**PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO**
277 East Town Street, Columbus, Ohio 43215

June 23, 2003

MEMORANDUM

TO: Ohio Retirement Study Commission
Ohio House Health, Retirement and Aging Committee
Ohio Senate Ways and Means Committee

FROM: Laurie Fiori Hacking, Executive Director

RE: Reporting requirements under ORC Section 145.22(E)

The following document fulfills the requirements of the Ohio Public Employees Retirement System as outlined in Ohio Revised Code Section 145.22, Section E. The section and the System's responses follows:

(E) The board shall have prepared annually a report giving a full accounting of the revenues and costs relating to the provision of benefits under sections 145.325 and 145.58 of the Revised Code. The report shall be made as of December 31, 1997 and the thirty-first day of December of each year thereafter. The report shall include the following:

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

Attachments A and B are copies of ORC Sec. 145.325 (Medicare benefits for members of Ohio Public Employees Retirement System), and ORC Sec. 145.58 (Group Hospitalization coverage; ineligible individuals; service credit; alternative use of HMO).

(2) **A summary of benefits**

Following is an outline of the current OPERS health care benefits:

The OPERS Health Care Plan

The OPERS health care plan utilizes a Preferred Provider Organization (PPO). This PPO network is a partnership between doctors, hospitals, our health plan administrators (Aetna and Medical Mutual), and our benefit recipients. Doctors and medical facilities that join the PPO network agree to perform services at a discounted rate. Because these providers of service provide a cost savings to OPERS, the design of our health plan encourages the use of these providers. While benefit recipients may choose any provider and still receive benefits, they receive a higher level

of reimbursement if they choose network providers of service. Once a recipient is eligible for Medicare, however, he or she may choose any provider of service (regardless of network status) without a decrease in benefits. The OPERS health plan pays secondary to Medicare.

Currently, there are thirteen states in the OPERS PPO network (Ohio, Arizona, California, Florida, Indiana, Kentucky, Michigan, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas and West Virginia). Benefit recipients living outside of these states may choose any provider of services (regardless of Medicare status) without a decrease in benefits.

## How Benefits Are Paid

For benefit recipients eligible for Medicare, those living outside of a network state and those using network providers of service, the following benefits are available (subject to medical necessity and the reasonable and customary rate*):

| | | |
|---|---|---|
| Most Medical Benefits | 80% | |
| Certain Preventative Benefits | 100% | No deductible applies |
| Inpatient Hospital Benefits | 100% | |

The calendar year deductible is $100 per person and $200 for a family. The maximum out-of-pocket amount (the amount after which the plan pays at 100% for the remainder of the calendar year) is $500 for an individual and $750 for a family. There is a lifetime maximum benefit of $2,500,000 per covered person.

Benefit recipients who live in a network state and who are not eligible for Medicare receive the following benefits if they do not use network providers of service (subject to medical necessity and the reasonable and customary rate):

| | | |
|---|---|---|
| Most Medical Benefits | 70% | |
| Certain Preventative Benefits | 100% | No deductible applies |
| Inpatient Hospital Benefits<br>(For elective admissions) | 70% | |

A calendar year deductible of $150 per individual or $300 per family applies. The maximum out of pocket amount (after which the plan pays at 100% for the remainder of the calendar year) is $750 for an individual and $1125 for a family. The lifetime maximum benefit is $2,500,000 regardless of network usage.

* Benefit recipients cannot be billed for charges above the reasonable and customary rates when they use network providers or service

## Alternate Health Care Coverage

Alternative health care coverage is available to OPERS benefit recipients who reside in certain counties in Ohio (and a few border counties in Indiana, Kentucky and Michigan). HMO products include Aetna, HMO Health Ohio, Kaiser Permanente, Paramount and United Health Care. HMO products offer hospital and medical services through participating physicians and facilities.

In general, coverage under an HMO program is more comprehensive than coverage provided by the OPERS health plan. Benefit recipients are responsible for the cost difference in HMO coverage if that cost is more than the cost of the OPERS health care plan.

AultCare is a preferred provider organization that is offered to members in Stark and surrounding counties in Ohio. It was offered to qualifying members beginning January 1, 2002.

## Prescription Drug Coverage

Prescription drug coverage is available for benefit recipients (regardless of the OPERS medical plan they choose) and their covered dependents. When covered persons use retail pharmacies, they can receive a 34- day supply of medication. When benefit recipients choose the mail service plan, they can receive up to 120- days of medication at one time.

Co-payments are designed to encourage use of generic products as well as the use of the mail service. The following co-payments apply to a 34- day supply at retail and a 120- day supply at mail:

| | |
|---|---|
| $4.50 | Generic Medication |
| $9.00 | Single Source Brand (no generic is available) |
| $12.00 | Multi-Source Brand (generic is available) |

## Medicare

If an OPERS benefit recipient is eligible for Medicare Part A (hospital) at no cost, he or she must enroll in Medicare coverage (if covered by OPERS health care). If Medicare Part A is not available to the benefit recipient without cost, OPERS will provide comparable substitute coverage.

Benefit recipients who turn age 65 (and who are enrolled in OPERS health care) must enroll in Medicare Part B (medical).

When a benefit recipient or covered spouse reaches the age of 65, OPERS requests a copy of the Medicare card. If the covered individual is not eligible for free Medicare A, OPERS requests a copy of his or her card

showing part B coverage or a letter from Social Security, stating there will be a charge assessed for Medicare A.

## Medicare Direct

Benefit recipients who are enrolled in Medicare B (medical) and who are enrolled in the OPERS health plan (not HMOs) may use Medicare Direct.

The Medicare Direct program is available in certain states and covers Medicare B charges only. The Medicare Direct program allows the health care provider of services to mail a claim to the Medicare paying agency. The agency makes a payment and forwards the remainder of the bill (along with a Medicare explanation of benefits) to the OPERS health plan administrator.

## Medicare Reimbursement

If our benefit recipient is enrolled in OPERS health care and is not being reimbursed for his or her Medicare B premium, he or she is eligible for OPERS reimbursement. In order to receive this reimbursement, the benefit recipient must send a copy of his or her Medicare card, showing enrollment in Part B. As long as the benefit recipient remains enrolled in part B coverage, the full reimbursement is added to the recipient's monthly retirement check.

## Medicare Deduction

If a benefit recipient must pay the Medicare B premium to the Social Security Administration directly, he or she may ask OPERS to make a payment to Social Security, rather than having the amount added to his or her pension check.

## The Dental Plan

Dental coverage is available to all OPERS benefit recipients and their eligible dependents regardless of whether or not they are covered by the OPERS health plan. The dental plan is intended to help defray the costs of dental coverage, including oral examinations, diagnostic services, and extractions, as well as crowns, bridges, and dentures. If a recipient chooses to be covered under the dental plan, a premium payment will be deducted from each monthly benefit check.

Currently, OPERS subsidizes 25% of the benefit recipient’s cost of dental coverage.

## The Vision Plan

Vision coverage is also available to all OPERS benefit recipients and their eligible dependents regardless of whether or not they are covered by the OPERS health plan. This plan covers services provided by an ophthalmologist, optometrist, or optician for examinations, frames, and lenses. A premium payment is deducted from each monthly benefit check for those recipients who choose to participate.

Currently, OPERS subsidizes 25% of the benefit recipient's cost of vision coverage.

## The Long Term Care Plan

This is a program in which any OPERS benefit recipient, regardless of health care coverage, his or her spouse, adult children, parents and parents-in-law may apply for protection from the expense of long term care.

This plan was designed to cover those long-term care expenses not covered by the basic hospital/medical coverage (e.g. custodial care), including Medicare. It is intended to provide daily cash benefits when the insured is no longer able to independently perform the activities of daily living.

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

Following are the current eligibility requirements for the OPERS health care plan:

## Age and Service Retirement

When applying for age and service retirement, a benefit recipient must have 10 years of Ohio service credit to qualify for the OPERS health care plan. These 10 years may not include out-of-state or military service purchased after January 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992.

## Disability Retirement

If a person is receiving a disability benefit from OPERS, health care coverage is provided regardless of years of services credit.

Coverage for Surviving Spouses

If a member retires, chooses a joint and survivor annuity plan of payment (Plan A, C or D) and dies, the beneficiary will be entitled to health care coverage if the deceased retiree was eligible.

If a member dies before retirement, health care coverage will be available to survivors receiving monthly benefits regardless of the member's years of service credit.

Eligible Dependents

Eligible dependents include the member's spouse; unmarried child(ren) under age 18, or under age 22 if attending school (on at least a two-thirds full time basis) and dependent on the benefit recipient's support. Also eligible are dependent children, regardless of age, who have physical or mental handicaps, are unable to earn their living, and who became incapacitated prior to age 18 (or 22 if attending school).

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

As of December 31, 2002, there were 123,845 benefit recipients and 46,994 dependents covered under the OPERS health care plan. There were an additional 7,619 who receive a pension but do not have sufficient service credit to qualify for the OPERS health care plan. These persons do have the option of participating in the OPERS dental and vision plans.

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

OPERS utilizes an accrual basis of accounting under which expenses are recorded when the liability is incurred and revenues are recorded in the accounting period they are earned and become measurable. Under this method, OPERS estimates health care claims which have been incurred at year end, but which are not yet known to the Retirement System. Investment purchases and sales are recorded as of their trade date. Investment expenses are financed exclusively through investment income.

Plan investments are reported at fair value. Fair value is, "the amount that a plan can reasonable expect to receive for an investment in a current sale between a willing buyer and a willing seller that is, other than in a forced liquidation sale." All investments, with the exception of real estate and private equity, are valued based on closing market prices or broker quotes. The fair value of real estate and private equity investments is based on estimated current values and independent appraisals.

Employer contributions and investment earnings are used to fund health care expenses. Under this method, employer contributions equal to 5

percent of covered payroll are used to fund health care liabilities. Based upon our most recent actuarial projections, these contributions along with investment income on allocated assets and periodic adjustments in health care provisions are expected to be sufficient to sustain the program through 2032 assuming that health care inflation increases at the same rate as wage inflation, OPERS continues to earn its actuarial assumption rate of eight percent on investment assets, and 5% of employer contributions continue to be allocated toward health care funding. Other less optimistic assumptions show solvency extending only through 2013.

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

Please see Attachment C, "Statements of Plan Net Assets - Health Care".

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

Please see Attachment D, "Statements of Changes in Plan Net Assets - Health Care".

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

Please see Attachment D, "Statements of Changes in Plan Net Assets - Health Care".

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

No significant changes affect these reports.

**Sec. 145.325 Medicare benefits for members of public employees retirement system**

(A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, 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. One-half of the cost of the premium for the spouse shall be paid from the appropriate funds of the public employees retirement system and one-half 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 section 145.48 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and shall contract for such coverage as provided in section 145.58 of the Revised Code.

(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 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance.

*(ENACTED: HB 402, Eff. 12/14/67; HB 1, Eff. 6/13/75; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; SB 346, Eff. 7/29/92; HB 628, 9/21/00)*

**Sec. 145.58 Group hospitalization coverage; ineligible individuals; service credit; alternative use of HMO**

(A) As used in this section, "ineligible individual" means all of the following:

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years' service credit, exclusive of credit obtained pursuant to section 145.297 or 145.298 of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 or 145.301 of the Revised Code, and credit obtained after May 4, 1992, pursuant to section 145.28 of the

Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code.

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

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to ineligible individuals if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.325 of the Revised Code for any ineligible individual.

The board may provide for self-insurance of risk, or level of risk as set forth in the contract with the companies, corporations, or agencies, and may provide through the self-insurance method specific benefits as authorized by rules of the board.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or survivor benefit under the public employees retirement system who is eligible for medical insurance coverage under part B of Title XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended, an amount equal to the basic premium for such coverage, except that the board shall make no such payment to any ineligible individual.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 145.325 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

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

*(ENACTED: SB 256, Eff. 10/14/59; HB 957, Eff. 10/27/61; HB 225, Eff. 11/13/65; HB 430, Eff. 11/20/73; HB 268, Eff. 8/20/76; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; HB 236, Eff. 2/2/82; HB 631, Eff. 3/28/85; HB 706, Eff. 12/16/86; SB 124, Eff. 10/1/87; HB 382, Eff. 6/30/91; HB 383, Eff. 5/4/92; SB 346, Eff. 7/29/92; HB 151, Eff. 2/9/94; SB 82, Eff. 3/6/97; SB 67, Eff. 6/4/97; HB 222, Eff. 11/2/99; HB 535, Eff. 4/1/01; SB 247, Eff. 10/1/02)*

Attachment C

## Statement of Plan Net Assets
Health Care

| | 2002 | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 |
|---|---|---|---|---|---|---|---|
| **Assets** | | | | | | | |
| Cash and Short Term Investment | $185,571,147 | $152,283,582 | $299,551,036 | $193,521,934 | $471,335,326 | $487,746,980 | $499,169,867 |
| Receivables: | | | | | | | |
| Employers' | $46,467,195 | $26,975,696 | $20,915,187 | $27,145,428 | $29,510,057 | $21,388,190 | $24,240,915 |
| Retirement Incentive Plan | $18,188,956 | $6,775,267 | $3,721,569 | $2,777,067 | $2,964,960 | $3,829,808 | $3,527,193 |
| Investment Sales Proceeds | $39,388,483 | $14,246,185 | $26,467,886 | $117,162 | $86,793,714 | $46,184,481 | $1,971,383 |
| Accrued Interest and Dividends | $27,438,280 | $29,271,211 | $46,815,613 | $46,415,084 | $52,727,381 | $51,018,811 | $46,742,776 |
| Total Receivables | $131,482,914 | $77,268,359 | $97,920,255 | $76,454,741 | $171,996,112 | $122,421,290 | $76,482,267 |
| Investments, at fair value: | | | | | | | |
| Bonds | $1,147,148,273 | $1,271,358,373 | $2,134,491,585 | $2,162,313,014 | $2,795,959,387 | $3,031,100,715 | $3,035,272,679 |
| Mortgage & Mortgage Backed | $734,293,155 | $757,309,894 | $1,493,537,925 | $1,429,145,862 | $1,413,860,311 | $1,115,901,122 | $1,025,311,866 |
| Stocks | $4,129,397,805 | $4,750,774,185 | $3,850,714,985 | $3,911,196,263 | $3,805,758,533 | $2,580,763,906 | $2,059,686,377 |
| Real Estate | $866,566,452 | $967,004,493 | $1,046,691,262 | $1,118,361,190 | $930,135,999 | $609,166,124 | $518,242,690 |
| Venture Capital | $48,181,864 | $12,933,389 | $16,733,040 | $18,111,104 | $8,565,060 | $6,485,887 | $4,977,458 |
| International Securities | $1,776,052,122 | $2,002,672,885 | $2,045,814,900 | $2,287,215,780 | $477,774,232 | $207,407,199 | $160,034,275 |
| Collateral on Loaned Securities | | | | | $1,135,559,244 | $944,925,686 | $2,013,574,900 |
| Total Investments | $8,701,639,671 | $9,762,053,219 | $10,587,983,697 | $10,926,343,213 | $10,567,612,766 | $8,495,750,639 | $8,817,100,245 |
| Collateral on Loaned Securities | $435,303,084 | $593,251,558 | $799,148,208 | $865,608,588 | | | |
| Fixed Assets: | | | | | | | |
| Land | $697,663 | $691,687 | $717,831 | $724,575 | $723,204 | $307,514 | $316,739 |
| Building and Building Improvements | $17,702,101 | $12,387,633 | $6,016,564 | $3,868,237 | $3,657,787 | $3,282,978 | $3,366,657 |
| Furniture, Fixtures, and Equipment | $8,335,682 | $7,067,342 | $5,357,308 | $4,428,341 | $3,784,916 | $2,953,821 | $2,803,422 |
| | $26,735,446 | $20,146,662 | $12,091,703 | $9,021,153 | $8,165,907 | $6,544,313 | $6,486,818 |
| Accumulated Depreciation | ($4,668,983) | ($3,946,684) | ($3,644,071) | ($3,384,156) | ($3,014,820) | ($2,438,487) | ($2,153,523) |
| Total Fixed Assets | $22,066,463 | $16,199,978 | $8,447,632 | $5,636,997 | $5,151,087 | $4,105,826 | $4,333,295 |
| Prepaid Expenses and Other | $22,941,138 | $19,931,824 | $18,677,709 | $15,985,801 | $14,580,242 | $12,714,410 | $600,084 |
| TOTAL ASSETS | $9,499,004,417 | $10,620,988,520 | $11,811,728,537 | $12,083,551,274 | $11,230,675,533 | $9,122,739,145 | $9,397,685,758 |
| Liabilities: | | | | | | | |
| Undistributed Deposits | $1,026,008 | $6,313,108 | $477,657 | $251,682 | $110,336 | $689,534 | $1,175,971 |
| Medical Benefits Payable | $95,374,085 | $72,859,185 | $41,684,800 | $53,846,033 | $46,398,790 | $44,621,490 | $49,130,163 |
| Investment Commitments Payable | $79,530,542 | $10,355,578 | $4,259,704 | | $36,238,584 | $7,962,109 | $1,685,348 |
| Accrued Administrative Expenses | $1,488,612 | $1,825,097 | $728,799 | $631,714 | $528,321 | $1,148,310 | $996,534 |
| Obligations Under Securities Lending | $435,303,084 | $593,251,558 | $799,148,208 | $865,608,588 | $1,135,559,244 | $944,925,686 | $2,013,574,900 |
| TOTAL LIABILITIE! | $612,722,331 | $684,604,526 | $846,299,168 | $920,338,017 | $1,218,835,275 | $999,347,129 | $2,066,562,916 |
| Net assets held in trust for pension and post-employment health care benefits | $8,886,282,086 | $9,936,383,994 | $10,965,429,369 | $11,163,213,257 | $10,011,840,228 | $8,123,392,016 | $7,331,122,842 |

Attachment D

## Statements Of Changes In Plan Net Assets
## Health Care

| | 2002 | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995 | 1994 |
|---|---|---|---|---|---|---|---|---|---|
| **Additions:** | | | | | | | | | |
| **Contributions:** | | | | | | | | | |
| Members' | | | | | | | | | |
| Employers' | $573,038,298 | $431,103,750 | $452,867,242 | $392,459,727 | $379,761,098 | $422,152,429 | $403,816,027 | $381,803,227 | $371,768,137 |
| TOTAL CONTRIBUTIONS | $573,038,298 | $431,103,750 | $452,867,242 | $392,459,727 | $379,761,098 | $422,152,429 | $403,816,027 | $381,803,227 | $371,768,137 |
| **Investment Income:** | | | | | | | | | |
| Net Appreciation in Fair Value of Instruments | ($1,087,158,561) | ($1,396,124,511) | ($546,918,282) | $888,386,350 | $1,593,731,660 | $370,211,565 | ($223,614,062) | $603,341,894 | ($335,838,310) |
| Bond Interest | $135,276,163 | $361,752,777 | $284,384,050 | $254,543,745 | $250,812,003 | $285,716,854 | $250,836,769 | $212,206,050 | $338,940,321 |
| Dividends | $65,521,483 | $130,998,066 | $90,565,240 | $69,366,846 | $49,322,412 | $45,080,119 | $33,889,761 | $29,152,640 | $30,278,070 |
| Real Estate Operating Income, net | $45,652,477 | $137,855,938 | $82,658,021 | $71,472,483 | $56,358,214 | $60,159,183 | $41,976,169 | $27,318,784 | $31,826,019 |
| Securities Lending Income * | $1,104,834 | $47,293,017 | $37,328,394 | $29,062,059 | $2,476,890 | $1,727,809 | $1,082,848 | $1,404,426 | $1,011,109 |
| | ($839,603,604) | ($718,224,713) | ($51,982,577) | $1,312,831,483 | $1,952,701,179 | $762,895,530 | $104,171,485 | $873,423,794 | $66,217,209 |
| Less: Investment Expenses * | ($3,462,304) | ($45,351,114) | ($37,183,505) | ($28,561,474) | ($1,698,418) | ($1,005,080) | ($798,761) | ($593,144) | ($433,624) |
| Net Investment Income | ($843,065,908) | ($763,575,827) | ($89,166,082) | $1,284,270,009 | $1,951,002,761 | $761,890,450 | $103,372,724 | $872,830,650 | $65,783,585 |
| TOTAL ADDITIONS | ($270,027,610) | ($332,472,077) | $363,701,160 | $1,676,729,736 | $2,330,763,859 | $1,184,042,879 | $507,188,751 | $1,254,633,877 | $437,551,722 |
| **Deductions:** | | | | | | | | | |
| Benefits | $776,006,852 | $693,484,110 | $559,606,294 | $523,599,349 | $440,596,663 | $389,845,273 | $369,213,858 | $353,685,547 | $327,578,426 |
| Refunds of Contributions | | | | | | | | | |
| Administrative Expenses | $4,067,446 | $3,089,188 | $1,878,754 | $1,757,358 | $1,718,984 | $1,928,432 | $1,724,482 | $1,470,710 | $845,251 |
| TOTAL DEDUCTIONS | $780,074,298 | $696,573,298 | $561,485,048 | $525,356,707 | $442,315,647 | $391,773,705 | $370,938,340 | $355,156,257 | $328,423,677 |
| Net Increase | ($1,050,101,908) | ($1,029,045,375) | ($197,783,888) | $1,151,373,029 | $1,888,448,212 | $792,269,174 | $136,250,411 | $899,477,620 | $109,128,045 |
| Net assets held in trust for pension and | | | | | | | | | |
| Postemployment health care benefits: | | | | | | | | | |
| Balance, Beginning of Year (as restated) | $9,936,383,994 | $10,965,429,369 | $11,163,213,257 | $10,011,840,228 | $8,123,392,016 | $7,331,122,842 | $7,194,872,431 | $6,295,394,811 | $6,186,266,766 |
| BALANCE, END OF YEAR | $8,886,282,086 | $9,936,383,994 | $10,965,429,369 | $11,163,213,257 | $10,011,840,228 | $8,123,392,016 | $7,331,122,842 | $7,194,872,431 | $6,295,394,811 |

* Securities lending income is displayed net of expense prior to 1999; investment expenses shown without securities income related expenses prior to 1999.