Rules

November 9, 2023

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145-1-71 **Withdrawal of benefit application.**

(A) Except as provided in paragraph (F) of this rule, a member or contributor of the public employees retirement system may withdraw an application for retirement, disability, or annuity payments pursuant to section 145.384 or 145.64 of the Revised Code by either of the following methods:

(1) Returning to the retirement system not later than thirty days after issuance of the initial benefit payment, all uncashed payments, along with a written request over the member's or retirant's signature to withdraw the application;

(2) Remitting to the retirement system a personal check or money order repaying the benefit payment(s) transmitted by or on behalf of the retirement system to the member's or retirant's financial institution not later than thirty days after the institution's receipt of the initial benefit payment, along with a written request over the member's or retirant's signature to withdraw the application.

(B) Except as provided in division (C)(1) of section 145.45 of the Revised Code or paragraph (F) of this rule, a beneficiary eligible for monthly benefits pursuant to division (A) or (B) of section 145.45 of the Revised Code may withdraw an application for those benefits by either of the following methods:

(1) Returning to the retirement system not later than thirty days after issuance of the initial benefit payment, all uncashed payments, along with a written request over the beneficiary's signature to withdraw the application and a completed application for a lump sum payment of the member's accumulated account;

(2) Remitting to the retirement system a personal check or money order repaying the benefit payments(s) transmitted by the retirement system to the beneficiary's financial institution, not later than thirty days after the institution's receipt of the initial benefit payment, along with a written request over the beneficiary's signature to withdraw the application and a completed application for a lump sum payment of the member's accumulated account.

(C) If a member participating in the member-directed or combined plan, or the member's beneficiary, withdraws an application as provided in this rule and all or any portion of the member's individual defined contribution account is used to pay the benefit, the member or the beneficiary is not entitled to any investment gains or losses on the amount that was used to pay the benefit for the period beginning on the date the retirement system converts the units in the account for payment and ending on the date the account is reestablished by the retirement system as provided in this rule. The amount used to pay the benefit as provided in this rule shall be credited to the member's individual defined contribution account and invested in the same OPERS

investment options and in the same proportion as the account existed immediately prior to the payment.

(D) Any non-vested amounts that were forfeited by a member participating in the member-directed plan or the member's beneficiary who withdraws a retirement application under this rule shall be restored to the member's individual defined contribution account or retiree medical account, as defined in rule 145-4-01 of the Administrative Code. Investment gains or losses shall not be applied to the amounts for the period that the amounts were not in the member's individual defined contribution account.

(E)

(1) If a member or contributor participating in the traditional pension plan withdraws an application as provided in this rule, the application of the member or contributor for an additional annuity payment under section 145.64 of the Revised Code, if any, shall also be withdrawn.

(2) All payments issued pursuant to section 145.64 of the Revised Code shall be returned to the retirement system in accordance with paragraph (A) of this rule.

(3) A member is not entitled to any investment gains or losses on the additional annuity account for the period beginning on the date the retirement system converts the units in the account for payment and ending on the date the account is reestablished by the retirement system. The member's additional annuity account shall be credited based on the daily value of the OPERS stable value fund on the date the account is reestablished by the retirement system.

(F) A member, contributor, or beneficiary may not withdraw an application as described in this rule if any of the following have occurred:

(1) The retirement system has made a distribution from the health reimbursement arrangement, as defined in rule 145-4-27 of the Administrative Code, or retiree medical account ~~or wellness retiree medical account~~, as ~~those terms are~~ defined in rule 145-4-01 of the Administrative Code, for an eligible benefit recipient or eligible dependent.

(2) The retirement system has paid a portion of the benefit to satisfy a court order.

(3) The retirement system has made a distribution in accordance with paragraph (E) of rule 145-1-21 of the Administrative Code.

(4) In the case of an application for an additional annuity payment under section 145.64 of the Revised Code, the member, contributor, or beneficiary fails to

also withdraw the individual's application for retirement, disability, or annuity payments under section 145.384 of the Revised Code.

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Certification

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145-4-01 **Health care definitions.**

As used in this chapter:

~~(A) "Wellness retiree medical account" means the public employees retirement system of Ohio retiree medical account plan established on January 1, 2007 by the former versions of rules 145-4-40, 145-4-42, and 145-4-44 of the Administrative Code, funded by the 115 trust.~~

~~(B)~~(A) "115 trust" means the Ohio public employees retirement system trust agreement for funding employee benefit plans, the assets of which qualify for exclusion from federal income taxation under section 115 of the Internal Revenue Code of 1986, 26 U.S.C.A. 115.

~~(C)~~(B) "Retiree medical account" means the group health plan described in the document entitled the "public employees retirement system of Ohio retiree medical account" that was effective on January 1, 2003, and includes amendments adopted through ~~June~~January ~~30~~1, ~~2016~~2024. The text of the public employees retirement system of Ohio retiree medical account shall not be incorporated into this or any other rule of the Administrative Code. The current version is available at www.opers.org.

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145-4-02 **Health care fund.**

(A) Within the funds described in section 145.23 of the Revised Code, there shall be a separate account established pursuant to section 115 of the Internal Revenue Code of 1986, 26 U.S.C.A. 115, for the purpose of funding the agreements authorized under sections 145.58 and 145.584 of the Revised Code. The account shall be known as the "health care fund." The assets in the health care fund shall be accounted for separately from the other assets of the public employees retirement system, but may be commingled with the other assets of the system for investment purposes. Investment earnings and expenses shall be allocated on a reasonable basis. All assets in the health care fund shall be held in trust for the exclusive benefit of members, benefit recipients, and eligible dependents.

(B) Contributions to the health care fund shall be funded by employer contributions as described in sections 145.48, 145.51, 145.58 and 145.584 of the Revised Code. Contributions to the health care fund are subordinate to the contributions to the funds for retirement benefits under the traditional pension plan and combined plan. Such contributions shall be reasonable and ascertainable.

(C) Forfeitures shall be used to fund qualified medical expenses, dental and vision coverage, administrative expenses of the health care fund, reimbursement of the medicare part A and B premiums, if provided by the system, and as provided in former rule 145-4-44 of the Administrative Code and section 145.584 of the Revised Code.

(D) The assets of the health care fund shall only be used for the payment of qualified medical expenses, dental and vision coverage, and reimbursement of the medicare part A and B premiums, if provided by the system.

(E) At no time prior to the satisfaction of all liabilities under this rule and sections 145.58 and 145.584 of the Revised Code shall any assets in the health care fund be used for, or diverted to, any purpose other than as provided in paragraph (D) of this rule and for the payment of administrative expenses. Assets in the health care fund may not be used for retirement, disability, or survivor benefits, or for any other purpose for which the other funds of the system are used.

(F)

(1) Effective as of July 1, 2016, the public employees retirement board herein terminates the accounts established pursuant to section 401(h) of the Internal Revenue Code of 1986, 26 U.S.C.A. 401. Upon satisfaction of all liabilities to be paid from the prior 401(h) account under this rule, as requied by the Internal Revenue Code, the public employees retirement system has the authority, acting on behalf of itself and as the employers' agent, to terminate the 401(h) account. Upon termiantion, the assets in the 401(h) account, if any, shall be returned

to the retirement system, as the employers' agent, in accordance with section 401(h)(5) of the Internal Revenue Code. The system shall notionally credit each contributing employer with the contributing employer's respective share of the terminated 401(h) account assets and immediately assess each employer a contribution due to the 115 trust in an equal amount.

(2) Upon satisfaction of all liabilities under this rule, any assets in the 115 trust, if any, that are not used as provided in paragraph (E) of this rule shall revert to a vehicle designated by the public employees retirement board, and in no case will the assets be distributed to any entity that is not a state, a political subdivision of a state, or an entity the income of which is excluded from gross income under section 115 of the Internal Revenue Code.

(G) It is the intent of the public employees retirement board in adopting this rule to comply in all respects with sections 115, 401(a) and 401(h) (for purposes of compliance with the section 401(h) termination requirements) of the Internal Revenue Code and regulations interpreting those sections. In applying this rule, the board will apply the interpretation that achieves compliance with those sections and preserves the qualified status of the system as a governmental plan in accordance with sections 401(a) and 414(d) of the Internal Revenue Code of 1986, 26 U.S.C.A. 401 and 414.

(H) This rule is intended to codify past practices and procedures of the system with respect to funding the former coverage authorized under sections 145.58 and 145.584 of the Revised Code and does not confer any new rights to members, retirants, survivors, beneficiaries, or their dependents.

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145-4-11 **Rescission of coverage.**

The dental and vision coverage of an enrolled benefit recipient or dependent and eligibility for participation in the health reimbursement arrangement plan shall be rescinded if the individual is convicted of falsification under section 2921.13 of the Revised Code regarding any coverage or plan or performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact regarding the coverage or plan. The effective date of the termination of coverage or plan participation shall be the earlier of the date of the conviction or the act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact, unless otherwise limited by Ohio law. The retirement system shall notify the individual of the rescission at least thirty days prior to processing the rescission. The rescission of a benefit recipient's coverage applies to all enrolled dependents and all coverage and plan options.

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145-4-24 **Retiree medical account for member-directed plan.**

(A) For each member who is contributing to the member-directed plan under section 145.85 of the Revised Code, the public employees retirement system shall credit to a retiree medical account a portion of the employer contribution under section 145.86 of the Revised Code. The portion of employer contribution to be credited shall be determined by the board.

(B) The rights of a member participating in the member-directed plan to reimbursement under a retiree medical account shall be governed exclusively by the provisions of the "public employees retirement system of Ohio retiree medical account." The member shall vest in amounts accumulated in the retiree medical account as provided in the "public employees retirement system of Ohio retiree medical account."

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Prior Effective Dates: 04/15/2004, 10/27/2006, 07/01/2016 (Emer.), 09/01/2016

145-4-25 **Dental and vision coverage.**

(A) As used in this rule:

(1) "Benefit recipient" means person receiving a benefit from the public employees retirement system. "Benefit" means monthly amounts paid to an individual pursuant to section 145.32, 145.33, 145.331, 145.332, 145.35, 145.36, 145.361, 145.37, 145.384, 145.45, or 145.46 of the Revised Code, or section 9.02, article X, or article XI of the combined plan docment.

(2) "Dependent" means:

(a) The spouse of a benefit recipient.

(b) The biological or legally adopted child of a benefit recipient who is under the age of twenty-six.

(c) The grandchild of a benefit recipient for whom the benefit recipient has been ordered pursuant to section 3109.19 of the Revised Code, or equivalent order from another state, to provide dental and vision coverage.

A benefit recipient shall inform the retirement system, in writing, not later than thirty days after an eligible dependent no longer meets the requirements of this rule. The retirement system may require a benefit recipient to certify the status of an individual as an eligible dependent for coverage. Failure to provide certification within sixty days of the request by the retirement system shall result in the denial or withdrawal of coverage for such individual until the open enrollment period.

(3) "Initial benefit payment" has the same meaning as in rule 145-1-65 of the Administrative Code.

(B)

(1) Except as provided in paragraph (B)(2) of this rule, the public employees retirement system may offer dental or vision coverage that is administered by a third party administrator(s) to benefit recipients and dependents provided that the benefit exceeds the premium set by the public employees retirement board for coverage under this rule.

(2)

(a) A spouse of a benefit recipient shall cease to be eligible for coverage on the first day of the month following the date of the final decree of divorce or dissolution from the benefit recipient.

(b) A dependent described in paragraph (A)(2)(b) of this rule shall cease to be eligible for coverage on the first day of the month following the child's twenty-sixth birthday. A dependent described in paragraph (A)(2)(c) of this rule shall cease to be eligible for dental and vision coverage on the first day of the month following the dependent's eighteenth birthday.

(C) Enrollment

(1) Except as provided in paragraph (C)(2) of this rule, a benefit recipient's application for dental or vision coverage must be received by the retirement system not later than thirty days after the benefit recipient's initial benefit payment. During the thirty-day period, the applicant may make one change to the filed application.

(2) A benefit recipient that does not enroll as provided in paragraph (C)(1) of this rule may enroll by filing an application for enrollment in dental or vision coverage during one of the following:

(a) The annual open enrollment period;

(b) Within sixty days of involuntary termination of coverage under another group plan, and with proof of such termination.

(3) A benefit recipient may enroll an eligible dependent in coverage during the annual open enrollment period or at any time outside of open enrollment if any of the following apply and the application is received not later than sixty days after the occurrence of the event:

(a) The benefit recipient may enroll a new spouse upon marriage;

(b) The benefit recipient may enroll an eligible child upon the birth or adoption of the child;

(c) The benefit recipient may enroll an eligible dependent who has involuntarily lost vision and dental coverage from another source;

(d) The benfit recipient is ordered to enroll a child pursuant to a national medical support order;

(e) The dependent first achieves an eligibility threshold descibed in this rule.

(4) Enrollment of a benefit recipient or eligible dependent under this rule shall be made on an application provided by the retirement system.

(D) Effective date of coverage

(1) The effective date of dental and vision coverage of a benefit recipient receiving a benefit pursuant to section 145.32, 145.33, 145.331, 145.332, division (B)(1) of section 145.37, or 145.384 of the Revised Code, or section 9.02 of the combined plan document shall be the later of the following:

(a) The effective benefit date of the benefit that is the basis of the coverage;

(b) The first day of the month during which an application for the benefit is received by the retirement system.

(c) If the retirement system or health care administrator has not paid claims for coverage for an eligible benefit recipient or eligible dependent, the benefit recipient may elect an effective date of coverage that is after the date descibed in paragraph (D)(1)(a) or (D)(1)(b) of this rule but is not later than thirty days after the inital benefit payment. An election under this paragraph shall be made not later than thirty days after the initial benefit payment.

(2) The effective date of dental and vision coverage of a benefit recipient receiving a benefit pursuant to section 145.35, 145.36, 145.361, division (B)(2) of section 145.37, 145.45, or 145.46 of the Revised Code, or Article X or Article XI of the combined plan document shall be the first day of the month following the initial benefit payment.

(3) Notwithstanding paragraphs (D)(1) and (D)(2) of this rule, in the case of enrollment during open enrollment, the effective date of coverage shall be January first of the following year.

(E) The following provisions apply to the dental and vision coverage offered by the retirement system:

(1) The coverage shall be in effect for a calendar year.

(2) An individual enrolled in coverage can voluntarily terminate the individual's enrollment in the coverage or a dependent's enrollment in the coverage only at the end of each calendar year by filing the notice of cancellation in a form and manner approved by the retirement system during the open enrollment period.

(3) The system shall require the automatic withholding of coverage premiums from the benefit paid to the enrolled individual.

(F) The retirement system shall offer continuation coverage, as applicable, in accordance with the requirements of the Consolidated Omnibus Budget and Reconciliation Act 1985 ("COBRA"), 42 U.S.C.A. 300gg-1.

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145-4-27 **Health reimbursement arrangement.**

(A) As used in this rule:

(1) "Health reimbursement arrangement" or "HRA" means the public employees retirement system of Ohio health reimbursement arrangement plan, effective November 1, 2021, funded by the 115 trust or such other funding vehicle or mechanism established by the retirement system, from which the reimbursement of qualifying medical expenses may be made. The HRA may have component plans as determined by the public employees retirement board. The text of the public employees retirement system of Ohio health reimbursement arrangement plan shall not be incorporated into this or any other rule of the Administrative Code. The current version is available at www.opers.org.

(2) "Pre-Medicare health reimbursement arrangement" or "PMCR" means the public employees retirement system of Ohio pre-medicare health reimbursement arrangement plan, a component plan of the HRA, effective November 1, 2021, funded by the 115 trust or such other funding vehicle or mechanism established by the retirement system, from which the reimbursement of qualifying medical expenses may be made. The text of the public employees retirement system of Ohio pre-medicare health reimbursement arrangement plan shall not be incoporated into this or any other rule of the Administrative Code. The current version is available at www. opers.org.

(3) "Medicare health reimbursement arrangement" or "MCR" means the public employees retirement system of Ohio medicare health reimbursement arrangement plan, a component plan of the HRA, effective October 1, 2015, and restated January 1, 2022, funded by the 115 trust or such other funding vehicle or mechanism established by the retirement system, from which the reimbursement of qualifying medical expenses may be made. The text of the public employees retirement system of Ohio medicare health reimbursement arrangement plan shall not be incorporated into this or any other rule of the Administrative Code. The current version is available at www. opers.org.

(4) "Monthly health care allowance" or "monthly allowance" means the monthly amount that is allocated to each individual enrolled in the HRA. The monthly allowance shall be determined by the board and offered in the form of a notional credit to the health reimbursement arrangement consistent with the provisions of that plan.

(5) "Qualified years of employer contributions" shall mean years of employer contributions and the years purchased or transferred under section 145.295, 145.2911, or 145.37 of the Revised Code that, if earned or obtained in the public

employees retirement system, would be the equivalent of the years of employer contributions. Qualified years of employer contributions do not include the contributions that are the basis of a lump sum pursuant to division (I)(2)(b) or (I)(3)(b) of section 145.332 of the Revised Code, unless the lump sum is issued pursuant to division (N)(3) of section 145.332 of the Revised Code.

(6) "Years of employer contributions" means the years or portions of a year for which the member's employer contributed to the public empoyees retirement system under section 145.302, 145.48, or 145.483 of the Revised Code, section 3.02 of the combined plan document, or article VI of the combined or member-directed plan document. Beginning January 1, 2014, "years of employer contributions" means the years or portions of a year described in this paragraph for which the member's monthly earnable salary on and after January 1, 2014, is one thousand dollars or greater.

(B) Except as provided in this rule, the rights of an individual participating in the PMCR or MCR to a monthly allowance or to reimbursement under the PMCR or MCR, including eligibility to participate and coordination of coverage, shall be governed exclusively by the provisions of the health reimbursement arrangement plans described in paragraph (A)(2) or (A)(3) of this rule.

(1) Eligibility to participate shall be set by the board and described in the PMCR and MCR and shall be based upon qualified years of employer contibutions, age, and medicare eligibility. The board shall set the minimum required qualified years of employer contibutions subject to the following:

(a) Except as provided in paragraph (B)(1)(c) of this rule, the board shall require at least ten years of service credit, as described in paragraph (A)(1) of former rule 145-4-06 of the Administrative Code, for individuals with a benefit effective date prior to January 1, 2015.

(b) Except as provided in paragraph (B)(1)(c) of this rule, the board shall not set the minimum required qualified years of employer contributions below twenty years of qualified years of employer contributions for individuals with a benefit effective date on or after January 1, 2015.

(c) The following individuals shall not be subject to the requirements of paragraphs (B)(1)(a) and (B)(1)(b) of this rule:

(i) A disability benefit recipient with a benefit effective date prior to January 1, 2014;

(ii) A disability benefit recipient with a benefit effective date on or after Januray 1, 2014, who has been receiving disability benefits for less than five years;

(iii) A disability benefit recipient that is eligible for medicare prior to age 65 on the basis of disability.

(C) For purposes of determining eligibility, the retirement system shall aggregate years of employer contributions earned and purchased in both the traditional pension plan and the combined plan if both of the following apply:

(1) The member is eligible to retire independently from both the traditional pension plan and the combined plan;

(2) The member applies for retirement under both the traditional pension plan and the combined plan with the same effective date of benefits under both plans.

(D) Any person eligible to receive a monthly allowance or reimbursement under the PMCR or MCR shall inform the retirement system, in writing, not later than thirty days after the person no longer meets the requirements of the health reimbursement arrangement plans described in paragraphs (A)(2) or (3) of this rule.

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145-4-28 **Health care plan provisions regarding the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").**

(A) As used in this rule:

(1) "Electronic protected health information" means protected health information that is transmitted by electronic media or maintained in electronic media.

(2) "Enrollment/disenrollment information" means information on whether the individual is participating in the health plan, or is enrolled in or has disenrolled from a health insurance issuer, health maintenance organization, or health insuring corporation offered by the plan.

(3) "Plan" means any health plan maintained by the Ohio public employees retirement system under the authority granted in section 145.58 of the Revised Code.

(4) "Plan administration functions" means administrative functions performed by the plan sponsor of a health plan on behalf of the health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

(5) "Plan sponsor" means the Ohio public employees retirement system.

(6) "Protected health information" means individually identifiable health information that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

(7) "Summary health information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health coverage under the plan; and (b) from which the information described at 42 C.F.R. Section 164.514(b)(2)(i), 67 F.R. 53270 (2002), has been deleted, except that the geographic information described in 42 C.F.R. Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(B) The plan may disclose to the plan sponsor enrollment/disenrollment information at any time.

(C) The plan (or a health insurance issuer, health maintenance organization, or health insuring corporation with respect to the plan) may disclose summary health information to the plan sponsor, provided that the plan sponsor requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the plan; or (2) modifying, amending, or terminating the plan.

(D)

(1) Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph (E) of this rule and obtaining written certification pursuant to paragraph (G) of this rule, the plan (or a health insurance issuer, health maintenance organization, or health insuring corporation on behalf of the plan) may disclose protected health information and electronic protected health information to the plan sponsor, provided that the plan sponsor uses or discloses such protected health information and electronic protected health information only for plan administrative purposes. "Plan administration purposes" means administration functions performed by the plan sponsor on behalf of the plan, such as quality assurance, claims processing, auditing, and monitoring and other administrative services related to the plan. Plan administration functions do not include functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor or any employment-related actions or decisions.

(2) Notwithstanding any provisions of this plan to the contrary, in no event shall the plan sponsor be permitted to use or disclose protected health information or electronic protected health information in a manner that is inconsistent with 45 C.F.R. Section 164.504(f), 68 F.R. 8381 (2003).

(E)

(1) Plan sponsor agrees that with respect to any protected health information (other than enrollment/disenrollment information and summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. Section 164.508, 67 F.R. 53268 (2002), which are not subject to these restrictions) disclosed to it by the plan (or a health insurance issuer, health maintenance organization, or health insuring corporation on behalf of the plan), plan sponsor shall:

(a) Not use or further disclose the protected health information other than as permitted or required by the plan or as required by law;

(b) Ensure that any agent, including a subcontractor, to whom it provides protected health information received from the plan agrees to the same restrictions and conditions that apply to the plan sponsor with respect to protected health information;

(c) Not use or disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(d) Report to the plan any use or disclosure of the protected health information of which it becomes aware that is inconsistent with the uses or disclosures provided for;

(e) Make available protected health information to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") right to access in accordance with 45 C.F.R. Section 164.524, 67 F.R. 53271 (2002);

(f) Make available protected health information for amendment, and incorporate any amendments to protected health information, in accordance with 45 C.F.R. Section 164.526, 65 F.R. 82802 (2002);

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(h) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the plan available to the secretary of health and human services for purposes of determining compliance by the plan with HIPAA's privacy requirements;

(i) If feasible, return or destroy all protected health information received from the plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure that the adequate separation between plan and plan sponsor (i.e., the firewall), required by 45 C.F.R. Section 164.504(f)(2)(iii), is established.

(2) Plan sponsor further agrees that if it creates, receives, maintains, or transmits any electronic protected health information (other than enrollment/disenrollment information and summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. Section 164.508, which are not subject to these restrictions) on behalf of the plan, it will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

(b) Ensure that the adequate separation between the plan and plan sponsor (i.e., the firewall), required by 45 C.F.R. Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the plan any security incident of which it becomes aware, as follows: plan sponsor will report to the plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic protected health information or to interfere with systems operations in an information system containing electronic protected health information; in addition, plan sponsor will report to the plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of electronic protected health information or interference with systems operations in an information system containing electronic protected health information.

(F)

(1) The plan sponsor shall allow only those employees or other persons under the control of the plan sponsor who are involved in the administration of the health plan access to the protected health information. No other persons shall have access to protected health information. These specified employees (or classes of employees) shall only have access to and use of protected health information to the extent necessary to perform the plan administration functions that the plan sponsor performs for the plan. In the event that any of these specified employees does not comply with the provisions of this rule, that employee shall be subject to disciplinary action by the plan sponsor for non-compliance pursuant to the plan sponsor's employee discipline and termination procedures.

(2) The plan sponsor shall ensure that the provisions of this rule are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit electronic protected health information on behalf of the plan.

(G) The plan (or a health insurance issuer, health maintenance organization, or health insuring corporation with respect to the plan) shall disclose protected health information to the plan sponsor only upon the receipt of a certification by the plan sponsor that the plan has been amended to incorporate the provisions of 45

C.F.R. Section 164.504(f)(2)(ii), and that the plan sponsor agrees to the conditions of disclosure set forth in paragraph (E) of this rule.

Five Year Review (FYR) Dates: 9/29/2023 and 09/28/2028

CERTIFIED ELECTRONICALLY

Certification

09/29/2023

Date

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Rule Amplifies: 145.58, 145.584
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145-4-70 **Reimbursement of medicare part "A" premium.**

(A) The public employees retirement system shall make available to each eligible benefit recipient and spouse, in its sole discretion, one of the following: the coverage equivalent to medicare part A hospital coverage or an amount determined by the public employees retirement board to reimburse the premium of such coverage as described in section 145.584 of the Revised Code.

(B) If the board provides a reimbursement amount described in paragraph (A) of this rule, all of the following requirements shall be met:

(1) The benefit recipient or spouse provides proof of enrollment in medicare part A coverage in the form required by the system containing the medicare part A premium amount and effective date;

(2) The benefit recipient or spouse certifies to the retirement system that the premium amount is not reimbursed from another source;

(3) A medicare supplemental plan that is not sponsored by the system and that would allow for participation in the health reimbursement arrangement is in effect.

The reimbursement shall be effective in the month that all of the requirements of this paragraph are met.

(C) The retirement system shall not pay to an eligible benefit recipient or spouse more than one monthly medicare part A premium reimbursement for any month of enrollment in medicare part A or to an individual who is receiving more than one monthly retirement allowance from this system.

(D) The system shall annually request evidence of an eligible benefit recipient's or spouse's medicare part A enrollment and premium amount and may specify a deadline for receipt of such information. If an eligible benefit recipient or spouse fails to provide the requested information or certification by the specified deadline, the system may, following notice to the benefit recipient or spouse, suspend or cancel the premium reimbursement for any month that the certification is not received. Any reimbursement paid for which the benefit recipient or spouse was not eligible may be collected as provided in section 145.563 of the Revised Code.

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145-4-72 **Reimbursement of medicare part "B" premium.**

(A) The public employees retirement board shall determine the monthly amount paid to reimburse for medicare part "B" coverage, if any. The amount paid shall be the following, except that the board shall make no payment that exceeds the amount paid by the recipient for the coverage:

(1) For calendar year 2013, ninety-six dollars and forty cents;

(2) For calendar year 2014, ninety-six dollars and forty cents;

(3) For calendar year 2015, sixty-three dollars and sixty-two cents;

(4) For calendar year 2016, thirty-one dollars and eighty-one cents;

(5) For calendar year 2017 and each year thereafter, zero.

(B) The amount described in paragraph (A) of this rule shall be reimbursed to an eligible benefit recipient in each monthly benefit payment when such benefit recipient submits both of the following:

(1) Proof of enrollment in and evidence of the premium amount paid for medicare part B coverage;

(2) Certification that the benefit recipient is not receiving reimbursement for the premium and that it is not being paid by any other source.

(C) Except as provided in paragraph (D) of this rule, the effective date for the reimbursement of the premium amount pursuant to division (C) of section 145.58 of the Revised Code and this rule shall be the later of:

(1) The effective date of medicare part B coverage;

(2) The first day of the month following receipt by the system of the information described in paragraph (B) of this rule.

(D) If the benefit recipient's initial benefit payment was issued not later than thirty days prior to receipt of the information described in paragraph (B) of this rule, the effective date for the reimbursement shall be the first day of the month following the later of:

(1) The effective date of participation in the health reimbursement arrangement as defined in rule 145-4-27 of the Administrative Code;

(2) The effective date of medicare part B coverage.

(E) The retirement system shall not pay more than one monthly medicare part B premium to an eligible benefit recipient who is receiving more than one monthly retirement allowance from this system.

(F) If a benefit recipient fails to certify the amount paid for medicare part B coverage, the board may, following notice to the benefit recipient, suspend the premium reimbursement for any month that certification is not received. The board shall not reimburse the benefit recipient for any period of suspension.

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742-3-30 **Agents standard of conduct.**

(A) All attorneys, agents and representatives of an OP&F member shall abide by the following standards of conduct while representing the member in any dealings with OP&F:

(1) Provide competent representation to a member, which requires the knowledge, skill, thoroughness and preparation reasonably necessary for the representation. This also includes being, or becoming, familiar with OP&F's governing statutes, administrative rules and procedures;

(2) Abide by OP&F's governing provisions and procedures at all times;

(3) Conduct his or her dealings in an ethical manner that furthers the efficient, fair and orderly conduct of the administrative decision-making process. This includes acting with reasonable diligence and promptness in representing a member and providing prompt and responsive answers to requests from OP&F for any relevant information or documentation;

(4) Be forthright in his or her dealings with OP&F and with the member; and

(5) Otherwise act in a manner that is consistent with OP&F's core values, which includes acting with prudence, integrity and empathy.

(B) All attorneys, agents and representatives of an OP&F member shall not do any of the following while representing the member in any dealings with OP&F:

(1) In any manner or by any means threaten, coerce, intimidate, deceive or knowingly mislead any member or beneficiary regarding benefits or other rights;

(2) Knowingly make or present any misleading oral or written statements, assertions or representations about a material fact or provision of law concerning any matter;

(3) Through his or her own actions or omissions, unreasonably delay or cause to be delayed any benefit process;

(4) Divulge, without the member's written consent, any information from the member's personal history record;

(5) Attempt to influence, directly or indirectly, the outcome of a decision, determination or other administrative action by offering a loan, gift or anything of value to a board member or employee of OP&F; and

(6) Engage in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings, including, but not limited to, threatening or intimidating language, gestures or actions.

(C) All attorneys, agents and representatives of an OP&F member shall be required to sign a letter of engagement on a form provided by OP&F in which they acknowledge the provisions of this rule and agree to abide by such standards when representing an OP&F member in any dealings with OP&F. Any attorney, agent or representative of an OP&F member who fails to sign the letter of engagement or violates any provision of this rule shall not be permitted to practice or represent parties before OP&F's board of trustees.

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Rule Amplifies: 742.10, 742.41
Prior Effective Dates: 09/19/2008 (Emer.), 12/04/2008

742-4-11 Termination of a member's active service in an police or fire department.

(A) For purposes of section 742.444 of the Revised Code, "termination of a member's active service in a police or fire department" is presumed to occur if OP&F does not receive consecutive reports or payments of contributions from an employer on behalf of the DROP participant, regardless of which employer reports or pays such contributions to OP&F, as more fully illustrated in the following examples. For example, if the DROP participant works for city A through January 25, 2003 and then begins employment with city B, who is a employer within the meaning assigned to it in division (D) of section 742.01 of the Revised Code, on February 1, 2003, then no termination would exist. On the other hand, if the DROP participant terminated employment with city A on January 25, 2003 and did not resume employment in an OP&F covered position until March 1, 2003, a termination would result under section 742.444 of the Revised Code. This presumption may be rebutted by the member or employer by timely submitting documentation to OP&F that shows the continuation of the employment relationship within the time period requested by OP&F.

(B) "Employer" shall have the meaning assigned to it in division (D) of section 742.01 of the Revised Code.

(C) Capitalized terms used in this rule shall have the meaning assigned to them in rule 742-4-01 of the Administrative Code.

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Rule Amplifies: 742.444
Prior Effective Dates: 12/31/2002 (Emer.), 04/06/2003, 08/28/2008, 11/23/2018

742-4-12 **Impact of family medical leave.**

(A) "Family Medical Leave Act" shall mean the statutory provisions outlined in 29 U.S.C. 2601, as amended.

(B) If a DROP participant elects to exercise his/her rights under the Family Medical Leave Act, such election shall not extend the time during which the DROP participant can participate in DROP.

(C) If the DROP participant uses vacation or sick leave so that he/she can stay on his/her employer's payroll, contributions shall be accrued for his/her benefit according to section 742.443 of the Revised Code and rule 742-4-06 of the Administrative Code. In cases where no "salary" is paid to the DROP participant as a result of this election, no accrual of contributions shall be made for his/her benefit.

(D) This rule shall be subject to the provisions of division (C) of section 742.444 and section 742.445 of the Revised Code.

(E) Capitalized terms used in this rule shall have the meaning assigned to them in rule 742-4-01 of the Administrative Code.

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Rule Amplifies: 742.443
Prior Effective Dates: 12/31/2002 (Emer.), 04/06/2003, 08/22/2013, 11/23/2018

742-4-15 **Optional plan of payment.**

(A) If, as part of the DROP election, a DROP participant elected an optional plan of payment under section 742.3711 of the Revised Code to have the member's monthly pension calculated as a retirement allowance that continues or is paid to a surviving beneficiary, the DROP participant shall be eligible to cancel such optional plan or continuation of all or part of the allowance in accordance with the provisions of division (B) of section 742.3711 of the Revised Code.

(B) Notwithstanding the provisions of paragraph (A) of this rule, a DROP participant shall not be eligible to exercise the rights under division (C) of section 742.3711 of the Revised Code until the DROP participant has filed an application for retirement with OP&F under division (C)(1) of section 742.37 of the Revised Code. In the case of a member who is required by a court order to designate a former spouse as a beneficiary, the provisions of rule 742-3-28 of the Administrative Code shall apply.

(C) Capitalized terms used in this rule shall have the meaning assigned to them in rule 742-4-01 of the Administrative Code (definitions).

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Rule Amplifies: 742.444
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742-4-16 **Selection of distributions.**

(A) A DROP participant who is eligible for distributions under division (B)(3) of section 742.444 of the Revised Code may select periodic payments under division (B)(3)(b) of section 742.444 of the Revised Code according to the following methods:

(1) Partial distributions, which are one-time payments and not recurring, in a gross amount equal to or greater than one thousand dollars per request, with a maximum of four distributions being made by OP&F during a calendar year; and

(2) Monthly distributions in a gross amount equal to or greater than one hundred dollars per payment, which will be paid on a monthly basis until OP&F receives proper written direction from the DROP participant to change such selection; and

(3) Notwithstanding the foregoing provisions, the final distribution shall be a one-time payment in the gross amount due the DROP participant, according to OP&F's books and records.

(B) If an eligible DROP participant elects a partial distribution, this distribution may consist of multiple methods of payment and such request will constitute one partial distribution for purposes of the limits set forth in paragraph (A)(1) of this rule. For example, a member may request a partial DROP distribution and choose to rollover a portion of the partial distribution to an eligible account and have the balance of the partial distribution paid directly to him or her and this would constitute one partial distribution of DROP benefits.

(C) Capitalized terms used in this rule shall have the meaning assigned to them in rule 742-4-01 of the Administrative Code (definitions).

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742-5-08 **Service credit purchases by payroll deduction.**

(A) A member of Ohio police and fire pension fund ("OP&F") may purchase any type of service credit through payroll deduction that a member is eligible to purchase under any provisions of Chapter 742. of the Revised Code, including but not limited to, sections 742.21 (service credit earned for full-time service as member of state or municipal retirement system, 742.221 (conditions to receive credit for time spent on pregnancy or medical disability leave), 742.23 (credit to police officers for service time as firefighters), 742.24 (credit to firefighters for service time as police officers), 742.27 (credit for lay off period), 742.371 (redeposit of withdrawn contributions), 742.375 (credit for service as a member of the state highway patrol retirement system), 742.376 (credit for service as a full-time member of a police or fire department prior to January 1, 1967), 742.52 (purchase of credit for military service), and 742.521 (granting of credit for military service) of the Revised Code.

(B) Upon a member's request to OP&F to purchase service credit by payroll deduction for service credit the member is eligible to purchase pursuant to section 742.56 of the Revised Code and this rule, OP&F will prepare an authorization form which states the following:

(1) The service to be purchased, including the total months of service and the type of service;

(2) The total cost of the service credit to be purchased through payroll deduction;

(3) An authorization from the member to make the total number of payroll deductions in the stated amount, starting with the proposed start date and ending on the proposed completion date; provided, however, that the payroll deduction cannot exceed the member's net compensation after all deductions and withholdings required by law.

(C) If the member wishes to complete the payroll plan referenced in paragraph (B) of this rule, the member must sign, and cause his or her employer to sign, the authorization form prepared by OP&F and return the form to OP&F. The member shall provide his or her employer with a copy of the authorization form in a timely manner so that the employer can properly implement the payroll deduction plan elected by the member.

(D) The procedure to be followed by OP&F in determining the total cost of the eligible service credit to be purchased by an OP&F member through a payroll deduction will be based upon the assumption that the purchase is to be made in a single lump-sum payment on the proposed date of the completion of the purchase, with the total cost then being divided by the number of payroll periods between the proposed start and the proposed completion date of the payroll deduction in order to yield a level amount of the deduction, which is all based upon the member's original request.

(E) As required by section 742.56 of the Revised Code, OP&F will certify the amount to the employer through a monthly billing the amount of each deduction and the payrolls from which deductions are to be made. The employer shall forward that payroll deduction to OP&F so that the applicable payroll deduction and the payroll deduction statement are received by OP&F by the close of business on the last business day of the following month, excluding any legal holidays, consistent with the reporting requirements in section 742.32 of the Revised Code. The employer's payroll deduction statement shall be accompanied by a completed OP&F recap form, as referenced in rule 742-9-17 of the Administrative Code.

(F) For purposes of assessing the penalties prescribed by section 742.352 of the Revised Code and rule 742-8-07 of the Administrative Code for all filings due OP&F under section 742.56 of the Revised Code, OP&F shall take the following course of action:

(1) No payroll deduction report/no payroll deduction. If the required payroll deduction prescribed by section 742.56 of the Revised Code is not made in accordance with the deadline outlined in such section and no payroll deduction report is filed with OP&F in accordance with the deadline outlined in such section, OP&F shall assess the penalties prescribed by section 742.352 of the Revised Code and rule 742-8-07 of the Administrative Code.

(2) Payroll deduction report/no payroll deduction. If the required payroll deduction report prescribed by section 742.56 of the Revised Code is filed with OP&F in accordance with the deadline outlined in such section, but the proper payroll deduction is not paid to OP&F in accordance with the deadline outlined in such section, OP&F shall assess the penalties prescribed by section 742.352 of the Revised Code and rule 742-8-07 of the Administrative Code.

(3) No payroll deduction report/payroll deduction. If the required payroll deduction report prescribed by section 742.56 of the Revised Code is not filed with OP&F in accordance with the deadline outlined in such section, but a payroll deduction is made with OP&F in accordance with the deadline outlined in such section, OP&F shall assess the penalties prescribed by section 742.352 of the Revised Code.

(4) All other cases, the following shall apply:

(a) Non-conforming payroll deduction report. OP&F shall initially give verbal notice to the employer of the non-conforming nature of the report and allow the employer to have an opportunity to take corrective actions to cure such deficiencies within thirty days of OP&F's verbal notice of deficiency. If the employer has not submitted a writing to OP&F that properly addresses the noted deficiencies by Friday of the week in which

OP&F gave the verbal notice, OP&F shall then send a written notice to the employer of the non-conforming nature of the report and allow the employer to still have an opportunity to take the corrective actions identified in the written notice from OP&F within thirty days of OP&F's initial verbal notice (referred to herein as the "cure period"), and the following shall apply:

(i) If the employer files a corrected payroll deduction report and such report is received by OP&F on or before the expiration of the cure period, no penalties will be assessed by OP&F against the employer.

(ii) If OP&F does not receive from the employer a corrected payroll deduction report, as noted in OP&F's written notice to the employer, on or before the expiration of such cure period, then OP&F will assess the penalties prescribed by section 742.352 of the Revised Code and rule 742-8-07 of the Administrative Code, beginning the day after the expiration of the cure period.

(b) In all other situations, OP&F will notify the employer in writing of the employer's failure to comply with the provisions of section 742.56 of the Revised Code and allow the employer to take the corrective actions identified in the written notice from OP&F within thirty days of OP&F's initial verbal notice (referred to herein as the "cure period"), and the following shall apply:

(i) If the employer files a correct payroll deduction report and such report is received by OP&F on or before the expiration of the cure period, no penalties will be assessed by OP&F against the employer.

(ii) If OP&F does not receive from the employer the proper payroll deduction report, as noted in OP&F's written notice to the employer, on or before the expiration of such cure period, then OP&F will assess the penalties prescribed by section 742.352 of the Revised Code and rule 742-8-07 of the Administrative Code, beginning the day after the expiration of the cure period.

(5) Even with the cure period, the employer will still be assessed any statutory fines for late filings and/or payments, as the case may be under the applicable statutory provision.

(6) This rule shall apply once the payment and/or report has been filed with OP&F and shall not limit any other remedies available to OP&F by law.

(G) Upon receipt of the applicable monthly payroll deduction, as certified by OP&F, OP&F will grant the service credit to the member based on the percentage of the service credit for which the member is eligible to receive multiplied by the ratio of the amount actually received by OP&F divided by the total amount due OP&F pursuant to section 742.56 of the Revised Code and this rule.

(H) All payroll deduction plans may last no longer than sixty months, or if less, the period of service to be purchased.

(I) No member may participate in more than one payroll deduction plan to purchase service credit provided for in section 742.56 of the Revised Code and this rule, even though the payroll deduction plan may include various types of service credit.

(J) Tax deferred payroll deduction plans (i.e. pick-up plans) shall be irrevocable and may only be terminated upon the member's termination of employment with the employer who is implementing the member's payroll deduction plan.

(K) Except for tax deferred payroll deduction plans (i.e. pick-up plans), a member can increase or decrease the member's payroll deduction by written notice to the member's employer and OP&F, except that in no event shall a deduction be decreased to less than an amount specified by OP&F in a board policy or the current month's interest, whichever is greater.

(L) OP&F will not treat a member who is purchasing credit pursuant to this rule with amounts designated by the employer as picked-up contributions under section 414(h)(2) of the Internal Revenue Code of 1986, 26 U.S.C.A. 414(h)(2) unless the employer certifies in writing the tax deferred status of the payroll deduction plan as part of the employee's enrollment in the payroll deduction plan. OP&F will rely upon certification in determining the taxability of benefits due the member, as outlined in rule 742-9-14 of the Administrative Code. In the event that the employer fails to provide such certification, then OP&F will treat the payroll deduction plan as a regular non-tax deferred payroll deduction plan. In all events, it shall be the responsibility of the employer to establish the tax deferred payroll deduction plan, as required by the applicable terms of the Internal Revenue Code. Employers that wish to pay all or part of the voluntary contributions for the purchase of service credit through payroll deductions shall submit the standard resolution in the form adopted by OP&F's board of trustees, as required by rule 742-7-14 of the Administrative Code.

(M) For members who are purchasing credit pursuant to this rule with amounts designated by the employer as picked-up contributions under section 414(h)(2) of the Internal Revenue Code of 1986, 26 U.S.C.A. 414(h)(2), such members cannot do any of the following:

(1) Decrease or increase the payroll deduction;

(2) Terminate the payroll deduction, unless the member has terminated employment with such employer or all of the service credit has been purchased through the applicable payroll deduction plan; or

(3) Make a partial payment for the purchase of service credit outlined in this rule.

(N) For members who are purchasing credit pursuant to this rule with amounts designated by the employer as picked-up contributions under section 414(h)(2) of the Internal Revenue Code of 1986, 26 U.S.C.A. 414(h)(2), the employer cannot decrease, increase, or terminate such payroll deduction unless the member has terminated employment or all of the service credit has been purchased through the applicable payroll deduction plan.

(O) Except for tax deferred payroll deduction plans (i.e. a pick-up plan), a payroll deduction plan may be terminated upon any of the following events:

(1) The failure of the employer to forward to OP&F the monthly payroll deduction for three consecutive months, with the termination being effective the first month in which the employer failed to forward the deduction to OP&F without any further action on the part of the employee, the employer or OP&F;

(2) Upon the member's termination of employment with the employer who is implementing the member's payroll deduction plan;

(3) In cases where a payroll deduction exceeds the member's net pay after all deductions and withholdings required by law; or

(4) When the payroll deductions received by OP&F equal the total cost of the eligible service credit, as originally outlined in OP&F's authorization form signed by the member.

(P) On early termination of the payroll deduction plan, the member will be credited with a proportion of the service to be purchased equal to the proportion of time the payroll deduction plan became effective to the time the payroll deduction plan was scheduled to complete the purchase. In addition, OP&F will provide written notice of such termination to the member.

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Prior Effective Dates:	12/29/1986, 06/24/2001, 10/26/2006, 05/22/2008, 08/19/2013, 11/23/2018

742-10-01 **Policy on employee bonuses.**

In accordance with division (B) of section 742.102 of the Revised Code, any discretionary non-recurring awards (bonuses) shall be determined and approved each year by the board of trustees of Ohio police and fire pension fund (OP&F). Non-recurring awards may be granted only if OP&F's board of trustees had adopted a budget allocation for non-recurring awards. Each OP&F department director may use allotted funds to reward employees, as appropriate, throughout the year, subject to the limitations set forth in this rule and terms of the discretionary non-recurring award (bonus) program adopted by OP&F's board of trustees. The recommended awards are limited to one payment per year, which shall be limited by the terms of the approved budget and subject to approval by the executive director. At no time shall any non-recurring award in a given calendar year, exceed the lesser of three per cent of an individual's base wages or three thousand five hundred dollars.

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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 any of the following group plans offered by the system:

(a) A medical and prescription drug plan;

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

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

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

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

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

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

(B) Eligibility

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

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

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

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

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

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

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

(4) On or after January 1, 2021, eligibility for SERS health care coverage shall terminate when a person listed in paragraph (B)(1) of this rule becomes eligible for medicaid and is ineligible for medicare. For purposes of this rule, a benefit recipient and their dependent(s) shall be presumed to be eligible for medicaid if their gross monthly SERS benefit is less than the percentage of the federal poverty level used by the Ohio department of medicaid to determine medicaid eligibility under agency 5160 and division 5160:1 of the Administrative Code. Upon request, a benefit recipient presumed to be eligible for medicaid must provide SERS with satisfactory proof of ineligibility for medicaid in their state of residence within ninety days from the date of SERS' request.

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

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

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

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

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

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

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

(b) A benefit recipient requesting reinstatement to SERS health care coverage under paragraph (I) of this rule on or after June 1, 2023 shall complete counseling before the later of the following:

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

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

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

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

(e) Counseling shall not be required if the marketplace counselor is unable to determine available marketplace plans based on the benefit recipient's address or other demographic information. The marketplace counselor

will notify SERS when a marketplace plan cannot be determined based on the circumstances.

(C) Enrollment

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Cancellation of health care coverage

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

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

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

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

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

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

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

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

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

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

(E) Effective date of coverage

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

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

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

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

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

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

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

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

(F) Premiums

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

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

(3) After cancellation for default, health care coverage can be reinstated as provided in paragraph (I) of this rule, or upon submission of an application for reinstatement

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

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

(a) A dependent child.

(b) An age and service retirant who:

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

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

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

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

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

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

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

(ii) ~~A disability benefit recipient with~~Has an effective benefit date on or after August 1, 2008 who:

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

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

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

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

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

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

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

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

~~(d)~~(e) A spouse:

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

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

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

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

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

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

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

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

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

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

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

(G) Waiver

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

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

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

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

(H) Medicare advantage or medicare part D

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

(I) Reinstatement to SERS health care coverage

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

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

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

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

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

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

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

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

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

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

(J) Medicare part B

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

(2)

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

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

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

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

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

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

(i) January 1, 1977; or

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

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

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

(ii) The effective date of SERS health care.

(4) The board shall not:

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

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

Effective:

Five Year Review (FYR) Dates: 2/1/2024

Certification

Date

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5505-3-02 **Disability retirement application and hearing process.**

(A) For the purpose of sections 5505.18 and 5505.181 of the Revised Code and agency 5505 of the Administrative Code:

(1) "Member" shall have the meaning described in division (I~~J~~) of section 5505.01 of the Revised Code except "member" does not include state highway patrol cadets attending training schools pursuant to section 5503.05 of the Revised Code.

(2) A terminated employee, whether the termination from the state highway patrol is voluntary or involuntary, ceases to be a member of the state highway patrol retirement system (HPRS). Except as provided in rule 5505-3-07 of the Administrative Code, a member shall not be considered terminated while receiving benefits pursuant to section 124.385 of the Revised Code.

(3) "Totally and permanently incapacitated" means a disabling condition that physically or mentally totally incapacitates a member from the performance of regular duty for a period of at least twelve months from the date of HPRS's receipt of the completed application packet.

(4) "In the line of duty" means an illness or injury that occurred during or resulted from the performance of official duties under the direct supervision of the state highway patrol.

(5) "Not in the line of duty" means an illness or injury that did not occur during or result from the performance of official duties under the direct supervision of the state highway patrol. Unless the illness or injury meets the presumption criteria outlined in division (A) ~~of section~~ of section 5505.18 of the Revised Code or competent and credible evidence is submitted to HPRS, a disability condition is presumed to be not in the line of duty.

To be eligible for retirement on account of a disability ~~disabilty~~ incurred not in the line of duty, the member must have accrued five years of service credit since becoming a "member" as defined by this rule and section 5505.18 of the Revised Code.

(6) "Disability committee," as referred to in this rule, shall mean the "health, wellness, and disability" standing committee established pursuant to paragraph (A)(1) of 5505-9-08 of the Administrative Code.

(7) "Medical advisor," as referred to in this rule, shall mean the expert physician appointed by HPRS' board who advises the disability committee and board during its deliberations relating to disability applications.

(8) "Examining physician" means a physician recommended by the medical advisor and approved by the HPRS board.

(9) Unless otherwise stated in this rule, all notifications or correspondence shall be sent by regular U.S. mail to the ~~member's~~member's address included in disability benefits application unless HPRS receives notice in writing of an alternative address.

(B) A disability benefits application packet, hereafter referred to as application packet, provided by HPRS may be filed by a member, a person acting on behalf of a member, or the superintendent of the state highway patrol. In order for the application packet submission to be considered complete, the applicant will submit the following:

(1) A completed application for disability benefits, on a form approved by the board, listing the disabling condition(s),

(2) Attending physician medical evaluation form and statement, on a form approved by the board, supporting the disabling condition(s) listed in the application,

(3) Employer determination and completed form of ~~applicant's~~applicant's inability to perform his/her job duties and responsibilities, and

(4) All medical reports and documentation that relate to the disabling conditions listed in the application. All medical reports must be received within one week of initial submission of application.

(5) An incomplete application packet will not be accepted and will not be considered filed.

(6) Once an application packet has been accepted by HPRS and submitted to the medical advisor, additional medical reports or documentation will not be accepted unless requested by the board, disability committee or the medical advisor. Any documentation that is received by HPRS after submission of the application packet to the medical advisor shall be held and included as part of any reconsideration hearing as described within this rule. Should the right to reconsideration not be exercised, the additional medical evidence will be returned to the applicant.

(7) An application packet that does not include an attending physician medical evaluation statement that indicates the applicant is totally and permanently incapacitated will not be accepted.

(C) Upon receipt of a completed application packet, HPRS shall schedule the applicant for an examination by at least one examining physician with expertise in the disabling

condition(s) listed in the application as recommended by the medical advisor, unless the medical advisor recommends it is inadvisable to do so.

(1) Payment of any fees connected to the acquisition of records or the preparation of reports of the attending physicians shall be the responsibility of the member.

(2) Payment of any fees connected with the preparation of reports of the examining physician(s) shall be the responsibility of HPRS.

(D) After examining the applicant and reviewing the application packet, any medical reports submitted by the applicant, and the results of any additional medical testing, the examining physician will file a written report with HPRS with the following information:

(1) Whether the member is totally incapacitated for duty in the employ of the patrol,

(2) Whether the incapacity is expected to be permanent, and

(3) The cause of the ~~member’s~~ member's incapacity.

(E) After the examining physician(s)’ report(s) is submitted, the medical advisor shall review the entire record and file a written report with HPRS with the following information:

(1) A recommendation of whether the applicant should be granted disability retirement benefits based on the medical ~~advisor’s~~advisor's independent review or the record,

(2) Whether the injury or illness was in the line of duty or not in the line of duty,

(3) Recommended medical treatment and medical reports.

The medical advisor’s report shall be considered an independent medical opinion.

(F) When all necessary medical reports and records have been received by HPRS, including the completed application packet, examining physician’s report described in paragraph (D) of this rule, and the medical ~~advisor’s~~advisor's report / recommendation described in paragraph (E) of this rule, HPRS shall schedule a hearing to be held at the next disability committee meeting. If HPRS does not receive the required information described in this paragraph of this rule at least fourteen days before the next disability committee meeting, the application will be heard at the following scheduled meeting of the disability committee.

(G) No less than fourteen days prior to the hearing, the applicant will be sent notification of:

(1) The hearing date and time, and

(2) The right to appear at the hearing, with or without counsel, to present testimony.

(3) If circumstances warrant it, the notice requirement may be waived upon mutual consent of the applicant and HPRS.

(H) The disability committee hearing will be held in executive session. An audio recording of testimony on behalf of the applicant will be made to provide the disability committee and board with a record for further review, notwithstanding rule 5505-9-07 of the Administrative Code. The disability committee will consider the application packet, the examining ~~physician’s~~physician's report, the recommendation of the medical advisor, and other relevant information.

(1) Consideration of a ~~member’s~~member's application by the disability committee and board shall be limited to the disabling condition(s) listed in the application and listed in the attending ~~physician’s~~physician's report as described in paragraph (B)(2) of this rule that are supported by medical documentation provided to HPRS.

(2) Acts occurring after the application packet is completed and accepted that create new disabling condition(s) or progress the disabling condition(s) described in paragraph (H)(1) of this rule will not be considered by the disability committee or the board. Nothing in this division shall preclude a member from filing a new application for disability benefits.

(I) The disability committee may recommend one or more of the following to the board:

(1) Approval or denial of the application,

(2) A finding on whether or not the disability occurred in the line of duty,

(3) A finding that disability retirement be contingent on compliance with a treatment plan,

(4) Postpone determination, pending an additional examination, or the submission of additional fact, or

(5) No decision, if the disability committee cannot agree on a recommendation or acquire a majority vote.

(J) No more than five days after the hearing, the applicant will be sent notification of:

(1) The disability ~~committee’s~~committee's recommendations,

(2) The right to request reconsideration of the disability ~~committee’s~~committee's decision.

(K) No more than twenty days after the initial hearing, the applicant may file a written request for reconsideration. The written request shall be accompanied by a statement from the applicant, his or her counsel and/or attending physician that the request for reconsideration will be based on evidence contrary to the findings of the examining physician or the committee.

(1) The request for reconsideration will be considered at the next regularly scheduled meeting of the disability committee unless rescheduled for the reasons outlined in paragraph (K)(2) of this rule.

(2) No more than ten days after requesting reconsideration, the member must file new medical evidence relative to the disabling condition(s) considered by the disability committee. The member may request one extension of twenty days to submit new medical information. One additional extension, of no greater than twenty days, will be granted if the member can show, and the medical advisor concurs, that additional time is needed to obtain relevant new medical evidence that is already in progress. If additional extensions are granted, the request for reconsideration will be rescheduled to the next available disability committee meeting. HPRS shall void the request for reconsideration if new medical evidence is not received by HPRS in the time described in this paragraph.

(3) Copies of the reports of the examining physician will be sent to the member and the ~~member’s~~member's agent upon written authorization of the member, unless the release of such reports is otherwise prohibited by law. The medical ~~advisor’s~~advisor's recommendation will not, however, be released until the committee has made a recommendation regarding the ~~member’s~~member's disability application.

(4) The disability committee will consider only new medical evidence and new relevant information submitted in support of the request for reconsideration.

(5) The applicant has the right to appear at the hearing, with or without counsel, to present new relevant evidence and testimony, and

(6) Evidence, information, or other documentation not already submitted in accordance with this rule will not be permitted.

(L) At the conclusion of the reconsideration hearing, the disability committee may recommend one or more of the following to the board:

(1) Approval or denial of the application,

(2) A finding on whether or not the disability occurred in the line of duty,

(3) A finding that disability retirement be contingent on compliance with a treatment plan,

(4) Postpone determination, pending an additional examination, or the submission of additional fact, or

(5) No decision, if the disability committee cannot agree on a recommendation or acquire a majority vote.

(M)

(1) Except as provided in paragraph (M)(2) of this rule, the ~~committee's~~committee's recommendation will be considered at the next regularly scheduled meeting of the board. The board may adopt or reject the recommendation, in whole or in part, or remand the recommendation to the disability committee for further consideration. Unless requested by the board, an applicant may not appear before the board. The decision of the board is final.

(2) If the disability committee postpones determination pursuant to paragraph (L)(4) of this rule, no more than five days after the hearing, the applicant will be sent notification of the reason for the postponement and the date the committee will make a final recommendation to the board.

(N) The member will be notified of the ~~board's~~board's action no more than ten days after the board meets. If benefits are granted, the member shall be advised of the ~~member's~~member's right to:

(1) Accept the benefit granted; or

(2) Waive the benefit and continue working

(a) No later than thirty days after the board's final action, the member shall elect, on a form provided by the board, either to accept or waive the board's grant of disability benefits.

(b) If no such election is made within the ~~thirty day~~thirty-day period provided in paragraph (N)(2)(a) of this rule, the award shall be rescinded. If benefits are accepted but the member fails to terminate employment with the state highway patrol within the ~~thirty day~~thirty-day period provided in paragraph (N)(2)(a) of this rule, the award shall be rescinded.

(O) As a condition to granting an application for disability benefits, the member shall agree in writing, on a form provided by the board, to obtain any medical treatment recommended by the examining physician or medical advisor and submit the required medical reports as required by the board.

(1) Such additional medical treatment shall be of common medical acceptance and readily available, and may include, but is not limited to, medicine, alcohol and/ or drug rehabilitation, or mechanical devices.

~~(2) Such additional medical treatment must be an allowable medical expense under HPRS' medical expense benefits program.~~

~~(3)~~(2) The member shall also agree in writing to provide, upon HPRS' request, any existing medical report relevant to the ~~member's~~member's disability.

~~(4)~~(3) If the member fails to submit a required medical report or does not continue treatment, the ~~member's~~member's disability benefit shall be suspended until such report is received by HPRS, the member resumes treatment or the physician providing treatment certifies, and the medical advisor concurs, that treatment is no longer helpful or advisable. If such failure continues for one year, the disability benefit shall be terminated.

(P) Any subsequent application for a disability benefit filed after a denial of a disability application or termination of previously granted disability benefits shall be submitted with medical evidence, to the satisfaction of the medical advisor, supporting progression of the disabling condition or evidence of a new disabling condition.

(Q) A member may withdraw an application packet prior to the disability ~~committee's~~committee's initial recommendation described in paragraph (H) of this rule.

Effective:

Five Year Review (FYR) Dates: 9/15/2023

Certification

Date

Promulgated Under: 111.15
Statutory Authority: 5505.04, 5505.07, 5505.18
Rule Amplifies: 5505.18
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5505-7-05 **Cost of living benefit.**

(A) For the purpose of section 5505.174 of the Revised Code and this rule, "pension effective date" means:

(1) For age and service retirement benefits, the date following the last working date as a member, with no duplication of salary and pension.

(2) For reduced service retirement benefits and deferred service retirement benefits, the date following the last working date as a member and the date the member is eligible and elects to receive a retirement benefit, with no duplication of salary and pension.

(3) For disability benefits, the date disability benefits commence, with no duplication of salary and pension.

(4) For members participating in DROP, pursuant to section 5505.54 of the Revised Code, the effective date of a member's election to participate in DROP.

(5) For a beneficiary receiving benefits in accordance with section 5505.162 or division (A)(3)(a), (A)(3)(b), (A)(3)(d), (A)(4), (A)(5), (A)(6), or (A)(7) of section 5505.17 of the Revised Code, the date the benefit commences.

(B) For a member or beneficiary with a pension effective date prior to January 7, 2013:

(1) Prior to January 7, 2013, an annual three per cent cost of living benefit shall be added to the pension allowance of a benefit recipient.

(2) On or after January 7, 2013, an annual three per cent cost of living benefit shall be added to the pension allowance of a benefit recipient until the cost of living benefit is changed as described in paragraph (B)(3) of this rule.

(3) The annual cost of living benefit, not to exceed three per cent, shall be determined by the board at its ~~October~~August meeting and shall be based on the actuarial valuation required by section 5505.12 of the Revised Code and the determination shall become effective January first of the following year. Notwithstanding this paragraph, an initial cost of living benefit may be determined by the board at its February, 2013 meeting and shall be based on the actuarial valuation required by section 5505.12 of the Revised Code and the determination shall become effective as determined by the board.

(4) Notwithstanding paragraph (B)(3) of this rule, an annual three per cent cost of living benefit shall be added to the pension allowance of a benefit recipient sixty-five years of age or older who is receiving a pension not greater than one

hundred eighty-five per cent of the federal poverty level for a family of two persons, as defined by section 5505.174 of the Revised Code.

(5) A service retirant and DROP participant shall become eligible for a cost of living benefit the later of the first month following the retirant's or DROP participant's fifty-third birthday or the thirteenth month after the benefit commences.

(6) A disability retirant shall become eligible for a cost of living benefit the earlier of the first month following the retirant's fifty-third birthday or the sixty-first month following the effective date of retirement.

(7) A beneficiary receiving benefits in accordance with section 5505.162 or division (A)(3), (A)(4), (A)(5), (A)(6), or (A)(7) of section 5505.17 of the Revised Code shall become eligible for a cost of living benefit the thirteenth month after the benefit commences.

(C) For a member or beneficiary with a pension effective date on or after January 7, 2013:

(1) An annual cost of living benefit determined by the board shall be added to the pension allowance of a benefit recipient.

(2) The annual cost of living benefit, not to exceed three per cent, shall be determined by the board at its ~~October~~August meeting and shall be based on the actuarial valuation required by section 5505.12 of the Revised Code and the determination shall become effective January first of the following year.

(3) Notwithstanding paragraph (C)(2) of this rule, an annual three per cent cost of living benefit shall be added to the pension allowance of a benefit recipient sixty-five years or age or older who is receiving a pension not greater than one hundred eighty-five per cent of the federal poverty level for a family of two persons, as defined by section 5505.174 of the Revised Code.

(4) A service retirant and DROP participant shall become eligible for a cost of living benefit the later of the first month following the retirant's or DROP participant's sixtieth birthday or the thirteenth month after the benefit commences.

(5) A disability retirant shall become eligible for a cost of living benefit the later of the first month following the disability retirant's sixtieth birthday or the thirteenth month after the benefit commences.

(6) A beneficiary receiving benefits in accordance with section 5505.162 or division (A)(3)(a), (A)(3)(b), (A)(3)(d), (A)(4), (A)(5), (A)(6), or (A)(7) of section 5505.17 of the Revised Code shall become eligible for a cost of living benefit

the later of the first month following the beneficiary's sixtieth birthday or the thirteenth month after the benefit commences.

(D) The pension allowance that a benefit recipient is receiving upon cost of living benefit eligibility shall become the base pension upon which all future cost of living increases are calculated, unless a new base amount is established.

(E) The date of the first cost of living increase shall be the anniversary date for any future cost of living increases.

Effective:

Five Year Review (FYR) Dates: 9/15/2023

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Certification

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Date

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