3309-1-30 **Payment of additional actuarial liability.**

(A) This rule amplifies division (A)(1) of section 3309.34 of the Revised Code.

(B) For purposes of division (A) of section 3309.34 of the Revised Code and this rule:

(1) "Total service credit" means all service credit earned in the public employees retirement system, state teachers retirement system, or school employees retirement system, except credit for service subject to section 3309.341 of the Revised Code. Total service credit shall not exceed one year of credit for any twelve-month period.

(2) "Buy-up" means to ~~make~~ pay an additional voluntary contribution in an amount equal to the additional actuarial liability to the school employees retirement system of retiring under the retirement eligibility criteria contained in division (A)(1)(a) of section 3309.34 of the Revised Code.

(C) ~~A member with less than twenty-five years of total service credit as of August 1, 2017 may submit a written request to buy-up to the school employees retirement system.~~

(1) SERS administrative staff shall provide a cost estimate of a member's buy-up amount to any member or their designee upon request. A member who wishes to buy-up after receiving a cost estimate shall submit a written request for an actuarial cost calculation.

~~(1)~~(2) The actuarial cost calculation of the additional liability shall be ~~determined~~performed by the school employees retirement system actuary based on factors recommended by the ~~school employees retirement system~~ actuary and approved by the retirement board. The factors used in calculating the additional liability will be revised no more than once annually and shall apply only to payments made after such revision is approved by the school employees retirement board.

(a) SERS will send notice of the actuarial cost calculation to the member upon receipt from the actuary.

(b) The buy-up payment shall be made in a lump sum payment and shall be received by SERS within ninety days following the date of the notice or by August 1, 2017, whichever is earlier. If SERS does not receive the payment within ninety days of the notice, a new cost calculation is required.

(c) Members can request no more than four actuarial cost calculations in any calendar year.

~~(2) The buy-up shall be made in a lump sum payment by August 1, 2017.~~

(3) The amount of any buy-up ~~contribution~~payment cannot exceed the limitations set forth in Internal Revenue Code section 415. If the cost of the additional liability exceeds the limitations set forth in the Internal Revenue Code, the member is not eligible to retire under division (A)(1)(a) of section 3309.34 of the Revised Code.

(D) Buy-up payments shall be treated as part of a member's accumulated contributions as defined in section 3309.01(J) of the Revised Code. Contributions paid by a member pursuant to this rule shall be credited to the employees' savings fund.

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Certification

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Date

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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.

(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 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 a medicare advantage plan or medicare part D plan as provided in paragraph (H) of this rule;

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

(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 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 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) 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) 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.

(6) 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.

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3309-1-55 **Responsibility for health care coverage.**

(A) This rule amplifies division (F) of section 3309.69 of the Revised Code.

(B) For the purpose of this rule:

(1) "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.

(2) "Cost paid by the benefit recipient" means the amount equal to the percentage as of January 1, 1998 paid by the benefit recipient multiplied by the system's cost per benefit recipient.

(3) "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.

(4) "Eligible benefit recipient" means an age and service retirant, disability or survivor benefit recipient who is eligible for health care coverage under this system.

(5) "Eligible dependent" means an eligible spouse or child of an eligible benefit recipient.

(6) "Health care coverage" means the medical plan and the prescription drug plan offered by this system ~~including, but not limited to, the medical plan, the prescription drug program,~~ and the medicare part B premium reimbursement.

(7) "Ohio retirement system" means public employees retirement system, state teachers retirement system, school employees retirement system, Ohio police and fire pension fund, or highway patrol retirement system.

(8) "Survivor benefit recipient" means a beneficiary receiving a benefit pursuant to section 3309.45 or 3309.46 of the Revised Code.

(C) Health care coverage provided by this retirement system under sections 3309.69 and 3309.375 of the Revised Code shall pay covered medical expenses for eligible benefit recipients of this retirement system prior to payment under any available coverage from another Ohio retirement system if the available coverage is provided to the individual as the spouse or dependent of another person.

(D) Health care coverage provided by this system shall pay only the covered medical expenses not paid or reimbursed by any available coverage from another Ohio retirement system if either of the following occur:

(1) In the case of an eligible benefit recipient, the available coverage is not provided as a dependent of another person, and has been in effect for a longer time than the health care coverage provided by this system;

(2) In the case of a dependent, the available coverage is not provided as the dependent of another person or is provided as the dependent of another person but has been in effect for a longer time than the health care coverage provided by this system.

(E) Except as otherwise provided in this rule, the school employees retirement system shall not be the system responsible for health care coverage for eligible benefit recipients or eligible dependents of eligible benefit recipients of this system who waive or are otherwise eligible for any available coverage from another Ohio retirement system after December 31, 2007.

(F) Each eligible benefit recipient and eligible dependent enrolled in health care coverage provided by this system shall annually make a report to the system or, an entity designated by the system, stating whether the person has other available coverage. The report shall include any information requested by the system or entity.

(G)

(1) If an eligible benefit recipient of this system who also was an eligible benefit recipient of another Ohio retirement system irrevocably waived such health care coverage in this system on or before December 31, 2007 in order to be covered by the other Ohio retirement system, this system shall transfer to the other system annually for covered benefit recipients and dependents for each month covered an amount equal to the sum of:

(a) The lesser of this system's average monthly medical including health maintenance organization cost per benefit recipient less the cost paid by the benefit recipient, or the other system's average monthly medical cost including health maintenance organization cost per benefit recipient.

(b) The lesser of this system's average monthly cost of the prescription drug program per benefit recipient, or the other system's average monthly cost of the prescription drug program per benefit recipient.

(c) The lesser of the monthly cost of the medicare part B premium that would be reimbursed by this system for the benefit recipient, or the monthly cost of the medicare part B premium that would be reimbursed by the other system for the benefit recipient.

(2) This system shall transfer the amounts due pursuant to paragraph (G)(1) of this rule no later than the last business day of February each year for the preceding calendar year after the following occur:

(a) This system receives from the other system a list containing the names of benefit recipients and the number of months during which the recipients were covered by the other system for the preceding calendar year; and

(b) This system prepares an itemized accounting of the amount transferred for each such benefit recipient.

(H) Where an eligible benefit recipient or dependent of an eligible benefit recipient of this system has waived health care coverage in another Ohio retirement system on or before December 31, 2007, this system shall be responsible to provide health care coverage only if the other system pays annually to this system for covered benefit recipients and dependents for each month covered an amount equal to the sum of:

(1) The lesser of this system's average monthly medical including health maintenance organization cost per benefit recipient less the cost paid by the benefit recipient, or the other system's average monthly medical cost including health maintenance organization cost per benefit recipient.

(2) The lesser of this system's average monthly cost of the prescription drug program per benefit recipient, or the other system's average monthly cost of the prescription drug program per benefit recipient.

(3) The lesser of the monthly cost of the medicare part B premium that would be reimbursed by this system for the benefit recipient, or the monthly cost of the medicare part B premium that would be reimbursed by the other system for the benefit recipient.

(I)

(1)

(a) Paragraph (G) of this rule is rescinded effective January 1, 2016.

(b) This system shall transfer the amounts due pursuant to paragraph (G)(1) of this rule for calendar year 2015 no later than the last business day of February 2016 after the following occur:

(i) This system receives from the other system a list containing the names of benefit recipients and the number of months during which the recipients were covered by the other system for the preceding calendar year; and

(ii) This system prepares an itemized accounting of the amount transferred for each such benefit recipient.

(2) Paragraph (H) of this rule is rescinded effective January 1, 2016.

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