



SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

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JAMES R. WINFREE
Executive Director

LISA J. MORRIS
Deputy Executive Director

December 16, 2009

Mr. Aristotle Hutras, Director
Ohio Retirement Study Council
88 East Broad Street, Suite 1175
Columbus, OH 43215

Dear Mr. Hutras:

In accordance with section 3309.21(E) of the Ohio Revised Code, please find enclosed, as of June 30, 2009, a full accounting of the revenues and costs relating to the provision of health care under sections 3309.375 and 3309.69 of the Ohio Revised Code.

The School Employees Retirement System provided health care coverage to 52,134 eligible retirees and dependents at a net cost of \$118,125,328.

The amount paid for Medicare Part B reimbursement under 3309.69(C) of the Ohio Revised Code was \$25,449,935.

In FY 2009, 4.16% of the employer contribution was allocated to the health care program.

After reviewing this report, if you have any questions, please feel free to contact me.

Sincerely,

James R. Winfree
Executive Director

Enclosure

c: The Honorable Kevin Coughlin, Chair, Senate Health, Human Services and Aging
The Honorable Joseph Koziura, Chair, House Financial Institutions, Real Estate and Securities
Members, ORSC

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ANNUAL HEALTH CARE REPORT

FOR THE YEAR ENDED
JUNE 30, 2009



School Employees Retirement System of Ohio

School Employees Retirement System of Ohio Annual Health Care Report

December 2009

Table of Contents

	Page
Cost and Funding Summary	2
SERS Funding Policy	7
Summary of Coverage.....	10
Statutes	17
Administrative Rules	23
SERS Health Care Program History	30

COST AND FUNDING SUMMARY

HEALTH CARE FUNDING

Access to health care is provided in accordance with section 3309.69 of the Ohio Revised Code (ORC), and is financed primarily through a combination of employer contributions, retiree premiums, and copays and deductibles on covered health care expenses. In addition, investment earnings (or losses) contribute a portion of health care funding. Since 2006, money received as a result of the federal Medicare Part D program has also been added to health care funding.

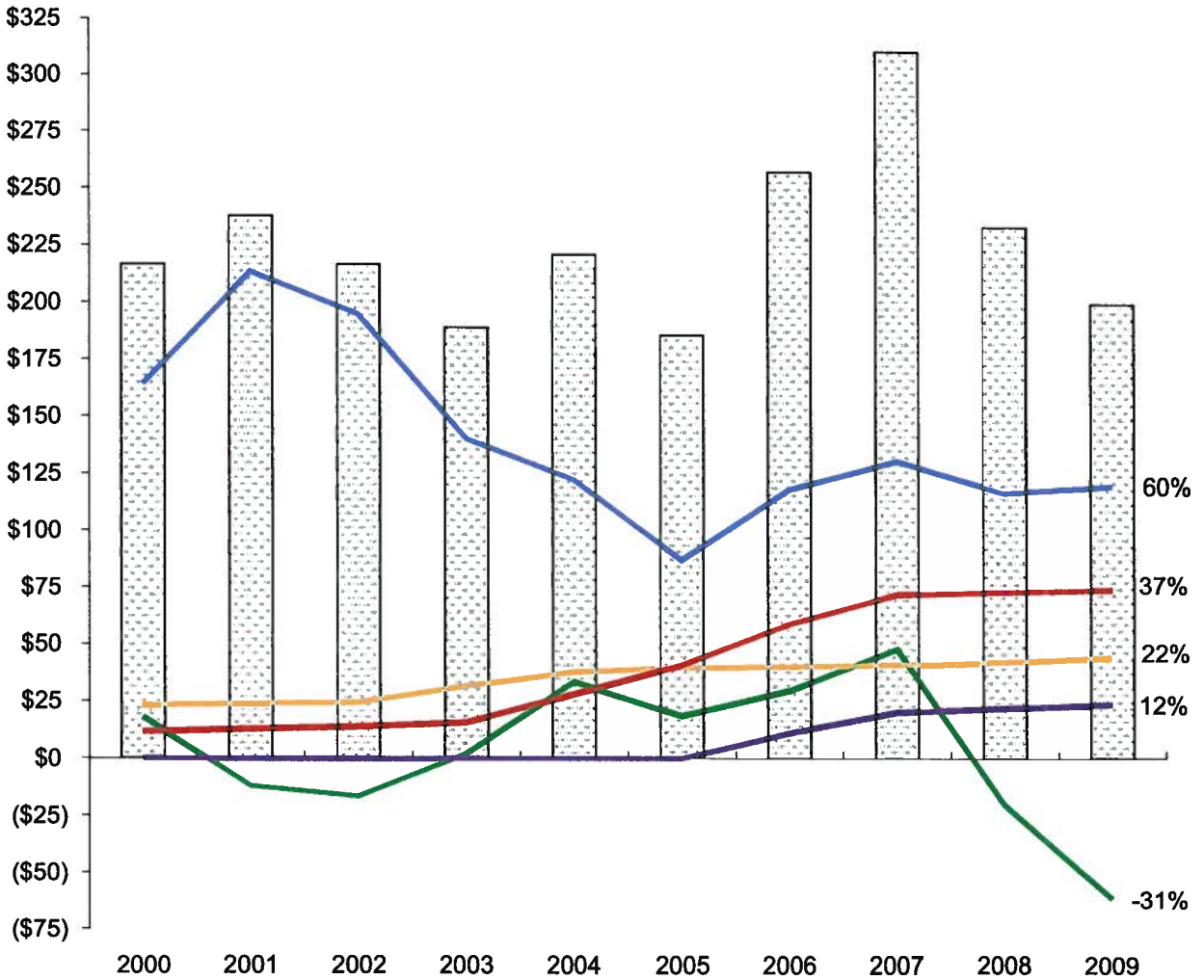
The System's goal is to maintain a health care reserve account with a 20-year solvency period in order to ensure that fluctuations in the cost of health care do not cause an interruption in the program.

The ORC permits SERS to offer access to health care to eligible individuals receiving retirement, disability, and survivor benefits as well as access to health care for their eligible dependents.

Normal employer payroll-based contributions alone (that portion of the total employer contributions remaining after the funding obligations for retirement benefits, Medicare Part B reimbursement and lump sum retiree death benefits are met) are not expected to be sufficient to finance health care to the level provided by this funding policy. This is due in large part to the fact that the annual compensation of SERS members is frequently based on less than full-time, year-round employment. In light of this demographic reality, a surcharge determined in accordance with ORC section 3309.491, is levied against employers whose employees earn less than a specified minimum salary. This employer surcharge is an important source of health care revenue and avoids shifting an onerous financial burden to our members and retirees.

As of June 30, 2009, SERS projects health care solvency until FY2014, based on projected funding needs and expected revenue.

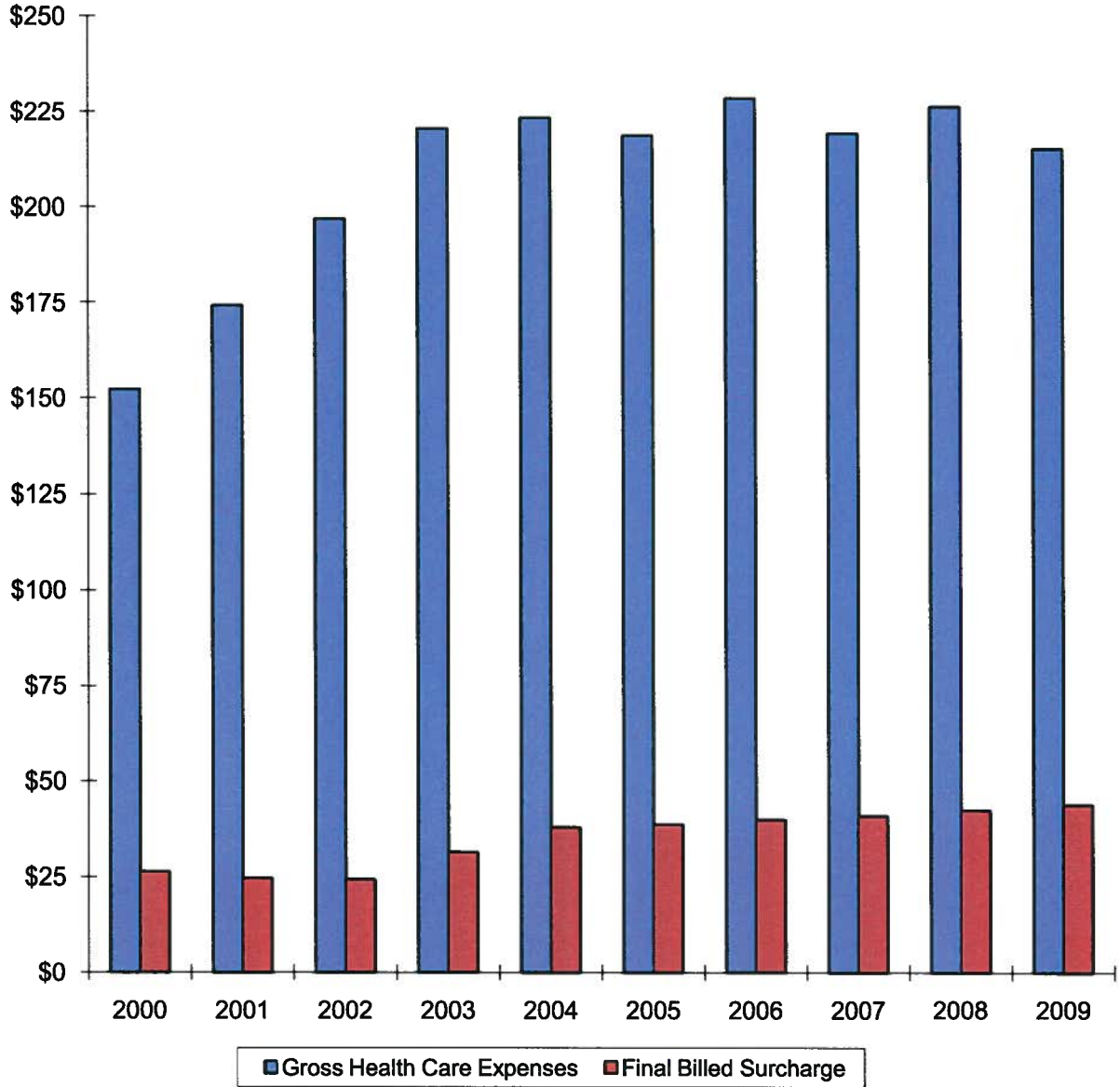
Health Care Fund Income FY2000 through FY2009 (millions)



Fiscal Year	Employer Surcharge	Employer Contributions	Benefit Recipient Contributions	Investment Income/(Loss) *	Medicare Part D Subsidy	Total Income
2000	\$23,103,887	\$163,970,484	\$11,470,378	\$17,960,400	-	\$216,505,149
2001	\$23,763,818	\$213,134,883	\$12,705,398	(\$12,053,203)	-	\$237,550,896
2002	\$24,304,260	\$194,663,469	\$13,855,142	(\$16,501,778)	-	\$216,321,093
2003	\$31,423,865	\$139,890,087	\$15,580,840	\$1,940,352	-	\$188,835,144
2004	\$37,566,163	\$121,984,779	\$27,947,708	\$33,249,249	-	\$220,747,899
2005	\$39,446,854	\$86,908,721	\$40,595,447	\$18,486,989	-	\$185,438,011
2006	\$39,909,334	\$117,827,594	\$58,683,818	\$29,426,851	\$11,135,723	\$256,983,320
2007	\$40,785,061	\$130,163,213	\$71,620,083	\$47,460,777	\$20,202,965	\$310,232,099
2008	\$42,000,617	\$116,393,144	\$72,707,047	(\$20,292,279)	\$21,953,659	\$232,762,188
2009	\$44,134,423	\$119,277,065	\$73,780,246	(\$61,507,699)	\$23,504,101	\$199,188,136

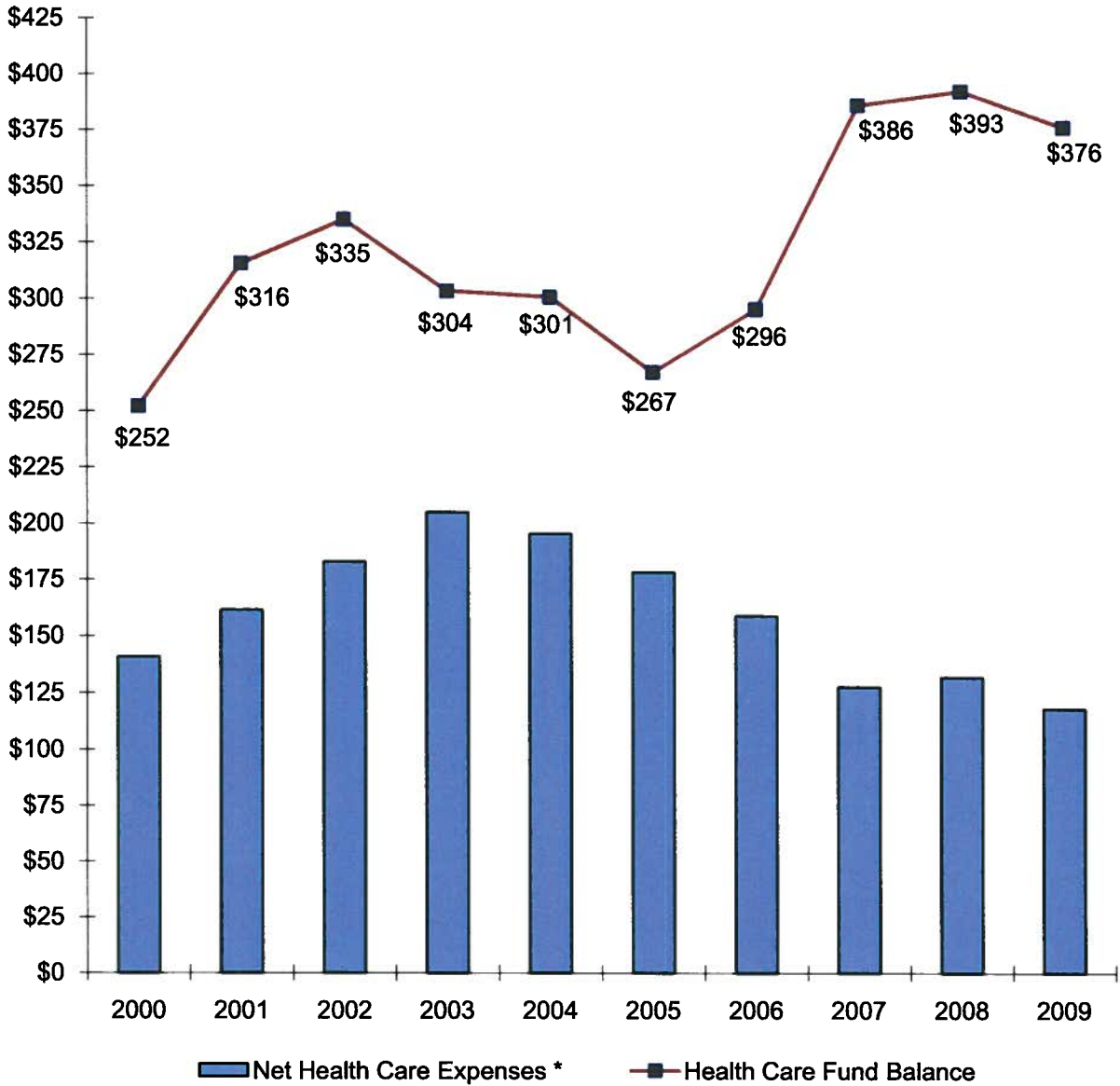
* Includes administrative expenses

**Gross Health Care Expenses and SERS Surcharge
FY2000 through FY2009 (millions)**



Fiscal Year	Gross Health Care Expenses	Final Billed Surcharge	As % of Payroll
2000	\$152,166,718	\$26,357,670	1.34%
2001	\$174,145,332	\$24,593,508	1.17%
2002	\$196,801,919	\$24,271,001	1.07%
2003	\$220,511,577	\$31,445,523	1.30%
2004	\$223,443,805	\$37,863,018	1.50%
2005	\$218,816,560	\$38,631,044	1.50%
2006	\$228,570,748	\$39,875,425	1.50%
2007	\$219,438,662	\$40,847,419	1.50%
2008	\$226,436,827	\$42,309,568	1.50%
2009	\$215,409,645	\$43,751,195	1.50%

**Net Health Care Expenses and Health Care Fund Balance
FY2000 through FY2009 (millions)**



Fiscal Year	Net Health Care Expenses *	Health Care Fund Balance
2000	\$140,696,340	\$252,308,305
2001	\$161,439,934	\$315,713,869
2002	\$182,946,777	\$335,233,043
2003	\$204,930,737	\$303,556,610
2004	\$195,496,097	\$300,860,704
2005	\$178,221,113	\$267,482,155
2006	\$158,751,207	\$295,561,933
2007	\$127,615,614	\$386,355,370
2008	\$131,776,121	\$392,680,731
2009	\$118,125,328	\$376,459,222

* Gross expenses less benefit recipient premiums paid

Historical Allocation of the SERS Employer Contribution

Fiscal Year	Pension Allocation	Health Allocation	Total
1987	9.00%	5.00%	14.00%
1988	9.58%	4.42%	14.00%
1989	9.72%	4.28%	14.00%
1990	9.78%	4.22%	14.00%
1991	9.63%	4.37%	14.00%
1992	9.48%	4.52%	14.00%
1993	9.13%	4.87%	14.00%
1994	9.13%	4.87%	14.00%
1995	9.45%	4.55%	14.00%
1996	10.50%	3.50%	14.00%
1997	9.79%	4.21%	14.00%
1998	9.02%	4.98%	14.00%
1999	7.70%	6.30%	14.00%
2000	5.55%	8.45%	14.00%
2001	4.20%	9.80%	14.00%
2002	6.56%	7.44%	14.00%
2003	8.17%	5.83%	14.00%
2004	9.09%	4.91%	14.00%
2005	10.57%	3.43%	14.00%
2006	10.58%	3.42%	14.00%
2007	10.68%	3.32%	14.00%
2008	9.82%	4.18%	14.00%
2009	9.84%	4.16%	14.00%

SERS FUNDING POLICY

I. Purpose.

The purpose of this Statement of Funding Policy is to describe the funding philosophy and objectives of the Retirement Board of the School Employees Retirement System of Ohio (Board). This Statement sets forth policy and describes the organization and division of responsibilities to prudently implement the Board philosophy and objectives in accordance with sections 3309.21 and 3309.211 of the Ohio Revised Code (ORC). It also establishes the framework and specific objectives to monitor the System's funded status and to promote effective communication between the Board and SERS staff.

II. Background.

The School Employees Retirement System of Ohio (SERS or System) was initially established by the Ohio Legislature to provide retirement and disability benefits for all non-certificated persons employed by Ohio's public schools. This purpose is sustained by the member and employer contributions, and the return realized from investment of those contributions.

The System is governed by a nine-member Board, including four members elected by the general membership (those who contribute to SERS), two members elected by the retirees and three members with investment expertise appointed by the governor, treasurer of state and the legislature. The Board is responsible for managing the System in accordance with Chapter 3309 of the ORC, and establishing the employer and employee contribution rates (sections 3309.49 and 3309.47, respectively) in accordance with section 3309.21.

III. Funding Philosophy.

The Board realizes that its primary responsibility is to assure that, at the time benefits commence, sufficient funds will be available to provide retirement, disability and survivor benefits along with Medicare B reimbursements and lump sum retiree death benefits for the System's members. The Board also recognizes that the law governing SERS financing intends the contribution rates to remain approximately level from generation to generation (a level percentage of payroll.)

Finally, the Board is cognizant of the necessity to balance the needs of System members for proper funding of retirement, disability and survivor benefits, as well as the Medicare Part B reimbursement and lump sum retiree death benefits, with the desire to receive, where possible, an appropriate level of retiree health care coverage.

IV. Funding Objectives.

In defining funding objectives, the Board seeks to enhance the soundness of the System in order to balance as efficiently as possible the affordability and adequacy of the retirement benefits and health care coverage provided to System members. To that end, the Board establishes the following funding objectives:

- A. The program of retirement benefits at SERS reflects that primary consideration is given to the career school employee. The accumulation of assets shall be for the purpose of funding retirement benefits for members who commit a significant portion of their working lives to an educational institution. Members who do not qualify for a retirement benefit shall be entitled only to a refund of contributions.
- B. The System shall amortize its unfunded actuarial accrued liability over a closed period of time, decreasing one year with each annual actuarial valuation. However, the Board

may approve a flat or increasing amortization period over the short term if necessary to meet the goals of affordability and adequacy of retirement benefits and health care coverage. The ORC section 3309.211 establishes a 30-year maximum amortization period.

- C. The funded ratio, that percentage of actuarial accrued liabilities covered by actuarial assets, shall be stable or increasing each year, with a minimum of 80% unless a lower funding ratio is approved by the Board.
- D. After satisfying objectives B. and C., above, and while maintaining its funding philosophy of annually reducing the amortization period, the Board may choose to pursue any of the following objectives:
 - 1. To improve the funded ratio of the System
 - 2. To achieve a twenty year solvency period for the Health Care Reserve Fund
 - 3. To propose legislation that provides for affordable benefit enhancements for active members and/or retirees
 - 4. To reduce employee and/or employer contributions

V. Responsibilities.

In order to implement this Statement of Funding Policy, the following responsibilities are delineated:

A. To the Board.

- 1. After consultation with the Actuary, the Executive Director and SERS staff, the Board will determine the economic assumptions and actuarial funding method and establish the non-economic assumptions used in the annual actuarial valuation.
- 2. Where possible and when appropriate, the Board will provide statements of policy to direct and focus the activities of SERS' staff and outside consultants.

B. To the Staff.

- 1. In accordance with the Board's statements of policy, SERS' staff will implement the Mission of SERS: To provide pension benefit programs and services to our members, retirees, and beneficiaries through benefit programs and services that are soundly financed, prudently administered and delivered with understanding and responsiveness.
- 2. The SERS Executive Director or, in the absence of the Executive Director, the Deputy Executive Director, will report to the Board annually on SERS' actions and activities in carrying out the Board's funding policies and directives, and more often, as necessary, when Board action may be required under the terms of this Policy.
- 3. The staff is responsible for providing the Actuary with timely and accurate information regarding SERS' members, retirees and the benefits provided by SERS.

C. To the System Actuary.

- 1. In addition to preparing the various reports required by law, the Actuary will assist the Board and SERS' staff by providing education and insight regarding effective administrative practices within the community of public pension plans.

2. When requested, the System Actuary will assist in SERS' strategic planning by identifying emerging trends pertaining to benefits and health care.

VI. Review and evaluation.

In order to establish appropriate and effective policy, and to maintain the efficient, ongoing administration of the System, the System will employ the services of a qualified actuary who will prepare, at a minimum, the following:

A. Annual Reports

1. Basic Benefits Actuarial Valuation
2. Gain/Loss Analysis of Financial Experience of Basic Benefits
3. Basic Health Care Actuarial OPEB Valuation
4. Report on the solvency period of the Health Care Reserve Fund

B. Five Year Experience Study

VII. Health Care.

Access to health care is provided in accordance with section 3309.69 of the ORC, and is financed through a combination of employer contributions and retiree premiums, copays and deductibles on covered health care expenses. The System's goal is to maintain a health care reserve account with a 20- year solvency period in order to ensure that fluctuations in the cost of health care do not cause an interruption in the program.

The ORC permits SERS to offer access to health care to eligible individuals receiving retirement, disability and survivor benefits and to their eligible dependents. Health care coverage may be changed at any time, resulting in adjustments in the required funding of the health care program.

Normal employer payroll-based contributions alone (that portion of the total employer contributions remaining after the funding obligations for retirement benefits, Medicare Part B reimbursement and lump sum retiree death benefits are met) are not expected to be sufficient to finance health care to the level provided by this funding policy. This is due in large part to the fact that the annual compensation of SERS members is frequently based on less than full-time, year-round employment. In light of this demographic reality, a surcharge determined in accordance with ORC section 3309.491, is levied against employers whose employees earn less than a specified minimum salary. In order to avoid shifting an onerous financial burden to our members and retirees, the employer surcharge will continue to be an important source of health care revenues.

HISTORICAL REFERENCE

RESOLUTION Approved by SERS Board at the November 21, 1997 Board Meeting

Re-affirmed at the December 17, 1998 Board Meeting

Re-affirmed at the April 19, 2000 Board Meeting

RESOLUTION Approved by SERS Board at the September 19, 2008 Board Meeting

SUMMARY OF COVERAGE

LEGAL NOTICE/DISCLAIMER

The following information is a general summary of the current SERS health care plan. It is not a guarantee of the type or amount of coverage, if any, which may be available to retirees, or to members when they retire.

To the extent resources permit, SERS intends to continue to offer access to health care coverage. However, it reserves the right to change or discontinue any plan or program as necessary.

ELIGIBILITY REQUIREMENTS

Eligibility for SERS' health insurance coverage is based on service credit. In 1981, the Ohio legislature passed H.B. 126 which requires SERS' members to earn at least 10 years of service credit, exclusive of most types of purchased credit, in order to participate in the health plan. The effective date was June 13, 1986.

Thus, members who retire after June 1, 1986 need 10 years of service credit to qualify to participate in SERS' health plan. The following types of credit purchased after January 29, 1981 do not count toward insurance eligibility: military, federal, out of state, municipal, private school, exempted, and early retirement incentive credit.

SUMMARY OF COVERAGE

The plans offered by SERS for those *without* Medicare are:

- Aetna Managed Care PPO and Express Scripts prescription drug plan
- Medical Mutual PPO and Express Scripts prescription drug plan
- AultCare PPO in 19 Ohio counties and BioScrip prescription drug plan
- Kaiser HMO in eight Ohio counties and Kaiser prescription drug plan
- Paramount HMO in 10 Ohio and two Michigan counties and Express Scripts prescription drug plan
- Aetna HMO in 70 Ohio counties and Express Scripts prescription drug plan

The plans offered by SERS for those *with* Medicare are:

- Aetna Medicare Advantage Private Fee for Service and Express Scripts prescription drug plan
- Primetime Medicare Advantage HMO in five counties and BioScrip prescription drug plan
- Kaiser HMO in seven counties and Kaiser prescription drug plan
- Paramount Medicare Advantage HMO in three Ohio and two Michigan counties and Express Scripts prescription drug plan

The initial choice will be in effect until the next open enrollment period. If no plan choice is made on the Retirement Application, the member will be enrolled in the Aetna Managed Care or Medicare Advantage plan.

PLAN DESIGN

Plans offered for those *without* Medicare:

Deductible: \$340 per person; \$700 per family

Co-insurance: \$1,500 per person; \$3,000 per family

Office visit copay: \$25

Inpatient hospital deductible: \$250 per admission

Durable medical equipment: member pays 20%

All other services: member is responsible for 20% co-insurance payment

Skilled nursing facility: The plan will pay 80% of the room and board charges for skilled treatment only. If private accommodations are used, the plan will cover the facility's average daily semi-private room charge.

Also covered: physical therapy, use of special treatment rooms, drugs, casts, and dressing. These expenses will be payable for up to 365 days of confinement in any convalescent period.

Plans offered for those *with* Medicare:

Deductible: \$0

Co-insurance: \$0

Office visit copay: \$25

Inpatient hospital deductible: \$250 per admission

Durable medical equipment: member pays \$0

Emergency room copay: \$50

Ambulance copay: \$75

All other services: member is responsible for 0% co-insurance payment

Skilled nursing facility:

Member pays \$0 for days 1–10

Member pays \$25 per day for days 11–20

Member pays \$50 per day for days 21–100

Also covered: routine physical exams; and pneumonia, flu, and hepatitis B immunizations at 100%.

Coordination of Benefits (for those not enrolled in a Medicare Advantage Plan)

The SERS plan contains a "Coordination of Benefits" (COB) provision. Payment on covered expenses will be reduced to the extent of duplicate coverage by any other group carrier determined to be the primary insurer under the model COB provisions recommended by the National Association of Insurance Commissioners and adopted by the SERS Board of Trustees.

Prevailing Fee

The insurers have established prevailing fees for medically necessary charges and reimburses at the prevailing fee level.

Out-of-Pocket Maximum (for those not enrolled in a Medicare Advantage Plan)

The maximum out-of-pocket limit under the SERS basic plan is \$1,840 per person per calendar year, including the deductible, or \$2,090 including the deductible and one hospital admission charge. The office visit co-pay of \$25 for those in the managed care network does not accrue toward the out-of-pocket limit.

There is no maximum expense limit for a retiree in the managed care network who does not use participating providers. The plan will pay up to \$2.5 million of covered expenses during a person's lifetime.

PRESCRIPTION DRUG COVERAGE

SERS offers both a retail and a mail-order prescription drug plan for covered retirees and dependents.

Retail Plan

Benefit recipients receive a card to use at participating pharmacies. Retirees pay 20% of the cost for a preferred prescription drug and 35% for a non-preferred prescription drug. Retirees may receive up to a 34-day supply, or 100 units, whichever is less.

If a participant does not use a participating pharmacy, there is no reimbursement, except for nursing home confinements.

Mail-Order Plan

Basic plan enrollees and dependents living in the continental U.S. can receive prescriptions by mail. Most prescriptions can be filled for up to a 90-day supply. Retirees pay a \$15 co-pay for a generic prescription drug, a \$45 co-pay for a brand-preferred prescription drug, and an \$80 co-pay for a brand-nonpreferred prescription drug.

DENTAL COVERAGE (Aetna PPO Dental)

SERS offers two levels of reimbursement, depending on the network the retiree chooses to access:

Preventive	100% or 80%	No deductible
Basic	80% or 60%	\$50 deductible
Major	50% or 40%	Deductible applies

COST SHARING: DEDUCTIBLES, PREMIUMS, AND CO-PAYS

Deductible

The annual deductible is \$340 per person. For those in managed care who do not use participating providers, the calendar year deductible is \$700 per person.

Hospital Admission Charge

The retiree is charged \$250 for each hospital admission unless readmitted within 60 days. The charge for those in managed care who do not use a participating hospital is \$290.

Premiums

Following is the percentage of the premium paid by those retiring on service retirement or **before** August 1, 2008, along with the monthly premium equivalent of percentages for those who retire before August 1, 2008:

Years of Service	Percent of Premium	Premium
10-14.999	100%	\$1,082 (with Medicare \$221)
15-19.999	50%	\$541 (with Medicare \$111)
20-24.999	25%	\$271 (with Medicare \$55)
25 years and over	17.5%	\$189 (with Medicare \$39)

The premium rates listed above are for the basic plan for members without Medicare and the plan for members with Medicare who retired before August 1, 2008; rates under the HMOs are in some cases higher and some cases lower.

Dependent premiums are based on the retiree's qualified years of service, for example: with up to 25 years of service, a spouse without Medicare will pay \$860 per month. A spouse with Medicare will pay \$221 per month.

Children without Medicare A will pay \$131 per month. Children with Medicare A will pay \$155 per month.

All premium rates are indexed to the increase in health care expenses and are subject to change yearly.

Retirees may enroll in an optional Aetna Dental plan with a monthly premium required. SERS does not subsidize dental premiums.

	Monthly Premium
Retiree only	\$ 27.78
Retiree and one dependent	\$ 52.67
Retiree and two or more dependents	\$ 79.69

Following is the percentage of the premium paid by those retiring on service retirement or **after** August 1, 2008, along with the monthly premium equivalent of percentages for those who retire before August 1, 2008:

Years of Service	Percent of Premium	Premium
10-19.999	100%	\$1,082 (with Medicare \$221)
20-24.999	50%	\$1,082 (with Medicare \$221)
25-29.999	30%	\$325 (with Medicare \$66)
30-34.999	20%	\$216 (with Medicare \$44)
35 years and over	15%	\$162 (with Medicare \$33)

The premium rates listed above are for the basic plan for members without Medicare and the plan for members with Medicare who retired **after** August 1, 2008; rates under the HMOs are in some cases higher and some cases lower.

Dependent premiums are based on the retiree's qualified years of service, for example, with up to 25 years of service, a spouse without Medicare will pay \$860 per month. A spouse with Medicare will pay \$221 per month.

Children without Medicare A will pay \$131 per month. Children with Medicare A will pay \$155 per month.

All premium rates are indexed to the increase in health care expenses and are subject to change yearly.

Retirees may enroll in an optional Aetna Dental plan with a monthly premium required. SERS does not subsidize dental premiums.

	Monthly Premium
Retiree only	\$ 27.78
Retiree and one dependent	\$ 52.67
Retiree and two or more dependents	\$ 79.69

Co-Pays

Under the basic medical plan, the retiree pays 20% of doctor and other medical charges, up to the maximum yearly limit. Retirees in the managed care network pay \$25 for each doctor office visit. Those in the managed care network who do not use participating providers pay 90%.

Medicare B Reimbursement

The Medicare Part B reimbursement rate is \$45.50 per month. Retirees must pay the difference between the \$45.50 and the current Medicare Part B premium, which is \$96.40.

Rev. 12/09

2009 Non-Medicare Plan Coverage

	Medical Mutual PPO (In Network) Aetna Managed Care (In Network)	AultCare PPO (In-Network)	Aetna HMO	Kaiser HMO	Paramount HMO
Calendar Year Deductible	\$340/person \$700/family	\$340/person \$700/family	None	None	None
Calendar Year Co-insurance Limit	\$1,500/person \$3,000/family	\$1,500/person \$3,000/family	\$1,500/single \$3,000/family	\$2,000/single \$6,000/family	\$1,500/single \$3,000/family
Lifetime Max	\$2,500,000	\$2,500,000	None	None	None
Office visit	\$25 co-pay	\$25 co-pay	\$25 co-pay	\$15 co-pay	\$15 co-pay
Specialist	\$25 co-pay	\$25 co-pay	\$30 co-pay	\$15 co-pay	\$30 co-pay
Surgery	80% after \$340 deductible	80% after \$340 deductible	100% coverage	100% coverage	100% coverage
Inpatient Hospital	80% after \$250 hospital co-pay and \$340 deductible	80% after \$250 hospital co-pay and \$340 deductible	\$250 co-pay for each admission	\$250 co-pay per benefit period	\$250 co-pay for each admission
Emergency Room	80% after \$340 deductible	80% after \$340 deductible	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted
Ambulance	80% after \$340 deductible	80% after \$340 deductible	100% if emergency	\$50 co-pay	100% coverage
Outpatient Diagnostic X-Ray	80% after \$340 deductible	80% after \$340 deductible	100% coverage	100% coverage	100% coverage
Outpatient Diagnostic Lab	80% after \$340 deductible	80% after \$340 deductible	100% coverage	100% coverage	100% coverage
Outpatient Surgery (Facility Only)	100% after \$340 deductible	80% after \$340 deductible	100% coverage	\$15 co-pay	100% coverage
Chiropractic	80% after \$340 deductible	80% after \$340 deductible	Not covered	Not covered	Not covered
Durable Medical Equipment	80% after \$340 deductible	80% after \$340 deductible	80% coverage	80% coverage	80% coverage
Skilled Nursing Facility	80% coverage/365 day maximum	80% coverage/365 day maximum	Co-pay: \$0 per day 1-20, \$75 per day 21-000	100% coverage/ 100 days	Co-pay: \$0 per day 1-15, \$95 day per 16-100
Home Health Care	80% after \$340 deductible	80% after \$340 deductible	100% coverage	100% coverage	100% coverage
Hospice	Refer to Certificate of Coverage Medical Plan Description <u>Express Scripts</u>	100% after deductible, 30 day lifetime limit. Outpatient: 80% after deductible, \$5,000 lifetime limit	100% coverage	100% coverage	100% coverage
Prescription Drugs	Retail 34 day max supply 20% Generic or Preferred Brand, 35% Non-Preferred Brand Mail Order 90 day max supply \$15 Generic, \$45 Preferred Brand, \$80 Non-Preferred Brand	BioScrip Pharmacy Retail 34 day max supply 20% Generic or Preferred Brand, 35% Non-Preferred Brand Mail Order 90 day max supply \$15 Generic, \$45 Preferred Brand, \$80 Non-Preferred Brand	Express Scripts Retail 34 day max supply 20% Generic or Preferred Brand, 35% Non-Preferred Brand Mail Order 90 day max supply \$15 Generic, \$45 Preferred Brand, \$80 Non-Preferred Brand	Kaiser Pharmacy Retail 31 day max supply \$10 Co-payment Mail Order 90 day max supply \$25 Co-payment	Express Scripts Retail 34 day max supply 20% Generic or Preferred Brand, 35% Non-Preferred Brand Mail Order 90 day max supply \$15 Generic, \$45 Preferred Brand, \$80 Non-Preferred Brand

2009 Medicare Plan Coverage

	AultCare PrimeTime Medicare Advantage HMO	Aetna Medicare Advantage Private Fee for Service (PFFS)	Kaiser HMO Medicare	Paramount Elite Medicare Advantage HMO
Deductible	None	None	None	None
Co-Insurance Limit	None	None	\$2,000/single \$6,000/family	None
Lifetime Max	None	None	None	None
Office visit	\$20 co-pay	\$25 co-pay	\$25 co-pay	\$20 co-pay
Specialist	\$25 co-pay	\$25 co-pay	\$25 co-pay	\$25 co-pay
Surgery	100% coverage	100% coverage	100% coverage	100% coverage
Inpatient Hospital	\$250 co-pay per admission	\$250 co-pay per admission	\$250 co-pay per admission	\$250 co-pay per admission
Emergency Room	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted	\$50 co-pay, waived if admitted
Ambulance	\$75 co-pay	20% co-pay/80% coverage	\$50 co-pay	100% coverage
Outpatient Diagnostic X-Ray	100% coverage	\$25 co-pay	100% coverage	100% coverage
Outpatient Diagnostic Lab	100% coverage	100% coverage	100% coverage	100% coverage
Outpatient Surgery	100% coverage	100% coverage	\$25 co-pay	100% coverage
Chiropractic	\$25 co-pay limited to Medicare coverage	\$35 co-pay limited to Medicare coverage	\$25 co-pay for manual manipulations/sublux	\$25 co-pay limited to Medicare coverage
Durable Medical Equipment	85% coverage	100% coverage	100% coverage	80% coverage
Skilled Nursing Facility	Co-pay: \$0 per day 1-15, \$20 per day 16-30, \$0 per day 31-100 (100 day maximum)	Co-pay: \$0 per day 1-10, \$25 per day 11-20, \$50 per day 21-100 (100 day maximum)	100% coverage/100 day maximum	Co-pay: \$0 per day 1-15, \$95 per day 16-100 (100 day maximum)
Home Health Care	100% coverage	100% coverage	100% coverage	100% coverage
Hospice	100% coverage	Covered per Medicare rules	100% coverage	Covered per Medicare rules
Prescription Drugs	BioScrip Pharmacy Retail 30 day max supply \$5 Generic, \$15 Preferred Brand, \$30 Non-Preferred Brand Mail Order 90 day max supply \$10 Generic, \$30 Preferred Brand, \$60 Non-Preferred Brand Subject to Medicare Part D out-of-pocket and catastrophic limits	Express Scripts Retail 34 days 20% Preferred, 35% Non-Preferred Mail Order 90 day \$15 Generic, \$45 Brand Preferred, \$80 Brand Non-Preferred	KaiserL Retail 31 day max supply \$15 Generic, \$30 Brand Formulary Mail Order 90 day max supply \$15 Generic, \$30 Brand Formulary	Express Scripts Retail 34 days 20% Preferred, 35% Non-Preferred Mail Order 90 day \$15 Generic, \$45 Brand Preferred, \$80 Brand Non-Preferred

STATUTES

Sec. 3309.375 Hospital insurance coverage for retirants.

(A) Except as otherwise provided in division (B) of this section, the board of the school employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, "Social Security Amendments of 1965," 79 Stat. 291, 42 U.S.C.A. 1395c, as amended. This coverage shall also be made available to the spouse, widow, or widower of such retirant or disability benefit recipient provided such spouse, widow, or widower has attained age sixty-five and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage only if he or she is the recipient of a monthly allowance or benefit from this system. Not less than twenty-five per cent of the cost for such coverage shall be paid from the appropriate funds of the school employees retirement system and the remainder by the recipient of the allowance or benefit.

The cost of such coverage, paid from the funds of the system, shall be included in the employer's rate provided by sections 3309.49 and 3309.51 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and shall contract for such coverage as provided in section 3309.69 of the Revised Code.

Notwithstanding sections 3309.49 and 3309.51 of the Revised Code, the employer's contribution rate shall not be increased until July 1, 1969, or later to reflect the increased costs created by this section.

(B) The board need not make the hospital insurance coverage described in division (A) of this section available to any person for whom it is prohibited by section 3309.69 of the Revised Code from paying or reimbursing the cost of such insurance.

Eff.	7/29/92	S.B. 346
	6/30/91	H.B. 382
	6/13/81	H.B. 126
	6/13/75	H.B. 1
	12/14/67	H.B. 402
OAC Reference:		3309-1-55

Sec. 3309.49 Employer's contribution rate.

Each employer shall pay annually to the school employees retirement system an amount certified by the secretary that shall be a certain per cent of the earnable compensation of all employees, and shall be known as the "employer contribution." The rate per cent of such contribution shall be fixed by the actuary on the basis of the actuary's evaluation of the liabilities of the school employees retirement system, but shall not exceed fourteen per cent, and shall be approved by the school employees retirement board. The school employees retirement board may raise the rate per cent of the contribution to fourteen per cent of the earnable compensation of all employees. In making such evaluation, the actuary shall use, as the actuarial assumptions, regular interest and such mortality and other tables as are adopted by the school employees retirement board. The actuary shall compute the percentage of such earnable

compensation, to be known as the “employer rate,” required annually to fund the liability for all allowances, annuities, pensions and other benefits, and any deficiencies in the various funds, provided for in this chapter, after deducting therefrom the annuity and other benefits provided by the contributor’s accumulated contributions and deposits or other applicable moneys.

Eff. 4/9/01 S.B. 270
6/30/91 H.B. 382
OAC Reference: 3309-1-02

3309.491 Employer minimum compensation contribution to fund future health care benefits.

(A) An actuary employed by the school employees retirement board shall annually determine the minimum annual compensation amount for each member that will be needed to fund the cost of providing future health care benefits under section 3309.69 of the Revised Code. The amount determined by the actuary under this division shall be approved by the board and shall be known as the “minimum compensation amount.”

(B) (1) The secretary of the school employees retirement board shall annually determine for each employer the “employer minimum compensation contribution.”

Subject to division (B)(2) of this section, the amount determined shall be the lesser of the following:

(a) An amount equal to two per cent of the compensation of all members employed by the employer during the prior year;

(b) The total of the amounts determined as follows for each member whose compensation for the prior year was less than the minimum compensation amount:

(i) Subtract the member’s compensation for the prior year from the minimum compensation amount;

(ii) Multiply the remainder obtained under division (B)(1)(b)(i) of this section by one, or if the member earned less than a year’s service credit for the prior year, by the same fraction as the fraction of a year’s service credit credited to the member under section 3309.30 of the Revised Code;

(iii) Multiply the product obtained under division (B)(1)(b)(ii) of this section by the employer contribution rate in effect for the year the service credit was earned.

(2) If the total of the employer minimum contribution amounts determined under division (B)(1) of this section exceeds one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution, the school employees retirement board shall reduce the amount determined for each employer so that the total amount determined does not exceed one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution. Any reduction shall be applied to each employer in the same proportion as the employer’s minimum compensation contribution bears to the total employer minimum compensation contribution.

(C) The secretary shall annually certify to each employer the employer minimum compensation contribution determined under division (B) of this section. In addition to the employer contribution required by section 3309.49 of the Revised Code, each employer shall pay annually to the employers’ trust fund the amount certified to the employer under this division.

(D) Annually by the first day of August, the secretary shall submit to the superintendent of public instruction a list of the payments made by each employer under this section during the preceding fiscal year.

Eff.	4/9/01	S.B. 270
	9/9/88	H.B. 290

Section 3309.69 Group hospitalization coverage; ineligible individuals; service credit; alternative use of health insuring corporation

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

- (1) A former member receiving benefits pursuant to section 3309.34, 3309.35, 3309.36, 3309.38, or 3309.381 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years 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;
 - (2) The spouse of the former member;
 - (3) The beneficiary of the former member receiving benefits pursuant to section 3309.46 of the Revised Code.
- (B) The school employees retirement board may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving service retirement or a disability or survivor benefit subscribing to the plan and their eligible dependents.

If all or any portion of the policy or contract premium is to be paid by any individual receiving service retirement or a disability or survivor benefit, the person shall, by written authorization, instruct the board to deduct the premiums agreed to be paid by the individual to the companies, corporations, or agencies.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the school employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 3309.49 and 3309.491 of the Revised Code. The board shall not pay or reimburse the cost for health care under this section or section 3309.375 of the Revised Code for any ineligible individual.

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

- (C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, make a monthly payment to each recipient of service retirement, or a disability or survivor benefit under the school employees retirement system who is eligible for insurance coverage under part B of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, except that the board shall make no such payment to any ineligible individual. Effective on the first day of the month after April 9, 2001, the amount of the payment shall be the lesser of an amount equal to the basic premium for such coverage, or an amount equal to the basic premium in effect on January 1, 1999.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 3309.375 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, Ohio police and fire pension fund, state teachers retirement system, or state highway patrol retirement system.

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

Eff.	10/1/02	S.B. 247
	4/9/01	S.B. 270
	11/2/99	H.B. 222
	12/8/98	H.B. 673
	6/4/97	S.B. 67
	3/6/97	S.B. 82
	7/29/92	S.B. 346
	6/30/91	H.B. 382
	5/4/92	H.B. 383
OAC Reference:		3309-1-35
		3309-1-55

Sec. 3309.691 Long term health care programs.

The school employees retirement board shall establish a program under which members of the retirement system, employers on behalf of members, and persons receiving service, disability, or survivor benefits are permitted to participate in contracts for long-term health care insurance. Participation may include dependents and family members. If a participant in a contract for long-term care insurance leaves employment, the participant and the participant's dependents and family members may, at their election, continue to participate in a program established under this section in the same manner as if the participant had not left employment, except that no part of the cost of the insurance shall be paid by the participant's former employer.

Such program may be established independently or jointly with one or more of the other retirement systems. For purposes of this section, "retirement systems" has the same meaning as in division (A) of section 145.581 of the Revised Code.

The board may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a long-term care insurance policy or contract. However, prior to entering into such an agreement with an insurance company or health insuring corporation, the board shall request the superintendent of insurance to certify the financial condition of the company or corporation. The board shall not enter into the agreement if, according to that certification, the company or corporation is insolvent, is determined by the superintendent to be potentially unable to fulfill its contractual obligations, or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or under an order of supervision by the superintendent.

The board shall adopt rules in accordance with section 111.15 of the Revised Code governing the program. The rules shall establish methods of payment for participation under this section, which may include establishment of a payroll deduction plan under section 3309.27 of the Revised Code, deduction of the full premium charged from a person's service, disability, or survivor benefit, or any other method of payment considered appropriate by the board. If the program is established jointly with one or more of the other retirement systems, the rules also shall

establish the terms and conditions of such joint participation.

Eff.	6/4/97	S.B. 67
	7/1/93	H.B. 152
	10/29/91	H.B. 180
OAC Reference:		3309-1-51

Sec. 3309.70 Overpayment of benefit; recovery.

If a person who is a member, former member, contributor, former contributor, retirant, beneficiary, or alternate payee, as defined in section 3105.80 of the Revised Code, is paid any benefit or payment by the school employees retirement system to which the person is not entitled, the benefit shall be repaid to the retirement system by the person. If the person fails to make the repayment, the retirement system shall withhold the amount due from any benefit due the person or the person's beneficiary under this chapter, or may collect the amount in any other manner provided by law.

Eff.	1/1/02	H.B. 535
	7/29/92	S.B. 346

Sec. 3305.01 Alternative Retirement Plans-Definitions.

As used in this chapter:

- (A) "Public institution of higher education" means a state university as defined in section 3345.011 of the Revised Code, the northeastern Ohio universities college of medicine, or a university branch, technical college, state community college, community college, or municipal university established or operating under Chapter 3345., 3349., 3354., 3355., 3357., or 3358. of the Revised Code.
- (B) "State retirement system" means the public employees retirement system created under Chapter 145. of the Revised Code, the state teachers retirement system created under Chapter 3307. of the Revised Code, or the school employees retirement system created under Chapter 3309. of the Revised Code.
- (C) "Eligible employee" means any person employed as a full-time employee of a public institution of higher education.

In all cases of doubt, the board of trustees of the public institution of higher education shall determine whether any person is an eligible employee for purposes of this chapter, and the board's decision shall be final.

- (D) "Electing employee" means any eligible employee who elects, pursuant to section 3305.05 or 3305.051 of the Revised Code, to participate in an alternative retirement plan provided pursuant to this chapter or an eligible employee who is required to participate in an alternative retirement plan pursuant to division (C)(4) of section 3305.05 or division (F) of section 3305.051 of the Revised Code.
- (E) "Compensation," for purposes of an electing employee, has the same meaning as the applicable one of the following:
 - (1) If the electing employee would be subject to Chapter 145. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "earnable salary" as defined in division (R) of section 145.01 of the Revised Code;

- (2) If the electing employee would be subject to Chapter 3307. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "compensation" as defined in division (L) of section 3307.01 of the Revised Code;
 - (3) If the electing employee would be subject to Chapter 3309. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "compensation" as defined in division (V) of section 3309.01 of the Revised Code.
- (F) "Provider" means an entity designated under section 3305.03 of the Revised Code as a provider of investment options for an alternative retirement plan.

Eff.	7/1/06	H.B. 478
	8/1/05	S.B. 133
	4/01/01	H.B. 535
	3/31/97	H.B. 586

ADMINISTRATIVE RULES

3309-1-35 Health care.

(A) Definitions

As used in this rule:

- (1) "Ineligible person" has the same meaning as in section 3309.69 of the Revised Code.
- (2) "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.
- (3) "Member" has the same meaning as in section 3309.01 of the Revised Code.
- (4) "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.
- (5) "Disability benefit recipient" means a member who is receiving a benefit or allowance pursuant to section 3309.35, 3309.40 or 3309.41 of the Revised Code.
- (6) "Child" means an unmarried, biological, adopted or step-child of the retirant, member, deceased retirant or deceased member or other child who lives or lived with the retirant, member, deceased retirant or deceased member in a parent-child relationship in which the retirant, member, deceased retirant or deceased member has or had custody of the child.
- (7) "Dependent child" means a child who:
 - (a) (i) Is under age eighteen or under age twenty-two if attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirements of such institution, or
 - (ii) Regardless of age is physically or mentally incompetent, provided that the incompetence existed prior to the retirant's or member's death and prior to the dependent child reaching age eighteen or age twenty-two if attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirements of such institution, and
 - (b) During the twelve-month period preceding the application for health care coverage or the member or retirant's death, lived with the member or retirant in a parent-child relationship or received at least one-half of his/her support from the member, retirant, deceased member or deceased retirant.
- (8) "Health care coverage" means any plan offered by the system including, but not limited to, the medical plan, and the prescription drug program.
- (9) "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.

(B) Eligibility

- (1) Any person who is not an “ineligible person” as defined in section 3309.69 of the Revised Code, 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 retiree or the retiree’s spouse or dependent child,
 - (b) A disability benefit recipient or the recipient’s spouse or dependent child,
 - (c) The spouse or dependent child of a deceased member, age and service retiree or disability benefit recipient, if the spouse or dependent child is receiving a benefit pursuant to section 3309.45 or 3309.46 of the Revised Code,
 - (d) The dependent child of a deceased member or deceased retiree who is living with the primary recipient of a benefit under section 3309.45 or 3309.46 of the Revised Code in a parent-child relationship in which the primary recipient has custody of the dependent child.
- (2) Eligibility for health care coverage shall terminate when the person ceases to qualify as one of the persons listed in paragraph (B)(1) of this rule.

(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 benefits pursuant to section 3309.45 of the Revised Code.
- (2) An eligible spouse of an age and service retiree or disability benefit recipient may only be enrolled in the system’s health care coverage as follows:
 - (a) At the time the retiree or recipient applies for an age and service retirement or disability benefit; or,
 - (b) Within thirty-one days of the eligible spouse’s:
 - (i) Marriage to the retiree or recipient;
 - (ii) Attaining age sixty-five; or
 - (iii) Involuntary termination of health care coverage under another group plan, medicare advantage plan, or medicare part D only plan.
- (3) An eligible dependent child of an age and service retiree, disability benefit recipient, or deceased member may be enrolled in the system’s health care coverage as follows:
 - (a) At the time the retiree, disability benefit recipient, or surviving spouse applies for an age and service retirement, disability benefit, or benefit under section 3309.45 of the Revised Code; or,
 - (b) Within thirty-one days of the eligible dependent child’s:
 - (i) Birth or adoption;
 - (ii) Attendance at an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full time curriculum requirement of the institution, if aged eighteen or older; or

- (iii) Involuntary termination of health care coverage under another group plan, medicare advantage plan, or medicare part D only plan.

(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 health care coverage is cancelled for default as provided in paragraph (F) of this rule;
- (c) The person's health care coverage is waived as provided in paragraph (G) of this rule;
- (d) The person's health care coverage is cancelled due to the person's enrollment in medicare part D coverage only as provided in paragraph (H) of this rule; or
- (e) The health care coverage of a spouse or dependent child is cancelled when the health care coverage of a benefit recipient is cancelled.
- (f) 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, or division (D) of section 3309.41 of the Revised Code.

(E) Effective date of coverage

(1) 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, spouse or dependent child of a disability benefit recipient health care coverage shall be effective on the first of the month following approval of the benefit or the benefit effective date, whichever is later.
- (b) For an age and service retirant, spouse or dependent child 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 the benefit effective date, whichever is later.
- (c) For an eligible spouse or dependent child of a deceased member or deceased 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.

(F) Premiums

(1) The school employees retirement board may establish premiums for a benefit recipient's health care coverage, including dependent coverage with the system.

- (a) 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.
- (b) Premium payments billed to a benefit recipient shall be deemed in default after three

consecutive months of nonpayment. A benefit recipient who is in default shall be sent notice by certified U.S. mail informing 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 is received. 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.

- c) After cancellation for default, health care coverage can be reestablished and coverage reinstated as provided in paragraph (l) 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.
- (2) A person enrolled in SERS' health care plan cannot receive a premium subsidy unless that person is:
- (a) A dependent child;
 - (b) (i) An age and service retiree with an effective retirement date before August 1, 2008, and the age and service retiree's spouse;
(ii) An age and service retiree with an effective retirement date on or after August 1, 2008 who was eligible to participate in the health care plan of his or her employer at the time of retirement or separation from service, and the age and service retiree's spouse;
 - (c) (i) A disability benefit recipient with an effective benefit date before August 1, 2008, and the disability benefit recipient's spouse;
(ii) A disability benefit recipient with an effective benefit date on or after August 1, 2008 who was eligible to participate in the health care plan of his or her employer at the time disability was awarded or at the time of separation from service, and the disability benefit recipient's spouse;
 - (d) (i) A surviving spouse of a deceased member with an effective benefit date before August 1, 2008;
(ii) A surviving spouse of a deceased member who was eligible to participate in the health care plan of his or her employer at the time of death or separation from service with an effective benefit date on or after August 1, 2008 ; or
 - (e) A surviving spouse of a retiree or disability benefit recipient described in paragraphs (F)(2)(b) or (F)(2)(c) of this rule.

(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 spouse or dependent child may be waived as follows:

- (a) For non-medicare eligible spouses and dependent children, the benefit recipient may waive their coverage by completing and submitting a SERS waiver form to SERS on their behalf.
- (b) For medicare eligible spouses and dependent children, the spouse and dependent child may waive their coverage by completing and submitting a SERS waiver form to SERS.

(H) Medicare part D

- (1) SERS shall cancel the health care coverage of a benefit recipient, spouse, or dependent child who enrolls in a medicare part D plan that is not offered by the system unless SERS receives proof of cancellation within ninety days of receipt of notice of enrollment. The cancellation shall be effective on the first day of the month after SERS notifies the benefit recipient that the coverage has been cancelled.

(I) Reinstatement to SERS health care coverage

- (1) An eligible benefit recipient, or spouse or dependent child of a benefit recipient with health care coverage, whose coverage has been previously 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 thirty-one days after reaching age sixty-five. Health care coverage shall be effective the later of the first day of the month after reaching sixty-five 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 another group plan, medicare advantage plan, or medicare part D only 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 group 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)(f) of this rule shall be reinstated to SERS health care plan when benefit payments are reinstated.

- (3) An eligible benefit recipient, or spouse or dependent child of a benefit recipient with health care coverage, whose coverage has been previously cancelled and who is enrolled in medicare A and B or medicare 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.

- (4) An eligible benefit recipient, or spouse or dependent child 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 A and B or medicare 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.

(J) Medicare part "B"

- (1) A benefit recipient shall enroll in medicare part B at the recipient's first eligibility date for medicare part B.

- (2) The effective date of the medicare "B" premium to be paid by the board shall be the later of:

- (a) January 1, 1977; or
 - (b) The first of the month following the date that the school employees retirement system received satisfactory proof of coverage; or
 - (c) The effective date of SERS health care coverage.
- (3) The board shall not:
- (a) Pay more than one monthly medicare "B" premium when a retirant or benefit recipient is receiving more than one monthly benefit from this system; nor
 - (b) Pay a medicare "B" premium to a retirant or benefit recipient who is receiving reimbursement for this premium from any other source.

HISTORY: 5/22/09 (Emer.), 1/8/09, 8/8/08, 12/24/07, 9/28/07 (Emer.), 3/1/07, 1/2/04, 6/13/03, 11/9/98, 8/10/98, 1/2/93, 7/20/89, 3/20/80, 1/1/77

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.69
Review Dates: 11/20/06, 2/1/11

3309-1-51 Long-term care coverage.

- (A) The school employees retirement system may contract directly with an insurer to establish a program that provides contracts for long-term care insurance for members and benefit recipients of the system and members of their families. If the program is established jointly with another retirement system, the contract shall separately establish the terms and conditions for participation through the school employees retirement system.
- (B) Members of the school employees retirement system who have contributed to the system during the previous eighteen months may make application to participate in contracts effective on and after July 1, 1994 for long-term care coverage offered pursuant to section 3309.691 of the Revised Code, provided:
 - (1) Application for coverage shall be made directly to the insurer during enrollment periods specified by the school employees retirement system; and
 - (2) Determination of eligibility for participation under the terms of any such contract shall be made by the insurer with approval of the school employees retirement system.
- (C) The recipient of any monthly benefit may participate in contracts for long-term care coverage, subject to the same conditions as those applicable to members under the terms of paragraph (B) of this rule.
- (D) Payment for coverage shall be made by the member or benefit recipient to the insurer in such amounts and by such methods as determined under the contract for long-term care coverage.
- (E) A spouse, parent or parent-in-law of any individual who has made application pursuant to paragraph (B) or (C) of this rule may apply for coverage subject to the same terms and conditions as those applicable to members under the terms of paragraph (B) of this rule, provided that in the case of a spouse, the individual participating pursuant to paragraph (B) or (C) of this rule agrees to remit the cost of such coverage along with his or her own payment.

HISTORY: 5/3/02, 6/10/94

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.691
Review Date: 2/1/07; 2/1/12

SERS HEALTH CARE PROGRAM HISTORY

- 1962**— SERS offers its first health care insurance plan. It is underwritten by Blue Cross/Blue Shield, and members paid 100% of the premiums.
- 1974**— Aetna replaces the Blue Cross/Blue Shield Program. All benefit recipients are enrolled with no cost for coverage. The Board sets a \$20,000 maximum lifetime coverage per covered person for hospital and medical coverage. Coordination of benefits insures that total claim payment does not exceed total cost when an individual is covered by more than one health care plan.
- 1975**— The Board increases the maximum lifetime coverage amount to \$250,000. SERS offers Kaiser HMO to benefit recipients and dependents in Northeast Ohio.
- 1977**— SERS begins reimbursing benefit recipients for the cost of Medicare Part B premiums.
- 1980**— Aetna implements an on-site hospital billing audit program; Aetna staff audits all hospital bills over \$15,000 and bills with ancillary charges greater than 70% of the total bill.
- 1981**— The Board increases the Aetna maximum lifetime coverage amount to \$500,000.
- SERS introduces its first mail-order prescription drug program through National Rx Services, Inc. A 90-day supply of prescription drugs is available for a \$1 co-pay.
- Aetna implements individual case management to provide cost-effective alternative treatments.
- The Aetna Split Funded Agreement replaces the traditional indemnity-type insurance program, which permits detailed analysis of health care expenses and better control of claim processing costs. As a result, reserves previously held by Aetna now remain with SERS, and SERS establishes the Health Care Reserve account to receive these funds. Separate accounting insures no commingling of health care coverage funds with pension benefit funds.
- 1982**— SERS becomes the first Ohio retirement system to publicly disclose long-term actuarial accrued liabilities of retiree health care. The actuary determines the employer contribution rate required for health care funding; SERS staff initiates annual transfer of assets (based on this actuarially-determined rate) to the Health Care Reserve.
- 1983**— The Board approves premium charges for spouse and dependent insurance coverage and establishes the annual program deductible.
- 1984**— SERS organizes a Special Health Care Task Force. Representatives from member and employer organizations, the Retirement Study Commission, health care providers, actuaries, and accountants meet to study SERS' increasing health care costs.
- 1986**— Effective June 13, 1986, Ohio law requires a minimum of 10 years of service to qualify for health care coverage (previously five years was required).
- 1987**— SERS introduces the Kaiser Plus and United Health Plan HMOs.
- Although not required by law, SERS chooses to disclose health care liabilities as part of the Pension Benefit Obligation to draw attention to the long-term nature of health care funding issues. This is accomplished by SERS' early adoption of Governmental Accounting Standards Board Statement No. 5.

- 1987**— SERS introduces H.B. 290. Health care provisions in legislation and Board action include:
- a) establish “career” vesting of health care coverage — 25 years of service required for full coverage subsidy. Coverage subsidy established at 25% (10-14 years), 50% (15-19 years), and 75% (20-24 years)
 - b) 40% reduction of System’s subsidy of dependent health care premiums, to be phased-in over five years
 - c) freeze Medicare Part B reimbursement at current level
 - d) establish 80/20% relationship between System costs and retiree costs for mail-order drug program
 - e) establish an employer surcharge (additional employer contribution) on members who earn less than an actuarially-determined minimum salary; the surcharge revenues to be used exclusively for funding health care coverage.
- 1988**— In June of 1988, H.B. 290 becomes law.
- 1990**— SERS implements changes to the mail-order drug program to encourage use of lower-cost generic drugs; retiree cost of brand name drugs is increased 25%, while making generic drugs available at no cost. The projected one-year savings of modification is \$1 million or 6-7% of total mail-order program costs. SERS implements a retail drug program, creating significant discounts for drugs dispensed at the retail level and electronic filing of retirees’ prescription drug claims.
- 1993**— SERS adopts a new Administrative Services Only Contract agreement with Aetna, signifying what is truly the beginning of managed care for SERS participants who are not eligible for Medicare. Networks are available to those who reside in the greater Cincinnati, Cleveland, and Columbus areas.
- 1996**— The managed-care program expands and becomes available for the entire state.
- 2000**— SERS offers Medical Mutual of Ohio as an additional choice to its HMO and Aetna PPO offerings.
- 2001**— SERS offers a retiree-pay-all based dental plan that is administered by Delta Dental.
- 2004**— The Board makes several changes to the SERS Health Care Plan, affecting deductibles, drug and office co-pays, and out-of-pocket maximums. SERS establishes 15% of the Plan cost as the minimum threshold a benefit recipient will pay for health care premiums. The PPO product is extended outside of Ohio for non-Medicare retirees. SERS’ Medicare Coordination of Benefits methodology is changed from Government Exclusion to Maintenance of Benefits. The Board approves switching dental coverage from Delta Dental to Aetna Dental, with a two-year lock-in premium guarantee.
- SERS introduces the Premium Contribution Discount Program, granting a monthly premium discount to benefit recipients who have a qualifying household income equal to or less than a set percentage of the federal poverty level.
- 2006**— The Board approves the selection of LifeMasters as SERS’ disease management program vendor and passes a resolution authorizing funding of a three-year contract. The program initially covers five chronic disease states: congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease, and asthma for non-Medicare SERS health plan participants.

SERS introduces the Quit-Line program to provide telephone smoking cessation counseling services and nicotine replacement therapy patches to benefit recipients. The cost of the program is shared 50/50% between SERS and the Ohio Tobacco Use Prevention and Control Foundation.

SERS receives its first Medicare Part D Retiree Drug Subsidy (“RDS”) payment.

In late 2006, the Board approves the formation of the Health Care Preservation Task Force, assembling staff, Board members, constituents, advocacy groups, consultants, and actuaries to address the issue of long-term health care fund solvency.

2007— Several activities, all focusing on improving solvency, take place in 2007. SERS joins with Ohio Public Employees Retirement System (OPERS) and State Teachers Retirement System of Ohio (STRS) as a founding partner in the Rx Ohio Collaborative and is subsequently joined by The Ohio State University and the Ohio Highway Patrol Retirement System in that effort. The three founders select Express Scripts, Inc. as their pharmacy benefit manager and work toward a 2008 implementation.

The Health Care Preservation Task Force continues its work to improve the health care fund solvency.

The SERS Board approves changes to the premium subsidies available to service retirees, survivor benefit recipients, disability retirees, and spouses/dependents who are eligible for health care benefits. Although most spousal and dependent premiums increase in January 2008, premiums for retirees with Medicare decrease.

Effective in 2008, SERS selected two Medicare Advantage plans as replacements for the self-insured Medicare supplement plan currently offered. These plans provide competitive rates for retirees, improved wellness benefits, and are fully insured products.

2008— The Health Care Preservation Task Force presents its recommendations to the SERS Board. Some key components of the recommendations include increased population health management and better use of health care data as a means to control costs. Staff and the Board work in collaboration to adopt the task force recommendations.

2009— SERS issues a Request for Proposal (RFP) seeking a wellness vendor, and enters into a contract with Health Fitness to provide comprehensive wellness and health management services to under 65 Non-Medicare retirees and their adult dependents. The program includes Health Risk Assessments, member outreach in the form of wellness fairs around the state, and individual wellness coaching. A second RFP is completed, which focuses on identifying medical plan administrators. As a result, SERS elects to consolidate its two under-65 plans into one for 2010 as a means of keeping member premiums lower.