Rules for June 12, 2014

STRS

3307:1-12-02 Maximum permissible benefits

SERS

3309-1-35 Health care

3307:1-12-02 **Maximum permissible benefits.**

Applicability of the final 415 regulations effective beginning on the limitation year commencing on January 1, 2008.

(A) In general. The final regulations for section 415 of the Internal Revenue Code are accelerated and applicable to distributions to members and beneficiaries as of January 1, 2008. Effective January 1, 2008 and pursuant to section 3307.58 of the Revised Code and section 415 of the Internal Revenue Code, the maximum annual benefit distributed to a member or beneficiary shall be determined as of the date the benefit commences and shall be limited to the maximum amounts permitted under section 415(b)(1)(A) of the Internal Revenue Code. In general, section 415 limits a member's maximum annual benefit to one hundred eighty-five thousand dollars (one hundred ninety-five thousand dollars for 2009, which amount shall be increased to reflect cost of living increases pursuant to Internal Revenue Code section 415) payable in a straight life annuity but if the member has not completed ten years of participation, such maximum annual dollar limitation is reduced by the ratio which the number of his years of participation bears to ten. The maximum dollar limitation applies to a benefit payable at age sixty-two and shall be adjusted in accordance with cost of living increases in the amount determined by the commissioner of Internal Revenue. The limits of this paragraph do not apply to benefits attributable to rollover contributions made pursuant to paragraph (N) of rule 3307:1-3-11 of the Administrative Code and the annual benefit attributable to any such rollover contributions shall be determined in accordance with section 1.415(b)-1(b)(2)(v) of the Treasury Regulation.

(B) No adjustment shall be made for any benefit payment which is to commence after age sixty-two.

(C) For any benefits paid prior to age sixty-two, the maximum dollar limit shall be reduced as follows:

(1) For annuity starting dates on or before December 31, 2007. The maximum annual benefit shall be reduced to an annual straight-life annuity beginning at the annuity starting date that is the actuarial equivalent of the maximum annual benefit (adjusted for members with fewer than ten years of participation, if necessary), using whichever of the following produces a smaller annual amount: (a) an interest rate and mortality table determined and adjusted periodically by the state teachers retirement board, or (b) a five per cent interest rate assumption and the modified unisex version of the mortality tables for the plan year in which the annuity begins as prescribed by the secretary of the treasury for use in determining present value under subparagraphs (A) and (B) of section 417(e)(3) of the Internal Revenue Code. Such mortality tables shall be based on the actual experience of pension plans and projected trends in such experience as specified in subparagraph (A) of

section 430(h)(3) of the Internal Revenue Code without regard to subparagraphs (C) and (D) of that section ~~applicable mortality table described in section 417(e)(3)(A) of the Internal Revenue Code~~.

(2) For annuity starting dates after December 31, 2007. The maximum annual benefit shall be reduced to the lesser of:

(a) An annual straight-life annuity beginning at the annuity starting date that is the actuarial equivalent of the maximum annual benefit (adjusted for members with fewer than ten years of participation, if necessary), using for this purpose a five per cent interest rate assumption and the modified unisex version of the mortality tables for the plan year in which the annuity begins as prescribed by the secretary of the treasury for use in determining present value under subparagraphs (A) and (B) of section 417(e)(3) of the Internal Revenue Code. Such mortality tables shall be based on the actual experience of pension plans and projected trends in such experience as specified in subparagraph (A) of section 430(h)(3) of the Internal Revenue Code without regard to subparagraphs (C) and (D) of that section ~~applicable mortality table described in section 417(e)(3)(A) of the Internal Revenue Code~~; or

(b) The maximum annual benefit (adjusted for members with fewer than ten years of participation, if necessary), multiplied by the ratio of the annual amount of the immediately commencing straight life annuity at the annuity starting date to the annual amount of the immediately commencing straight life annuity at age 62.

(3) The member's age for the purposes of calculating the benefits to be paid prior to age sixty-two shall be expressed as the age of the member, in completed calendar year months, as of the annuity starting date.

(D) No actuarial adjustment to the maximum annual benefit shall be made for the following:

(1) Survivor benefits payable to a spouse under a qualified joint and survivor annuity pursuant to section 3307.60 of the Revised Code, to the extent such benefits would not be payable if the member's benefit were paid in another form;

(2) Any benefits provided to members that are not directly related to retirement benefits, including qualified disability benefits or allowances set forth in sections 3307.63 and 3307.631 of the Revised Code and health benefits set forth in section 3307.39 of the Revised Code; or

(3) The inclusion of automatic periodic increases to benefits calculated in the manner set forth in section 3307.67 of the Revised Code, provided that the form of benefit is not subject to section 417(e)(3) of the Internal Revenue Code (which applies based on the form of benefit and not the status of the plan described in sections 3307.50 to 3307.79 of the Revised Code), would otherwise satisfy this rule, and complies with the determination of benefit increases as calculated in paragraph (B) of rule 3307:1-10-01 of the Administrative Code.

(E) If an adjustment is required because the member selects a form of payment under section 3307.60 of the Revised Code to which section 415(b)(2)(E) of the Internal Revenue Code applies based on the form of benefit and not the status of the plan described in sections 3307.50 to 3307.79 of the Revised Code and that is not subject to section 417(e)(3) of the Internal Revenue Code, the value of the equivalent straight-life annuity for testing purposes of section 415(b) is the greater of (i) the annual amount of the straight-life annuity (if any) payable to the member commencing at the same annuity starting date as the form of benefit payable to the member and (ii) the annual amount of the straight-life annuity commencing at the same annuity starting date that has the same actuarial present value as the form of benefit payable to the member, computed using a five per cent interest assumption and the modified unisex version of the mortality tables for the plan year in which the annuity begins as prescribed by the secretary of the treasury for use in determining present value under subparagraphs (A) and (B) of section 417(e)(3) of the Internal Revenue Code. Such mortality tables shall be based on the actual experience of pension plans and projected trends in such experience as specified in subparagraph (A) of section 430(h)(3) of the Internal Revenue Code without regard to subparagraphs (C) and (D) of that section ~~applicable mortality table described in section 417(e)(3)(A) of the Internal Revenue Code for the annuity starting date~~.

(F) If an adjustment is required because the member selects a form of payment under section 3307.60 of the Revised Code to which sections 415(b)(2)(E) and 417(e)(3) of the Internal Revenue Code apply based on the form of benefit and not the status of the plan described in sections 3307.50 to 3307.79 of the Revised Code, the actuarial straight-life annuity for testing under 415(b) for annuity starting dates on and after January 1, 2008 is determined by calculating the greatest annual straight-life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using (i) an interest rate and mortality table determined and adjusted periodically by the state teachers retirement board, (ii) a 5.5 per cent interest rate assumption and the modified unisex version of the mortality tables for the plan year in which the annuity begins as prescribed by the secretary of the treasury for use in determining present value under subparagraphs (A) and (B) of section 417(e)(3) of the Internal Revenue Code, and such mortality tables shall be based on the actual experience of pension plans and projected trends in such experience as specified in subparagraph

(A) of section 430(h)(3) of the Internal Revenue Code without regard to subparagraphs (C) and (D) of that section ~~applicable mortality table described in section 417(e)(3)(A) of the Internal Revenue Code for the distribution~~, and (iii) the applicable interest rate and the modified unisex version of the mortality tables for the plan year in which the annuity begins as prescribed by the secretary of the treasury for use in determining present value under subparagraphs (A) and (B) of section 417(e)(3) of the Internal Revenue Code, and such mortality tables shall be based on the actual experience of pension plans and projected trends in such experience as specified in subparagraph (A) of section 430(h)(3) of the Internal Revenue Code without regard to subparagraphs (C) and (D) of that section ~~applicable mortality table described in section 417(e)(3)(A) of the Internal Revenue Code for the distribution~~, with the result divided by 1.05.

(G) For a member who has or will have distributions commencing at more than one annuity starting date, the maximum annual benefit shall be determined as of each such annuity starting date (and shall satisfy the limits in section 415 of the Internal Revenue Code as of each starting date), actuarially adjusting for past and future distributions of benefits commencing at the other annuity starting dates as required under the application authority.

(H) The application of the provisions of this rule shall not cause the maximum annual benefit provided to a member to be less than the member's accrued benefit as of the end of December 31, 2007 under provisions of Chapter 3307. of the Revised Code and division 3307:1 of the Administrative Code that were both adopted and in effect prior to April 5, 2007.

(I) Effective January 1, 2009, the term "compensation" as defined in section 3307.01 of the Revised Code includes differential wage payments as defined in section 3401(h)(2) of the Internal Revenue Code.

Effective:

R.C. 119.032 review dates: 03/24/2019

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Certification

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Date

Promulgated Under:	111.15
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Rule Amplifies:	3307.46, 3307.58, 3307.63, 3307.67
Prior Effective Dates:	07/16/2009, 09/03/2012

3309-1-35 **Health care.**

(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 the medical plan and the prescription drug plan offered by the system.

(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.

(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 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) Eligibility for 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.

(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 as follows:

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

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

(i) Marriage to the retirant or disability benefit 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 plan.

(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 as follows:

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

(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 group plan, medicaid, medicare advantage plan, or medicare part D 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 eligibility terminates as provided in paragraph (B)(3) of this rule;

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

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

~~(d)~~(e) 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;

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

~~(f)~~(g) 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 or dependent 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 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 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.

(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 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.

(3) After cancellation for default, health care coverage can be reestablished and coverage 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.

(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:

(i) An age and service retirant with an effective retirement date before August 1, 1989; or

(ii) An age and service retirant with 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) An age and service retirant with 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:

(i) A disability benefit recipient with an effective benefit date before August 1, 2008; or

(ii) A disability benefit recipient with 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 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.

(e) 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.

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

(g) 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 unless SERS receives proof of cancellation within fourteen 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 dependent 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, medicaid, 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 ~~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 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.

~~(3)~~(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 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)~~(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 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.

~~(5)~~(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.

(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 B coverage before January 7, 2013, or

(ii) An eligible person who is a benefit recipient, is eligible for

medicare B coverage, and is enrolled in SERS' health care.

(3) The effective date of the medicare "B" premium 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 "B" premium when a benefit recipient is receiving more than one monthly benefit from this system; nor

(b) Pay a medicare "B" premium to a benefit recipient who is receiving reimbursement for this premium from any other source.

Effective:

R.C. 119.032 review dates: 02/01/2015

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Certification

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Date

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