Alameda County Employees' Retirement Association

Actuarial Valuation of the OPEB and Non-OPEB Benefits Provided by the Supplemental Retiree Benefits Reserve Including Sufficiency of Funds as of December 31, 2024

Segal

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September 19, 2025

Board of Retirement
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612

Dear Board Members:

We are pleased to submit this report on our actuarial valuation of the sufficiency of funds for benefits provided by the Supplemental Retiree Benefits Reserve (SRBR) as of December 31, 2024. ACERA's accounting disclosures required under Statement No. 74 of the Governmental Accounting Standards Board (GASB) for retiree health benefits provided by the SRBR were included in our GASB 74 report dated May 23, 2025. ACERA's accounting disclosures required under GASB Statement No. 67 for non-vested supplemental COLA and retired member death benefits provided by the SRBR were included in our GASB 67 report dated May 23, 2025, together with the statutory pension benefits.

The current year census and financial information used in preparing this report was prepared by ACERA. We gratefully acknowledge that assistance. The actuarial projections were based on the assumptions and methods described in Exhibit 1 and on the plan of benefits as summarized in Exhibit 2.

The actuarial calculations were completed under the supervision of Eva Yum, FSA, MAAA, Enrolled Actuary and Mehdi Riazi, FSA, MAAA, EA, FCA. The undersigned are members of the American Academy of Actuaries and collectively meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein. To the best of our knowledge, the information supplied in this actuarial valuation is complete and accurate. The assumptions used in this actuarial valuation were selected by the Board of Retirement based upon our analysis and recommendations. In our opinion, the assumptions are reasonable and take into account the experience of the Plan and reasonable expectations. In addition, in our opinion, the combined effect of these assumptions is expected to have no significant bias.

Segal makes no representation or warranty as to the future status of the Plan and does not guarantee any particular result. This document does not constitute legal, tax, accounting or investment advice or create or imply a fiduciary relationship. The Board is

encouraged to discuss any issues raised in this report with the Plan's legal, tax and other advisors before taking, or refraining from taking, any action.

We look forward to reviewing this report at your next meeting and to answering any questions.

Sincerely,

Segal

Andy Yeung, ASA, MAAA, FCA, EA
Vice President and Actuary

Eva Yum, FSA, MAAA, EA
Vice President and Actuary

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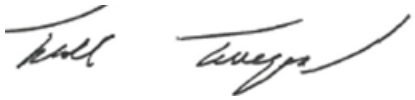

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Senior Vice President and Actuary

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Table of Contents

Section 1: Introduction

Purpose

Other postemployment benefits (OPEB)

This report presents the results of our actuarial valuation as of December 31, 2024 of the Alameda County Employees' Retirement Association (ACERA) postretirement medical, dental and vision benefits provided through ACERA's 401(h) account. ACERA has allocated a portion of the Supplemental Retiree Benefits Reserve (SRBR) to be treated as pension contributions if the employers make contributions to the 401(h) account.[1] The results of this report have been prepared with the goal of determining sufficiency of funds. Actuarial calculations for other purposes may differ significantly from the results reported here.

The actuarial calculations used to prepare this report have been made on a basis consistent with our understanding of the "substantive plan designs" of the OPEB Plan provided by ACERA using guidelines provided by the Board. The most important plan design assumption incorporated in our valuation is that the future monthly medical allowance (MMA) will increase at one-half of our anticipated medical trend assumptions for all years after 2026. However, the SRBR OPEB Plan will reimburse the fully indexed premium required for dental, vision, and enrollment in the Medicare Part B program.

In Section 2 of this report, we show the unlimited OPEB liabilities (i.e., the liabilities not limited by the current SRBR assets). The unlimited liabilities in this report will be used as the basis when we roll forward the liabilities for the next GASB 74 valuation report as of December 31, 2025.

Non-OPEB benefits

The SRBR currently provides benefits in addition to those that qualify as OPEB. These "non-OPEB" benefits include supplemental COLAs and death benefits related to the underlying statutory defined benefit pension plan.[2]

In Section 2 of this report, we show the unlimited non-OPEB liabilities. The unlimited liabilities in this report will be used as the basis when we roll forward the liabilities for the next GASB 67 valuation report as of December 31, 2025.

[1] It is our understanding that GASB requires such benefits to be reported under GASB Statement No. 74 and, accordingly, they have been included in our December 31, 2024 GASB 74 report dated May 23, 2025.

[2] It is our understanding that GASB requires such benefits to be reported under GASB Statement No. 67 together with the underlying statutory defined benefit pension plan and, accordingly, they have been included in our December 31, 2024 GASB 67 report dated May 23, 2025.

Special note pertaining to OPEB and non-OPEB benefits

The calculation of benefit obligations pursuant to prescribed accounting requirements included in the above mentioned GASB reports does not, in and of itself, imply that ACERA has any legal liability to provide the benefits valued.

Actuarial valuations involve estimates of benefit amounts and assumptions about the probability of their payment far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

Important information about actuarial valuations

An actuarial valuation is a budgeting tool with respect to the financing of future projected obligations of a OPEB and non-OPEB Plan. It is an estimated forecast – the actual long-term cost of the plan will be determined by the actual benefits and expenses paid and the actual investment experience of the plan.

In order to prepare a valuation, Segal relies on a number of input items. These include:

Input Item	Description
Plan provisions	Plan provisions define the rules that will be used to determine benefit payments, and those rules, or the interpretation of them, may change over time. Even where they appear precise, outside factors may change how they operate. It is important to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary in this report to confirm that Segal has correctly interpreted the plan of benefits.
Member information	An actuarial valuation for a plan is based on data provided to the actuary by the Association. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
Financial information	The valuation is based on the fair value of assets as of the valuation date, typically reported by the Association. The Association uses an "actuarial value of assets" that differs from fair value to gradually reflect six-month changes in the fair value of assets in determining the sufficiency of funds to pay the benefits provided by the SRBR.
Actuarial assumptions	In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan members for the rest of their lives and the lives of their beneficiaries. This requires actuarial assumptions as to the probability of death, disability, withdrawal, and retirement of members in each year, as well as forecasts of the plan's benefits for each of those events. In addition, the benefits forecasted for each of those events in each future year reflect actuarial assumptions as to health care trends and member enrollment in retiree health benefits for the OPEB Plan, and actuarial assumptions as to salary increases and cost-of-living adjustments for the non-OPEB Plan. The forecasted benefits are then discounted to a present value, typically based on an estimate of the rate of return that will be achieved on the plan's assets. All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions are selected within that range. That is, there is no right answer (except with hindsight). It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model may use approximations and estimates that will have an immaterial impact on our results. In addition, the actuarial assumptions may change over time, and while this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

Input Item	Description
Models	Segal valuation results are based on proprietary actuarial modeling software. The actuarial valuation models generate a comprehensive set of liability and cost calculations that are presented to meet regulatory, legislative and client requirements. Our Actuarial Technology and Systems unit, comprised of both actuaries and programmers, is responsible for the initial development and maintenance of these models. The models have a modular structure that allows for a high degree of accuracy, flexibility and user control. The client team programs the assumptions and the plan provisions, validates the models, and reviews test lives and results, under the supervision of the responsible actuary. Our claims costs assumptions are based on proprietary modeling software as well as models that were developed by others. These models generate per capita claims cost calculations that are used in our valuation software. Our Health Technical Services Unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of our health models. They are also responsible for testing models that we purchase from other vendors for reasonableness. The client team inputs the paid claims, enrollments, plan provisions and assumptions into these models and reviews the results for reasonableness, under the supervision of the responsible actuary.

The user of Segal's actuarial valuation (or other actuarial calculations) should keep the following in mind:

- The actuarial valuation is prepared at the request of the Association to determine sufficiency of funds related to the payments of OPEB and non-OPEB benefits out of the SRBR. Segal is not responsible for the use or misuse of its report, particularly by any other party.
- An actuarial valuation is a measurement at a specific date — it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of financial measurements, except where otherwise noted.
- If the Association is aware of any event or trend that was not considered in this valuation that may materially change the results of the valuation, Segal should be advised, so that we can evaluate it.
- Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience, health care trend, and investment losses, not just the current valuation results.
- Segal does not provide investment, legal, accounting or tax advice and is not acting as a fiduciary to the Plan. This valuation is based on Segal's understanding of applicable guidance in these areas and of the Plan's provisions, but they may be subject to alternative interpretations. The Association should look to their other advisors for expertise in these areas.
- While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
- Segal's report shall be deemed to be final and accepted by the Association upon delivery and review. The Association should notify Segal immediately of any questions or concerns about the final content.

Section 2: Valuation Results

Valuation highlights

Assumptions and substantive plan

- The actuarial assumptions used in this study are consistent with those assumptions approved by the Retirement Board for the December 31, 2024 pension valuation, including the use of a 7.00% investment return assumption.
- In the last SRBR valuation, we utilized the following medical trend assumptions:
  - All non-Medicare plans: starting at 8.50% in 2024,[1] then reduced by 1.00% in 2025 and 0.50% in 2026, then reduced by 0.25% each year for 10 years until an ultimate rate of 4.50%.
  - All Medicare Advantage plans: starting at 16.47% in 2024,[1] then 7.00% in 2025, then reduced by 0.25% each year for 10 years until it reaches 4.50%.
  - Medicare Part B premiums: 4.50% per year.

  For this valuation, we recommended to the Board in our letter dated March 21, 2025 that the medical trend assumptions be changed as follows:
  - All non-Medicare plans: starting at 7.75% in 2025,[2] then grading down by 0.25% each year for 13 years until an ultimate rate of 4.50%.
  - All Medicare Advantage plans: starting at 7.50% in 2025,[2] then grading down by 0.25% each year 12 years until reaching an ultimate rate of 4.50%.
  - Medicare Part B premiums: trend assumptions will be increased to 6.20% for calendar years 2025 through 2033, 5.75% for calendar year 2034, then grading down by 0.25% per year until an ultimate rate of 4.50%.
- The Board approved an increase in the 2026 Monthly Medical Allowance (MMA) on July 2, 2025. The maximum MMA for ACERA sponsored plans and individual (out-of-area) non-Medicare plans has been increased from $662.37 to $687.21 and the maximum MMA for individual Medicare plans has been increased from $507.43 to $526.46 for 2026.

[1] After we released our preliminary high-level summary letter dated May 24, 2024, the Association approved premiums for 2025. We have used those actual 2025 premiums in this study in lieu of estimating those premiums by using the 8.50% assumption for non-Medicare plans and the 16.47% assumption for Medicare plans.

[2] After we released our preliminary high-level summary letter dated May 27, 2025, the Association approved premiums for 2026. We have used those actual 2026 premiums in this study in lieu of estimating those premiums by using the 7.75% assumption for non-Medicare plans and the 7.50% assumption for Medicare plans.

Section 2: Valuation Results

- Health plan election assumptions were updated to incorporate migration assumption change for members enrolled in the UHC SVA plan, terminated effective February 1, 2026. This change had a very minor impact on the valuation results.
- The methodology Segal uses to estimate the implicit subsidy was modified this year to develop a more stable estimate of the long-term average. Key considerations behind this methodology change include:
  - The change from a downward trend for implicit subsidy reimbursements in 2023 and 2024 to a much larger estimate in 2025; and
  - An increase in volatility compared to the prior year (refer to page 35 for more details).

  The impact of this methodology change on the sufficiency period is discussed on page 11.
- For years after 2026 we have assumed that the MMA will increase with 50% of the lowest medical trend for the non-Medicare and Medicare plans.
- These and the other OPEB assumptions are provided in Exhibit 1.
- The determination of the "substantive plan" underlying ACERA's OPEB was based upon prior directions provided by ACERA, its auditors, as well as the administrative staff, auditors and consultants representing the County of Alameda, along with changes to the plan adopted by the Board on July 19, 2012 to allow retirees to select medical benefits available through the Medicare Exchange. These directions are provided in Exhibit 3.
- Based on action taken by the Board in February 2014, we continue to exclude the non-OPEB lump sum retiree death benefit from the pension valuation and have included this death benefit in the results presented herein.

Assets

- For this valuation, the Association has continued to provide to us the breakdown of the OPEB and non-OPEB assets as of December 31, 2024.

Sufficiency period

- The terminal year of the SRBR was determined by projecting how long the SRBR can provide for all OPEB and non-OPEB benefits under the substantive plan outlined in Exhibits 2 and 3. OPEB benefits can be paid through 2045,[1] while non-OPEB benefits can be paid through 2048.[1] Last year, it was projected that OPEB benefits could be paid through 2048 and non-OPEB benefits could be paid through 2047.

[1] Assets would only be sufficient to pay benefits for a part of the year indicated.

Section 2: Valuation Results

- Note that the OPEB sufficiency period included in this report of through 2045 is the same as that provided in our May 27, 2025 preview letter. Our preview letter estimated medical plan premiums and subsidies for 2026 and future years using our trend assumption. Subsequent to our issuing the preview letter, ACERA reported the 2026 medical plan premium renewals and subsidies and we have used the actual 2026 premiums and subsidies in our updated projection shown herein.

  There is an approximate three-year decrease in the sufficiency period to pay OPEB benefits between the last study and current study mainly due to the following factors:

  – The new implicit subsidy estimate decreased the sufficiency period for the OPEB SRBR by 23 months. As previously noted, this year's implicit subsidy methodology was modified to provide a more stable estimate of the long-term costs. If the methodology had remained the same as the prior year, the sufficiency period would have decreased by roughly 42 months due to the new implicit subsidy estimate.

    As shown in the table below, the implicit subsidy provided by the County's health consultant increased from $2.5 million in 2024 to $9.4 million in 2025 (an increase of roughly 280%). Under the prior methodology, the initial implicit subsidy modeled in the valuation would have been based solely on the 2025 amount of $9.4 million. Based on the new methodology, which incorporates a 3-year weighted average of the plan's unblended retiree premiums, the projected future implicit subsidies begin with $5.7 million for 2025.

Calendar Year	County's Implicit Subsidy
2021	$5,652,613
2022	7,981,476
2023	4,116,000
2024	2,472,346
2025	9,390,686

  – The new trend assumptions described in the March 21, 2025 trend assumptions letter decreased the sufficiency period by 17 months. Key changes include higher anticipated increases to Part B premiums and prescription drug costs. Reflecting the actual 2026 premium renewals and including assumed migration for retirees enrolled in the UHC SVA plan increased the sufficiency period by approximately 2 months. The combined impact of these updates decreased the sufficiency period by about 15 months.

  – The demographic and investment experience produced actuarial gains which increased the sufficiency period by 3 months.

- The main reason the terminal year of the SRBR for non-OPEB benefits is projected to be one year later than it was in last year's study is the somewhat low actual inflation of 2.38%[1] (before it is rounded to 2.50% at the nearest 0.50% increment) in the Bay Area for 2024 (versus the COLA assumption of 2.75%), which decreased the supplemental COLA costs.
- The funded ratio of the OPEB liabilities is 82.0% and the funded ratio of the non-OPEB liabilities is 56.4% as of December 31, 2024. The comparable funded ratios were 91.2% and 56.7% for the OPEB and non-OPEB liabilities, respectively, as of December 31, 2023.
- The funded ratio for the non-OPEB benefits is lower than for OPEB benefits because the Actuarial Value of Assets was initially allocated based on the benefit outflows for the OPEB and non-OPEB benefits. The benefit outflows for non-OPEB (in particular, the supplemental COLA) are "back loaded", i.e., they are expected to be larger in later years than in earlier years. This results in a smaller asset allocation relative to liabilities for the non-OPEB benefits. That difference in funded ratio is somewhat reduced after the asset transfer from OPEB SRBR assets to non-OPEB SRBR assets as of December 31, 2023 to equalize the sufficiency period.

Future expectation

- The terminal years the SRBR can be paid as well as the funded ratios have been developed to reflect only the actuarial value of assets allocated to the SRBR through December 31, 2024. As we indicated on page 24 of our December 31, 2024 actuarial valuation report for the Pension Plan, the Association had a deferred investment loss of $82.6 million that was not yet recognized in determining the combined actuarial value of assets for the Pension Plan and the SRBR Plan as of that date. The deferred loss of $82.6 million represents 0.7% of the market value of assets as of December 31, 2024. After offsetting this loss by the balance in the Contingency Reserve, the residual loss is $51.3 million. If a proportion of the net deferred loss that is commensurate with the size of the SRBR reserves were recognized immediately in the valuation value of assets, there would be a decrease in the SRBR Reserve of approximately $3.2 million to pay OPEB benefits and $0.3 million to pay non-OPEB benefits.[2]

Administrative expense

- Note that in preparing the 401(h) contribution letter for 2025/2026, we had included an additional allocation for expense related to the administration of the health benefits for retirees. However, as we previously demonstrated to the Association during our discussion with the Board on SB 1479, the values in both the employer reserves and the SRBR would remain unchanged relative

[1] Based on a comparison of the December 2024 Consumer Price Index (CPI) to the December 2023 CPI for the San Francisco-Oakland-Hayward Area, as published by the Bureau of Labor Statistics.

[2] It is important to note that this actuarial valuation is based on plan assets as of December 31, 2024. The Plan's actuarial status does not reflect short-term fluctuations of the market, but rather is based on the market values on the last day of the Plan Year. Segal is available to prepare projections of potential outcomes of market conditions and other demographic experience upon request.

to the values prior to that allocation, through the operation of SB 1479. For that reason, we have not included the explicit payment of administrative expense out of the 401(h) in preparing the cash flow requirements of the SRBR.

GASB

- As stated earlier in this report, it is our understanding that GASB requires the OPEB benefits to be reported under GASB Statement No. 74 and accordingly they have been included in our GASB 74 report dated May 23, 2025. Similarly, we understand that GASB requires the non-OPEB benefits to be reported under GASB Statement No. 67 together with the underlying statutory defined benefit pension plan and accordingly they have been included in our GASB 67 report dated May 23, 2025.

Summary of OPEB valuation results

Without Limiting Liabilities to Current Assets	December 31, 2024	December 31, 2023
Actuarial present value of projected benefits		
• Medical	$1,548,154,000	$1,328,877,000
• Dental and vision	154,484,000	143,987,000
– **Total**	**$1,702,638,000**	**$1,472,864,000**
Actuarial accrued liability[1]		
• Medical[2]	$1,223,389,000	$1,070,582,000
• Dental and vision[3]	123,165,000	115,053,000
– **Total**	**$1,346,554,000**	**$1,185,635,000**
Actuarial value of assets (Exhibit B)	**$1,104,808,000**	**$1,081,108,000**
Unfunded actuarial accrued liability	**241,746,000**	**104,527,000**
Funded ratio	**82.0%**	**91.2%**
Year current assets will be exhausted[4]	**2045**	**2048**

Note: The above results have been calculated using our understanding of the "substantive plan" as described in Exhibits 2 and 3. The liabilities provided in this report will have to be revised if our understanding of the "substantive plan" is inaccurate.

[1] These results will be used as the basis for the next GASB 74 valuation report based on a measurement date of December 31, 2025.
[2] Of the amount shown, $681.0 million is attributable to members currently receiving the benefit as of December 31, 2024 and $614.2 million is attributable to members receiving the benefit as of December 31, 2023. For treatment of implicit subsidy, see page 35.
[3] Of the amount shown, $72.9 million is attributable to members currently receiving the benefit as of December 31, 2024 and $68.3 million is attributable to members receiving the benefit as of December 31, 2023.
[4] Full benefits will be paid through the year prior to the year shown in the table. Full benefits will be paid for part of the year indicated.

Summary of non-OPEB valuation results

Without Limiting Liabilities to Current Assets	December 31, 2024	December 31, 2023
Actuarial present value of projected benefits		
• Supplemental COLA	$224,912,000	$211,852,000
• Retiree death benefit	5,169,000	5,034,000
– **Total**	**$230,081,000**	**$216,886,000**
Actuarial accrued liability[1]		
• Supplemental COLA[2]	$203,633,000	$191,796,000
• Retiree death benefit	4,742,000	4,617,000
– **Total**	**$208,375,000**	**$196,413,000**
Actuarial value of assets (Exhibit B)	**$117,558,000**	**$111,280,000**
Unfunded actuarial accrued liability	**90,817,000**	**85,133,000**
Funded ratio	**56.4%**	**56.7%**
Year current assets will be exhausted[3]	**2048**	**2047**

[1] These results will be used as the basis for the next GASB 67 valuation report based on a measurement date of December 31, 2025.
[2] Of the amount shown, $29.6 million is attributable to members currently receiving the benefit as of December 31, 2024 and $13.7 million is attributable to members receiving the benefit as of December 31, 2023.
[3] Full benefits will be paid through the year prior to the year shown in the table. Full benefits will be paid for part of the year indicated.

Projected cash flow

Provided by the Supplemental Retiree Benefits Reserve as of December 31, 2024

Year Ending December 31	Medical[1] Annual Benefit Cash Flows	Dental and Vision Annual Benefit Cash Flows	Non-OPEB[2] Annual Benefit Cash Flows
2025	$53,442,990	$6,045,522	$1,606,454
2026	57,812,279	6,510,208	1,896,344
2027	62,656,915	6,924,298	2,420,913
2028	67,595,798	7,315,957	3,224,314
2029	72,582,454	7,677,708	4,199,271
2030	77,903,874	8,053,227	5,249,385
2031	83,438,268	8,438,594	6,369,965
2032	88,867,879	8,835,849	7,514,176
2033	94,582,114	9,238,987	8,725,363
2034	100,095,113	9,645,430	10,074,842
2035	105,597,325	10,061,201	11,364,668
2036	110,419,951	10,461,595	12,581,387
2037	115,100,345	10,869,536	13,840,361
2038	119,606,965	11,266,729	15,499,023
2039	124,070,692	11,674,379	17,043,467
2040	128,256,028	12,063,445	18,534,667
2041	132,432,966	12,458,429	20,041,564
2042	136,491,764	12,844,041	21,388,595
2043	140,563,906	13,221,103	22,557,072
2044	144,547,536	13,594,382	23,621,818
2045	74,431,278[3]	7,006,313[3]	24,684,639
2046	0	0	25,858,995
2047	0	0	27,074,594
2048	0	0	18,436,938[3]

[1] Includes Medicare Part B and Implicit Subsidy Reimbursement made to the County.
[2] Includes Supplemental COLA and $1,000 Lump Sum Death Benefit.
[3] Benefits will be paid through the year prior to the year shown in the table. Full benefits will be paid for part of the year indicated.

Present value of projected benefits

Provided by the Supplemental Retiree Benefits Reserve as of December 31, 2024

Year Ending December 31	OPEB[1] Present Value as of December 31, 2024 of Projected Benefits through Year End	Non-OPEB Present Value as of December 31, 2024 of Projected Benefits through Year End	Total Present Value as of December 31, 2024 of Projected Benefits through Year End
2025	$57,509,715	$1,553,018	$59,062,733
2026	115,624,571	3,266,349	118,890,920
2027	174,377,909	5,310,532	179,688,441
2028	233,494,142	7,854,983	241,349,125
2029	292,687,507	10,952,024	303,639,531
2030	351,935,137	14,570,266	366,505,403
2031	411,120,130	18,673,653	429,793,783
2032	469,941,184	23,197,450	493,138,634
2033	528,356,068	28,106,770	556,462,838
2034	586,062,101	33,404,531	619,466,632
2035	642,901,305	38,989,581	681,890,886
2036	698,420,935	44,768,081	743,189,016
2037	752,492,569	50,708,953	803,201,522
2038	804,994,027	56,926,561	861,920,588
2039	855,887,173	63,316,448	919,203,621
2040	905,053,684	69,810,806	974,864,490
2041	952,500,848	76,373,758	1,028,874,606
2042	998,204,177	82,919,610	1,081,123,787
2043	1,042,190,141	89,371,439	1,131,561,580
2044	1,084,463,167	95,685,803	1,180,148,970
2045	1,104,808,157	101,852,596	1,206,660,753
2046	1,104,808,157	107,890,141	1,212,698,298
2047	1,104,808,157	113,797,957	1,218,606,114
2048	1,104,808,157	117,557,803	1,222,365,960

[1] Includes Medical, Dental and Vision.

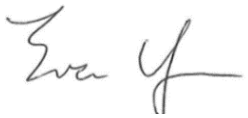
Actuarial certification

September 19, 2025

This is to certify that Segal has conducted an actuarial valuation of certain benefit obligations of the Alameda County Employees' Retirement Association provided by the Supplemental Retiree Benefits Reserve for the year ending December 31, 2024, in accordance with generally accepted actuarial principles and practices. The actuarial valuation is based on the plan of benefits verified by ACERA and on participant, claims and expense data provided by ACERA.

The actuarial computations made are for purposes of determining sufficiency of funds. Determinations for other purposes may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes such as judging benefit security at plan termination.

To the best of our knowledge, this report is complete and accurate and in our opinion presents the information necessary to determine the sufficiency of funds with respect to the benefit obligations addressed. The undersigned are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinion herein.



Eva Yum, FSA, MAAA, EA
Vice President and Actuary

Mehdi Riazi, FSA, MAAA, FCA, EA
Vice President and Actuary

Section 3: Valuation Details

Exhibit A: Table of plan coverage — members receiving SRBR benefits as of December 31, 2024

Category	Current Retirees
Category 1 — Medical	
• Number	6,909
• Average in force monthly medical reimbursements for 2025 (excluding Medicare Part B)	$432
• Average maximum (based on service at retirement) monthly medical reimbursements for 2025 (excluding Medicare Part B)	$570
• Monthly Medicare Part B premium reimbursements for 2025	$185
Category 1 — Supplemental COLA[1]	
• Number	1,192
• Average monthly supplemental COLA for 2025[2]	$87
Category 2 — Dental and vision	
• Number	8,537
• Average monthly medical reimbursements for 2025	$56
Category 2 — Retiree death benefit	
• Number[3]	Not Available
• Average lump sum benefits for 2025	$1,000

[1] The number of retirees receiving supplemental COLA as of December 31, 2024 increased from last year's count of 501 mainly because there is a group of Tiers 2, 2C, and 2D retirees who first became eligible for the supplemental COLA effective April 1, 2024. These retirees have retirement dates between April 2, 2001 and April 1, 2007 and their supplemental COLA effective April 1, 2024 is equal to 0.5% of their statutory plan benefit. Accordingly, the average monthly supplemental COLA decreased from $195 for 2024 to $87 for 2025.

[2] Estimate of supplemental COLA payable as of December 31, 2024. The average benefit does not take into account any adjustments to the members' COLA banks as of April 2025.

[3] Beneficiaries who received the $1,000 lump sum retiree death benefit were not separately identified in the data provided for the pension valuation.

Exhibit B: Determination of actuarial value of assets

Reserves Supporting SRBR Benefits

Reserve	December 31, 2024	December 31, 2023
401(h) account (allocated to OPEB)	$10,521,000	$10,117,000
Supplemental Retiree Benefits Reserve		
• OPEB	$1,094,287,000[1]	$1,070,991,000[2]
• Non-OPEB	117,558,000	111,280,000
– **SRBR total**	**$1,211,845,000**	**$1,182,271,000**
Total	**$1,222,366,000**	**$1,192,388,000**

Total Present Value of Projected SRBR Benefits Payable Through Terminal Year of the SRBR

Category	December 31, 2024	December 31, 2023
Present value of projected OPEB payable through terminal year of the SRBR		
• Medical	$1,004,508,000	$975,628,000
• Dental and vision	100,300,000	105,480,000
– **OPEB total**	**$1,104,808,000**	**$1,081,108,000**
Present value of projected non-OPEB payable through terminal year of the SRBR		
• Supplemental COLA	$113,393,000	$107,234,000
• Retiree death benefit	4,165,000	4,046,000
– **Non-OPEB total**	**$117,558,000**	**$111,280,000**
Grand total	**$1,222,366,000**	**$1,192,388,000**

[1] Adjusted to reflect estimated transfer of $2,472,000 (provided by ACERA) from SRBR to employer advance reserve for reimbursement of implicit retiree health benefit subsidy for calendar year 2024.

[2] Adjusted to reflect estimated transfer of $4,116,000 (provided by ACERA) from SRBR to employer advance reserve for reimbursement of implicit retiree health benefit subsidy for calendar year 2023.

Section 4: Supporting Information

Exhibit 1: Actuarial assumptions and actuarial cost method

Data

Detailed census data and summary plan descriptions for postretirement benefits were provided by ACERA.

Rationale for assumptions

The information and analysis used in selecting each assumption that has a significant effect on this actuarial valuation is shown in the December 1, 2019 through November 30, 2022 Actuarial Experience Study report dated January 8, 2024, the non-trend retiree health assumption letter dated April 30, 2025, and the health trend assumptions letter dated March 21, 2025. Unless otherwise noted, all actuarial assumptions and methods shown below apply to all tiers. These assumptions were adopted by the Board.

Measurement date

December 31, 2024

Discount rate

7.00%

Consumer price index (CPI or inflation)

Increase of 2.50% per year.

Retiree cost of living increases

The actual COLA granted by ACERA on April 1, 2025 has been reflected in the December 31, 2024 valuation for nonactive members.

General Tier 1, General Tier 3, and Safety Tier 1

For tiers with a 3.00% maximum COLA, retiree COLA increases of 2.75% per year.

For members with a sufficient COLA bank, withdrawals from the bank can be made to increase the retiree COLA up to 3% per year.

General Tier 2, General Tier 4, Safety Tier 2, Safety Tier 2C, Safety Tier 2D, and Safety Tier 4

For tiers with a 2.00% maximum COLA, retiree COLA increases of 2.00% per year.

Increase in Internal Revenue Code Section 401(a)(17) compensation limit

Increase of 2.50% per year from the valuation date.

Increase in California Government Code Section 7522.10 compensation limit

Increase of 2.50% per year from the valuation date.

Salary increases

The annual rate of compensation increase includes:

- Inflation at 2.50%, plus
- "Across-the-board" real salary increases of 0.50% per year, plus
- The following merit and promotion increases:

Years of Service	General	Safety
Less than 1	5.00%	8.40%
1–2	5.00%	8.40%
2–3	4.40%	8.40%
3–4	3.00%	5.40%
4–5	2.10%	4.00%
5–6	1.60%	2.50%
6–7	1.50%	1.80%
7–8	1.50%	1.60%
8–9	1.20%	1.20%
9–10	1.00%	1.20%
10–11	0.85%	1.00%
11 and over	0.45%	1.00%

Additional cashout assumptions

Additional pay elements are expected to be received during a member's final average earnings period. The percentages, added to the final average salary, used in this valuation are:

Tier	Service Retirement	Disability Retirement
General Tier 1	5.0%	4.0%
General Tier 2	2.7%	1.0%
General Tier 3	5.0%	4.0%
General Tier 4	N/A	N/A
Safety Tier 1	6.0%	5.0%
Safety Tier 2	2.3%	2.2%
Safety Tier 2C	2.3%	2.2%
Safety Tier 2D	2.3%	2.2%
Safety Tier 4	N/A	N/A

Post-retirement mortality rates

The Pub-2010 mortality tables and adjustments as shown below reasonably reflect the mortality experience as of the measurement date. These mortality tables were adjusted to future years using the generational projection to reflect future mortality improvement between the measurement date and those years.

Healthy

- **General members**: Pub-2010 General Healthy Retiree Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2021.
- **Safety members**: Pub-2010 Safety Healthy Retiree Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), with rates increased by 5% for males and unadjusted for females, projected generationally with the two-dimensional mortality improvement scale MP-2021.

Disabled

- **General members**: Pub-2010 Non-Safety Disabled Retiree Amount-Weighted Mortality Tables (separate tables for males and females) with rates unadjusted for males and decreased by 10% for females, projected generationally with the two-dimensional mortality improvement scale MP-2021.
- **Safety members**: Pub-2010 Safety Disabled Retiree Amount-Weighted Mortality Tables (separate tables for males and females) with rates increased by 5% for males and unadjusted for females, projected generationally with the two-dimensional mortality improvement scale MP-2021.

Beneficiaries

- **Beneficiaries not currently in pay status**: Pub-2010 General Healthy Retiree Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2021.
- **Beneficiaries currently in pay status**: Pub-2010 General Contingent Survivor Amount-Weighted Above-Median Mortality Tables (separate tables for males and females) with rates increased by 5% for males and unadjusted for females, projected generationally with the two-dimensional mortality improvement scale MP-2021.

The above tables are used for the projection of non-OPEB benefits. The headcount weighted instead of the benefit (or amount) weighted mortality tables were used in the projections of OPEB benefits.

Pre-retirement mortality rates

- **General members:** Pub-2010 General Employee Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2021.
- **Safety members:** Pub-2010 Safety Employee Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2021.

Age	General Male	General Female	Safety Male	Safety Female
20	0.04%	0.01%	0.04%	0.01%
25	0.02%	0.01%	0.03%	0.02%
30	0.03%	0.01%	0.04%	0.02%
35	0.04%	0.02%	0.04%	0.03%
40	0.06%	0.03%	0.05%	0.04%
45	0.09%	0.05%	0.07%	0.06%
50	0.13%	0.08%	0.10%	0.08%
55	0.19%	0.11%	0.15%	0.11%
60	0.28%	0.17%	0.23%	0.14%
65	0.41%	0.27%	0.35%	0.20%

Note that generational projections beyond the base year (2010) are not reflected in the above mortality rates.

All pre-retirement deaths are assumed to be non-service connected.

The above tables are used for the projection of non-OPEB benefits. The headcount weighted instead of the benefit (or amount) weighted mortality tables were used in the projections of OPEB benefits.

Disability incidence rates

Age	General	Safety
20	0.00%	0.00%
25	0.01%	0.03%
30	0.02%	0.38%
35	0.05%	0.96%
40	0.08%	1.50%
45	0.13%	1.70%
50	0.21%	2.33%
55	0.31%	3.62%
60	0.35%	4.44%
65	0.44%	0.00%
70	0.62%	0.00%

70% of General disabilities are assumed to be service-connected disabilities. The other 30% are assumed to be non-service-connected disabilities.

100% of Safety disabilities are assumed to be service-connected disabilities.

Termination rates

Years of Service	General	Safety
Less than 1	12.25%	5.20%
1–2	9.25%	4.20%
2–3	8.00%	4.20%
3–4	6.25%	4.00%
4–5	6.25%	4.00%
5–6	6.25%	4.00%
6–7	5.75%	4.00%
7–8	5.00%	2.40%
8–12	4.00%	2.00%
12–15	3.25%	2.00%
15–16	3.25%	1.50%
16–17	3.00%	1.40%
17–18	3.00%	1.30%
18–19	3.00%	1.20%
19–20	2.75%	1.10%
20 or more	2.75%	1.00%

For members with less than five years of service, 55% of all terminated members are assumed to choose a refund of contributions and the other 45% are assumed to choose a deferred vested benefit.

For members with five or more years of service, 25% of all terminated members are assumed to choose a refund of contributions and the other 75% are assumed to choose a deferred vested benefit.

No termination is assumed after a member is eligible for retirement.

Retirement rates

General Retirement Rates

Age	Tier 1	Tier 2 Less than 30 Years of Service	Tier 2 30 or More Years of Service	Tier 3	Tier 4 Less than 30 Years of Service	Tier 4 30 or More Years of Service
50	2.0%	1.5%	3.0%	10.0%	0.0%	0.0%
51	4.0%	1.5%	3.0%	10.0%	0.0%	0.0%
52	4.0%	2.0%	3.0%	10.0%	3.0%	3.0%
53	5.0%	2.0%	3.0%	10.0%	2.0%	2.0%
54	5.0%	2.5%	3.0%	10.0%	2.0%	2.0%
55	6.0%	3.0%	5.0%	12.0%	2.0%	5.0%
56	10.0%	3.5%	5.0%	14.0%	2.0%	2.5%
57	14.0%	4.0%	5.0%	16.0%	2.0%	3.5%
58	14.0%	4.5%	7.0%	18.0%	4.0%	4.0%
59	14.0%	5.0%	10.0%	20.0%	4.0%	4.5%
60	25.0%	7.5%	12.0%	20.0%	4.0%	5.0%
61	25.0%	9.5%	12.0%	20.0%	4.0%	5.0%
62	30.0%	15.0%	23.0%	30.0%	12.0%	18.0%
63	26.0%	15.0%	25.0%	25.0%	12.0%	15.0%
64	26.0%	17.0%	28.0%	25.0%	12.0%	17.0%
65	26.0%	27.0%	35.0%	50.0%	23.0%	25.0%
66	26.0%	27.0%	35.0%	50.0%	23.0%	30.0%
67	26.0%	27.0%	35.0%	50.0%	23.0%	30.0%
68	26.0%	30.0%	35.0%	50.0%	23.0%	30.0%
69	31.0%	30.0%	35.0%	50.0%	20.0%	30.0%
70	36.0%	30.0%	30.0%	60.0%	20.0%	25.0%
71	36.0%	30.0%	30.0%	60.0%	20.0%	25.0%
72	36.0%	30.0%	30.0%	60.0%	20.0%	25.0%
73	36.0%	30.0%	30.0%	60.0%	20.0%	25.0%
74	36.0%	30.0%	30.0%	60.0%	20.0%	25.0%
75 and over	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The retirement rates only apply to members that are eligible to retire at the age shown.

Safety Retirement Rates

Age	Tier 1	Tier 2, 2D Less than 30 Years of Service	Tier 2, 2D 30 or More Years of Service	Tier 2C	Tier 4 Less than 30 Years of Service	Tier 4 30 or More Years of Service
45	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%
46	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%
47	0.0%	2.0%	0.0%	0.0%	0.0%	0.0%
48	0.0%	4.0%	0.0%	0.0%	0.0%	0.0%
49	0.0%	10.0%	18.0%	0.0%	0.0%	0.0%
50	35.0%	14.0%	18.0%	4.0%	4.0%	4.0%
51	30.0%	10.0%	24.0%	2.0%	2.0%	2.0%
52	25.0%	10.0%	24.0%	2.0%	2.0%	2.0%
53	35.0%	10.0%	25.0%	3.0%	3.0%	3.0%
54	45.0%	11.0%	27.0%	6.0%	6.0%	6.0%
55	45.0%	11.0%	29.0%	10.0%	10.0%	10.0%
56	45.0%	12.0%	32.0%	12.0%	12.0%	12.0%
57	45.0%	12.0%	32.0%	20.0%	20.0%	20.0%
58	45.0%	14.0%	37.0%	10.0%	10.0%	10.0%
59	45.0%	14.0%	37.0%	15.0%	15.0%	15.0%
60	45.0%	30.0%	37.0%	40.0%	40.0%	60.0%
61	45.0%	30.0%	37.0%	40.0%	40.0%	60.0%
62	45.0%	30.0%	37.0%	40.0%	40.0%	60.0%
63	45.0%	30.0%	37.0%	40.0%	40.0%	60.0%
64	45.0%	30.0%	37.0%	40.0%	40.0%	60.0%
65 and over	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The retirement rates only apply to members that are eligible to retire at the age shown.

For Safety Tiers 1 and 2C, the retirement rate is 100% after a member accrues a benefit of 100% of final average earnings.

Retirement age and benefit for deferred vested members

General Non-Reciprocal Retirement Age	62
General Reciprocal Retirement Age	61
Safety Non-Reciprocal Retirement Age	56
Safety Reciprocal Retirement Age	55

Current and future deferred vested non-reciprocal members who terminate with less than five years of service and are not vested are assumed to retire at age 70 for both General and Safety if they decide to leave their contributions on deposit. For OPEB purposes, only the reciprocal retirement age assumptions are used.

20% of future General and 45% of future Safety deferred vested members are assumed to continue to work for a reciprocal employer. For reciprocal members, 3.45% and 4.00% compensation increases are assumed per annum for General and Safety members, respectively.

Future benefit accruals

1.0 year of service per year of employment, plus 0.003 years of additional service for General members and 0.006 years of additional service for Safety members, to anticipate conversion of unused sick leave for each year of employment.

Unknown data for members

Same as those exhibited by members with similar known characteristics. If not specified, members are assumed to be male. If not provided, salary is assumed to be equal to the average salary of the membership group.

Inclusion of deferred vested members

All deferred vested members to the extent they are reported by ACERA for this particular valuation are included.

Data adjustment

Data as of November 30 has been adjusted to December 31 by adding one month of age and, for active members, one month of service.

Form of pension payment

All active and inactive vested members are assumed to elect the unmodified option at retirement.

Percent married for pension

For all active and inactive members, 70% of male members and 50% of female members are assumed to be married at pre-retirement death or retirement.

Age and gender of spouse for pension

For all active and inactive members, male members are assumed to have a female spouse who is 3 years younger than the member and female members are assumed to have a male spouse who is 2 years older than the member.

Pre-retirement death optional form election

All active members with five or more years of service are assumed to elect the optional settlement 2 allowance that leaves a 100% continuance to their beneficiary upon the member's non-service-connected pre-retirement death.

Beneficiary Type	Percentage	Age Difference with Active Member
Child	50%	30 years younger
Sibling	25%	Same age
Parent	25%	30 years older

Note: We made the simplifying assumption that the beneficiary is of the opposite sex of the member.

Actuarial cost method

Entry Age Actuarial Cost Method.

Per capita health costs

The combined monthly per capita dental and vision claims cost for plan year 2025 was assumed to be $55.68. The monthly Medicare Part B premium reimbursement for 2025 is $185.00. For calendar year 2025, medical costs and health plan election rates for retirees are assumed as follows:

Medical Plan[1]	Election Assumption	Monthly Premium	Maximum Monthly Medical Allowance[2]
Under age 65[3]			
Kaiser HMO	69%	$1,097.88	$662.37
Via Benefits Individual Insurance Exchange[4]	16%	N/A	662.37
United Healthcare HMO Current Network	6%	1,594.36	662.37
United Healtcare HMO SVA Network[5]	9%	1,042.48	662.37
Age 65 and older			
Kaiser Senior Advantage	72%	$375.22	$662.37
Via Benefits Individual Insurance Exchange	28%	380.77[6]	507.43

[1] There are other plans available to retirees under age 65 and age 65 and older that have a range of premiums. We have assumed the same costs as Kaiser HMO and Kaiser Senior Advantage for current non-Medicare and Medicare retirees, respectively.

[2] The Maximum Monthly Medical Allowance of $662.37 ($507.43 for retirees purchasing individual insurance from the Medicare exchange) is subject to the following subsidy schedule:

Completed Years of Service	Percentage Subsidized
10–14	50%
15–19	75%
20+	100%

[3] Current retirees under age 65 as well as future retirees are assumed to elect medical plans in the same proportion upon age 65 as current retirees who are age 65 and over.

[4] Via Benefits individual insurance coverage is available to retirees under age 65 residing outside of ACERA medical plans' coverage area. We have assumed that these current retirees under 65 will draw the Maximum Monthly Subsidy ($662.37).

[5] Terminated effective February 2026. We have assumed that members in the UHC SVA plan will migrate to Kaiser and UHC Current Network in proportions of 92% and 8%, respectively.

[6] Derivation of the amount expected to be paid in 2025 from the Health Reimbursement Account for members with 20 plus years of service is shown in the table on the following page. We have also derived the amount expected to be paid for members with 10-14 and 15-19 years of service.

Section 4: Supporting Information

Derivation of Via Benefits monthly per capita costs

	Line Description	10–14 Years of Service	15–19 Years of Service	20+ Years of Service
1.	Maximum MMA for 2024	$243.37	$365.06	$486.74
2.	Total of Maximum MMA (From Jan. 2024 to Dec. 2024)	$643,821	$1,016,467	$6,849,183
3.	Total of Actual Reimbursement (From Jan. 2024 to Dec. 2024)	$463,913	$681,366	$4,182,062
4.	Ratio of Actual Reimbursement to Maximum 2024 MMA: **(3) ÷ (2)**	72.06%	67.03%	61.06%
5.	Average Monthly Per Capita Cost for 2024: **(1) × (4)**	$175.37	$244.70	$297.20
6.	Maximum MMA for 2025	$253.72	$380.57	$507.43
7.	Increase for Expected Medical Trend (16.47%) from 2024 to 2025:**(5) × 1.1647**	$204.25	$285.00	$346.15
8.	**Increase for Additional 10% Margin for 2024 Expenses Incurred in 2024 but Reimbursed after December 2024: (7) × 1.10**	**$224.68**	**$313.50**	**$380.77**

Section 4: Supporting Information

Implicit subsidy — retirees under age 65

We have estimated the average per capita premium for retirees under age 65 to be $13,529 per year. Because premiums for retirees under age 65 include active participants for purposes of underwriting, the retirees receive an implicit subsidy from the actives. Had the retirees under age 65 been underwritten as a separate group, their age-based premiums would be higher for most individuals. The excess of the age-based premium over the per capita premium charged makes up the implicit subsidy. Below is a sample of the average 2025 annual medical and prescription age-based claims costs for retirees and spouses under age 65.

Average Medical and Rx Costs

Age	Male	Female
50	$14,270	$15,068
55	16,102	16,357
60	18,540	17,731
64	22,531	19,249

The methodology Segal uses to estimate the implicit subsidy was modified this year to develop a more stable estimate of the long-term average. In prior years, we developed our estimates using the plan's unblended retiree rates and then we adjusted our estimate to match the projection provided by the County's health care consultant. Key features of our new approach include:

- The use of unblended retiree premiums and retiree demographics for the prior three years;
- A 7.88% assumption for trending the 2023 and 2024 experience forward to 2025; and
- The use of participant headcounts for determining the three-year weighted average. Note that as we developed our new methodology, we also considered using the County's blended premium, which might be viewed as more credible than the unblended retiree rates due to the inclusion of the active employee experience. However, after reviewing both approaches, we chose to include additional years of retiree experience, instead of incorporating the active claims experience, to increase the credibility of the calculation. We will continue to closely monitor the plan's implicit subsidy reimbursements and will report to the Board if we believe other changes are warranted.

Age-based claims costs for retirees age 65 and over

2025 medical and prescription drug age-based claims costs for retirees age 65 and over are shown below at selected ages. Spouses are only eligible for the implicit subsidy while under age 65.

Kaiser Senior Advantage

Age	Male	Female
65	$4,247	$3,527
70	4,770	3,946
75	5,269	4,149
80+	5,517	4,428

Via Benefits

Age	Male	Female
65	$4,250	$3,530
70	4,773	3,949
75	5,273	4,152
80+	5,521	4,431

Participation and coverage election — retired members and beneficiaries

MMA

MMA Status	Under Age 65	Upon Attaining Age 65
MMA on Record		
Current retirees under 65 on valuation date	100%	100% and assumed to choose carrier in same proportion as future retirees
Current retirees 65 and over on valuation date	N/A	100%

MMA Status	Under Age 65	Upon Attaining Age 65
No MMA on Record		
Less than 10 years of service	0%	0%
10+ years of service		
• Current retirees under 65 on valuation date	0%	60%
• Current retirees 65 and over on valuation date	N/A	0%

Medicare Part B Premium Subsidy

MMA Status	Under Age 65	Upon Attaining Age 65
MMA on Record		
Current retirees under 65 on valuation date	N/A	100%
Current retirees 65 and over on valuation date	N/A	100% if Part B reimbursement on record or purchasing individual insurance from the Medicare exchange
No MMA on Record		
Less than 10 years of service	N/A	0%
10+ years of service		
• Current retirees under 65 on valuation date	N/A	60%
• Current retirees 65 and over on valuation date	N/A	0%

Implicit subsidy

Current retirees, married dependents and surviving beneficiaries under age 65 and enrolled in an ACERA non-Medicare plan are assumed to have an implicit subsidy liability.

Dental and vision subsidy

Current retirees not self-paying ("Voluntary" or "Under 10 YOS" dental or vision code) are assumed to receive the dental and vision subsidy.

Participation and coverage election — active and inactive vested members

Medical plan subsidy (i.e., MMA)

Under Age 65	Upon Attaining Age 65
75% of eligible members	90% of eligible members

Medicare Part B Premium Subsidy

Under Age 65	Upon Attaining Age 65
75% of eligible members (disabled only)	90% of eligible members

Implicit subsidy

63.00% of eligible members under age 65 are assumed to have an implicit subsidy liability. In other words, 84% of the non-Medicare retirees who receive a Medical Plan Subsidy were assumed to enroll in an ACERA sponsored health plan.

Dental and vision subsidy

100% of eligible members are assumed to receive the dental and vision subsidy.

Health care cost trend rates (%)

Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are “net” and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is to be applied to that year’s cost to yield the next year’s projected cost. For example, the projected 2026 calendar year premium for Kaiser (under age 65) is $1,133.80 per month ($1,097.88 increased by 3.27%).

Section 4: Supporting Information

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[1]	Via Benefits & Kaiser Senior Advantage[2]	Dental[3]	Vision[4]	Medicare Part B
2025	7.75%[5]	7.50%[5]	6.00%[5]	3.00%[5]	6.20%
2026	7.50	7.25	5.00	3.00	6.20
2027	7.25	7.00	4.50	3.00	6.20
2028	7.00	6.75	4.00	3.00	6.20
2029	6.75	6.50	4.00	3.00	6.20
2030	6.50	6.25	4.00	3.00	6.20
2031	6.25	6.00	4.00	3.00	6.20
2032	6.00	5.75	4.00	3.00	6.20
2033	5.75	5.50	4.00	3.00	6.20
2034	5.50	5.25	4.00	3.00	5.75
2035	5.25	5.00	4.00	3.00	5.50
2036	5.00	4.75	4.00	3.00	5.25
2037	4.75	4.50	4.00	3.00	5.00
2038	4.50	4.50	4.00	3.00	4.75
2039 and later	4.50	4.50	4.00	3.00	4.50

[1] Non-Medicare plans.
[2] Medicare plans.
[3] We are aware of the 3-year rate guarantee of the 2026 dental premium, but for the purpose of the long term measurement, we will focus on the underlying trend.
[4] We are aware of the 5-year rate guarantee of the 2026 vision premium, but for the purpose of the long term measurement, we will focus on the underlying trend.
[5] The actual trends are shown below for ACERA-sponsored plans, based on premium renewals for 2026 as reported by ACERA.

Kaiser HMO Early Retiree	UHC HMO Signature Value Early Retiree	UHC HMO Signature Value Advantage Early Retiree	Kaiser Senior Advantage	Dental	Vision
3.27%	15.43%	N/A	6.08%	6.46%	0.00%

Assumed increase in annual maximum benefits

For the "substantive plan design" shown in this report, we have assumed:

1. Maximum medical allowance for ACERA sponsored plans and individual out-of-area non-Medicare plans for 2026 will increase to $687.21 per month ($526.46 for individual Medicare plans), then increase with 50% of trend for medical plans, or 3.625%, graded down to the ultimate rate of 2.25% over 11 years. If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend.
2. Dental and vision premium reimbursement will increase with full trend.
3. Medicare B premium reimbursement will increase with full trend.

Dependents

Demographic data was available for spouses of current retirees. For future retirees, male members are assumed to have a female spouse who is 3 years younger than the member and female members are assumed to have a male spouse who is 1 year older than the member. Of the future retirees who elect to continue their medical coverage at retirement, 35% males and 15% females were assumed to have an eligible spouse who also opts for health coverage at that time.

Please note that these assumptions are only used to determine the cost of the implicit subsidy.

Plan design

An administrative expense load was not added to projected incurred claim costs in developing per capita health costs.

Administrative expenses

An administrative expense load was not added to projected incurred claim costs in developing per capita health costs.

Exhibit 2: Summary of benefits

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plan provisions as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility

Service retirees

Retired with at least 10 years of service (including deferred vested members who terminate employment and receive a retirement benefit from ACERA).

Disabled retirees

A minimum of 10 years of service is required for non-duty disability. The 10 years of service requirement is only used for determining eligibility for health benefits. For pension benefits, the eligibility requirement is 5 years of service. There is no minimum service requirement for duty disability.

Other postemployment benefits (OPEB)

Monthly Medical Allowance

Service retirees

For retirees not purchasing individual insurance through the Medicare exchange, a Maximum Monthly Medical Allowance of $662.37 per month is provided, effective January 1, 2025 and through December 31, 2025. For the period January 1, 2026 through December 31, 2026, the maximum allowance will increase to $687.21 per month.

For those purchasing individual insurance through the Medicare exchange, the Monthly Medical Allowance is $507.43 per month for 2025 and will increase to $526.46 per month in 2026. These Allowances are subject to the following subsidy schedule:

Completed Years of Service	Percentage Subsidized
10–14	50%
15–19	75%
20+	100%

Disabled retirees

Non-duty disabled retirees receive the same Monthly Medical Allowance as service retirees. Duty disabled retirees receive the same Monthly Medical Allowance as those service retirees with 20 or more years of service.

Medicare Benefit Reimbursement Plan

The SRBR reimburses the full Medicare Part B premium to qualified retired members.

To qualify for reimbursement, a retiree must:

- Have at least 10 years of ACERA service,
- Be eligible for Monthly Medical Allowance,
- Provide proof of enrollment in Medicare Part B.

Dental and vision plans

The SRBR provides dental and vision benefits for retirees only. The maximum combined monthly dental and vision premiums are $55.68 in 2025 and $58.98 in 2026. The eligibility for these premiums is as follows.

Service retirees

Retired with at least 10 years of service.

Disabled retirees

For non-duty disabled retirees, 10 years of service is required. For grandfathered non-duty disabled retirees (with effective retirement dates on or before January 31, 2014), there is no minimum service requirement.

For duty disabled retirees, there is no minimum service requirement.

Note about Monthly Medical Allowance

The maximum levels of subsidy are reviewed by the Board annually and are not indexed to increase automatically.

In addition, the Monthly Medical Allowance can only be used to pay for retiree medical benefits. There is no benefit payable to beneficiaries, current spouses, former spouses, or dependents.

If the actual cost of coverage is less than the Monthly Medical Allowance, the difference is not paid in cash or applied towards the coverage for beneficiaries, current spouses, former spouses, or dependents.

Deferred benefit

Members who terminate employment with 10 or more years of service before reaching Pension eligibility commencement age may elect deferred MMA and/or dental/vision benefits.

Death benefit

Surviving spouses/domestic partners of members who die before the member commences retiree health benefits may enroll in an ACERA group medical plan on the date that the member would have been eligible to commence benefits. The surviving spouse/domestic partner must pay 100% of the premium. Because premiums for surviving spouses/domestic partners under age 65 include active participants for purposes of underwriting, the surviving spouses/domestic partners receive an implicit subsidy from the actives, which creates a liability for the SRBR.

Non-OPEB benefits

Supplemental COLA

When inflation is higher than the ACERA cost of living allowance for a year, the excess of inflation over the cost of living allowance (3% for Tier 1 and Tier 3, and 2% for Tier 2, Tier 2C, Tier 2D, and Tier 4) is banked for future years when inflation may be less than the cost of living allowance. In 1998, the Board of Retirement approved a supplemental COLA payable through the SRBR for members whose COLA banks exceeded 15%. The supplemental COLA for a year is equal to the percentage of excess of the member's COLA bank over 15% times the member's current annual retirement allowance.

The cost of living adjustment and any supplemental COLA must be approved yearly by the ACERA Board of Retirement. For this valuation, we have assumed the Board will maintain its current level of supplemental COLA (i.e., COLA banks will not exceed 15%) during the projection period.

Retired member death benefit

A one-time $1,000 lump sum retiree death benefit is payable to the beneficiary of a retiree. This benefit is only paid upon the death of a retiree; it is not paid upon the death of a beneficiary.

Exhibit 3: Assumptions about the "substantive plan"

The determination of the "substantive plan" underlying ACERA's OPEB was based upon prior directions provided by ACERA, its auditors, as well as the administrative staff, auditors and consultants representing the County of Alameda. Those directions are provided below.

1. **Commitment to provide benefits currently paid out of the SRBR**

   We understand that health and other supplemental benefits currently paid out of the SRBR will continue to be paid as long as there are assets available in the SRBR. However, when the assets in the SRBR are fully depleted, no additional health and other supplemental benefits will be paid by the Association and the employer. To our knowledge, the employer has not made any implicit or explicit commitment to continue those benefits.

2. **Continuation of coverage in the employer's active employee medical plans for the Association's retirees**

   Currently, the Association's retirees are enrolled in the same medical plans as the employer's active employees. The retiree experience is pooled and used in setting the medical plan premium rates for active employee. The Association has begun in 2007 to reimburse the County for the adverse premium experience created by the retirees.

   In this study, for purposes of determining sufficiency of funds we have included the liability associated with reimbursing the County for the adverse premium experience but only through the period up to the exhaustion of assets in the SRBR. In other words, there may be a residual liability to the employer if the Association's retirees continue to participate and are rated together in the employer's active employee medical plans.

3. **Fully indexed subsidies for dental, vision and Medicare Part B premium and increase at one-half of the rate of increase for monthly medical allowance (MMA)**

   Following guidelines provided by the Board and ACERA, we have assumed in this study that the OPEB Plan will reimburse the fully indexed premium required for dental, vision and for a retiree to enroll in Medicare Part B. In addition, we have assumed in this study that future MMA will increase at one-half of the rate of our anticipated medical inflation assumptions.

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