs, which was $8,550 for 2021.

2021 Financial Highlights

The investment market continued strong in 2021 despite the ongoing pandemic. The OPERS Defined Benefit portfolio had an investment gain of 15.3% and ended the year at $109.5 billion. The Health Care portfolio reported an investment gain of 14.34% in 2021, compared to a gain of 10.96% in 2020. The overall 115 Health Care Trust (115 Trust) net asset balance increased to $14.2 billion in 2021 from $13.2 billion in 2020. Currently, OPERS is unable to allocate any of the employer contribution to the health care fund as all the employer contribution is being used to fund the pension benefit. As such, the only revenue source for the Health Care Trust is investment income.

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 remains steadfast in accomplishing 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.

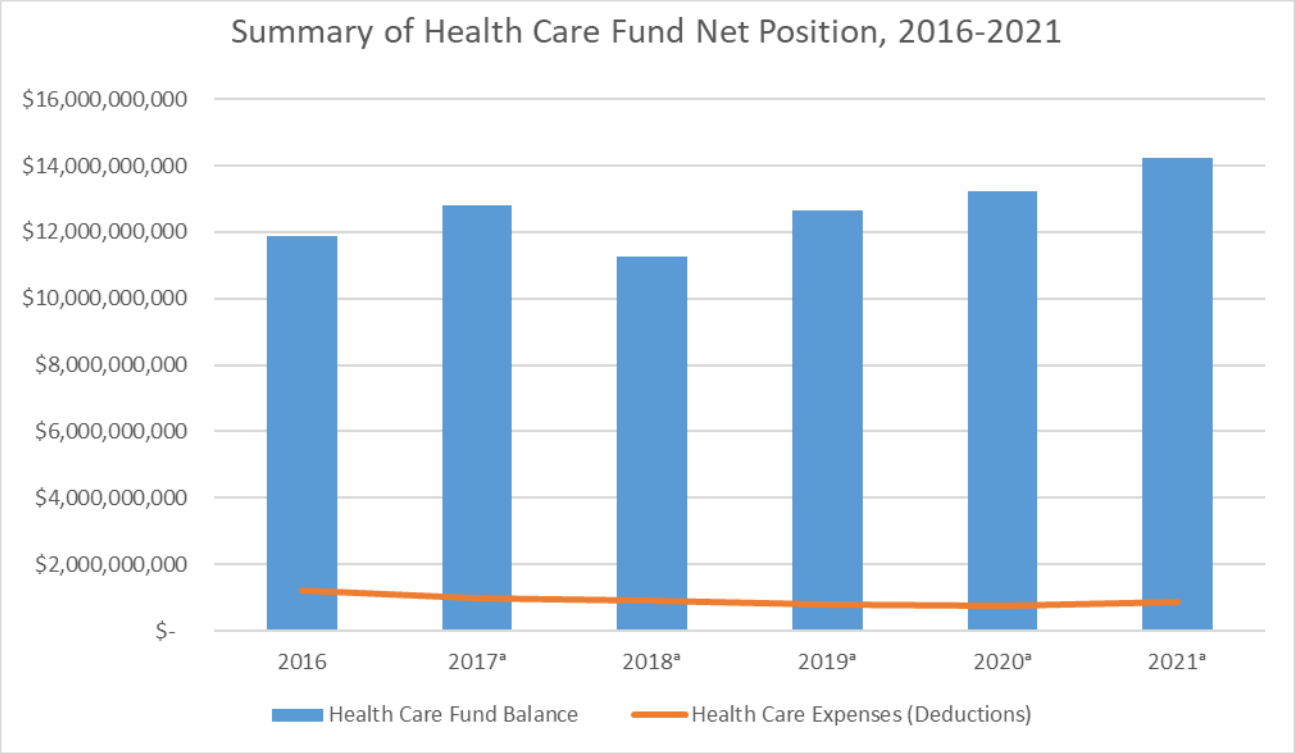
In 2021, a five-year experience study was completed for the period January 1, 2016 through December 31, 2020. The Board adopted changes to the demographic and economic assumptions for pension and health care as a result of the study. The most notable changes in economic assumptions were a reduction in the long-term pension investment return assumption from 7.2% to 6.9%, a reduction in the long-term expected wage inflation from 3.25% to 2.75%, and a reduction in long-term expected price inflation from 2.50% to 2.35%. There were no changes made to the long-term health care investment return assumption, which remains at 6.0%.

On January 15, 2020, the Board approved several changes to the health care plan offered to Medicare and non-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 the OPERS-sponsored self-insured medical plans for non-Medicare retirees with monthly allowances, similar to the program for Medicare retirees. These changes are not reflected in the current year financial statements however, they are reflected beginning in the December 31, 2019 measurement date health care valuation. These changes significantly decreased the total Other post-employment benefits (OPEB) liability for the measurement date December 31, 2020.

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, 2020, the date of the latest health care actuarial valuation, the actuarial liability for health care was $11.2 billion and the System had accumulated assets of $12.4 billion for that obligation, an excess of $1.2 billion. This compares to the 2019 excess assets of $0.5 billion. The funded ratio increased from 104.2% at the end of 2019 to 110.4% in 2020. The improvement from the prior year results from the combination of investment gains from 2021, the realization of the impact from changes to the health care plan, and the impact of demographic changes resulting from the experience study.

Financial Information

Additions	Deductions	Fund Balance	Solvency Period[1]	Employer Allocation[2]
$ 1,866,494,095	$ 868,573,891	$ 14,225,339,304	25	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance	Health Care Expenses (Deductions)
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
2020ª	$ 13,227,419,100	$ 741,460,732
2021ª	$ 14,225,339,304	$ 868,573,891

[1]Solvency period based on each system's individual valuation and underlying assumptions.

[2]No employer contributions were allocated to health care in 2017 through 2021 for the Traditional Pension and Combined plans. The contributions for the Member-Directed RMAs for 2021 remained at 4%.

[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.

Average Annual Cost Per Participant Paid by OPERS

Pre-Medicare Recipients	Re-employed Pre-Medicare Recipients	Medicare Recipients
$14,952	$11,647	$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 included OPERS benefit recipients who were not yet eligible for Medicare, met OPERS health care program eligibility requirements and had returned to work in an OPERS-covered position. OPERS required these recipients to enroll in their employer's health plan, provided the employer offered coverage to other employees in similar positions, allowing the OPERS Pre-Medicare plan to be a secondary payer.

Medicare Recipients included OPERS benefit recipients who meet OPERS health care program eligibility requirements, were Medicare-eligible, were enrolled in Medicare Parts A and B and were enrolled in an individual Medicare plan through the OPERS Medicare Connector. This group also includes re-employed Medicare-eligible recipients who were enrolled in the Medical Mutual Medicare Secondary Plan and received 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
137,693	16,919	5,340	159,952	82.8%

2021 Medical Mutual PPO Plan for OPERS Pre-Medicare and Pre-Medicare Re-Employed Participants

	In-Network	Out-of-Network
Deductible	$2,500	$5,000
Out-of-Pocket limit	$5,750	No limit
Lifetime Maximum	Unlimited	Unlimited
Outpatient	75%	60%
Mental health	75%	60%
Surgery	75%	60%
Emergency Room	$250* copay (emergency) $550 copay (non-emergency) 75% facility 75% all other charges	$250* copay (emergency) $550 copay (non-emergency) 75% facility 75% all other charges
Urgent Care	$60 copay	60%
Annual physical	100%**	60%***
Flu vaccines	100%**	60%***
PAP, Mammography, Colonoscopy, Sigmoidoscopy, Bone Density Testing†	100%**	60%***

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. Plan Features are general descriptions of coverage.

Out-of-pocket limit includes deductibles, copays and co-insurance amounts.
**Waived if admitted*
***Not subject to co-insurance or deductible*
****Subject to annual deductible*
† Subject to age and frequency limitations

2021 Prescription Drug Plan for Pre-Medicare and Pre-Medicare Re-Employed Participants

	Retail Preferred/Home Delivery	Retail/Non-Preferred Network
Annual deductible	$200 (generics) $400 (brands)	$200 (generics) $400 (brands)
Generic	25% co-insurance $4 min/$12 max retail $10 min/$30 max mail	30% co-insurance $7 min/$20 max
Formulary brand	35% co-insurance $30 min/$80 max retail $75 min/$200 max mail	40% co-insurance $35 min/$100 max
Non-formulary Brand	Not Covered	Not Covered
Specialty Drugs – Brand, Biosimilar/Generic	$300 max	$300 max
Annual out-of-pocket maximum	$2,800 (per ACA limits)	$2,800 (per ACA limits)

Supplemental Drug List (by request)

No Requests for 2021

OPERS Health Care Coverage for Medicare-eligible Retirees

OPERS Medicare Connector Health Reimbursement Arrangement (HRA)

During 2021, 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 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,
- Qualifying medical expenses for a spouse or child,
- Future qualifying medical expenses, including premium increases as the member ages.

Medical Mutual Medicare Secondary Plan

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

Medical Mutual Plan for OPERS Medicare-eligible Participants

Deductible	$1,000
Co-insurance Amount (excluding deductible)	$2,500
Out-of-Pocket limit	$3,500*
Medical Services (% covered by plan)	
Outpatient Hospice	80% (covered by Medicare at a certified hospice agency)
Mental health	80%
Surgery	80%
Emergency Services	
Emergency Room	$150 copay (waived if admitted)
Urgent Care	$50 copay
Preventive Services**	
Annual physical	100%
Flu vaccines	100%
PAP, Mammography, Colonoscopy, Sigmoidoscopy, Bone Density Testing	100%

**Out-of-pocket limit includes deductibles, copays and co-insurance amounts.*

***This is just a representative list of the preventive services covered.*

All charges 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%.

A look ahead

Although health care is neither mandated nor guaranteed, OPERS recognizes the importance of providing access to meaningful health care as it is a significant component of a secure retirement. This dedication to maintaining access to meaningful health care has become increasingly expensive as OPERS retirees, similar to national trends, have increased in number, have longer life expectancies, and health care costs continue to increase significantly faster than inflation.

OPERS faces two major challenges to providing access to health care. First, we anticipate that health care expenses will continue to increase based on the combination of the growing number of retirees, their increasing life expectancies and overall increases in the cost of health care due to medical advances, especially in the prescription drug component. Second, the funding status of the pension requires that all contributions be allocated to strengthen the pension funding. Thus, until the pension funding improves no employer contributions will be allocated to health care for the foreseeable future.

OPERS cannot control many aspects of the business of pensions, including market volatility, global economies and other unpredictable events, such as the global pandemic. However, we are diligent in making responsible decisions for the actions we can control and anticipating challenges beyond our control. We have taken significant action in recent years to preserve the health care fund through incremental changes designed to lengthen the solvency of that fund.

Health Care Preservation Plan

In 2020, the OPERS Board voted to adopt further changes to health care coverage for Medicare and Pre-Medicare retirees. These changes, referred to as the Health Care Preservation Plan (HCPP 3.1), were designed to improve the sustainability of the health care program. A high-level summary of changes to the health care program is provided on the following page.

Pre-Medicare Transition to an HRA

Effective January 1, 2022, OPERS will discontinue the group plans currently offered to Pre-Medicare retirees and re-employed retirees. Instead, eligible Pre-Medicare retirees will select an individual medical plan. OPERS will provide a subsidy or allowance via a Health Reimbursement Arrangement (HRA) to those retirees who meet health care eligibility requirements. Retirees will be able to seek reimbursement for plan premiums and other qualifying medical expenses. Pre-Medicare retirees will also have the option to select the federally provided premium subsidy in lieu of the OPERS allowance based on their financial economics.

Eligibility

Retirees who were eligible to participate in the OPERS health care program prior to January 1, 2022, will continue to be eligible after January 1, 2022. Eligibility requirements will change for those retiring after January 1, 2022.

Effective January 1, 2022, retirees in the Traditional Pension Plan or Combined Plan must meet the following health care eligibility requirements to receive an HRA allowance:

1) Medicare Retirees—Medicare-eligible with a minimum of 20 years of qualifying service credit.
2) Pre-Medicare Retirees—Pre-Medicare retirees qualify based on the following age-and-service criteria:
    a) Group A—30 years of qualifying service credit at any age;
    b) Group B—32 years of qualifying service credit at any age or 31 years of qualifying service credit and minimum age 52;
    c) Group C—32 years of qualifying service credit and minimum age 55; or,
    d) A retiree from groups A, B or C who qualifies for an unreduced pension, but a portion of their service credit is not health care qualifying service can still qualify for health care at age 60 if they have at least 20 years of qualifying health care service credit.

Retirees who don't meet the requirement for coverage as a Pre-Medicare participant can become eligible for coverage at age 65 if they have at least 20 years of qualifying service.

HRA Allowances

Effective December 31, 2021, OPERS no longer sponsors a medical and prescription drug group plan for Pre-Medicare retirees. Instead, effective January 1, 2022, eligible Pre-Medicare retirees began receiving a monthly HRA allowance for reimbursement of health care coverage premiums and other qualifying medical expenses. The OPERS Connector will assist them with enrolling in a medical plan on the open market. The Pre-Medicare monthly base allowance is $1,200. Retirees receive a percentage (ranging between 51%-90%) of the base allowance determined by their age and qualified years of service at retirement.

Also, effective January 1, 2022, the base allowance used to determine the monthly HRA allowance for Medicare-eligible retirees decreased from $450 per month to $350 per month. Additionally, Medicare-eligible retirees who retired prior to January 1, 2015, and were granted an allowance of 75% now have their allowance determined based on their age when they first enrolled and their years of service at retirement. Their allowance percentage is currently between 51% and 74% of the base allowance as calculated on the OPERS allowance table.

Transition Deposit

A one-time HRA deposit of $1,200 was provided to retirees who were enrolled in the OPERS Pre-Medicare group plan effective December 1, 2021. This deposit is to assist in the transition to the individual marketplace.

Dependent Children

Effective January 1, 2022, retirees no longer receive an additional allowance for eligible dependent children, regardless of age, ability or mental capacity. The retiree is able to use their HRA to reimburse any qualifying medical expenses incurred by their eligible dependents.

Re-employed Retirees

Effective January 1, 2022, eligible re-employed retirees will no longer have their HRA suspended during the re-employment period. Instead, re-employed retirees will receive

the HRA allowance throughout the re-employment period provided enrollment requirements are met. The monthly HRA deposits will accrue in a Re-employed Accumulated HRA. However, re-employed retirees will not be able to use the accumulated HRA balance to be reimbursed for qualified medical expenses during the re-employment period. Upon completion of the re-employment period, all funds will be available for reimbursement of eligible expenses incurred outside of re-employment.

Incorporating the results from HCPP 3.1, as of December 31, 2020, the date of the most recent health care valuation, the health care assets accumulated to fund the liabilities exceeded the liabilities by $1.2 billion resulting in a funded ratio of 110.4%. Based on the combination of level of health care expenditures and that OPERS is currently unable to allocated employer contributions to the health care fund, the current trust fund is expected to last approximately 25 years, a significant improvement over the prior year's solvency period.

The OPERS Board, management and staff acknowledge that access to meaningful health care is a significant component of a secure retirement to members. Our tradition of working to preserve the health care fund through incremental changes designed to lengthen the solvency of that fund will continue.

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 2021. Both sections were amended by Substitute Senate Bill 343, effective January 7, 2013 and Senate Bill 42, effective March 23, 2015

(2) A summary of coverage for 2021:

The following is an outline of OPERS health care coverage in 2021:

The 2021 OPERS Retiree Health Plan for Pre-Medicare Recipients

The 2021 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 agreed 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. An allowance, based on the retiree's years of service and age when first enrolled in the plan, was used to offset a portion of the monthly plan premium. **A more detailed explanation of coverage can be found on page 7.**

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 2021, 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 differed based on the delivery method, whether a drug was a generic, name brand or specialty and its formulary status. **A more detailed explanation of coverage can be found on page 8.**

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 or after. Account funds can be used to reimburse the retiree's qualifying medical expenses.

Member-Directed Retiree Medical Account (RMA)

Upon termination from OPERS-covered employment and a distribution from the Member-Directed Plan (refunded or pensioned), a participant may use the vested funds in their Member-Directed RMA to reimburse qualifying medical 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 2021, 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. Retirees were also eligible for a monthly allowance 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,
- Qualifying medical expenses for a spouse or child,
- Future qualifying medical 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-enrolled retirees who are not eligible to participate in the OPERS Medicare Connector and receive an HRA allowance during re-employment. These retirees include Medicare-enrolled, re-employed retirees and their eligible Medicare dependents as well as early Medicare retirees under age 65. Retirees and dependents enrolled in the Medical Mutual Medicare Secondary Plan are also enrolled in the Express Scripts Prescription Drug plan. Similar to the pre-Medicare plan, an allowance, based on the retiree's years of service and age when first enrolled in the plan, was used to offset a portion of the monthly premium. **A more detailed explanation of prescription drug and medical coverage can be found on pages 8 and 10, respectively.**

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 select a plan through the Connector and retirees may receive an HRA allowance.

The Dental Plan

During 2021, 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 2021 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 member's group also affects when members will be eligible for health care coverage through OPERS. In 2021, members in Group A are eligible for coverage at any age with 30 or more years of qualifying service. Members in Group B are eligible at any age with 32 years of qualifying service, or at age 52 with 31 years of qualifying service. Members in Group C are eligible for coverage with 32 years of qualifying service and a minimum age of 55.

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 was 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 dies, 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 2021, 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 2021, 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.

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 and refund 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, 2021, there were 164,987 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 economic resources measurement focus and accrual basis of accounting under which deductions are recorded when the expense is incurred and revenues are recognized when earned. Health care payments are considered an expense and recognized as a liability 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 their trade date. 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, risk parity 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 some real estate investments, private equity, risk parity 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 can be 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, 2021. The health care contribution rate allocation for the Member-Directed Plan retiree medical accounts (RMAs) for 2021 remained at 4%. In 2017, OPERS implemented Governmental Accounting Standards Board Statement No. 74 (GASB 74), Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans. GASB 74 requires that certain health care receipts, or payments, from retirees and health care vendors to OPERS, 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 previously included 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. Beginning 2016, 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, 2020, the most recent actuarial valuation, was 110.4%. The funding progress of health care is measured in terms of solvency years, or the number of years 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 approximately 25 years as of the December 31, 2020 valuation.

The Board approved changes to the OPERS health care plans in 2012. The ultimate goal of the health care changes was to match the funding of the health care trust and disbursements from the health care trust. Additionally, the Board established a health care stabilization fund to hold investment earning income in excess of the funding assumption. 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 a percentage during the year. The stabilization fund is an accounting function only and not listed separately in the financial statements. This stabilization fund is included in the health care results provided throughout this report. 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 the OPERS-sponsored self-insured medical plans for non-Medicare retirees with monthly allowances, similar to the

program for Medicare retirees. These changes are not reflected in the current year financial statements however, they are reflected beginning in the December 31, 2020, measurement date health care valuation. These changes significantly decreased the total OPEB liability for the measurement date December 31, 2020.

(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:

No significant changes affecting the comparability of the report.

(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

	2021	2020	2019	2018	2017	2016
115 Health Care Trust[1]						
Assets						
Cash and Cash Equivalents	**$601,259,856**	**$1,027,292,218**	**$818,204,587**	**$595,183,342**	**$823,866,242**	**$874,632,840**
Receivables						
Members and Employers	3,073,969	1,911,304	1,892,495	2,016,190	17,310,993	28,954,270
Vendor and Other	13,324,552	17,761,491	12,585,164	12,173,150	10,325,432	67,090,996
Investment Sales Proceeds	27,052,473	31,752,833	52,212,702	38,943,225	58,028,023	70,760,106
Accrued Interest and Dividends	39,152,066	45,461,914	46,169,385	44,840,466	44,801,284	41,092,533
Total Receivables	**82,603,060**	**96,887,542**	**112,859,746**	**97,973,031**	**130,465,732**	**207,897,905**
Investments						
Fixed Income	4,990,704,874	4,895,416,249	4,855,122,000	4,117,147,799	4,348,639,837	4,087,785,698
Domestic Equities	4,955,808,406	3,518,558,498	3,183,847,864	2,911,258,188	3,403,242,732	3,071,759,733
International Equities	3,430,623,707	3,079,326,933	2,674,811,901	2,240,589,009	2,645,509,612	2,265,107,975
Risk Parity	302,208,248					
Other Investments	27,222,822	726,811,028	1,237,576,242	1,495,996,430	1,654,750,270	1,534,240,696
Total Investments	**13,706,568,057**	**12,220,112,708**	**11,951,358,007**	**10,764,991,426**	**12,052,142,451**	**10,958,894,102**
Collateral on Loaned Securities	**1,473,586,654**	**53,244,143**				
Capital Assets						
Land	942,728	942,728	942,728	942,728	942,728	942,728
Building and Building Improvements	27,877,452	27,894,673	27,971,184	27,986,068	27,998,673	28,004,098
Furniture and Equipment	39,229,340	32,258,995	34,246,182	32,854,966	33,676,485	32,759,796
Intangible Right-to-use Assets	2,641,732	2,521,393				
Total Capital Assets	70,691,252	63,617,789	63,160,094	61,783,762	62,617,886	61,706,622
Accumulated Depreciation and Amortization	(43,023,677)	(40,619,545)	(41,103,250)	(38,171,032)	(36,873,343)	(33,678,510)
Net Capital Assets	**27,667,575**	**22,998,244**	**22,056,844**	**23,612,730**	**25,744,543**	**28,028,112**
TOTAL ASSETS	**15,891,685,202**	**13,420,534,855**	**12,904,479,184**	**11,481,760,529**	**13,032,218,968**	**12,069,452,959**
Liabilities						
Undistributed Deposits	412,404	22,848	196,350	214,798	230,367	287,413
Benefits Payable	178,969,160	107,300,342	115,181,776	119,532,084	114,643,770	109,142,271
Investment Commitments Payable	12,158,010	32,561,762	142,043,307	109,027,945	98,511,166	79,535,412
Accounts Payable and Other Liabilities	904,288					
Obligations Under Securities Lending	1,473,902,036	53,230,803				
TOTAL LIABILITIES	**1,666,345,898**	**193,115,755**	**257,421,433**	**228,774,827**	**213,385,303**	**188,965,096**
Net Position Restricted for OPEB	**$14,225,339,304**	**$13,227,419,100**	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**	**$11,880,487,863**

Source: 2016-2021 Annual Comprehensive 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 D

Statements of Changes in Fiduciary Net Position – Health Care

	2021	2020	2019	2018	2017	2016
115 Health Care Trust[1]						
Additions						
Employer Contributions	$25,631,727	$24,489,938	$24,318,141	$23,441,668	$157,417,888	$274,419,455
Contract and Other Receipts[2]	235,362	513,509	540,809	279,178	857,541	93,306,585
Retiree-Paid Health Care Premiums[2]						184,368,783
Federal Subsidy[2]						4,065,058
Other Income, net	35,954	430,729	1,724	732,193	117,882	15,715
Interplan Activity						6,036,782
Total Non-investment Additions	**25,903,043**	**25,434,176**	**24,860,674**	**24,453,039**	**158,393,311**	**562,212,378**
Income/(Loss) From Investing Activities						
Net Increase/(Decrease) in the Fair Value of Investments	1,558,420,836	1,098,039,399	1,600,900,770	(862,731,054)	1,303,745,052	160,473,865
Bond Interest	146,678,770	136,102,586	162,002,938	108,077,693	162,929,606	92,284,043
Dividends	145,288,202	92,781,749	428,602,794	88,148,545	325,553,345	130,678,719
International Income/(Loss)[3]		(45,357)	227,029	398,457	248,369	(1,998)
Other Investment Income/(Loss)	1,858,827	(832,267)	2,172,948	293,975	396,299	(282,340)
External Asset Management Fees	(11,143,188)	(24,247,532)	(33,296,008)	(28,772,749)	(36,062,800)	(27,669,191)
Net Investment Income/(Loss)	**1,841,103,447**	**1,301,798,578**	**2,160,610,471**	**(694,585,133)**	**1,756,809,871**	**355,483,098**
From Securities Lending Activity						
Securities Lending Income	6,516,945	452,507				
Securities Lending Expenses	(766,175)	(229,778)				
Net Securities Lending Income	5,750,770	222,729	-	-	-	-
Unrealized Gains/(Loss)	(328,074)	12,692				
Net Income from Securities Lending	**5,422,696**	**235,421**	-	-	-	-
Investment Administrative Expenses	(5,935,091)	(5,646,094)	(5,552,500)	(5,824,547)	(5,447,329)	(2,853,560)
Net Income/(Loss) from Investing Activity	**1,840,591,052**	**1,296,387,905**	**2,155,057,971**	**(700,409,680)**	**1,751,362,542**	**352,629,538**
TOTAL ADDITIONS	**1,866,494,095**	**1,321,822,081**	**2,179,918,645**	**(675,956,641)**	**1,909,755,853**	**914,841,916**
Deductions						
Health Care Expenses[2]	853,113,419	725,265,912	767,888,929	870,284,919	952,001,573	1,195,956,899
Administrative Expenses	15,460,472	16,194,820	17,957,667	19,606,403	19,408,478	21,693,387
TOTAL DEDUCTIONS	**868,573,891**	**741,460,732**	**785,846,596**	**889,891,322**	**971,410,051**	**1,217,650,286**
Special Item[1]						
Interplan Activity—Trust Closures						**11,342,184,193**
Net Increase/(Decrease)	997,920,204	580,361,349	1,394,072,049	(1,565,847,963)	938,345,802	11,039,375,823
Net Position Restricted for OPEB						
Balance, Beginning of Year	13,227,419,100	12,647,057,751	11,252,985,702	12,818,833,665	11,880,487,863	841,112,040
Balance, End of Year	**$14,225,339,304**	**$13,227,419,100**	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**	**$11,880,487,863**

Source: 2016-2021 Annual Comprehensive 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 Contract and Other Receipts, has been revised and is now included in Health Care Expenses, beginning in 2017 upon implementation of this standard.

[3] Beginning in 2021, International Income/(Loss) is included in Other Investment Income/(Loss)

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2016
401(h) Health Care Trust[1]	
Additions	
Income/(Loss) From Investing Activities	
Net Increase in the Fair Value of Investments	$428,632,525
Bond Interest	(60,085,563)
Dividends	131,736,664
International Income	3,751
Other Investment Income	14,158
External Asset Management Fees	(7,012,448)
Net Investment Income	**493,289,087**
Investment Administrative Expenses	(3,080,517)
Net Income from Investing Activity	**490,208,570**
TOTAL ADDITIONS	**490,208,570**
Special Item[1]	
Interplan Activity—Trust Closures	**(11,161,276,751)**
Net Decrease	(10,671,068,181)
Net Position Restricted for OPEB	
Balance, Beginning of Year	10,671,068,181
Balance, End of Year	**$0**

Source: 2016 Comprehensive Annual Financial Report

[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. No activity exists for years ended December 31, 2017 through 2021.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2016
Voluntary Employees' Beneficiary Association Trust[1]	
Additions	
Employer Contributions[2]	$10,483,804
Contract and Other Receipts	22,722
Total Non-investment Additions	**10,506,526**
Income/(Loss) From Investing Activities	
Net Increase in the Fair Value of Investments	2,277,759
Bond Interest	1,222,858
Dividends	1,738,911
Real Estate Operating Income	1,026,057
International Income	79
Other Investment Income	517,933
External Asset Management Fees	(92,819)
Net Investment Income	**6,690,778**
From Securities Lending	
Securities Lending Income	92,902
Securities Lending Expense	(41,106)
Net Securities Lending Income	51,796
Unrealized Gains	4,152
Net Income from Securities Lending	**55,948**
Investment Administrative Expenses	(40,192)
Net Income from Investing Activity	**6,706,534**
TOTAL ADDITIONS	**17,213,060**
Deductions	
Health Care Expenses	1,417,445
Administrative Expenses	629,201
Interplan Activity	727,192
TOTAL DEDUCTIONS	**2,773,838**
Special Item[1]	
Interplan Activity—Trust Closures	**(180,886,028)**
Net Increase/(Decrease)	(166,446,806)
Net Position Restricted for OPEB	
Balance, Beginning of Year	166,446,806
Balance, End of Year	**$0**

Source: 2016 Comprehensive Annual Financial Report

[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. No activity exists for years ended December 31, 2017 through 2021.

[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.