

State Teachers Retirement System
2025 ORSC Health Care Report

State Teachers Retirement System
ORSC Health Care Report as of June 30, 2025
(For period July 1, 2024-June 30, 2025)
(Submitted to ORSC December 29, 2025)

As Required by Section 3307.51, Ohio Revised Code

State Teachers Retirement System
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Year in Review-2025

The State Teachers Retirement Board is permitted by law to offer a cost-sharing, multiple-employer health care plan. STRS Ohio provides access to health care coverage to eligible retirees who participated in the defined benefit or combined plan and their eligible dependents.

Coverage under the current program includes hospital inpatient and outpatient services, physicians' services, prescription drugs and partial reimbursement of monthly Medicare Part B premiums. The State Teachers Retirement Board has discretionary authority over how much, if any, of the associated health care costs the plan will absorb. Benefit recipients pay a portion of the health care costs through a monthly premium. STRS Ohio has established a health care assistance program for low-income career teachers that provides health care coverage at no cost to the benefit recipient.

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2025, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total STRS Ohio investment portfolio.

In December 2018, the Retirement Board adopted a health care plan policy. The policy including the Metrics to Guide Funding Policy and Metrics to Guide Health Care Plan Management Policy in the Board Policy Appendices states the board's objectives for the health care plan and lays out clear criteria for making decisions regarding changes to benefits, as well as when those changes should be considered by the board. The policy indicates the goal is to provide a sustainable long-term health care program and to make benefit adjustments as conditions allow or are necessary.

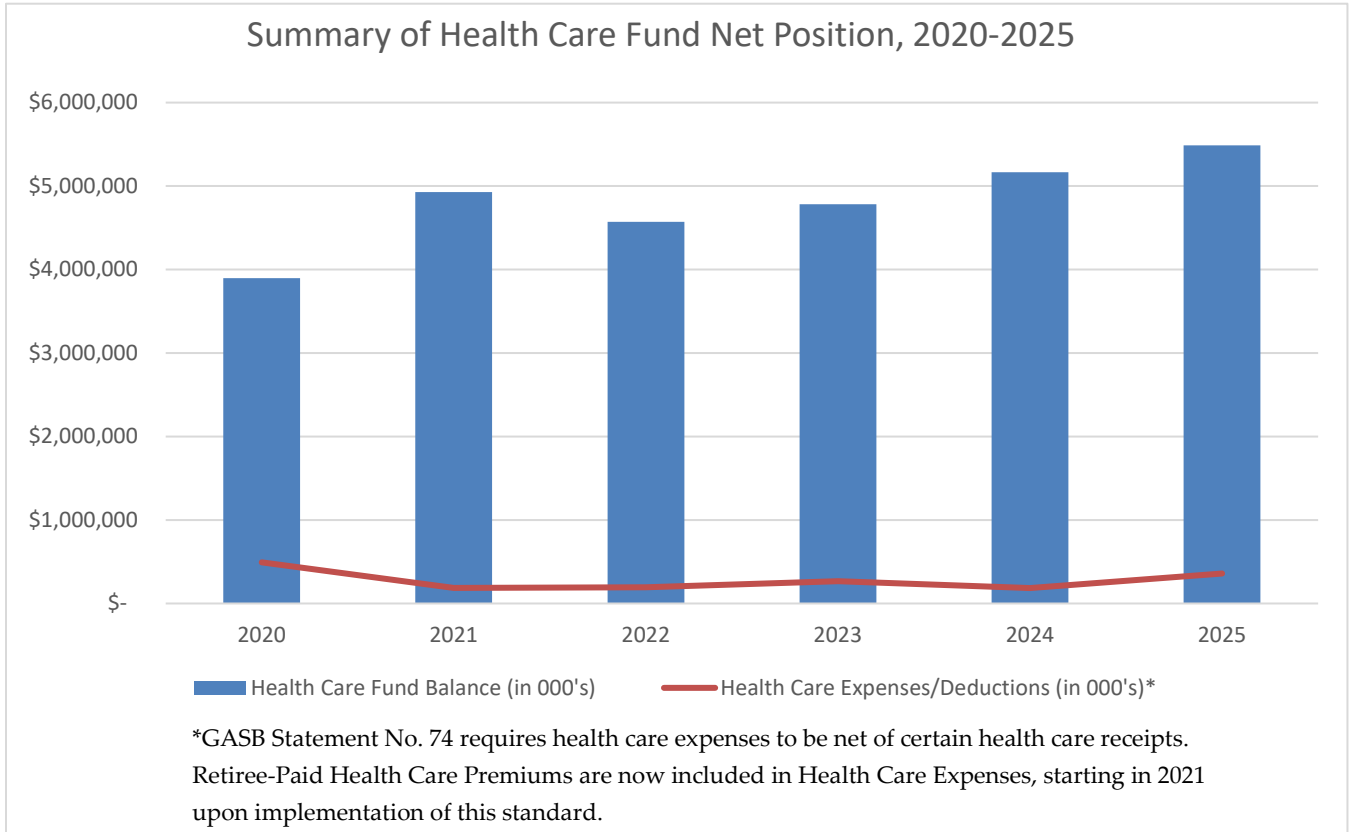
The Health Care Fund net position increased to \$5.5 billion as of June 30, 2025, from \$5.2 billion the previous fiscal year, primarily as a result of net investment income in fiscal 2025. Government reimbursements totaled \$148.1 million in fiscal 2025 compared to \$91.9 million the prior year due to the increase in federal direct subsidies for the STRS Ohio Medicare Part D drug plan as part of the Inflation Reduction Act. Payments for health care claims, net of health care premiums and provider administrative fees, totaled \$357.1 million in fiscal 2025. The increase of \$174.2 million or 95.3% from the previous fiscal year was primarily attributed to increased health care costs, coupled with decreasing premiums and vendor recoveries. The board continued the health care changes from fiscal 2024 with another year of premium decreases in the 2024 calendar year, along with the elimination of the in-network deductible and other enhancements for the Aetna Medicare Plan. Additionally, in early 2025, the board approved increases in subsidy levels for benefit recipients with retirement dates on or after August 1, 2023.

The June 30, 2025, annual health care actuarial valuation performed by Cheiron shows the funded ratio of the plan dropped to 128.3%, down from 158.0% as of June 30, 2024. Benefit payments for the 12-month period ended June 30, 2025, totaled \$491.9 million — an average of about \$1.3 million per day spent for health care program enrollees. The health care program does not receive employer contributions and is susceptible to volatility from investment returns, government reimbursement changes, enrollment fluctuations and health care inflation.

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Financial Information
Fiscal Year 2025 (in 000's)

Additions	Deductions	Fund Balance	Solvency Period ¹	Employer Allocation
\$ 681,074	\$ 359,690	\$ 5,488,071	Solvent for all current retirees with a 32% chance of funding 60 years from now	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance (in 000's)	Health Care Expenses/Deductions (in 000's)*
2020	\$ 3,897,296	\$ 492,817
2021	\$ 4,929,739	\$ 185,734
2022	\$ 4,570,040	\$ 195,912
2023	\$ 4,783,404	\$ 267,851
2024	\$ 5,166,687	\$ 184,917
2025	\$ 5,488,071	\$ 359,690

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

*GASB Statement No. 74 requires health care expenses to be net of certain health care receipts. Retiree-Paid Health Care Premiums are now included in Health Care Expenses, starting in 2021 upon implementation of this standard.

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Average Cost Per Participant Paid by State Teachers Retirement System Fiscal Year 2025

Non-Medicare Recipients	Medicare Recipients
\$863	\$125

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

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

Population of Benefit Recipients As of June 30, 2025

Age and Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare A&B	Percent Medicare B-only	Percent Non-Medicare
90,344	2,575	3,871	96,790	82%	9%	9%

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Aetna Basic (Non-Medicare)

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

¹ For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

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

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Aetna Basic Health Care Assistance Plan (Non-Medicare)

	In-Network & Indemnity ¹	Out-of-Network ¹
Deductible ²	\$300 per enrollee	\$300 per enrollee
Out-of-Pocket Limit ²	\$1,100 per enrollee (includes deductible, copayments and coinsurance)	\$3,300 per enrollee (includes deductible, copayments and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays \$150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays \$40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

¹ For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

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

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Aetna Medicare Plan (Medicare)

	In-Network or Extended Service Area ¹	Out-of-Network ¹
Deductible ²	\$0 per enrollee	\$500 per enrollee
Out-of-Pocket Limit ²	\$1,500 per enrollee (includes deductible, copayments and coinsurance)	\$2,500 per enrollee (includes deductible, copayments and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	Plan pays 92%
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays \$25 (no deductible)	Inpatient: Plan pays 92% Outpatient: Enrollee pays \$55 after deductible
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays \$75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays \$40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations or Medicare guidelines when applicable	

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

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

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Aetna Basic Plan (Medicare)

	In-Network & Indemnity ^{1,3}	Out-of-Network ^{1,3}
Deductible ²	\$2,500 per enrollee	\$5,000 per enrollee
Out-of-Pocket Limit ²	\$6,500 per enrollee (includes deductible, copayments and coinsurance)	\$13,000 per enrollee (includes deductible, copayments and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80% ⁴	Plan pays 50% ⁴
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays \$150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays \$40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations or Medicare guidelines when applicable	

¹ For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

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

³ Benefits are payable after Medicare payments.

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

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Aetna Basic Health Care Assistance Plan (Medicare)

	In-Network & Indemnity ¹	Out-of-Network ¹
Deductible ²	\$300 per enrollee	\$300 per enrollee
Out-of-Pocket Limit ²	\$1,100 per enrollee (includes deductible, copayments and coinsurance)	\$3,300 per enrollee (includes deductible, copayments and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80% ³	Plan pays 50% ³
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays \$150; waived if admitted	
Urgent Care	Enrollee pays \$40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations or Medicare guidelines when applicable	

¹ For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

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

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

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CVS Caremark Prescription Plan (Non-Medicare)

Retail/Mail Service	
Annual Deductible	\$275 per enrollee for covered brand-name drugs
Generic	<p>Retail: Enrollee pays \$10</p> <p>Mail Service: Enrollee pays \$9 for Low-Cost Generic Drug Program medications; \$25 for all other generic medications</p>
Preferred Brand	<p>Retail: Enrollee pays \$30 after deductible</p> <p>Mail Service: Enrollee pays \$75 after deductible</p>
Non-Preferred Drug	<p>Retail: Enrollee pays \$75 after deductible for brand-name drugs</p> <p>Mail Service: Enrollee pays \$187.50 after deductible for brand-name drugs</p>
Nonformulary Drug	Not covered
Specialty Drugs	<p>Retail: Not available; must use CVS Specialty Pharmacy</p> <p>Mail Service (CVS Specialty Pharmacy): After deductible, enrollee pays the lesser of 8% of the cost or \$450 for supply of 1–31 days, \$900 for supply of 32–60 days and \$1,350 for supply of 61–90 days</p>
Maximum Annual Expense	If an enrollee pays a total of \$4,000 out of pocket in copayments/coinsurance/deductible for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.

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CVS Caremark Prescription Plan (Non-Medicare)
For Health Care Assistance Program

Retail/Mail Service	
Annual Deductible	Not applicable
Generic	Retail: Enrollee pays \$5 Mail Service: Enrollee pays \$10
Preferred Brand	Retail: Enrollee pays \$20 Mail Service: Enrollee pays \$40
Non-Preferred Drug	Retail: Enrollee pays \$50 Mail Service: Enrollee pays \$100
Nonformulary Drug	Not covered
Specialty Drugs	Retail: Not available; must use CVS Specialty Pharmacy Mail Service (CVS Specialty Pharmacy): Enrollee pays \$10 for Generic; \$40 for Preferred Brand; \$100 for Non-Preferred Drug
Maximum Annual Expense	If an enrollee pays a total of \$500 out of pocket in copayments for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.

SilverScript Medicare Part D Prescription Plan (Medicare)

Retail/Mail Service	
Annual Deductible	\$275 per enrollee for covered brand-name drugs
Generic	Retail: Enrollee pays \$10 Mail Service: Enrollee pays \$9 for Low-Cost Generic Drug Program medications; \$25 for all other generic medications
Preferred Brand	Retail: Enrollee pays \$30 after deductible Mail Service: Enrollee pays \$75 after deductible
Non-Preferred Drug	Retail: Enrollee pays \$75 after deductible for brand-name drugs Mail Service: Enrollee pays \$187.50 after deductible for brand-name drugs
Nonformulary Drug	Not covered
Specialty Drugs	Retail/Mail Service: After deductible, enrollee pays the lesser of 8% of the cost or \$450 for supply of 1–31 days, \$900 for supply of 32–60 days and \$1,350 for supply of 61–90 days
Maximum Annual Expense	If an enrollee pays a total of \$2,000 out of pocket in copayments/coinsurance/deductible for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.

SilverScript Medicare Part D Prescription Plan (Medicare)

For Health Care Assistance Program

Retail/Mail Service	
Annual Deductible	Not applicable
Generic	Retail: Enrollee pays \$5 Mail Service: Enrollee pays \$10
Preferred Brand	Retail: Enrollee pays \$20 Mail Service: Enrollee pays \$40
Non-Preferred Drug	Retail: Enrollee pays \$50 Mail Service: Enrollee pays \$100
Nonformulary Drug	Not covered
Specialty Drugs	Retail: Enrollee pays \$5 for Generic; \$20 for Preferred Brand; \$50 for Non-Preferred Drug Mail Service: Enrollee pays \$10 for Generic; \$40 for Preferred Brand; \$100 for Non-Preferred Drug
Maximum Annual Expense	If an enrollee pays a total of \$500 out of pocket in copayments for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.

Health Care Future – Fiscal Year 2025

Based on the 7.00% expected rate of investment return, the STRS Ohio Health Care Program dropped in its financial position for fiscal year 2025, moving from the period where plan enhancements could be supported and paid solely by monies in the health care fund to now looking for increased costs being funded by enrollees and additional funding to maintain the long-term sustainability goal. As of June 30, 2025, the program is 128.3% funded, meaning there is, if all actuarial assumptions are met, projected solvency for all current retirees with a 32% probability that the plan will remain solvent for 60 or more years.

To better align with the Pension's Sustainable Benefit Plan (SBP) process, the Board revised the health care funding policy in October 2025, with the expectation that 2027 would be the first year its resulting actions could have impact. The goal of the new measurement is to provide more specificity around when and how much the Board can make in health care plan enhancements as conditions allow, or to identify when it's necessary to take corrective actions and how much those actions need to be. The results of the new scorecard fall into one of three color ranges – Red indicates corrective action needs to be taken; Yellow indicates corrective action is recommended but not required, and Green opens the threshold to test if enhancements may be supported. The scorecard result as of June 30, 2025 fell into the Red action range, indicating corrective action is required to mitigate risk.

A significant contributor to the current funding status has been the continuing consistent levels of federal government reimbursements resulting from operating a Medicare Advantage and self-insured Prescription Part D (MAPD) program and the increasing formulary drug rebates. STRS Ohio recognizes these payments are not guaranteed and are subject to significant volatility. Additionally, the system has investment return volatility associated with the current asset mix. It is also important to note that employer contributions to the Health Care Fund ceased beginning July 1, 2014. As a result of potential funding volatility and lack of employer contributions, benefit changes are unlikely or will be minimal until the health care scorecard is no longer in the red scoring range, and the slope of the 20 year actuarially projected funded ratio moves back to being positive.

Due to the red scorecard funding level, the Retirement Board did not make any benefit coverage improvements for 2026 beyond increasing the Medicare prescription program's annual out-of-pocket limit to \$2,100 to follow Medicare.

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Eligibility and subsidy changes for the STRS Ohio Health Care Program were made in multiple steps between August 2023 and May 2025. Members who retired before Aug. 1, 2023, are grandfathered under their current requirements. This change, announced in 2013, originally required members who retire on or after Aug. 1, 2023, to have at least 20 years of total service credit to access coverage, and required five additional years of service credit to receive the same subsidy grandfathered retirees receive. In March and May 2024, the subsidy changes were modified to grandfather health care subsidies to match those who retired prior to August 1, 2023 for anyone who retires between August 1, 2023 and July 31, 2032 with 29 or more years of service to align with the revised requirements for unreduced pensions. For premiums paid between January and May 2025, subsidy requirements were modified to grandfather health care subsidies to match those who retired prior to August 1, 2023 for benefit recipients with 28 or more years of service and, beginning June 2025, further reduced to 27 years of service to continue following enhancements approved for unreduced pensions. Each enhancement that is applied to Pension requirements places further pressure on the long-term funding levels for the Health Care Program. The Retirement Board is scheduled to assess changes to the health care levers – subsidy and benefit levels – to address the funding levels projected out to when the pension plan is projected to be fully funded. After July 31, 2032, the maximum subsidy for health care plan participants who retire August 1, 2032 or later will align with the eligibility for pensions.

Supplementary Statutory Requirements

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

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

Ohio Revised Code, section 3307.39, states:

The State Teachers Retirement Board may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical coverage, or any combination thereof, for those individuals receiving, under the STRS defined benefit plan, service retirement or a disability or survivor benefit who subscribe to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children as the board considers appropriate.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the state teachers retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by section 3307.28 of the Revised Code.

Ohio Revised Code section 3307.39, also states "the board may make a monthly payment to each recipient of service retirement, or a disability or survivor benefit under the STRS defined benefit plan who is enrolled in coverage under part B of the Medicare program established under Title XVIII of "The Social Security Amendments of 1965," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended."

(2) A summary of coverage for 2024:

A summary of the coverage for calendar year 2025 is provided on pages 5 through 13 in the attached ORSC Health Care Report.

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

In general, service retirees who retired before August 1, 2023 are required to have 15 years of qualified service credit to be eligible for the STRS Ohio Health Care Program, and eligibility is extended to disability recipients and some survivor annuitants and survivor benefit recipients. Service retirees who retire on or after August 1, 2023, will need 20 years of service to be eligible for the STRS Ohio Health Care Program.

More details on eligibility requirements for the STRS Ohio Health Care Program are provided in Attachment A on pages 22 and 23.

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

As of June 1, 2025, there were 141,669 benefit recipients eligible to participate in the STRS Ohio Health Care Program.

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

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2025, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total STRS Ohio investment portfolio.

The actuarial cost method required for GASB 74 and 75 calculations is the Entry Age Normal Actuarial Cost Method. Under this method, the Actuarial Present Value of the projected benefits of each individual included in an actuarial valuation is allocated on a level basis over the individual's earnings between Entry Age and the assumed exit ages. The portion of this Actuarial Present Value allocated to a valuation year is referred to as the service cost. The portion of this Actuarial Present Value not provided for at a valuation date by the Actuarial Present Value of future service costs is called the Total OPEB Liability

The Actuarially Determined Contribution (ADC), is the recommended contribution to the Retiree Health Care Benefits Plan for the reporting period, determined in conformity with Actuarial Standards of Practice. The ADC calculation consists of adding the Normal Cost of the Plan to the amortization of the Unfunded Liability or Surplus. When the Plan is in a surplus position, as it is now, the surplus is amortized using an open 30-year amortization period calculated as a level percent of payroll. The ADC for June 30, 2025,

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was calculated to be greater than \$0 due to the normal cost being larger than the amortization of surplus.

State Teachers Retirement System of Ohio Retiree Health Care Benefits Plan currently does not receive employer or employee contributions. Without contributions to the Plan, the Plan relies on investment returns to fund the payment of benefits into the future.

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

**Post-Employment Health Care
Statement of Fiduciary Net Position**

As of June 30, 2025
(In Thousands)

Assets:

Cash and short-term investments	\$ 108,642
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Receivables:

Accrued interest and dividends	25,835
Securities sold	32,685
Medical benefits receivable	0
Total receivables	58,520

Investments, at fair value:

Fixed income	1,331,169
Domestic equities	1,312,894
International Equities	1,185,617
Real estate	546,078
Alternative investments	1,149,453
Total investments	5,525,211
Invested securities lending collateral	66,466
Total assets	5,758,839

Liabilities:

Securities purchased and other investment liabilities	63,592
Debt on real estate investments	112,771
Accrued expenses and other liabilities	3,704
Medical benefits payable	24,262
Obligations under securities lending program	66,439
Total liabilities	270,768

Fiduciary net position restricted for post-employment health care coverage:

5,488,071

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

**Post-Employment Health Care
Statement of Changes in Fiduciary Net Position**

Year Ended June 30, 2025

(In Thousands)

Additions:

Contributions:

Employer	\$ 0
Government reimbursements	148,074
<i>Total contributions</i>	148,074

Investment income from investing activities:

Net appreciation (depreciation) in fair value of investments	439,663
Interest	53,687
Dividends	51,302
Real estate income	5,976
<i>Investment income (loss)</i>	550,628
Less internal investment expenses	(2,580)
Less external asset management fees	(15,312)
<i>Net income (loss) from investing activities</i>	532,736
Securities lending income	297
Securities lending expenses	(33)
<i>Net income from securities lending activities</i>	264
<i>Net investment income (loss)</i>	533,000
Total additions	681,074

Deductions:

Health care	357,047
Administrative expenses	2,643
Total deductions	359,690
Net increase (decrease) in net position	321,384

Fiduciary net position restricted for post-employment health care coverage:

Beginning of year	5,166,687
End of year	5,488,071

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

		Six-Year History					
		Fiscal Year Ended (in Thousands)					
		2025	2024	2023	2022	2021	2020
Employer contributions	\$	0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
Government reimbursements	\$	148,074	\$ 91,900	\$ 100,515	\$ 97,713	\$ 96,478	\$ 81,876
Retiree-paid health care premiums	\$	0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 295,779
Net investment income (loss)	\$	533,000	\$ 476,300	\$ 380,700	\$ (261,500)	\$ 1,121,699	\$ 140,300
Health care expenses	\$	357,047	\$ 182,827	\$ 265,603	\$ 193,572	\$ 183,390	\$ 490,559
Administrative expenses	\$	2,643	\$ 2,090	\$ 2,248	\$ 2,340	\$ 2,344	\$ 2,258
Fiduciary net position available for benefits	\$	5,488,071	\$ 5,166,687	\$ 4,783,404	\$ 4,570,040	\$ 4,929,739	\$ 3,897,296

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

GASB Statement No. 74 requires health care expenses to be net of certain health care receipts. Retiree-Paid Health Care Premiums are now included in Health Care Expenses, starting in 2021 upon implementation of this standard.

- (10) As applicable, a statement of the amount paid under division (C) of section 145.58 of the Revised Code, division (B) of section 742.45 of the Revised Code, division (B) of section 3307.39 of the Revised Code, division (E) of section 3309.69 of the Revised Code, division (B) of section 5505.28 of the Revised Code:

In calendar year 2022, STRS Ohio reimbursed benefit recipients who were enrolled in an STRS Ohio health care plan and Medicare Part B \$29.90 per month toward their total Medicare Part B premium. Starting in calendar year 2023, the Medicare Part B premium reimbursement was moved to a \$30 subsidy credit for all benefit recipients who pay Medicare enrollee premiums.

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

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

(A) Eligibility

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

- (1) A service retiree with an effective benefit date:
 - (a) Before January 1, 2004; or
 - (b) Between January 1, 2004 and July 1, 2023, and the benefit is based on fifteen or more years of total service credit; or
 - (c) After August 1, 2023 and the benefit is based on twenty or more years of total service credit.
- (2) A service retiree who began receiving service retirement benefits with no break in monthly benefits following the termination of disability benefits, with a disability effective benefit date:
 - (a) Before January 1, 2004; or
 - (b) Between January 1, 2004 and July 1, 2023 and the service retiree benefit is based on fifteen or more years of total service credit; or
 - (c) After August 1, 2023 and the service retiree benefit is based on twenty or more years of total service credit.
- (3) A disability benefit recipient.
- (4) A survivor annuitant.
- (5) A survivor benefit recipient under division (C)(1) of section [3307.66](#) of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death where the effective date of survivor benefits or the effective date of disability benefits of the deceased member is:
 - (a) Before January 1, 2004; or

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- (b) Between January 1, 2004 and July 1, 2023 provided that the deceased member had fifteen or more years of total service credit at the time of death; or
 - (c) After August 1, 2023 provided the deceased member had twenty or more years of total service credit at the time of death.
- (6) A survivor benefit recipient under division (C)(2) of section [3307.66](#) of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death.
- (7) Dependents, to the extent that a medical plan and/or ancillary plan allows for dependent coverage.
- (8) Notwithstanding paragraphs (A)(1) to (A)(7) of this rule, an individual not eligible for medicare coverage is not eligible for primary coverage in a medical plan offered by the retirement system if the individual is employed and has access to an entity's medical plan or if similarly situated, non-retired employees have access to an entity's medical plan, provided the medical plan includes prescription coverage and provides equivalent coverage at a cost no more than what is available to full-time employees as defined by the entity. The retirement board may require each enrollee to annually file a verification of employment statement disclosing the availability for enrollment as an employee in an entity's medical plan.
- (a) When an individual is enrolled in an entity's medical plan and a medical plan offered by the retirement system, coverage in the retirement system's medical plan will be limited to secondary coverage applied only to those covered medical expenses not paid by the entity's medical plan.
 - (b) An employed individual not eligible for Medicare who does not file a verification of employment statement with the retirement system when requested by the retirement system; does not enroll in the entity's medical plan when eligible to enroll, or is excluded from the entity's medical plan based upon being an enrollee is not eligible to enroll or remain enrolled in a medical plan offered by the retirement system.