
# Annual Health Care Report

For the Year Ended June 30, 2019

School Employees Retirement System of Ohio

*Serving the People Who Serve Our Schools®*

**SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO**
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RICHARD STENSRUD
*Executive Director*

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December 27, 2019

Bethany Rhodes, Director/General Counsel
Ohio Retirement Study Council
30 E. Broad St., 2nd Floor
Columbus, OH 43215

Dear Ms. Rhodes:

In accordance with section 3309.21(E) of the Ohio Revised Code, please find enclosed, as of June 30, 2019, a full accounting of the revenues and costs relating to the provision of health care under sections 3309.375 and 3309.69 of the Ohio Revised Code.

Please note the following information of interest:

- The School Employees Retirement System provided health care coverage to 42,547 eligible retirees and dependents at a net cost of $57,139,536;
- The amount paid for Medicare Part B reimbursement under 3309.69(C) of the Ohio Revised Code was $23,990,512; and
- In FY2019, 0.50% of the 14% employer contribution was allocated to the health care program. This is in addition to the 1.5% employer surcharge.

After reviewing this report, if you have any questions, please feel free to contact me.

Sincerely,

Richard Stensrud

**Richard Stensrud**
Executive Director

Enclosures

c: The Honorable William Coley, Chair, Senate Government Oversight and Reform
The Honorable Tim Ginter, Chair, House Aging and Long-Term Care
Kimberly Munieks, Director, Office of Budget and Management

# School Employees Retirement System of Ohio
# 2019 Annual Health Care Report

For the Year Ended June 30, 2019

# FY2019 YEAR IN REVIEW

Access to health care is provided in accordance with section 3309.69 of the Ohio Revised Code and rule 3309-1-35 of the Ohio Administrative Code. During FY2019, the School Employees Retirement System of Ohio (SERS) has continued to provide Non-Medicare and Medicare group coverage for eligible benefit recipients through a combination of investment income, federal subsidies, employer contributions, and premiums. Employer contributions are distributed to the Health Care Fund by a health care surcharge to compensate for low-wage earners. Additional contributions are allocated at the Retirement Board's discretion, in accordance with its Funding Policy, requiring a pension funded ratio of 70% before any additional health care contribution can be made.

At the outset of FY2019, the Health Care Fund had reached $435.6 million, and the actuary's valuation predicted solvency for 17 years to 2035. The Retirement Board elected to allocate 0.5% of employer contributions to the Health Care Fund for the fiscal year. The health of the Fund allowed the Retirement Board to approve reductions in premiums for both Non-Medicare and Medicare enrollees beginning January 1, 2019.

The Health Care Fund value continued to improve during FY2019, ending the fiscal year on June 30, 2019, at $463.8 million. The Retirement Board elected to allocate no employer share to the Health Care Fund for FY2020, and the actuarial valuation anticipated 15 years of solvency at of the end of FY2019, until 2034.

SERS operates two programs designed to reduce costs for the Non-Medicare population.

The SERS Marketplace Wraparound Program assists eligible enrollees to select a federal Marketplace plan as primary health care coverage, after which the Wraparound Plan reimburses for certain eligible out-of-pocket costs. Approximately 10% of SERS' Non-Medicare enrollees elect this plan, saving nearly $4 million during 2019.

The SERS Early Medicare program reviews Non-Medicare claims experience to identify enrollees potentially eligible for Medicare prior to age 65. SERS disability benefit recipients who elect SERS Non-Medicare health care coverage also are required to apply for early Medicare. In total since 2017, the early Medicare program has saved the Health Care Fund more than $3.9 million through FY2019.

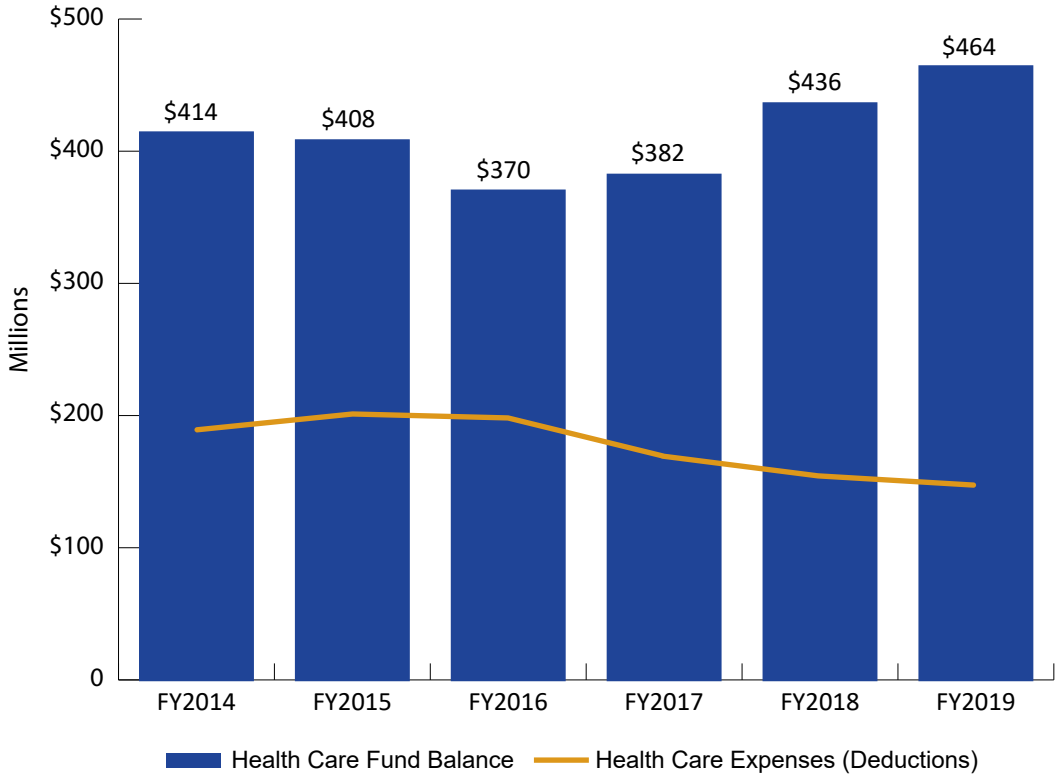
During the fiscal year, SERS renegotiated both its Medicare Advantage and prescription drug contracts to achieve additional savings. The SaveonSP specialty drug manufacturer program also saved the Health Care Fund more than $600 thousand during FY2019.

The SERS Board is currently reviewing the Health Care Fund status and program requirements to ensure continued funding for health care benefits. Although funding health care is not statutorily mandated, SERS members consider this benefit fundamental to their retirement security.

# FINANCIAL SUMMARY - FY2019

| Additions | Deductions | Fund Balance | Solvency Period | Employer Allocation |
|---|---|---|---|---|
| $175,875,434 | $147,694,392 | $463,810,679 | 15 years | 0.5% |

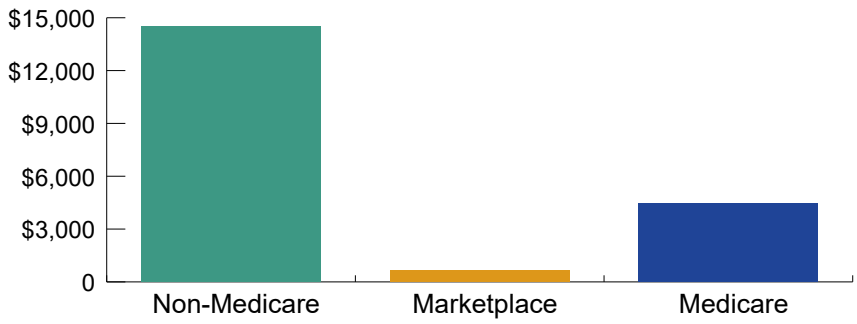
# SUMMARY OF HEALTH CARE FUND NET POSITION, 2014-2019




## Health Care Fund Balance (As Graphed Above)

| Fiscal Year | Health Care Fund Balance | Health Care Expenses (Deductions) |
|---|---|---|
| FY2014 | $413,858,201 | $190,267,910 |
| FY2015 | $408,363,598 | $202,043,473 |
| FY2016 | $370,204,515 | $199,191,727 |
| FY2017 | $382,109,560 | $169,689,112 |
| FY2018 | $435,629,637 | $155,080,363 |
| FY2019 | $463,810,679 | $147,694,392 |

## AVERAGE COST PER PARTICIPANT PAID BY SERS

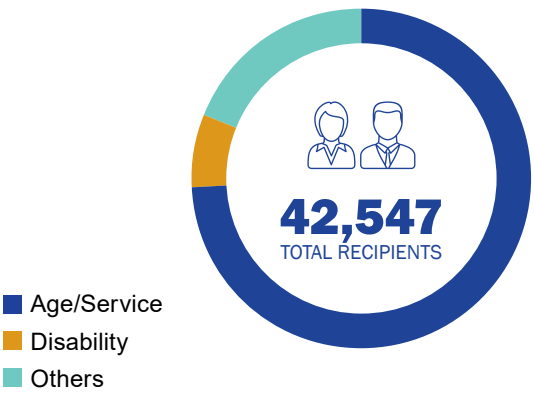


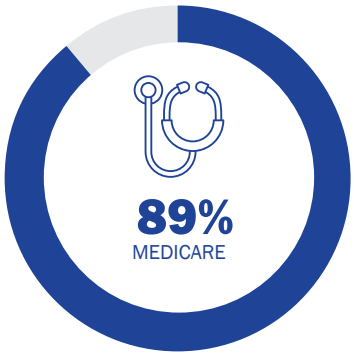

| Non-Medicare Recipients | Marketplace Wraparound Plan Recipients | Medicare Recipients |
|---|---|---|
| $14,500 | $660 | $4,440 |

**Non-Medicare and Marketplace Wraparound Plan recipients** include benefit recipients, and dependents who meet SERS' health care eligibility requirements and are not enrolled in Medicare.

**Medicare recipients** include benefit recipients and dependents who meet SERS' health care eligibility requirements and are enrolled in a SERS Medicare plan.

## POPULATION OF RECIPIENTS




| Age and Service | Disability | All Others (Survivors, Beneficiaries, etc.) | Total Recipients | Percent Medicare |
|---|---|---|---|---|
| 31,605 | 2,955 | 7,987 | 42,547 | 89% |

# MEDICARE PARTICIPANTS

**SERS' Primary Medicare Plan is Aetna Medicare Plan (PPO), a Medicare Advantage Plan**

| | In-Network | Out-of-Network | Out of Area |
|---|---|---|---|
| Deductible | $0 | $0 | Out-of-state residents are placed in the Aetna Medicare (PPO) Extended Service Area. In-network rates apply when using a provider who accepts Medicare and bills Aetna. |
| Out-of-Pocket limit | $3,000 per person | $6,700 per person | |
| Lifetime Maximum | Not limited | Not limited | |
| **Medical Services (% covered by plan)** | | | |
| Outpatient Diagnostic Lab | 100% | 80% | |
| Mental health, Inpatient | Member copay $150 per day(s) 1-5, then plan pays 100% | 80% per stay | |
| Mental health, Outpatient | Member copay $30, then plan pays 100% | 80% | |
| Surgery, Outpatient | Member pays 15% co-insurance ($200 max.) then plan pays 100% | 80% | |
| **Emergency Services** | | | |
| Emergency Room | Member copay $100 (waived if admitted), then plan pays 100% | Member copay $100 (waived if admitted), then plan pays 100% | |
| Urgent Care | Member copay $40, then plan pays 100% | Member copay $40, then plan pays 100% | |
| **Preventative Services - Screening** | | | |
| Annual physical | 100% | 80% | |
| Flu vaccines | 100% | 100% | |
| EKG, Lipid Cholesterol Test, and Blood Sugar, Colonoscopy, Sigmoidoscopy, and Bone Density Testing | 100% | 80% | |

## Express Scripts Part D Prescription Drug Plan with the Aetna Plan

| | Retail (30-day supply) | Home Delivery (90-day supply) |
|---|---|---|
| **Generic** | $7.50 co-pay, max. | $15 co-pay, max. |
| **Preferred brand name** | 25% of cost (min. $25, max. $100) | 25% of cost (min. $45, max. $200) |
| **Specialty medications** | 25% of cost (min. $25, max. $100) | 25% of cost (min. $15, max. $67 per 30-day supply) |
| **Non-preferred brand name** | No coverage | No coverage |
| **Insulin Only** | | |
| **Preferred brand name** | 25% of cost (min. $25, max. $30) | 25% of cost (min. $45, max. $60) |
| **Non-preferred brand name** | 25% of cost (max. $45) | 25% of cost (max. $115) |

# NON-MEDICARE PARTICIPANTS

**SERS' Primary Non-Medicare Group Plan is Aetna Choice POS II**

| | In-Network | Out-of-Network | Out of Area |
|---|---|---|---|
| Deductible | Individual $2,000 / Family $4,000 | Individual $4,000 / Family $8,000 | Network providers available out-of-area. Benefits are based on in-network or out-of-network usage for out-of-state residents. |
| Out-of-Pocket limit | Individual $7,350 / Family $14,700 | Not Limited | |
| Lifetime Maximum | No Limit | No Limit | |
| **Medical Services (% covered by plan)** | | | |
| Outpatient Diagnostic X-ray/Lab | 80% | 10% | |
| Mental health, Inpatient<br><br>Mental health, Outpatient | Member copay $250 after deductible, then the plan pays 80%<br><br>Member copay $20, then plan pays 100% | Member copay $290 after deductible, then the plan pays 10% | |
| Surgery, Outpatient | 80% | 10% | |
| **Emergency Services** | | | |
| Emergency Room | Member copay $150 (waived if admitted), then plan pays 100% | Member copay $150 (waived if admitted), then plan pays 100% | |
| Urgent Care | Member copay $40, then plan plays 100% | Member copay $40, then plan plays 100% | |
| **Preventative Services** | | | |
| Annual physical | 100% | 10% | |
| Flu vaccines | 100% | 100% | |
| EKG, Lipid Cholesterol Test, and Blood Sugar, Colonoscopy, Sigmoidoscopy, and Bone Density Testing | 100% | 10% | |

## Express Scripts Prescription Drug Plan for Aetna Choice POS II

| | Retail (30-day supply) | Home Delivery (90-day supply) |
|---|---|---|
| **Generic** | $7.50 co-pay, max. | $15 co-pay, max. |
| **Preferred brand name** | 25% of cost (min. $25, max. $100) | 25% of cost (min. $45, max. $200) |
| **Specialty medications** | 25% of cost (min. $25, max. $100) Only certain specialty medications allowed at retail. | 25% of cost (min. $15, max. $67 per 30-day supply) Different co-pay amounts apply for medications eligible for SaveonSP co-pay assistance program.* |
| **Non-preferred brand name** | No coverage | No coverage |
| **Insulin Only** | | |
| **Preferred brand name** | 25% of cost (min. $25, max. $30) | 25% of cost (min. $45, max. $60) |
| **Non-preferred brand name** | 25% of cost ($45 max.) | 25% of cost ($115 max.) |

*SERS participates in a co-pay assistance program with SaveonSP, which takes advantage of funds available from drug manufacturers to lower members' cost and the amount that SERS pays

# THE SERS MARKETPLACE WRAPAROUND PLAN

| Benefit | 2019 Maximum Reimbursement |
|---|---|
| **Deductible** | Up to $2,000 |
| **Covered prescription drugs copayment/ coinsurance** | 50% of the Marketplace plan's prescription drug copayment/coinsurance (up to $200 per prescription) |
| **Physician Office Visit copayment** | Up to $50 per visit |
| **Inpatient Hospital Admission copayment/ coinsurance** | Up to $300 per admission |
| **Imaging (X-rays, CT/PET Scans, MRI) copayment or coinsurance** | Up to $100 per service |
| **Hearing Aid** | One hearing aid per year; up to $1,500 |

The SERS Wraparound Plan is available to health care participants who are not eligible for Medicare and not enrolled in Medicaid.

Participants select an insurance plan through the Health Insurance Marketplace, and SERS then "wraps" the Marketplace plan by providing additional benefits to reimburse a portion of the deductible, copays, and other costs.

SERS began offering this option in 2017 as part of a three-year federal pilot program under the Affordable Care Act. The pilot expires at the end of the 2019 plan year.

# HEALTH CARE FUTURE

Beginning July 2019, the Retirement Board began structured sustainability discussions as part of its Strategic Plan activity to evaluate next steps to secure the Health Care Fund. The Retirement Board reviewed the history of health care policy changes, including eligibility for retiree health care and premium subsidy. Revenue and expenses for both the Medicare and Non-Medicare programs were reviewed, and the Retirement Board's discussions are continuing into FY2020.

Concurrently, health care and government relations staff are monitoring and evaluating the impact of proposed federal changes in Medicare, prescription drug pricing, and taxes required by the Affordable Care Act. SERS' federal liaison is pursuing legislative authority to continue the SERS Marketplace Wraparound Plan, which is scheduled to sunset December 31, 2019. Beginning January 1, 2020, an alternative Wraparound Health Reimbursement Arrangement (HRA) will be offered as a similar replacement option.

Cost-saving efforts have stabilized the SERS Health Care Fund during this period of cost inflation, lower investment returns, and the absence of additional employer contributions in FY2020. The Retirement Board's continuing review of the program will evaluate further changes necessary to provide health care access for SERS retirees into the future.

# SUPPLEMENTARY STATUTORY REQUIREMENTS

In accordance with section 3309.21(E) of the Ohio Revised Code (ORC), the SERS Retirement Board is required to prepare an annual report as of December 31 documenting full accounting of the revenues and costs relating to provision of health care coverage under sections 3309.375 and 3309.69 of the ORC.

Ohio law mandates that SERS 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 SERS as outlined in ORC Section 3309.21(E). The requirements and the System's responses include:

## (1) A Description of the Statutory Authority for the Benefits Provided

Access to health care is provided in accordance with the following sections of the Ohio Revised Code (ORC) and rule 3309-1-35 of the Ohio Administrative Code, and is financed through a combination of employer contributions and retiree premiums, copays, and deductibles on covered health care expenses, investment returns, and any reimbursements received as a result of SERS' participation in Medicare programs:

**Sec. 3309.375 Hospital insurance coverage for retirants.**

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

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

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

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

Eff. 7/29/92 S.B. 346
6/30/91 H.B. 382
6/13/81 H.B. 126
6/13/75 H.B. 1
12/14/67 H.B. 402
OAC Reference: 3309-1-55

**Sec. 3309.392 Social security disability insurance benefits.**

(A) A recipient of a disability benefit granted under this chapter on or after January 7, 2013, but before the effective date of this amendment, who is enrolled in health care coverage under section 3309.69 of the Revised Code shall apply for social security disability insurance benefit payments under 42 U.S.C. 423 if the recipient meets the requirements of divisions (a)(1)(A), (B), and (C) of that section.

(B) A recipient of a disability benefit granted under this chapter on or after the effective date of this amendment who is enrolled in health care coverage under section 3309.69 of the Revised Code shall apply for both of the following:

(1) Social security disability insurance benefit payments under 42 U.S.C. 423 if the recipient meets the requirements of divisions (a)(1)(A), (B), and (C) of that section;

(2) Hospital insurance benefits under 42 U.S.C. 426(b), if both of the following are the case:

(a) The recipient had medicare qualified government employment, as defined in 42 U.S.C. 410(p).

(b) The recipient would have met the requirements of divisions (a)(1)(A), (B), and (C) of 42 U.S.C. 423 if the medicare qualified government employment was treated as employment under 42 U.S.C. 410(a).

(C) Unless the school employees retirement system determines that good cause exists to exempt the recipient from the requirements of this section, a recipient who is subject to division (A) or (B) of this section shall file the applications required by those divisions as follows:

(1) For a recipient who on the effective date of this amendment is enrolled in health care coverage under section 3309.69 of the Revised Code, not later than one hundred eighty days after the effective date of this amendment;

(2) For a recipient who enrolls in health care coverage under section 3309.69 of the Revised Code on or after the effective date of this amendment, not later than ninety days after enrolling.

(D) The recipient shall file a copy of each completed application and a copy of the social

security administration's acknowledgment of receipt of the application with the retirement system. The system shall accept the copy and acknowledgment as evidence of the recipient's application.

The recipient shall file with the system a copy of the social security administration's final action on the recipient's application for social security disability insurance benefit payments or hospital insurance benefits, as applicable.

(E) (1) Unless an exemption is granted under division (C) of this section:

(a) A recipient subject to division (A) or (B) of this section who fails without just cause to apply for social security disability insurance benefit payments or to comply with division (D) of this section shall have the recipient's disability benefit suspended until the recipient applies for the payments and complies with division (D) of this section.

(b) A recipient subject to division (B) of this section who fails without just cause to apply for hospital insurance benefits or to comply with division (D) of this section shall have the recipient's disability benefit suspended until the recipient applies for the benefits and complies with division (D) of this section.

(2) A recipient subject to division (B) of this section whose application for hospital insurance benefits is approved by the social security administration shall enroll in coverage for those benefits. A recipient who fails to enroll in coverage for hospital insurance benefits is not eligible for health care coverage under section 3309.69 of the Revised Code until the recipient enrolls in the coverage f or hospital insurance benefits.

(F) The school employees retirement board may adopt rules as it considers necessary to implement this section.

Eff. 4/6/17 H.B. 520
1/7/13 S.B. 341

**Sec. 3309.49 Employer's contribution rate.**

Each employer shall pay to the school employees retirement system at such times as required by the school employees retirement board under section 3309.51 of the Revised Code an amount that shall be a certain per cent of the earnable compensation of all employees, and shall be known as the "employer contribution." The rate per cent of such contribution shall be fixed by the actuary on the basis of the actuary's evaluation of the liabilities of the school employees retirement system, but shall not exceed fourteen per cent, and shall be approved by the school employees retirement board. The school employees retirement board may raise the rate per cent of the contribution to fourteen per cent of the earnable compensation of all employees. In making such evaluation, the actuary shall use, as the actuarial assumptions, regular interest and such mortality and other tables as are adopted by the school employees retirement board. The actuary shall compute the percentage of such earnable compensation, to be known as the "employer rate," required annually to fund the liability for all allowances, annuities, pensions and other benefits, and any deficiencies in the various funds, provided for in this chapter, after

deducting therefrom the annuity and other benefits provided by the contributor's accumulated contributions and deposits or other applicable moneys.

| | | |
|---|---|---|
| Eff. | 3/23/15 | S.B. 42 |
| | 4/9/01 | S.B. 270 |
| | 6/30/91 | H.B. 382 |
| OAC Reference: | | 3309-1-02 |
| | | 3309-1-18 |

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

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

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

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

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

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

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

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

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

(2) If the total of the employer minimum contribution amounts determined under division (B)(1) of this section exceeds one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution, the school employees retirement board shall reduce the amount determined for each employer so that the total amount determined does not exceed one and one-half per cent of the compensation of all members

employed by employers required to pay the employer minimum compensation contribution. Any reduction shall be applied to each employer in the same proportion as the employer's minimum compensation contribution bears to the total employer minimum compensation contribution.

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

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

Eff. 4/9/01 S.B. 270
9/9/88 H.B. 290
OAC Reference: 3309-1-18

**Sec. 3309.69 Group health care coverage for eligible individuals or dependents.**

(A) The school employees retirement board may establish a program to provide medical, hospital, surgical, prescription, or other health care coverage, benefits, reimbursement, or any combination thereof, to eligible individuals or dependents.

Any program established under this section shall be designed and administered by the board. In establishing a program, the board may do any of the following:

(1) Enter into an agreement with persons or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, prescription, surgical, or other health care benefits, or any combination thereof;

(2) Provide for self-insurance of risk or level of risk and provide through the self-insurance method specific benefits as authorized by the rules of the board;

(3) Provide reimbursements or subsidies to eligible participants;

(4) Make disbursements;

(5) Determine levels of coverage and costs for the program;

(6) Take any other action it considers necessary to establish and administer the program.

(B) If it establishes a health care program, the board shall establish eligibility criteria and any other requirements for participation. To be eligible, an individual must meet the criteria established by the board and be one or more of the following:

(1) A former member receiving benefits pursuant to section 3309.34, 3309.35, 3309.36, or 3309.381 or former section 3309.38 of the Revised Code;

(2) A disability benefit recipient receiving a disability benefit pursuant to section 3309.35, 3309.39, 3309.40, or 3309.401 of the Revised Code;

(3) A beneficiary receiving monthly benefits pursuant to section 3309.45 of the Revised Code;

(4) The beneficiary of a former member who is receiving monthly benefits pursuant to section 3309.46 of the Revised Code;

(5) A dependent, as determined under rules adopted by the board, of an individual described in divisions (B)(1) to (4) of this section.

(C) The cost paid from the funds of the system for coverage under this section shall be included in the employer contribution under sections 3309.49 and 3309.491 of the Revised Code.

(D) (1) The board may require payment of a premium for participation in the health care program. Participation is deemed consent for the deduction of premiums from any pension, benefit, or annuity provided under this chapter to an eligible participant.

(2) An individual who fails to pay any required premium or receives any coverage or payment to which the individual is not entitled shall pay or repay any amount due the system. If an individual fails to pay or repay an amount due, the system may withhold the amount from any pension, benefit, annuity, or payment due the individual or the individual's beneficiary under this chapter or collect the amount in any other manner provided by law.

(E) A health care program participant who is eligible for coverage under medicare part B, "Supplementary Medical Insurance Benefits for the Aged and Disabled," 42 U.S.C. 1395j, as amended, shall enroll for that coverage. The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, make a monthly payment to the participant in an amount determined by the board for such coverage that is not less than forty-five dollars and fifty cents, except that the board shall make no payment to a participant who is not eligible for coverage under medicare part B or pay an amount that exceeds the amount paid by the recipient for the coverage.

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

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

(H) This section does not require the board to establish, maintain, offer, or continue any health care program. This section does not require the board to provide or continue access to any health care program, or any level of coverage or costs provided under the program, if the board establishes or maintains a program under this section.

| | | |
|---|---|---|
| Eff. | 1/7/13 | S.B. 341 |
| | 10/1/02 | S.B. 247 |
| | 4/9/01 | S.B. 270 |
| | 11/2/99 | H.B. 222 |
| | 12/8/98 | H.B. 673 |
| | 6/4/97 | S.B. 67 |
| | 3/6/97 | S.B. 82 |
| | 7/29/92 | S.B. 346 |
| | 6/30/91 | H.B. 382 |
| | 5/4/92 | H.B. 383 |
| OAC Reference: | | 3309-1-35 |
| | | 3309-1-55 |

**Sec. 3309.691 Long term health care programs.**

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

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

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

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

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|---|---|---|
| Eff. | 3/23/15 | S.B. 42 |
| | 6/4/97 | S.B. 67 |
| | 7/1/93 | H.B. 152 |
| | 10/29/91 | H.B. 180 |
| OAC Reference: | | 3309-1-51 |

**3309-1-35 Health care.**

(A) Definitions

As used in this rule:

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

(2) “Member” has the same meaning as in section 3309.01 of the Revised Code.

(3) “Age and service retirant” means a former member who is receiving a retirement allowance pursuant to section 3309.34, 3309.35, 3309.36 or 3309.381 of the Revised Code. A former member with an effective retirement date after June 13, 1986 must have accrued ten years of service credit, exclusive of credit obtained after January 29, 1981 pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code.

(4) “Disability benefit recipient” means a member who is receiving a benefit or allowance pursuant to section 3309.35, 3309.39, 3309.40 or 3309.401 of the Revised Code.

(5) “Dependent” means an individual who is either of the following:

(a) A spouse of an age and service retirant, disability benefit recipient, or member,

(b) A biological, adopted or step-child of an age and service retirant, disability benefit recipient, member, deceased age and service retirant, deceased disability benefit recipient, or deceased member or other child in a parent-child relationship in which the age and service retirant, disability benefit recipient, member, deceased age and service retirant, deceased disability benefit recipient, or deceased member has or had custody of the child, so long as the child:

(i) Is under age twenty-six, or

(ii) Regardless of age is permanently and totally disabled, provided that the disability existed prior to the age and service retirant’s, disability benefit recipient’s, or member’s death and prior to the child reaching age twenty-six. For purposes of this paragraph “permanently and

totally disabled" means the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve months.

(6) "Health care coverage" means either of the following group plans offered by the system:

(a) A medical and prescription drug plan or

(b) Limited wraparound coverage, which provides limited benefits that wrap around an individual health insurance plan.

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

(8) "Employer" and "public employer" have the same meaning as in section 3309.01 of the Revised Code.

(B) Eligibility

(1) A person is eligible for health care coverage under the school employees retirement system's health care plan so long as the person qualifies as one of the following:

(a) An age and service retirant or the retirant's dependent,

(b) A disability benefit recipient or the recipient's dependent,

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

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

(2) Eligibility for health care coverage shall terminate when the person ceases to qualify as one of the persons listed in paragraph (B)(1) of this rule, except that a dependent described in paragraph (A)(5)(b)(i) of this rule shall cease to qualify on the first day of the calendar year following the dependent's twenty-sixth birthday.

(3) Except for a dependent described in paragraph (A)(5)(b) of this rule, eligibility for health care coverage shall terminate when the person is not enrolled in medicare part B and on or after January 1, 2016 commences employment that provides access to a medical plan with prescription coverage through the employer, or if employees of that employer in comparable positions have access to a medical plan available through the employer, provided the medical plan with prescription

drug coverage available through the employer is equivalent to the medical plan with prescription coverage at the cost available to fulltime employees as defined by the employer. For purposes of this paragraph, employer means a public or private employer.

(C) Enrollment

(1) Except as otherwise provided in this rule, an eligible benefit recipient may enroll in school employees retirement system's health care coverage only at the time the benefit recipient applies for an age and service retirement, disability benefit, or monthly benefits pursuant to section 3309.45 of the Revised Code.

(2) An eligible spouse of an age and service retirant or disability benefit recipient may only be enrolled in the system's health care coverage at the following times:

(a) At the time the retirant or disability benefit recipient enrolls in school employees retirement system's health care coverage.

(b) Within thirty-one days of the eligible spouse's:

(i) Marriage to the retirant or disability benefit recipient;

(ii) Voluntary or involuntary termination of health care coverage under medicaid; or

(iii) Involuntary termination of health care coverage under another plan, including a medicare advantage plan, or medicare part D plan.

(c) Within ninety days of becoming eligible for medicare.

(3) An eligible dependent child of an age and service retirant, disability benefit recipient, or deceased member may be enrolled in the system's health care coverage at the following times:

(a) At the time the retirant, disability benefit recipient, or surviving spouse enrolls in school employees retirement system's health care coverage.

(b) Within thirty-one days of the eligible dependent child's:

(i) Birth, adoption, or custody order; or

(ii) Voluntary or involuntary termination of health care coverage under medicaid;

(iii) Involuntary termination of health care coverage under another plan, including a medicare advantage plan, or medicare part D plan.

(c) Within ninety days of becoming eligible for medicare.

(D) Cancellation of health care coverage

(1) Health care coverage of a person shall be cancelled when:

(a) The person's eligibility terminates as provided in paragraph (B)(2) of this rule;

(b) The person's eligibility terminates as provided in paragraph (B)(3) of this rule;

(c) The person's health care coverage is cancelled for default as provided in paragraph (F) of this rule;

(d) The person's health care coverage is waived as provided in paragraph (G) of this rule;

(e) The person's health care coverage is cancelled due to the person's enrollment in a medicare advantage plan or medicare part D plan as provided in paragraph (H) of this rule;

(f) The health care coverage of a dependent is cancelled when the health care coverage of a benefit recipient is cancelled; or

(g) The person's benefit payments are suspended for failure to submit documentation required to establish continued benefit eligibility under division (B)(2)(b)(i) of section 3309.45 of the Revised Code, division (F) of section 3309.39 of the Revised Code, division (D) of section 3309.41 of the Revised Code, or division (D) of section 3309.392 of the Revised Code.

(E) Effective date of coverage

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

(a) For a disability benefit recipient or dependent of a disability benefit recipient, health care coverage shall be effective on the first of the month following the determination and recommendation of disability to the retirement board or on the benefit effective date, whichever is later.

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

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

(F) Premiums

(1) Payment of premiums for health care coverage shall be by deduction from the

benefit recipient's monthly benefit. If the full amount of the monthly premium cannot be deducted from the benefit recipient's monthly benefit, the benefit recipient shall be billed for the portion of the monthly premium due after any deduction from the monthly benefit.

(2) Premium payments billed to a benefit recipient shall be deemed in default after the unpaid premiums for coverage under this rule and supplemental health care coverage under rule 3309-1-64 of the Administrative Code reach a total cumulative amount of at least three months of billed premiums. The retirement system shall send written notice to the benefit recipient that payments are in default and that coverage will be cancelled on the first day of the month after the date of the notice unless payment for the total amount in default is received prior to the date specified in the notice. If coverage is cancelled due to a recipient's failure to pay premium amounts in default, the recipient shall remain liable for such amounts due for the period prior to cancellation of coverage.

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

(4) A person enrolled in SERS' health care plan cannot receive a premium subsidy unless that person is:

(a) A dependent child.

(b) An age and service retirant:

(i) An age and service retirant with an effective retirement date before August 1, 1989; or

(ii) An age and service retirant with an effective retirement date on or after August 1, 1989 and before August 1, 2008 who had earned fifteen years of service credit; or

(iii) An age and service retirant with an effective retirement date on or after August 1, 2008 who had earned twenty years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code, and who;

*(a)* Was eligible to participate in the health care plan of his or her employer at the time of retirement or separation from SERS service; or

*(b)* Was eligible to participate in the health care plan of his or her employer at least three of the last five years of service preceding retirement or separation from SERS service.

(c) A disability benefit recipient:

(i) A disability benefit recipient with an effective benefit date before August 1, 2008; or

(ii) A disability benefit recipient with an effective benefit date on or after August 1, 2008 who:

*(a)* Was eligible to participate in the health care plan of his or her employer at the time of separation from SERS service; or

*(b)* Was eligible to participate in the health care plan of his or her employer at least three of the last five years of service preceding separation from SERS service.

(d) A spouse:

(i) A spouse or surviving spouse of an age and service retirant or disability benefit recipient with an effective retirement date or benefit date before August 1, 2008 who had earned twenty-five years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code;

(ii) A spouse or surviving spouse of an age and service retirant or disability benefit recipient with an effective retirement date or benefit date on or after August 1, 2008 who had earned twenty-five years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code, and who:

*(a)* Was eligible to participate in the health care plan of his or her employer at the time of retirement or separation from SERS service; or

*(b)* Was eligible to participate in the health care plan of his or her employer at least three of the last five years of service preceding retirement or separation from SERS service.

(iii) A surviving spouse of a deceased member who had earned twenty-five years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code, with an effective benefit date before August 1, 2008; or

(iv) A surviving spouse of a deceased member who had earned twenty-five years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code, with an effective benefit date on or after August 1, 2008, and the member;

*(a)* Was eligible to participate in the health care plan of his or her employer at the time of death or separation from SERS service; or

*(b)* Was eligible to participate in the health care plan of his or her employer at least three of the last five years of service preceding the member's death or separation from SERS service.

(e) For purposes of determining eligibility for a subsidy under paragraph (F)(4) of this rule, when the last contributing service of an age and service retirant, disability benefit recipient, or member was as an employee as defined by division (B)(2) of section 3309.01 of the Revised Code, the health care plan participation requirement shall be if the individual would have been eligible for the public employer's health care plan if the individual were an employee as defined by division (B)(1) of section 3309.01 of the Revised Code.

(f) Any other individual covered under a SERS health care plan shall be eligible for a premium subsidy under the standard set forth for spouses.

(g) In all cases of doubt, the retirement board shall determine whether a person enrolled in a SERS health care plan is eligible for a premium subsidy, and its decision shall be final.

(G) Waiver

(1) A benefit recipient may waive health care coverage by completing and submitting a SERS waiver form to SERS.

(2) The health care coverage of a benefit recipient's dependent may be waived as follows:

(a) For non-medicare eligible dependents, the benefit recipient may waive their coverage by completing and submitting a signed written request to SERS on their behalf.

(b) For medicare eligible dependents, the dependent may waive their coverage by completing and submitting a signed written request to SERS.

(H) Medicare advantage or medicare part D

SERS shall cancel the health care coverage of a benefit recipient or dependent who enrolls in a medicare advantage or medicare part D plan that is not offered by the system.

(I) Reinstatement to SERS health care coverage

(1) An eligible benefit recipient, or dependent of a benefit recipient with health care coverage, whose coverage has been previously waived or cancelled may be reinstated to SERS health care coverage by filing a health care enrollment application as follows:

(a) The application is received no later than ninety days after becoming eligible for medicare. Health care coverage shall be effective the later of the first day of the month after becoming medicare eligible or receipt of the enrollment application by the system;

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

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

(2) An eligible person whose coverage was cancelled pursuant to paragraph (D)(1)(g) of this rule shall be reinstated to SERS health care plan when benefit payments are reinstated.

(3) An eligible person whose coverage was cancelled pursuant to paragraph (D)(1)(b) of this rule may be reinstated to SERS health care plan when they no longer have access to the medical plan of an employer by filing a health care enrollment application within thirty-one days of the employment ending.

(4) An eligible benefit recipient or dependent of a benefit recipient with health care coverage, whose coverage has been previously cancelled and who is enrolled in medicare parts A and B or medicare part B only on December 31, 2007 may be reinstated to SERS health care coverage by filing a healthcare enrollment application during the period of time beginning October 1, 2007 and ending November 30, 2007. Health care coverage shall be effective January 1, 2008.

(5) An eligible benefit recipient or dependent of a benefit recipient with health care coverage, whose coverage has been previously cancelled pursuant to paragraph (H) of this rule and who is enrolled in medicare parts A and B or medicare part B only on June 30, 2009 may be reinstated to SERS health care coverage by filing a health care enrollment application during the period of time beginning May 21, 2009 and ending July 15, 2009.

(6) An eligible benefit recipient who had an effective retirement or benefit date on or after August 1, 2008, who qualifies for a premium subsidy under paragraph (F)(4) of this rule, and whose coverage has previously been waived as provided in paragraph (G) of this rule, may be reinstated to school employees retirement system health care coverage by submitting a complete health care enrollment application on or before December 14, 2012. Health care coverage shall be effective January 1, 2013.

(7) An eligible benefit recipient for whom SERS is transferring funds to another Ohio retirement system in accordance with paragraph (G) of rule 3309-1-55 of the Administrative Code may be reinstated to SERS health care coverage by submitting a health care enrollment application during open enrollment periods for health care coverage starting January 1, 2015 or January 1, 2016.

(J) Medicare part B

(1) A person who is enrolled in SERS' health care shall enroll in medicare part B at the person's first eligibility date for medicare part B.

(2) (a) The board shall determine the monthly amount paid to reimburse an eligible benefit recipient for medicare part B coverage. The amount paid shall be no less than forty-five dollars and fifty cents, except that the board shall make no payment that exceeds the amount paid by the recipient for the coverage.

(b) As used in paragraph (J) of this rule, an "eligible benefit recipient" means:

(i) An eligible person who was a benefit recipient and was eligible for medicare part B coverage before January 7, 2013, or

(ii) An eligible person who is a benefit recipient, is eligible for medicare part B coverage, and is enrolled in SERS' health care.

(3) The effective date of the medicare part B reimbursement to be paid by the board shall be as follows:

(a) For eligible benefit recipients who were a benefit recipient and were eligible for medicare B coverage before January 7, 2013 the later of:

(i) January 1, 1977; or

(ii) The first of the month following the date that the school employees retirement system received satisfactory proof of coverage.

(b) For eligible benefit recipients not covered under paragraph (J)(3)(a) of this rule, the later of:

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

(ii) The effective date of SERS health care.

(4) The board shall not:

(a) Pay more than one monthly medicare part B reimbursement when a benefit recipient is receiving more than one monthly benefit from this system; nor

(b) Pay a medicare part B reimbursement to a benefit recipient who is eligible for reimbursement from any other source.

HISTORY: 5/3/19, 10/13/16, 8/13/15, 12/4/14, 7/12/14, 1/1/14, 3/8/13, 1/7/13 (Emer.), 9/30/12, 8/14/11, 9/26/10, 7/1/10 (Emer.), 6/11/10, 8/10/09, 5/22/09 (Emer.), 1/8/09, 8/8/08, 12/24/07, 9/28/07 (Emer.), 3/1/07, 1/2/04, 6/13/03, 11/9/98, 8/10/98, 1/2/93, 7/20/89, 3/20/80, 1/1/77

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.69
Review Date: 2/1/24

**3309-1-51 Long-term care coverage.**

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

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

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

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

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

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

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

HISTORY: 5/3/02, 6/10/94

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.691
Review Date: 2/1/22

**3309-1-55 Responsibility for health care coverage.**

(A) This rule amplifies division (F) of section 3309.69 of the Revised Code.

(B) For the purpose of this rule:

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

(2) “Cost paid by the benefit recipient” means the amount equal to the percentage as of January 1, 1998 paid by the benefit recipient multiplied by the system’s cost per benefit recipient.

(3) “Disability benefit recipient” means a member who is receiving a benefit or allowance pursuant to section 3309.35, 3309.39, 3309.40 or 3309.401 of the Revised Code.

(4) “Eligible benefit recipient” means an age and service retirant, disability or survivor benefit recipient who is eligible for health care coverage under this system.

(5) “Eligible dependent” means an eligible spouse or child of an eligible benefit recipient.

(6) “Health care coverage” means the medical plan and the prescription drug plan offered by this system and the medicare part B premium reimbursement.

(7) “Ohio retirement system” means public employees retirement system, state teachers retirement system, school employees retirement system, Ohio police and fire pension fund, or highway patrol retirement system.

(8) “Survivor benefit recipient” means a beneficiary receiving a benefit pursuant to section 3309.45 or 3309.46 of the Revised Code.

(C) Health care coverage provided by this retirement system under sections 3309.69 and 3309.375 of the Revised Code shall pay covered medical expenses for eligible benefit recipients of this retirement system prior to payment under any available coverage from another Ohio retirement system if the available coverage is provided to the individual as the spouse or dependent of another person.

(D) Health care coverage provided by this system shall pay only the covered medical expenses not paid or reimbursed by any available coverage from another Ohio retirement system if either of the following occur:

(1) In the case of an eligible benefit recipient, the available coverage is not provided as a dependent of another person, and has been in effect for a longer time than the health care coverage provided by this system;

(2) In the case of a dependent, the available coverage is not provided as the dependent of another person or is provided as the dependent of another person but has been in effect for a longer time than the health care coverage provided by this system.

(E) Except as otherwise provided in this rule, the school employees retirement system shall not be the system responsible for health care coverage for eligible benefit recipients or eligible dependents of eligible benefit recipients of this system who waive or are otherwise eligible for any available coverage from another Ohio retirement system after December 31, 2007.

(F) Each eligible benefit recipient and eligible dependent enrolled in health care coverage provided by this system shall annually make a report to the system or, an entity designated by the system, stating whether the person has other available coverage. The report shall include any information requested by the system or entity.

(G) (1) If an eligible benefit recipient of this system who also was an eligible benefit recipient of another Ohio retirement system irrevocably waived such health care coverage in this system on or before December 31, 2007 in order to be covered by the other Ohio retirement system, this system shall transfer to the other system annually for covered benefit recipients and dependents for each month covered an amount equal to the sum of:

(a) The lesser of this system's average monthly medical including health maintenance organization cost per benefit recipient less the cost paid by the benefit recipient, or the other system's average monthly medical cost including health maintenance organization cost per benefit recipient.

(b) The lesser of this system's average monthly cost of the prescription drug program per benefit recipient, or the other system's average monthly cost of the prescription drug program per benefit recipient.

(c) The lesser of the monthly cost of the medicare part B premium that would be reimbursed by this system for the benefit recipient, or the monthly cost of the medicare part B premium that would be reimbursed by the other system for the benefit recipient.

(2) This system shall transfer the amounts due pursuant to paragraph (G)(1) of this rule no later than the last business day of February each year for the preceding calendar year after the following occur:

(a) This system receives from the other system a list containing the names of benefit recipients and the number of months during which the recipients were covered by the other system for the preceding calendar year; and

(b) This system prepares an itemized accounting of the amount transferred for each such benefit recipient.

(H) Where an eligible benefit recipient or dependent of an eligible benefit recipient of this system has waived health care coverage in another Ohio retirement system on or before December 31, 2007, this system shall be responsible to provide health care coverage only if the other system pays annually to this system for covered benefit recipients and dependents for each month covered an amount equal to the sum of:

(1) The lesser of this system's average monthly medical including health maintenance organization cost per benefit recipient less the cost paid by the benefit recipient, or the other system's average monthly medical cost including health maintenance organization cost per benefit recipient.

(2) The lesser of this system's average monthly cost of the prescription drug program per benefit recipient, or the other system's average monthly cost of the prescription drug program per benefit recipient.

(3) The lesser of the monthly cost of the medicare part B premium that would be reimbursed by this system for the benefit recipient, or the monthly cost of the medicare part B premium that would be reimbursed by the other system for the benefit recipient.

(I) (1) (a) Paragraph (G) of this rule is rescinded effective January 1, 2016.

(b) This system shall transfer the amounts due pursuant to paragraph (G) (1) of this rule for calendar year 2015 no later than the last business day of February 2016 after the following occur:

(i) This system receives from the other system a list containing the names of benefit recipients and the number of months during which the recipients were covered by the other system for the preceding calendar year; and

(ii) This system prepares an itemized accounting of the amount transferred for each such benefit recipient.

(2) Paragraph (H) of this rule is rescinded effective January 1, 2016.

(J) Except as otherwise provided in this rule, where an eligible benefit recipient's benefit effective date in this system is the same date as the benefit effective date in another Ohio retirement system, this system shall not be the system responsible for health care coverage if the benefit recipient has less service credit in this system than in the other system. Where the benefit effective dates and service credit are the same in each system, this system shall not be the system responsible for health care coverage if the employee contributions in the account upon which the benefit in this system is based are less than the employee contributions in the account upon which the benefit in the other system is based.

HISTORY: 4/1/16, 7/12/14, 1/7/13, 12/10/09, 3/1/07, 5/2/01, 8/10/98

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|---|---|
| Promulgated Under: | 111.15 |
| Statutory Authority: | 3309.04 |
| Rule Amplifies: | 3309.375, 3309.69 |
| Review Date: | 2/1/20 |

**3309-1-64 Supplemental health care coverage.**

(A) Definitions

(1) "Benefit recipient," "Member," "Age and service retirant," "Disability benefit recipient," and "Dependent" shall have the meanings set forth in paragraph (A) of rule 3309-1-35 of the Administrative Code.

(2) "Supplemental health care coverage" means any dental or vision plan offered by the school employees retirement system.

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

(B) Eligibility

(1) A person is eligible for supplemental health care coverage under this rule so long as the person meets the eligibility requirements in section 3309.69 of the Revised Code and rule 3309-1-35 of the Administrative Code for the retirement system's health care coverage.

(2) Eligibility for supplemental health care coverage shall terminate when the person ceases to qualify as one of the persons listed in paragraph (B)(1) of rule 3309-1-35 of the Administrative Code.

(C) Enrollment

(1) An eligible benefit recipient may only enroll in one or more supplemental health care plans as follows:

(a) At the time the benefit recipient applies for an age and service retirement, disability benefit, or monthly benefit pursuant to section 3309.45 of the Revised Code;

(b) At the time the benefit recipient reinstates previously waived or cancelled health care coverage as provided in paragraph (I) of rule 3309-1-35 of the Administrative Code;

(c) Within thirty-one days after involuntary termination of another dental or vision plan; or,

(d) During the retirement system's open enrollment period.

(2) An eligible dependent of an age and service retirant or disability benefit recipient may only enroll in one or more supplemental health care plans as follows:

(a) At the time the age and service retirant or disability benefit recipient enrolls in the supplemental health care plan;

(b) During the retirement system's open enrollment period so long as the age and service retirant or disability benefit recipient is also enrolled in the supplemental health care plan; or

(c) Within thirty-one days after involuntary termination of another medical, dental, or vision plan, so long as the age and service retirant or disability benefit recipient is also enrolled in the supplemental health care plan.

(D) A person's supplemental health care coverage shall be cancelled when:

(1) The person's eligibility for health care coverage terminates as provided in paragraph (B)(2) of rule 3309-1-35 of the Administrative Code;

(2) The supplemental health care coverage of a dependent is cancelled when the supplemental health care coverage of a benefit recipient is cancelled;

(3) The person's supplemental health care coverage is cancelled for default as provided in paragraph (F) of this rule;

(4) The person's benefit payments are suspended for failure to submit documentation required to establish continued benefit eligibility under division (B)(2)(b)(i) of section 3309.45 of the Revised Code, division (F) of section 3309.39 of the Revised Code, or division (D) of section 3309.41 of the Revised Code;

(5) The benefit recipient elects to cancel the supplemental health care coverage for the following calendar year during the open enrollment period; or

(6) The benefit recipient elects to cancel health care coverage under paragraph (D) of rule 3309-1-35 of the Administrative Code.

(E) Effective date of coverage

(1) When a benefit recipient elects to enroll in supplemental health care coverage during an open enrollment period, the effective date of coverage shall be the first day of the calendar year following the open enrollment period.

(2) When a benefit recipient elects to enroll in supplemental health care coverage upon receipt of a benefit, the effective date of coverage shall be as follows:

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

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

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

(F) Premiums

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

(2) Premium payments billed to a benefit recipient shall be deemed in default after the unpaid premiums for coverage under this rule and health care coverage under rule 3309-1-35 of the Administrative Code reach a total cumulative amount of at least three months of billed premiums. The retirement system shall send written notice to the benefit recipient that payments are in default and that coverage will be cancelled on the first day of the month after the date of the notice unless payment for the total amount in default is received prior to the date specified in the notice. If coverage is cancelled due to a recipient's failure to pay premium amounts in default, the recipient shall remain liable for such amounts due for the period prior to cancellation of coverage. The benefit recipient shall be ineligible for reinstatement of coverage until payment for the total amount in default is received.

HISTORY: 5/3/19, 1/1/14

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.69
Review Date: 2/1/22

**3309-1-65 Medicare part B reimbursement account.**

(A) As used in this rule, "eligible benefit recipient" has the same meaning as in paragraph (J)(2)(b) of rule 3309-1-35 of the Administrative Code.

(B) The school employees retirement board has previously established a separate account within the funds described in section 3309.60 of the Revised Code for the purpose of reimbursing eligible benefit recipients for a portion of the cost of medicare part B coverage paid by the eligible benefit recipient, as authorized under section 3309.69 of the Revised Code, and in accordance with rule 3309-1-35 of the Administrative Code. The medicare part B reimbursement account shall be a separate account established pursuant to section 401(h) of the Internal Revenue Code, 26 U.S.C. 401(h). The assets in the medicare part B reimbursement account shall be accounted for separately from the other assets of the school employees retirement system, but may be commingled with the other assets of the system for investment purposes. Investment earnings and expenses shall be allocated on a reasonable basis.

(C) Each year the board designates the amount of contributions that are to be allocated to the medicare part B reimbursement account for any year. The contributions are funded by employer contributions under section 3309.49 of the Revised Code and are subordinate to the contributions for payment of retirement allowance and other benefits provided under Chapter 3309. of the Revised Code. At no time shall contributions to the medicare part B reimbursement account, when added to contributions for any life insurance benefits provided on behalf of eligible benefit recipients, be in excess of twenty-five per cent of the total aggregate actual contributions made to the school employees retirement system, excluding contributions to fund past service credit. In any event, all contributions to the medicare part B reimbursement account shall be reasonable and ascertainable.

(D) The assets of the medicare part B reimbursement account are only used to pay reimbursement of medicare part B premiums paid by eligible benefit recipients and

authorized under section 3309.69 of the Revised Code and in accordance with rule 3309-1-35 of the Administrative Code.

(E) If any rights of an individual who is eligible to receive medicare part B reimbursement authorized under section 3309.69 of the Revised Code and paid from the medicare part B reimbursement account are forfeited as provided in rule 3309-1-35 of the Revised Code, an amount equal to the amount of such forfeiture shall be applied as soon as administratively possible to reduce employer contributions allocated to the medicare part B reimbursement account.

(F) At no time prior to the satisfaction of all liabilities under this rule shall any assets in the medicare part B reimbursement account be used for, or diverted to, any purpose other than as provided in paragraph (D) of this rule and for the payment of administrative expenses relating to the medicare part B reimbursement account. Assets in the medicare part B reimbursement account may not be used for retirement, disability, or survivor benefits, or for any other purpose for which the other funds of the system are used.

(G) If the school employees retirement board discontinues medicare part B reimbursement authorized under section 3309.69 of the Revised Code, or upon satisfaction of all liabilities under this rule, any assets in the medicare part B reimbursement account, if any, that are not used as provided in this rule shall be returned to the employers, as required by 26 U.S.C. 401(h)(5).

(H) It is the intent of the school employees retirement board in adopting this rule to reflect its continuing compliance in all respects with sections 401(a) and 401(h) of the Internal Revenue Code, 26 U.S.C. 401, and regulations interpreting those sections. In applying this rule, the board will apply the interpretation that achieves compliance with those sections and preserves the qualified status of the system as a governmental plan under sections 401(a) and 414(d) of the Internal Revenue Code, 26 U.S.C. 401 and 414.

(I) This rule is intended to reflect past and current policies, practices and procedures of the system with respect to the funding and payment of medicare part B reimbursements and does not confer any new rights to or create any vested interest in receiving medicare part B reimbursement for members, retirees, survivors, beneficiaries, or their dependents.

HISTORY: 1/15/16, 10/30/15 (Emer.)

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.03, 3309.60, and 3309.69
Review Date: 2/1/20

**3309-1-66 Application for early medicare coverage.**

(A) This rule amplifies section 3309.392 of the Revised Code and applies to a disability benefit recipient whose disability benefit was granted on or after January 7, 2013 and who is enrolled in the school employees retirement system's health care coverage on or after April 6, 2017.

(B) A disability benefit recipient shall be exempt from the requirements in section 3309.392 of the Revised Code for good cause shown if any of the following apply:

(1) The disability benefit recipient has attained age sixty-three at the time of enrollment in the retirement system's health care coverage;

(2) The disability benefit recipient submits a written request to be exempt from the requirements due to circumstances that make compliance with section 3309.392 of the Revised Code impracticable, and the retirement system approves the request;

(3) The disability benefit recipient submitted an application for social security disability insurance benefits, provided the recipient files a copy of the application and the social security administration's acknowledgment with the retirement system;

(4) Prior to April 6, 2017, the disability benefit recipient submitted a signed statement to the retirement system certifying that the recipient does not meet the requirements to apply for social security disability insurance benefits; or

(5) The disability benefit recipient files with the retirement system written documentation from the social security administration verifying the recipient does not meet the requirements to apply for social security disability insurance benefits or medicare part A hospital insurance benefits.

HISTORY: 5/15/17

| | |
|---|---|
| Promulgated Under: | 111.15 |
| Statutory Authority: | 3309.04 |
| Rule Amplifies: | 3309.392, 3309.69 |
| Review Date: | 2/1/22 |

## (2) A Summary of Coverage for 2019

Plans offered for those without Medicare are:

- Aetna Choice POS II and Express Scripts prescription drug plan
- AultCare PPO and AultCare prescription drug plan in 19 Ohio counties
- SERS Marketplace Wraparound Plan

Plans offered for those with Medicare are:

- Aetna Medicare Plan (PPO) and Express Scripts prescription drug plan
- PrimeTime Health Plan and PrimeTime prescription drug plan in 10 counties
- Paramount Elite Medicare Advantage and Express Scripts prescription drug plan in six Ohio and two Michigan counties

Prescription drug coverage is provided with all group plans.

In 2019, SERS offered the SERS Marketplace Wraparound Plan through a three-year federal pilot program, which expires at the end of the 2019 plan year. The Wraparound Plan was available to health care participants who were not eligible for Medicare and not enrolled in Medicaid. Participants selected an insurance plan through the Health Insurance Marketplace, which provided their primary coverage. SERS then “wrapped” the Marketplace plan by providing additional benefits to reimburse a portion of the deductible, copays, and other costs.

Optional dental and vision plans were offered with separate premiums being charged. Dental coverage was administered through Delta Dental of Ohio, and the vision coverage through VSP Vision Care.

SERS does not subsidize the optional plan offerings.

The SERS Medicare Part B Reimbursement rate is $45.50 per month. It is paid to benefit recipients who retired prior to January 7, 2013, and are enrolled in Medicare Part B, as well as those who retired after that date who are enrolled in SERS’ health care coverage and Medicare Part B. SERS does not provide this reimbursement to anyone whose Medicare Part B is being paid by another source, such as Medicaid or a Medicare assistance program.

## (3) A Summary of the Eligibility Requirements for the Benefits

SERS offers access to health care to eligible individuals receiving retirement, disability, and survivor benefits as well as access to health care for their eligible dependents. Eligibility for SERS’ health care coverage is based on qualified service credit.

Members who retire after June 1, 1986, need 10 years of service credit, exclusive of some types of purchased credit, to qualify to participate in SERS’ health care coverage.

Disability benefit recipients and some beneficiaries receiving monthly benefits due to the death of a member or eligible retiree qualify for SERS’ health care coverage.

To sign up for dental and/or vision coverage, individuals have to be eligible for, but do not have to be enrolled in, SERS’ health care coverage. They have to be enrolled in dental/vision coverage in order to enroll their spouse and/or children.

### Service Retirees

Service retirees are eligible for coverage if they have at least 10 years of qualified service credit at retirement. Qualified service credit includes earned or restored service credit; contributing service credit from State Teachers Retirement System of Ohio (STRS), Ohio Public Employees Retirement System (OPERS), Ohio Police & Fire Retirement System (OP&F), Ohio Highway Patrol System (HPRS), and the Cincinnati Retirement System, if it was not earned at the same time as SERS' service credit; and, Workers' Compensation credit.

### Disability Benefit Recipients

Disability benefit recipients are eligible for SERS' health care coverage. The effective date of coverage is the later of the effective date of the disability benefit or the first day of the month following approval of the disability benefit. A disability benefit recipient who converts to an age and service retirement must have at least 10 years of qualified service credit, which includes the years they received a disability allowance.

### Dependents

Benefit recipients enrolled in SERS' coverage may cover their spouse and children as dependents. A child includes a biological or legally adopted child, stepchild, or child for whom they have legal custody, up to age 26; and, a child, regardless of age, who is permanently and totally disabled, if the disability existed prior to the child reaching age 26.

## (4) A Statement of the Number of Participants Eligible for Benefits

As of June 30, 2019, there were 77,026 benefit recipients eligible to participate in SERS health care coverage.

## (5) A Description of the Accounting, Asset Value, and Funding Method Used to Provide the Benefits

### Accounting

SERS' financial statements are prepared using the accrual basis of accounting. Revenues are recognized when earned, and deductions are recorded when a liability is incurred. Member premiums and employer contributions are recognized in the period in which the contributions are due based on statutory or contractual requirements.

Amounts accrued for health care expenses in the Health Care Fund payable for recipients less than age 65 are based upon estimates that have been developed from prior claims experience.

Investment purchases and sales are recorded as of the trade date. Dividend income is recognized on the ex-dividend date. Other investment income is recognized when earned.

Investments are reported at fair value. Fixed income securities, real estate investment trusts, derivatives, and common and preferred stocks are valued based on published market prices and quotations from national security exchanges and securities pricing services. International stocks are then adjusted to reflect the current exchange rate of the underlying currency. Investments for which no national exchanges or pricing services exist, such as private

equity assets, are valued at fair value by the investment partnership based on the valuation methodology outlined in the partnership agreement. Real estate may be valued by the manager or independent appraisers.

Commingled assets that are not traded on a national exchange are valued by the commingled manager. SERS performs due diligence reviews to assure that the asset values provided by the managers are reasonable.

Net appreciation is determined by calculating the change in the fair value of investments between the beginning of the year and the end of the year, less purchases of investments at cost, plus sales of investments at fair value. Investment expenses consist of external expenses directly related to SERS' investment operations, as well as internal administrative expenses associated with SERS' investment program.

The monies held by the Pension Trust, Medicare B, Death Benefit, and Health Care Funds are pooled for the purpose of the investment of those funds. Each fund holds units of the investment pool, which are adjusted on a monthly basis.

On June 2, 2015, Governmental Accounting Standards Board (GASB) Statement No. 74 and GASB Statement No. 75 (GASB 74 and 75) were adopted by the GASB Board. They required actuarial valuations of retiree medical and other post-employment benefit plans. GASB 74, which relates to accounting disclosures for plan sponsors, replaced GASB 43 beginning with fiscal years ending September 30, 2017. GASB 75, which relates to accounting disclosures for contributing employers, replaced GASB 45 beginning with fiscal years ending September 30, 2018.

GASB 74 requires plan sponsors to provide the net other post-employment benefits (OPEB) liability and other note disclosures along with supplementary information to employers. GASB 75 requires contributing employers to disclose the net OPEB liability on the statement of financial position and book an accounting expense based upon the entry age normal actuarial cost method. Beyond the use of a specified actuarial cost method, GASB's new disclosure standards also require the discount rate used to calculate liabilities to be based upon the yield of 20-year, tax-exempt municipal bonds, and the expected rate of return on plan assets, to the extent plan assets are projected to be available for the payment of future benefits.

Additionally, GASB 74 and 75 have brought about changes in the liability valuation and accounting disclosure processes which are expected to impact data collection, timing, and effort.

### Asset Value

In accordance with GASB 74 and GASB 75, the assets are valued at market value.

### Funding Method

SERS' health care is funded on a pay-as-you-go basis. SERS funds health care through a combination of investment income generated on the Health Care Fund, federal subsidies, premiums, and employer contributions, including a separate health care surcharge to compensate for low-wage earners. The surcharge is levied against employers whose employees

earn less than a specified minimum salary. It is an important source of health care revenue and avoids shifting a financial burden to members and retirees.

The medical and drug benefits of the health care plan are included in the actuarially calculated contribution rates, which are developed using the entry age normal actuarial cost method with the normal cost rate determined as a level percentage of payroll. GASB requires the discount rate used to value a plan to be based on the likely return of the assets held in trust to pay benefits. The discount rate used in this valuation is 5.25%.

In 2015, the SERS Retirement Board made changes to its Funding Policy to require that all 14% of the employers' contribution be allocated to SERS' basic benefits if the pension's funded ratio is less than 70%. If the funded ratio is 70% but less than 80%, at least 13.50% of the employers' contribution shall be allocated to SERS' basic benefits, with the remainder (if any) allocated to the Health Care Fund. If the funded ratio is 80% but less than 90%, at least 13.25% of the employers' contribution shall be allocated to SERS' basic benefits, with the remainder (if any) allocated to the Health Care Fund. If the funded ratio is 90% or greater, the Health Care Fund may receive any portion of the employers' contribution that is not needed to fund SERS' basic benefits.

As of June 30, 2019, the Health Care Fund solvency is projected until FY2034, about 15 years.

## (6) A Statement of the Net Assets Available for the Benefits as of the Last Day of the Fiscal Year

### Statements of Fiduciary Net Position-Health Care

| ASSETS | |
|---|---|
| **Cash & Operating Short Term Investments** | $73,512,957 |
| | |
| **Receivables** | |
| Contributions | |
| Employer | $49,645,526 |
| Investments Receivable | $5,007,112 |
| Other Receivables | $3,916,524 |
| **Total Receivables** | **$58,569,162** |
| | |
| **Investments at Fair Value** | |
| US Equity | $112,640,635 |
| Non-US Equity | $79,818,197 |
| Private Equity | $44,658,285 |
| Fixed Income | $56,148,333 |
| Real Estate | $58,087,667 |
| **Total Investments** | **$351,353,117** |
| | |
| **Securities Lending Collateral** | $3,108,476 |
| | |
| **Prepaids and Other Assets** | $1,441 |
| | |
| **TOTAL ASSETS** | **$486,545,153** |
| | |
| **LIABILITIES** | |
| **Accounts Payable & Accrued Expenses** | $13,284,058 |
| **Benefits Payable** | - |
| **Investments Payable** | $6,343,152 |
| **Obligations under Securities Lending** | $3,107,264 |
| | |
| **TOTAL LIABILITIES** | $**22,734,474** |
| | |
| | |
| **Fiduciary Net Position Restricted for Other Post employment Benefits** | **$463,810,679** |

## (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

### Statements of Changes in Fiduciary Net Position-Health Care
### For the Fiscal Year Ending June 30, 2019

| | |
|---|---|
| **ADDITIONS** | |
| **Contributions** | |
| Employer | $65,877,673 |
| **Other Income** | |
| Health Care Premiums | 71,920,959 |
| Federal Subsidies & Other Receipts | 16,067,175 |
| | 153,865,807 |
| **Income (Loss) from Investment Activity** | |
| Net Appreciation (Depreciation) in Fair Value | **15,480,994** |
| Interest and Dividends | 8,957,104 |
| | 24,438,098 |
| | |
| **Investment Manager Fees** | |
| Investment Administrative Expenses | (2,401,167) |
| | |
| **Net Income (Loss) - Investment Activity** | 22,036,931 |
| | |
| **Income (Loss) from Securities Lending** | |
| Gross Income (Loss) | 29,326 |
| Brokers' Rebates | (54,327) |
| Management Fees | (2,303) |
| **Net Securities Lending Income (Loss)** | (27,304) |
| | |
| **Total Investment Income (Loss), Net** | 22,009,627 |
| | |
| **TOTAL ADDITIONS** | **$175,875,434** |
| | |
| **DEDUCTIONS** | |
| **Benefits** | |
| Health Care Expenses | 145,127,670 |
| | **145,127,670** |
| | |
| **Administrative & Other Expenses (Less Inv. Exp.)** | 2,566,722 |
| | **2,566,722** |
| | |
| **TOTAL DEDUCTIONS** | **$147,694,392** |
| | |
| **Net Increase (Decrease)** | **$28,181,042** |
| | |
| **FIDUCIARY NET POSITION RESTRICTED FOR OTHER POST EMPLOYMENT BENEFITS** | |
| **Fiduciary Net Position - Beginning** | **435,629,637** |
| **Fiduciary Net Position - Ending** | **$463,810,679** |

## (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

### Statement of Changes in Fiduciary Net Position - Health Care

| | FY2019 | FY2018 | FY2017 | FY2016 | FY2015 | FY2014 |
|---|---|---|---|---|---|---|
| **ADDITIONS** | | | | | | |
| Contributions | | | | | | |
| Employer | $65,877,673 | $63,539,354 | $47,672,886 | $44,855,441 | $68,904,867 | $46,097,206 |
| Other Income | | | | | | |
| Health Care Premiums | 71,920,959 | 80,376,052 | 80,849,519 | 81,439,653 | 81,783,838 | 85,265,838 |
| Federal Subsidies & Other Receipts | 16,067,175 | 36,517,382 | 17,341,005 | 32,493,250 | 34,717,328 | 42,601,389 |
| | **153,865,807** | **180,432,788** | **145,863,410** | **158,788,344** | **185,406,033** | **173,964,433** |
| Income (Loss) from Investment Activity | | | | | | |
| Net Appreciation (Depreciation) in Fair Value | 15,480,994 | 22,420,488 | 31,369,736 | (1,203,896) | 6,972,137 | 46,837,034 |
| Interest and Dividends | 8,957,104 | 7,806,250 | 6,326,268 | 5,175,584 | 6,276,447 | 6,295,610 |
| | **24,438,098** | **30,226,738** | **37,696,004** | **3,971,688** | **13,248,584** | **53,132,644** |
| | | | | | | |
| Investment Manager Fees | | | | | | |
| Investment Administrative Expenses | (2,401,167) | (2,101,293) | (2,005,180) | (1,756,179) | (2,078,626) | (2,269,778) |
| | | | | | | |
| Net Income (Loss) - Investment Activity | 22,036,931 | 28,125,445 | 35,690,824 | 2,215,509 | 11,169,958 | 50,862,866 |
| | | | | | | |
| Income (Loss) from Securities Lending | | | | | | |
| Gross Income (Loss) | 29,326 | 66,444 | 48,392 | 23,540 | (45,229) | 100,590 |
| Brokers' Rebates | (54,327) | (21,400) | (4,345) | 10,246 | 25,491 | 26,682 |
| Management Fees | (2,303) | (2,837) | (4,124) | (4,995) | (7,383) | (9,486) |
| Net Securities Lending Income (Loss) | **(27,304)** | **42,207** | **39,923** | **28,791** | **(27,121)** | **117,786** |
| | | | | | | |
| Total Investment Income (Loss), Net | 22,009,627 | 28,167,652 | 35,730,747 | 2,244,300 | 11,142,837 | 50,980,652 |
| | | | | | | |
| **TOTAL ADDITIONS** | **175,875,434** | **208,600,440** | **181,594,157** | **161,032,644** | **196,548,870** | **224,945,085** |
| | | | | | | |
| **DEDUCTIONS** | | | | | | |
| Benefits | | | | | | |
| Health Care Expenses | 145,127,670 | 152,447,415 | 167,106,908 | 196,445,600 | 199,750,908 | 187,994,468 |
| | **145,127,670** | **152,447,415** | **167,106,908** | **196,445,600** | **199,750,908** | **187,994,468** |
| | | | | | | |
| Administrative & Other Expenses (Less Inv. Exp.) | 2,566,722 | 1,632,948 | 2,582,204 | 2,746,127 | 2,292,565 | 2,273,442 |
| | **2,566,722** | **1,632,948** | **2,582,204** | **2,746,127** | **2,292,565** | **2,273,442** |
| | | | | | | |
| **TOTAL DEDUCTIONS** | **147,694,392** | **154,080,363** | **169,689,112** | **199,191,727** | **202,043,473** | **190,267,910** |
| | | | | | | |
| **Net Increase (Decrease)** | **28,181,042** | **53,520,077** | **11,905,045** | **(38,159,083)** | **(5,494,603)** | **34,677,175** |
| | | | | | | |
| **FIDUCIARY NET POSITION RESTRICTED FOR OTHER POST EMPLOYMENT BENEFITS** | | | | | | |
| Fiduciary Net Position - Beginning | 435,629,637 | 382,109,560 | 370,204,515 | 408,363,598 | 413,858,201 | 379,181,026 |
| **Fiduciary Net Position - Ending** | **$463,810,679** | **$435,629,637** | **$382,109,560** | **$370,204,515** | **$408,363,598** | **$413,858,201** |

## (9) A Description of Any Significant Changes that Affect the Comparability of the Report Required under this Division

The portion of employer contributions allocated to health care has varied over the years.

Effective June 18, 2015, a change was made in the Retirement Board's Funding Policy. It required various funding levels to be met for the basic benefits before employer contributions could be allocated to the Health Care Fund.

The percentages of employer payroll contributed from 2014 through 2019 is reflected in the following chart:

| Fiscal Year | Portion of the 14% Employer Contribution Allocated to Health Care |
|---|---|
| FY2014 | 0.14 |
| FY2015 | 0.82 |
| FY2016 | 0.00 |
| FY2017 | 0.00 |
| FY2018 | 0.50 |
| FY2019 | 0.50 |

The employer surcharge is capped at 1.5% of statewide payroll and has been consistent.

## (10) A Statement of the Amount Paid under Division (E) of Section 3309.69 of the Revised Code

Medicare B reimbursements were $23,990,512 for the year ending June 30, 2019.