Ohio Administrative Code

Rule 3309-1-35 Health care.

Effective: January 1, 2024

(A) Definitions

As used in this rule:

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

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

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

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

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

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

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

(i) Is under age twenty-six, or

(ii) Regardless of age is permanently and totally disabled, provided that the disability existed prior to the age and service retirant's, disability benefit recipient's, or member's death and prior to the child reaching age twenty-six. For purposes of this paragraph "permanently and totally disabled" means the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve months.

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

(a) A medical and prescription drug plan;

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

(c) An excepted benefit health reimbursement arrangement, which provides reimbursement of medical expenses incurred under an individual health insurance plan.

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

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

(9) "Marketplace counselor" means an individual licensed to determine eligibility for, and enroll individuals in, a marketplace plan.

(10) "Marketplace plan" means an individual health plan available through either a state or federal health insurance marketplace.

(B) Eligibility

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

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

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

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

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

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

(3) Except for a dependent described in paragraph (A)(5)(b) of this rule, eligibility for SERS health care coverage shall terminate when the person is not enrolled in medicare part B and on or after January 1, 2016 commences employment that provides access to a medical plan with prescription coverage through the employer, or if employees of that employer in comparable positions have access to a medical plan available through the employer, provided the medical plan with prescription drug coverage available through the employer is equivalent to the medical plan with prescription coverage at the cost available to fulltime employees as defined by the employer. For purposes of this paragraph, employer means a public or private employer.

(4) On or after January 1, 2021, eligibility for SERS health care coverage shall terminate when a person listed in paragraph (B)(1) of this rule becomes eligible for medicaid and is ineligible for medicare. For purposes of this rule, a benefit recipient and their dependent(s) shall be presumed to be

eligible for medicaid if their gross monthly SERS benefit is less than the percentage of the federal poverty level used by the Ohio department of medicaid to determine medicaid eligibility under agency 5160 and division 5160:1 of the Administrative Code. Upon request, a benefit recipient presumed to be eligible for medicaid must provide SERS with satisfactory proof of ineligibility for medicaid in their state of residence within ninety days from the date of SERS' request.

(5) Eligibility for SERS health care coverage shall terminate when a person eligible for medicare part B fails to:

(a) Enroll in medicare part B during the person's initial enrollment period or special enrollment period under 42 U.S.C. 1395p that includes a date on or after January 1, 2019. If the failure to enroll occurred on or after January 1, 2019 and prior to January 1, 2022, the person must enroll in medicare part B during the general enrollment period ending March 31, 2022; or

(b) Enroll in medicare part B during the general enrollment period available under 42 U.S.C. 1395p immediately following a loss of medicare part B coverage that began on or after January 1, 2019. If the loss of medicare part B coverage began on or after January 1, 2019 and prior to January 1, 2022, the person must enroll in medicare part B during the general enrollment period ending March 31, 2022.

(6) Eligibility for SERS health care coverage shall terminate when a benefit recipient who is not eligible for medicare, and whose initial SERS health care eligibility date or reinstatement to SERS health care coverage under paragraph (I) of this rule is on or after June 1, 2023, fails to complete counseling with a SERS approved marketplace counselor to review marketplace plan options.

(a) A benefit recipient whose initial SERS health care eligibility date is on or after June 1, 2023 shall complete counseling before the later of the following:

(i) December thirty-first of the calendar year of initial health care eligibility; or

(ii) Within three months of initial health care eligibility.

(b) A benefit recipient requesting reinstatement to SERS health care coverage under paragraph (I) of

this rule on or after June 1, 2023 shall complete counseling before the later of the following:

(i) December thirty-first of the calendar year of the qualifying event entitling the benefit recipient to reinstatement; or

(ii) Within three months of the request for reinstatement.

(c) The benefit recipient shall provide the marketplace counselor with all information required to determine the cost of available marketplace plans. The marketplace counselor shall notify SERS when such counseling has been completed.

(d) A benefit recipient who fails to complete counseling in accordance with this rule shall be deemed to have waived SERS health care coverage until the individual becomes eligible for reinstatement as permitted under paragraph (I) of this rule.

(e) Counseling shall not be required if the marketplace counselor is unable to determine available marketplace plans based on the benefit recipient's address or other demographic information. The marketplace counselor will notify SERS when a marketplace plan cannot be determined based on the circumstances.

(C) Enrollment

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Cancellation of health care coverage

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

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

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

(c) The person's eligibility terminates as provided in paragraph (B)(4) of this rule;

(d) The person's eligibility terminates as provided in paragraph (B)(5) of this rule;

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

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

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

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

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

(E) Effective date of coverage

(1) Except as provided in paragraph (E)(2) of this rule, the effective date of health care coverage for persons eligible for health care coverage as set forth in paragraph (B) of this rule shall be as follows:

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

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

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

(2) The effective date of coverage for a person described in paragraph (B)(6) of this rule shall be the later of the following:

(a) The date provided under paragraph (E)(1) of this rule; or

(b) The first of the month following completion of counseling.

A benefit recipient may elect to defer SERS health care coverage until their first available marketplace plan effective date.

(F) Premiums

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

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

(3) After cancellation for default, health care coverage can be reinstated as provided in paragraph (I)

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

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

(a) A dependent child.

(b) An age and service retirant who:

(i) Has an effective retirement date before August 1, 1989; or

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

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

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

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

(c) A disability benefit recipient, except as provided in paragraph (F)(4)(d) of this rule who:

(i) Has an effective benefit date before August 1, 2008; or

(ii) Has an effective benefit date on or after August 1, 2008 who:

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

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

(d) A disability benefit recipient who is not enrolled in medicare part B on or after January 1. 2024, who:

(i) Has an effective benefit date before August 1, 1989; or

(ii) Has an effective benefit date on or after August 1, 1989 and before August 1, 2008 who had earned fifteen years of service credit; or

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

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

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

(e) A spouse:

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

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

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

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

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

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

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

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

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

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

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

(G) Waiver

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

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

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

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

(H) Medicare advantage or medicare part D

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

(I) Reinstatement to SERS health care coverage

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

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

eligible or receipt of the enrollment application by the system;

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

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

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

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

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

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

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

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

(J) Medicare part B

(1) A person who is enrolled in SERS' health care shall enroll in medicare part B at the person's first eligibility date for medicare part B. A person who fails to enroll in or maintain medicare part B coverage shall be ineligible for SERS health care coverage in accordance with paragraph (B)(5) of this rule.

(2)

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

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

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

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

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

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

(i) January 1, 1977; or

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

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

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

(ii) The effective date of SERS health care.

(4) The board shall not:

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

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