



Ohio Administrative Code Rule 3309-1-64 Supplemental health care coverage.

Effective: April 30, 2023

(A) Definitions

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

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

(B) Eligibility

A person is eligible for dental or vision coverage under this rule so long as the person meets the eligibility requirements in section 3309.69 of the Revised Code and paragraph (B)(1) of rule 3309-1-35 of the Administrative Code for the retirement systems health care coverage.

(C) Enrollment

(1) An eligible benefit recipient may only enroll in a dental or vision plan as follows:

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

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

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

(d) During the retirement systems open enrollment period.



(2) An eligible dependent of an age and service retiree or disability benefit recipient may only enroll in a dental or vision plan as follows:

(a) At the time the age and service retiree or disability benefit recipient enrolls in the plan;

(b) During the retirement systems open enrollment period so long as the age and service retiree or disability benefit recipient is also enrolled in the plan; or

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

(D) A person's dental or vision coverage shall be cancelled when:

(1) The person ceases to qualify as one of the persons listed in paragraph (B)(1) of rule 3309-1-35 of the Administrative Code;

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

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

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

(5) The benefit recipient elects to cancel the coverage during the open enrollment period.

(E) Effective date of coverage

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



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

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

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

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

(F) Premiums

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

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



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recipient shall be ineligible for reinstatement of coverage until payment for the total amount in default is received.