145-1-31 **Payment for periods of noncontributing service.**

(A) This rule amplifies section 145.483 of the Revised Code.

(B) For purposes of this rule:

(1) "Exempt" means exempt from membership in the public employees retirement system pursuant to Chapter 145. of the Revised Code as effective during the period of noncontributing service and for which there is a properly executed written exemption.

(2) "Excluded" means excluded from membership in the retirement system because Chapter 145. of the Revised Code specifically excludes a person, or the person is not a public employee.

(3) "Noncontributing service" means a period of employment or service for which employee contributions pursuant to section 145.47 of the Revised Code were due, but not deducted by an employer, because the service was neither exempt nor excluded.

(4) "Properly executed written exemption" means:

(a) For employment which began before November 20, 1973, an exemption form provided by the retirement system which was signed by both the employee and employer and received by the retirement system within one month from the date employment began.

(b) For employment beginning on or after November 20, 1973, an exemption form provided by the retirement system which was signed by both the employee and employer, received by the retirement system within one month from the date employment began, and approved by the retirement system.

(C) An employer that failed to deduct employee contributions from a public employee during a period of employment, after January 1, 1935, for state employees or after July 1, 1938, for all other employees, for which employee contributions were required shall certify the earnable salary for such noncontributing service period on a form provided by the retirement system. This certification must be based on records available to the employer.

(D)

(1) After receipt of the employer's certification, the retirement system shall prepare

an employer billing statement for employee and employer contributions and interest for the period of noncontributing service.

(2) Interest shall be calculated through the end of the year preceding the date of the employer billing statement.

(3) The amount of employee contributions shall be calculated using the employee contribution rate, earnable salary and maximum contribution limits in effect during the period of noncontributing service.

(4) The amount of employer contributions shall be calculated using the employer contribution rate in effect during the period of noncontributing service.

(5) The employer is liable for the total amount due in the employer billing statement.

(6) If the amount contained in the employer billing statement is not paid it will be added to the employer's quarterly billing summary.

(E)

(1) An employer shall not be billed for a period of noncontributing service which occurred before a period of contributing service for which a member received a refund of the member's accumulated contributions, pursuant to section 145.40 of the Revised Code or Article VIII of the combined plan document, until the member has made a redeposit of the refund, pursuant to section 145.31 of the Revised Code or rule 145-3-22 of the Administrative Code.

(2) The following applies when an employee who is or was exempt from membership pursuant to section 145.03 of the Revised Code with a public employer also has noncontributing service and is an employee with the same public employer.

(a) Absent a written exemption, the period of noncontributing service shall be billed to the employer pursuant to section 145.483 of the Revised Code and this rule.

(b) An employer shall not be billed for periods of exempt service that are subsequent to a period of noncontributing service unless the subsequent period of exempt service begins within three months from the last date of compensation for the noncontributing service.

(3) A member who has service that was exempt and not billed to an employer may purchase such exempt service pursuant to section 145.28 of the Revised Code and PERS rules.

(F) Except as provided in paragraph (F)(4) of this rule:

(1) Employee contributions paid by the employer pursuant to section 145.483 of the Revised Code and this rule shall be held in the employers' accumulation fund as defined in division (B) of section 145.23 of the Revised Code.

(2) Employee contributions paid by the employer, pursuant to section 145.483 of the Revised Code and this rule, shall be refunded to such employer in the event the member receives a refund of the member's accumulated contributions pursuant to section 145.40 of the Revised Code or a distribution under article VIII of the combined plan document. Amounts paid for employer contributions, interest or other fees, pursuant to section 145.483 of the Revised Code, shall remain with the retirement system.

(3) The employer which received employee contributions, pursuant to paragraph (F)(2) of this rule, shall be liable for a return of such employee contributions if the employee again becomes a member of the retirement system and either makes a redeposit pursuant to section 145.31 of the Revised Code or rule 145-3-22 of the Administrative Code. The retirement system shall bill the employer for the employee contributions plus interest calculated from the date of the refund through the end of the year preceding the date of the statement.

(4)

(a) For members participating in the member-directed plan, employee contributions and interest paid by the employer pursuant to section 145.483 and this rule shall be held in the member's employer contribution account, as defined in section 1.19 of the member-directed plan document. The amount credited to the member's employer contribution account pursuant to section 145.483 of the Revised Code shall vest in accordance with section 7.02 of the member-directed plan document. If the member receives a distribution under article VII of the member-directed plan document, the non-vested portion of the employee contributions shall be refunded ot the employer.

(b) For members participating in the member-directed plan, employer contributions and interest paid by the employer pursuant to section

145.483 of the Revised Code and this rule shall be credited to the member's employer contribution account, as defined in section 1.19 of the member-directed plan document, and the retiree medical account, as defined in rule 145-4-01 of the Administrative Code, in the percentages determined by the OPERS board. The amount credited shall vest in accordance with the relevant provisions of the member-directed and ~~VEBA health~~ retiree medical account plan documents. If the member receives a distribution under article VIII of the member-directed plan document, the non-vested portion of the amounts paid for employer contributions, corresponding interest or other fees pursuant to section 145.483 of the Revised Code shall be transferred as described in section 7.04 of the member-directed plan document or section 4.02 of the ~~VEBA health~~ retiree medical account plan document, as applicable.

(G) If a member has contributions in more than one retirement plan, the contributions paid by the employer pursuant to section 145.483 of the Revised Code shall be credited to the plan in which the noncontributing service would have been earned, if it were remitted at the time the service occurred. If the member no longer has contributions in the retirement plan in which the noncontributing service would have been earned, the contributions paid by the employer pursuant to section 145.483 of the Revised Code shall be credited to the plan in which the member is now contributing.

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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 either any of the following have occurred:

(1) The retirement system has made a distribution from ~~a~~ the health reimbursement arrangement, retiree medical account or ~~401(h)~~wellness retiree medical account, as those terms are defined in rule 145-4-01 of the Administrative Code.

(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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145-1-73 **Withdrawal of application for refund or money purchase or additional annuity lump sum payments.**

(A)

(1) Except as provided in paragraph (A)(2), (B), or (E) of this rule, a member or contributor of the public employees retirement system may withdraw a refund application by returning all uncashed refund payments to the retirement system not later than thirty days after issuance of the initial payment, along with a written request over the member's or contributor's signature to withdraw the application.

(2) A member or contributor who requested a rollover of a refund or lump sum payment to a financial institution may withdraw the application if both of the following occur:

(a) The member or contributor submits to the retirement system, not later than thirty days after issuance of the initial rollover payment, a written request over the member's or contributor's signature to withdraw the application;

(b) The financial institution transmits to the retirement system, not later than sixty days after issuance of the initial rollover payment, the amounts transmitted to the financial institution.

(B)

(1) Except as provided in paragraph (B)(2) or (E) of this rule, a beneficiary who elects to receive a lump sum payment of the member's contributions in lieu of a benefit pursuant to division (A) or (B) of section 145.45 of the Revised Code or article XI of the combined plan document may withdraw an application for that payment by returning all uncashed refund payments to the retirement system not later than thirty days after issuance of the initial payment, along with a written request over the beneficiary's signature to withdraw the application and a completed application for a benefit under division (A) or (B) of section 145.45 of the Revised Code or article XI of the combined plan document.

(2) A qualified spouse who elects to rollover the member's contributions to a financial institution may withdraw a refund application if all of the following occur:

(a) The qualified spouse submits to the retirement system, not later than thirty

days after issuance of the initial rollover payment, a written request over the spouse's signature to withdraw the application;

(b) The qualified spouse submits to the retirement system, not later than thirty days after issuance of the initial rollover payment, a completed application for benefits pursuant to division (A) or (B) of section 145.45 of the Revised Code or article XI of the combined plan document;

(c) The financial institution transmits to the retirement system, not later than sixty days after issuance of the initial rollover payment, the amounts transmitted to the financial institution.

(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, the member or the beneficiary is not entitled to any investment gains or losses on the amount that was paid from the member's individual defined contribution 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 payment(s) is reestablished in the account by the retirement system as provided in this rule. The amount paid from the member's individual defined contribution account that is returned to the retirement system 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 refund.

(D) Any non-vested amounts forfeited by a member participating in the member-directed plan or the member's beneficiary who withdraws a refund 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 and 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) A member, contributor, or beneficiary may not withdraw a refund application as provided in this rule if any of the following have occurred:

(1) The retirement system has made a distribution from ~~a~~ the health reimbursement arrangement, retiree medical account or ~~401(h)~~wellness retiree medical account, as those terms are defined in rule 145-4-01 of the Administrative Code;

(2) The retirement system has paid a portion of the refund or lump sum payment 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 payment under section 145.63 of the Revised Code, the member, contributor, or beneficiary fails to also withdraw the individual's application for a refund or for retirement, disability, or annuity payments under section 145.384 of the Revised Code.

(F) A member, contributor, or beneficiary who withdraws an application for an additional annuity payment under section 145.63 of the Revised Code 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.

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

As used in this chapter:

(A) "~~401(h)~~Wellness retiree medical account" means the retiree medical account of a benefit recipient within the account established by the public employees retirement board under rule 145-4-02 of the Administrative Code and described in rules 145-4-40, 145-4-42, and 145-4-44 of the Administrative Code.

(B) "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) "Age and service retirant" means a former member who is receiving a retirement allowance pursuant to section 145.33, 145.331, 145.332, 145.37 or 145.46 of the Revised Code or section 9.03 of the combined plan document.

(D) "Benefit recipient" means the primary benefit recipient who is eligible for health care coverage, if living. If the member or primary benefit recipient is deceased, "benefit recipient" shall mean the survivor benefit recipient who is eligible for health care coverage.

(E) " Disability benefit recipient" has the same meaning as in section 145.01 of the Revised Code and includes a member or former member who is receiving a disability benefit pursuant to article X of the combined plan document.

(F) "Health care coverage" means the coverage authorized under sections 145.58 and 145.584 of the Revised Code, excluding the reimbursement of the medicare part A and B premiums, the and dental and vision coverage, and the health reimbursement arrangement.

(G) "Health reimbursement arrangement" or "HRA" means the public employees retirement system of Ohio health reimbursement arrangement plan, effective October 1, 2015, 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 HRA shall not be incorporated into this or any other rule of the Administrative Code. The current version of the HRA is available at www.opers.org.

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

(I) "Monthly health care allowance" or "monthly allowance" means the monthly amount

that is allocated to each individual enrolled in health care coverage or health reimbursement arrangement. For health care coverage, this allowance shall be used to purchase health care coverage sponsored by the board and is based on the self-supporting rate, as determined by the board, and as adjusted by the member or primary benefit recipient's qualified years of employer contributions. For a medicare-eligible benefit recipient who is not subject to rule 145-4-62 of the Administrative Code, 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. For effective dates of retirement on and after January 1, 2015, the monthly health care allowance shall also be based on the member or primary benefit recipient's attained age at the time of initial enrollment in the coverage.

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

(K) "Primary benefit recipient" means an age and service retirant or disability benefit recipient is eligible for health care coverage.

(L) "Qualified medical expense" means medical care, as defined in section 213(d) of the Internal Revenue Code of 1986, 26 U.S.C.A. 213(d), and applicable regulations thereunder and are excludable from income in accordance with sections 105 and 106 of the Internal Revenue Code.

(M) "Qualified years of employer contributions" means 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.

(N) "Retiree medical account" means the ~~voluntary employees beneficiary association (VEBA) established by the public employees retirement board in accordance with section 501(c)(9) of the Internal Revenue Code of 1986, 26 U.S.C.A. 501, and~~ group health plan described in the document entitled the "public employees retirement system of Ohio ~~VEBA health plan~~retiree medical account" that was effective on January 1, 2003, and includes amendments adopted through ~~March 23, 2015~~June 30, 2016. The text of the public employees retirement system of Ohio ~~VEBA health plan~~ 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.

(O) "Self-supporting rate" means the adjusted per capita cost for providing health care coverage for any given year, as determined by the board.

(P) "Service manager" means the individual or entity appointed by the public employees retirement system to administer the retiree medical accounts or the ~~401(h)~~wellness retiree medical accounts.

(Q) "Survivor benefit recipient" means a qualified spouse or child who is eligible for health care coverage and receiving a benefit pursuant to section 145.45 or 145.46 of the Revised Code or section 9.03 of the combined plan document.

(R) "Years of employer contributions" means the years or portions of a year for which the member's employer contributed to the public employees 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.

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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 ~~accounts~~ account established pursuant to ~~section 401(h) of the Internal Revenue Code of 1986, 26 U.S.C.A. 401, and~~ section 115 of the Internal Revenue Code of 1986, 26 U.S.C.A. 115, for the purpose of funding the coverage authorized under sections 145.58 and 145.584 of the Revised Code. ~~These accounts~~ 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. ~~At no time shall contributions to the 401(h) account be in excess of twenty-five per cent of the total aggregate actual contributions made to the trust for the traditional pension plan and combined plan, excluding contributions to fund past service credit. In any event, such~~ Such contributions shall be reasonable and ascertainable.

(C) Forfeitures shall be used to fund health care coverage, 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 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 health care coverage, 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) ~~Upon satisfaction of all liabilities under this rule, any assets in the 401(h) account, if any, that are not used as provided in paragraph (E) of this rule shall be returned to the employers, in accordance with section 401(h)(5) of the Internal Revenue Code. 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.~~

(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 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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145-4-24 **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 ~~VEBA health plan~~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 ~~VEBA health plan~~retiree medical account."

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145-4-40 **~~401(h)~~Wellness retiree medical account.**

(A) A ~~401(h)~~wellness retiree medical account under this rule shall be invested by the public employees retirement board ~~with other funds held in the 401(h) account~~within the health care fund. For balances held in each ~~401(h)~~wellness retiree medical account for calendar years prior to and ending on December 31, 2014, interest or other earnings shall be credited at a rate and at such intervals as determined by the board. On and after January 1, 2015, ~~401(h)~~wellness retiree medical accounts shall not earn interest or other earnings. An administrative fee may be assessed against a ~~401(h)~~wellness retiree medical account as determined by the board.

(B) A ~~401(h)~~wellness retiree medical account established under this rule shall be available solely for the payment of the qualified medical expenses of a benefit recipient or eligible dependent.

(C) Payment or reimbursement of a qualified medical expense shall occur only after submission of a claim and approval pursuant to rule 145-4-42 of the Administrative Code. Payment of a qualified medical expense shall occur only by payment of a premium for health care coverage. Reimbursement of a qualified medical expense shall occur by direct payment to the benefit recipient. Payment or reimbursement is limited to expenses not paid by social security, medicare, or any other medical and health insurance coverage held by the benefit recipient or eligible dependent, or their employers. Payment or reimbursement may not be made for qualified medical expenses that are deductible by the benefit recipient under any other section of the Internal Revenue Code.

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145-4-42 **Administration of ~~401(h)~~wellness retiree medical account-claims and appeals.**

(A) An individual eligible for payment or reimbursement of a qualified medical expense shall submit a claim to the service manager. The service manager shall determine if the claim is a qualified medical expense, and if the claim is approved, the service manager shall make payment or reimburse the qualified medical expense not later than thirty days after the date of approval to the individual's direct deposit account on file with the public employees retirement system under rule 145-2-70 of the Administrative Code.

(B) If a claim is denied, in whole or in part, by the service manager, the service manager shall provide the claimant with written notice of its decision within thirty days after receipt of the claim, unless special circumstances require an extension of time for review of the claim.

(1) If special circumstances require an extension of time for the service manager to review a claim, the claimant shall be advised, in writing, of the extension, the special circumstances giving rise to the extension, and the date by which the service manager expects to render its decision. The extension period shall not be more than ninety days after receipt of the claim.

(2) Any denial of a claim shall clearly describe the reason for the denial, the authority upon which the service manager relied in making the decision, any additional information necessary for the claimant to complete the claim, and the steps the claimant may take to submit the claim for review pursuant to paragraph (C) of this rule.

(3) In the event written notice of a denial of a claim is not provided to the claimant in the manner set forth in paragraph (B)(2) of this rule, the claim shall be deemed denied as of the date on which the service manager's time period for rendering its decision expires.

(C) Any claimant whose request for payment or reimbursement has been denied, in whole or in part, or the claimant's authorized representative, may appeal the denial by submitting to the service manager a written request for a review of the denied claim. Except as provided in this paragraph, a request for review must be received by the service manager not later than sixty days from the date the claimant received written notification of the service manager's initial denial of the claimant's request or from the date the claim was deemed denied. The service manager, upon the written application of the claimant or authorized representative, may in its discretion agree in writing to an extension of the sixty-day period.

During the period for filing a request for review of a denied claim described in this paragraph, the service manager shall permit the claimant to review relevant

documents and submit to the service manager written issues and comments concerning the claim.

(D) Upon receiving a request for a review of a denied claim, the service manager shall promptly conduct an internal review of the denied claim and shall provide written notice to the claimant of its decision not later than sixty days after the date on which the request for review was received by the service manager, unless special circumstances require an extension of time for reviewing the denied claim. In the event special circumstances require an extension of time, the service manager shall, prior to the expiration of the initial sixty-day period described in this paragraph, provide the claimant with written notice of the following:

(1) The special circumstances which require an extension of time for review;

(2) The date by which the service manager expects to render its decision. In no event shall such extension exceed a period of one hundred twenty days from the date on which the service manager received the claimant's request for review.

(E) The service manager's decision shall meet all of the following:

(1) Be written to the claimant in a manner designed to be understood by the claimant;

(2) Include specific reasons for their decision;

(3) Include specific references to the pertinent Administrative Code or Internal Revenue Code provisions on which the decision is based.

(F) The service manager may, in its discretion, determine that a hearing is required in order to properly consider the claimant's request for review of a denied claim. In the event the service manager determines that a hearing is required, that determination shall constitute a special circumstance permitting an extension of time in which to consider the claimant's request for review.

(G) The claims procedures set forth in this rule shall be strictly adhered to by the claimant or the representative of the claimant. No judicial or arbitration proceedings with respect to any claim for payment or reimbursement, to the extent any such proceedings may be available under applicable law, shall be commenced by any claimant until the proceedings set forth in this rule have been exhausted in full.

Effective: 07/01/2016

CERTIFIED ELECTRONICALLY

Certification

06/15/2016

Date

Promulgated Under:	111.15
Statutory Authority:	145.09, 145.58
Rule Amplifies:	145.58, 145.584
Prior Effective Dates:	1/1/07, 1/1/09, 1/7/13 (Emer.), 3/24/13, 11/6/14, 1/1/16

145-4-44 **Administration of ~~401(h)~~wellness retiree medical account-forfeiture and unclaimed accounts.**

(A) Amounts standing to the credit of a benefit recipient in the ~~401(h)~~wellness retiree medical account at the time of death may be used by an eligible dependent of the benefit recipient for payment or reimbursement of qualified medical expenses.

(B) The ~~401(h)~~wellness retiree medical account shall be forfeited and used as provided in paragraph (C) of this rule if any of the following occur:

(1) The primary benefit recipient is not survived by any eligible dependents;

(2) All eligible dependents cease to meet the criteria set forth in rule 145-4-09 of the Administrative Code;

(3) The service manager has not received any claims for reimbursement from an eligible dependent within two years of the death of the benefit recipient;

(4) An eligible dependent has made a claim for reimbursement within two years of the benefit recipient's death, but fails to make a claim at least once within the twenty-four-month period following the date of the most recent claim was submitted.

(C) Forfeitures shall be used to fund the administrative expenses of the ~~401(h) account~~ health care fund and may be used as a credit against future employer contributions to the ~~401(h) account~~health care fund.

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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 either of the following group plans offered by the system: ~~the~~

(a) a medical ~~plan~~ and ~~the~~ prescription drug plan ~~offered by the system~~ or ~~.~~

(b) limited wraparound coverage, which provides limited benefits that wrap around 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.

(B) Eligibility

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

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

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

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

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

(2) Eligibility for health care coverage shall terminate when the person ceases to

qualify as one of the persons listed in paragraph (B)(1) of this rule, except that a dependent described in paragraph (A)(5)(b)(i) of this rule shall cease to qualify on the first day of the calendar year following the dependent's twenty-sixth birthday.

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

(C) Enrollment

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

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

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

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

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

(ii) ~~Attaining age sixty-five;~~ Voluntary or involuntary termination of health care coverage under medicaid; or

(iii) 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 ~~as follows~~:

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

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

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

(ii) Voluntary or involuntary termination of health care coverage under medicaid;

~~(ii)~~(iii) Involuntary termination of health care coverage under another plan, including a ~~medicaid,~~ 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 health care coverage is cancelled for default as provided in paragraph (F) of this rule;

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

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

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

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

(E) Effective date of coverage

(1) The effective date of health care coverage for persons eligible for health care coverage as set forth in paragraph (B) of this rule shall be as follows:

(a) For a disability benefit recipient or dependent of a disability benefit recipient, health care coverage shall be effective on the first of the month following 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.

(F) Premiums

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

(2) Premium payments billed to a benefit recipient shall be deemed in default after

three consecutive months of nonpayment. A benefit recipient who is in default shall be sent notice by certified U.S. mail informing the benefit recipient that payments are in default and that coverage will be cancelled on the first day of the month after the date of the notice unless payment is received. If coverage is cancelled due to a recipient's failure to pay premium amounts in default, the recipient shall remain liable for such amounts due for the period prior to cancellation of coverage.

(3) After cancellation for default, health care coverage can be ~~reestablished and coverage~~ reinstated as provided in paragraph (I) of this rule, or upon submission of an application for reinstatement supported by medical evidence acceptable to SERS that demonstrates that the default was caused by the benefit recipient's physical or mental incapacity. "Medical evidence" means documentation provided by a licensed physician of the existence of the mental or physical incapacity causing the default. Health care coverage reinstated after termination for default shall be effective on the first of the month following the date that the application for reinstatement is approved.

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

(a) A dependent child.

(b) An age and service retirant:

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

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

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

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

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

(c) A disability benefit recipient:

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

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

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

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

(d) A spouse:

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

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

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

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

preceding retirement or separation from SERS service.

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

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

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

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

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

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

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

(G) Waiver

(1) A benefit recipient may waive health care coverage by completing and

submitting a SERS waiver form to SERS.

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

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

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

(H) Medicare advantage or medicare part D

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

(I) Reinstatement to SERS health care coverage

(1) An eligible benefit recipient~~,~~ or dependent of a benefit recipient with health care coverage, whose coverage has been previously 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 ~~thirty-one~~ days after ~~reaching age sixty-five~~ becoming eligible for medicare. Health care coverage shall be effective the later of the first day of the month after ~~reaching sixty-five~~ becoming medicare eligible or receipt of the enrollment application by the system;

(b) The application is received no later than thirty-one days after voluntary or 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

~~(b)~~(c) The application is received no later than thirty-one days after involuntary termination of coverage under another plan, ~~medicaid,~~

medicare advantage plan, or medicare part D plan with proof of such termination. Health care coverage shall be effective the later of the first day of the month after termination of the other plan or receipt of proof of termination and the enrollment application by the system.

(2) An eligible person whose coverage was cancelled pursuant to paragraph (D)(1)(~~f~~g) 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.

(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" ~~premium~~ 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" ~~premium~~ reimbursement when a benefit recipient is receiving more than one monthly benefit from this system; nor

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

Effective:

Five Year Review (FYR) Dates: 02/01/2019

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Certification

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Date

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5505-3-05 **Selection of payment plan.**

(A) A member of the state highway patrol retirement system who retires under section 5505.16 of the Revised Code may elect a plan of payment and nominate a beneficiary pursuant to section 5505.162 of the Revised Code. The plan of payment selection and beneficiary nomination may be changed at any time prior to the pension eligibility date of retirement benefits as defined in rule 5505-3-01 of the Administrative Code. After the pension eligibility date, the plan of payment and beneficiary nomination is irrevocable except for as defined in this rule.

(B) A retirant may submit an application to change the plan of payment and beneficiary on a form prescribed by the board. Upon receipt of an application submitted by the retirant, except as provided in paragraph (F) of this rule, an optional plan of payment will be changed to a single lifetime pension:

(1) Option plan cancellation – the month following receipt of a completed application provided:

(a) the designated beneficiary consents to cancellation of his or her designation;

(b) the completed application is received from the retirant within one year of the retirant's first pension payment.

(2) Death of a beneficiary – the month after the date of death regardless of when the application is received. In the event appropriate documentation is not provided within ninety days of the beneficiary's death, HPRS shall reinstate the nomination of the beneficiary until such time as HPRS receives the appropriate supporting documentation on the death of the beneficiary.

(3) Divorce, annulment or marriage dissolution – the first month following receipt of a completed application provided the retirant submits spousal consent or a court order specifically authorizing the reselection of plan of payment on the basis of the marriage termination.

(C) There shall be no retroactive adjustment for the period of time that a joint and survivor annuity was paid.

(D) The allowance payable under the optional plan of payment selected or reselected under this rule shall be based on the annuity factors tables in effect and the ages of the retirant and beneficiary at the time of plan selection.

(E) A retirant may elect an optional plan of payment following marriage or remarriage provided:

(1) The application is received from the retirant within one-year of marriage or remarriage;

(2) Only the new spouse may be nominated as a new beneficiary; and

(3) If the retirant had selected a plan of payment pursuant to section 5505.162(A)(2)(d) of the Ohio Revised Code, the new spouse may be designated a beneficiary only if the retirant does not already have four beneficiaries designated under that plan at the time the retirant applies to add the new spouse.

(F) The death of any designated beneficiary under section 5505.162(A)(2)(d) of the Revised Code shall not change the plan of payment. The plan benefit shall continue to the remaining designated beneficiaries in their same percentages and the deceased beneficiary's portion shall revert to the retirant for the remainder of his or her lifetime. A retirant may not cancel the plan of payment and return to a single lifetime pension equivalent until the date of death of all designated beneficiaries under that plan. The effective date of this change shall be the first day of the month following the date of death of the last living beneficiary.

(G) For purposes of determining the priority of court orders issued under sections 3105.171 or 3105.65 of the Revised Code or the laws of another state regarding the division of marital property that require the member to elect a plan of payment set forth in division (A)(2)(d) of section 5505.162 of the Revised Code and designate a former spouse as beneficiary, HPRS shall process such court orders in the order in which they are received by HPRS. In no event shall the member's lesser allowance or portion of the lesser retirement allowance be paid to more than four surviving beneficiaries.

(H) Any benefit paid to a beneficiary under the joint and survivor annuity or life annuity certain and continuous is in addition to the automatic surviving spouse benefit in accordance with section 5505.17 of the Revised Code. Section 401(a)(9) of the Internal Revenue Code of 2015, 26 U.S.C.A. 401(a)(9) prohibits the payment of a benefit to a designated beneficiary or a combination of payments made to a surviving spouse and designated beneficiary that exceeds the amount the retirant was receiving at the time of death.

Replaces: 5505-3-05

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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5505-7-04 **Health care.**

(A) For the purpose of this rule:

(1) "Age and service retirant" shall mean a former member that applied for and was granted retirement benefits as described in section 5505.16 of the Revised Code.

(2) "Benefit recipient" shall mean an age and service retirant or disability retirant that is receiving a pension benefit as described in division (A)(1) of section 5505.17 of the Revised Code.

(3) "Child" shall mean a biological child, lawfully adopted child, child placed for adoption or stepchild of a benefit recipient or member provided that such child has not yet attained age twenty-six. "Child" shall also mean a child for whom a benefit recipient or member has been legally appointed as guardian, provided that such child has not yet attained age eighteen.

(4) "Dependent" shall mean the spouse or child as defined in this rule.

(5) "Disability retirant" shall mean a former member that applied for and was granted retirement benefits as described in section 5505.18 of the Revised Code.

(6) "Eligible dependent" shall mean a dependent that qualifies for health care coverage pursuant to paragraph (C) of this rule.

(7) "Member" shall have the same meaning as division (J) of section 5505.01 of the Revised Code.

(8) "Retirant" shall mean an age and service retirant or disability retirant.

(9) "Spouse" shall mean a wife or husband of a retirant or member as set forth in a statutorily-valid certificate.

(10) "Eligible Plan" shall mean:

(a) For a benefit recipient or eligible dependent that is enrolled in medicare part A and medicare part B, a medicare advantage plan.

(b) For those benefit recipients or eligible dependents other than those described in paragraphs (A)(10)(a) and (A)(10)(c) of this rule, any

medical or prescription drug plan, other than a medicare advantage plan, offered pursuant to section 5505.28 of the Revised Code.

(c) Eligible Plan does not include any Dental or Vision plan.

(B) Benefit recipients and eligible dependents may enroll an eligible plan offered pursuant to section 5505.28 of the Revised Code.

(1) The annual premium cost for each category of coverage will be determined by the board prior to the annual open enrollment period.

(2) All provisions of this rule are subject to current health care contracts and amendments.

(3) The board may implement cost control measures as it deems necessary.

(4) Only benefit recipients and eligible dependents who are enrolled under state highway patrol retirement system medical coverage are eligible for prescription drug coverage.

(5) Notwithstanding any other provision of this rule, any benefit recipient or eligible dependent that is or becomes employed by the state highway patrol in any capacity shall be ineligible for health care or prescription drug coverage.

(C) The dependents of a benefit recipient are eligible for health care, subject to the following conditions:

(1) The benefit recipient is enrolled in the HPRS medical and prescription plans.

(2) A child for whom the benefit recipient has been appointed as guardian is eligible for healthcare if the child is unmarried, chiefly dependent on the benefit recipient, and lives in the same household as the benefit recipient.

(3) The board may require documented proof of marriage, guardianship, or parenthood. The board reserves the right to deny or cancel coverage if the benefit recipient or dependent does not comply with the board's request for documents.

(D) Upon death of a retirant, or member, dependents are eligible for health care coverage, subject to the following conditions:

(1) The dependent, except as provided in paragraph (D)(2) of this rule, would have qualified as an eligible dependent had the retirant or member been a benefit recipient at the time of death.

(2) A child for whom a retirant or member has been legally appointed as guardian, who would have been eligible for coverage at the time of the retirant's or member's death had the retirant or member been a benefit recipient, may obtain or continue coverage, provided the spouse elects to continue coverage, the spouse is appointed guardian of the child within ninety days of the retirant or member's death, and the child is chiefly dependent on the spouse and lives in the same household as the spouse.

(3) In the event a spouse remarries, health care eligibility shall continue. Notwithstanding the forgoing, a spouse who has access to medical and/or prescription coverage through his or her new spouse must secure it as primary coverage, regardless of cost; secondary coverage may be maintained.

(E) Open enrollment for all health care options will be November first through November thirtieth each year.

(1) Eligible benefit recipients and dependents may enroll in ~~or delete~~ coverage only during open enrollment, except to the extent of (a) a qualifying event that affects that individual's eligibility for health benefits; (b) a medicare rule; or (c) a newly retired member may enroll up to sixty days after his or her retirement effective date. Coverage may be terminated at any time.

(2) Qualifying events include -

(a) Marriage,

(b) Birth, adoption, placement for adoption or legal guardianship of a child,

(c) Change in employment status,

(d) Divorce, annulment, or dissolution,

(e) Legal separation,

(f) Involuntary termination of other group coverage, or

(g) Death.

(3) The effective date of coverage will be -

(a) January first for an addition during open enrollment. ~~Deletions during open enrollment shall be effective December thirty-first.~~

(b) The beginning of the month following the receipt of an enrollment form based on a qualifying event.

(c) The date of marriage for the addition of a new spouse or stepchild.

(d) The date of birth for the addition of a newborn.

(e) The adoption date for the addition of a newly-adopted child or the date the child is placed for adoption.

(f) The date the legal guardianship becomes effective.

(4) Upon request, a benefit recipient or eligible dependent may designate an effective date of coverage that is the beginning of a month no later than two months after the effective date under paragraph (E)(3) of this rule.

(5) To qualify for coverage, an enrollment form based upon a qualifying event must be received by the retirement system no later than sixty days after the event.

(F) A termination of coverage will be effective at the end of the month during which an enrollment change form is received.

(1) Health care coverage for eligible dependents shall terminate under the following conditions:

(a) At the end of the month in which the spouse is no longer married to the benefit recipient.

(b) At the end of the month in which the child attains the age of twenty-six except in the case of a legal guardianship which shall be when the child is no longer eligible as defined by paragraph (D)(2) of this rule.

(c) At the end of the month in which the benefit recipient terminates coverage.

(2) Health care eligibility of a child of a deceased member or retirant will terminate at age twenty-six except in the case of a legal guardianship which shall be when the child is no longer eligible as defined by paragraph (D)(2) of this rule.

(G)

(1) Notwithstanding the provisions of paragraphs (F)(1)(b) and (F)(2) of this rule, health care coverage will continue for a disabled child who meets all of the following:

(a) Is unmarried,

(b) Is mentally or physically incapable of earning his or her own living,

(c) Became so incapable prior to the attainment of the limiting age for coverage of children, and

(d) Is chiefly dependent upon the retirant for support and maintenance.

(e) A disabled child that qualifies for coverage beyond age twenty-six under this section that has access to other medical and/or prescription coverage must secure the other coverage as primary coverage, regardless of cost.

(2) To determine whether a disabled dependent child qualifies for coverage under this section, the retirement board may require -

(a) A physician's statement,

(b) An independent medical examination,

(c) Two years of federal tax returns from both the parents and the dependent child, and

(d) Any other information that the board deems relevant.

(H)

(1) Effective January 1, 2015, a benefit recipient who is employed at least thirty hours each week may secure primary medical and/or prescription coverage through the employer or the state highway patrol retirement system. Alternatively, the benefit recipient may elect to secure primary coverage through a spouse's employment.

(a) If the benefit recipient is employed and secures primary coverage through the state highway patrol retirement system, he or she shall pay a premium set by the Board pursuant to paragraph (B)(1) of this rule. The premium will apply sixty days after employment commences except as detailed in this rule.

(b) If the benefit recipient is employed less than thirty hours per week, the benefit recipient may apply to the board for an exemption. The request for exemption must be accompanied with either: (i) certification from the benefit recipient's employer that the benefit recipient will not exceed an average of thirty work hours over four consecutive pay periods; or (ii) evidence of four consecutive pay periods showing that the benefit recipient worked on average less than thirty hours per pay period. No refunds of past premiums will be made.

(c) A benefit recipient must inform the state highway patrol retirement system within sixty days of commencing any employment. If a benefit recipient fails to inform the state highway patrol retirement system pursuant to this section, premiums may be payable pursuant to paragraph (H)(1)(a) of this rule effective sixty days after employment originally commenced unless the benefit recipient would have been eligible for an exemption pursuant to paragraph (H)(1)(b) of this rule.

(d) Notwithstanding this provision, primary dental and vision coverage and secondary medical and prescription coverage may be elected through the state highway patrol retirement system.

(2) Prior to January 1, 2015, a benefit recipient who has access to medical and/or prescription coverage through employment must secure it as primary coverage, regardless of cost. Alternatively, the benefit recipient may elect to secure primary coverage through a spouse's employment. Notwithstanding this provision, primary dental and vision coverage and secondary medical and prescription coverage may be elected through the state highway patrol retirement system. The requirement that primary prescription coverage be

obtained through an employer is effective for pension benefits payable on or after January 1, 2011.

(3) A spouse who has access to medical and/or prescription coverage through employment must secure it as primary coverage, regardless of cost. Notwithstanding this provision, primary dental and vision coverage and secondary medical and prescription coverage may be elected through the state highway patrol retirement system.

(4) A spouse who has access, as a benefit recipient of another retirement system or pension plan, to medical and/or prescription coverage must secure it as primary coverage, regardless of cost. Further, a spouse that receives a payment, stipend, or other remuneration of any kind from another retirement system or pension plan for the purpose of obtaining medical and/or prescription coverage may not elect state highway patrol retirement system coverage as primary coverage. Notwithstanding this provision, primary dental and vision coverage and secondary medical and prescription coverage may be elected through the state highway patrol retirement system. A dependent who had coverage through the state highway patrol retirement system prior to January 1, 2011 may continue that coverage until it is interrupted.

(5) Paragraphs (H)(1), (H)(2), (H)(3), and (H)(4) of this rule will not apply to a participant who has both medicare part A and medicare part B coverage.

(6) If the cost of primary coverage pursuant to paragraph (H)(1), (H)(2), (H)(3) or (H)(4) of this rule less any payment, stipend or other remuneration received for the purpose of securing medical and/or prescription coverage exceeds fifty per cent of the gross income provided by the employer, retirement system, or pension plan, the benefit recipient or spouse, if the benefit recipient is deceased, may apply for a hardship exemption to the board.

(I) An individual who receives benefits in accordance with section 5505.16, 5505.17, or 5505.18 of the Revised Code may be reimbursed for medicare part B premiums upon the receipt of evidence of coverage, up to a maximum amount established by the board.

(1) Evidence will consist of a medicare HIC number or other verification provided by the social security administration.

(2) The reimbursement amount, if any, for the following year will be established by the board no later than the December meeting.

(3) Reimbursement will be effective the month following receipt of evidence of coverage and will be added to each monthly pension payment.

(4) Reimbursement will not be due to a benefit recipient who is eligible to receive reimbursement from an employer, another retirement plan, or any other entity.

(5) An individual who is eligible for medicare part B coverage who does not enroll within thirty days after the individual's eligibility date shall be ineligible for HPRS medical and prescription coverage.

(6) To the extent an individual becomes eligible for medicare part B, from that date forward, the individual must purchase medicare part B. An individual that fails to enroll in medicare part B within thirty days of the eligibility date shall immediately become ineligible for HPRS medical and prescription coverage. A benefit recipient is not required to purchase retroactive medicare part B coverage in order to qualify for full benefits.

(J) If it is available at no cost, a participant is required to enroll in medicare part A. The board reserves the right to terminate medical and prescription coverage of an individual who does not maintain medicare part A coverage that is available at no cost.

(K) Anyone who is eligible for a benefit based only on (1) an election in accordance with section 5505.162 of the Revised Code, (2) divisions (A)(2) to (A)(9) of section 5505.17 of the Revised Code, or (3) being an alternate payee under section 5505.261 of the Revised Code is not eligible for health care coverage or medicare part B reimbursement.

(L) An enrolled benefit recipient's coverage shall be rescinded if the benefit recipient performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact regarding the health care coverage. The effective date of the termination of coverage shall be the date of 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 benefit recipient of the rescission at least thirty days prior to processing the rescission. The rescission applies to all enrolled dependents and all coverage options.

(M) The executive director is authorized to deny or cancel coverage if the benefit recipient or dependent does not comply with a request for documents or information the executive director deems necessary to carry-out the requirements of this rule.

Effective:

Five Year Review (FYR) Dates: 06/28/2016

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	5505.28
Rule Amplifies:	5505.28
Prior Effective Dates:	1/1/1987, 2/1/1990, 11/1/1990, 2/1/1992, 3/15/1992, 12/1/1994, 6/1/1996, 10/1/1996, 10/21/2005, 9/28/2010, 8/8/2011, 6/28/13 (Emer), 9/16/2013, 5/16/2014, 11/17/2014

5505-7-09 **Interim benefit payments.**

(A) For purposes of this rule:

(1) "Final Pension Benefit" means a monthly pension benefit paid pursuant to section 5505.16, 5505.17 or 5505.18 of the Revised Code that the retirement system calculates after the employer certifies the final contributions and service credit made on behalf of the member.

(2) "Estimated Pension Benefit" means a monthly pension benefit paid pursuant to section 5505.16, 5505.17 or 5505.18 of the Revised Code prior to the certification of a member's final contributions and service credit and the calculation of the final pension benefit.

(B) A member retiring under section 5505.16, 5505.17 or 5505.18 of the Revised Code who meets the following requirements shall receive an estimated pension benefit:

(1) The retirement system has received the member's application for age and service retirement and all required forms and documents necessary to process the retirement application at least fourteen days prior to the effective date of retirement.

(2) The member has sufficient service credit in this system to retire under section 5505.16 of the Revised Code, not including the following:

(a) Any additional service that may be credited following receipt of the certification of final deposits from the employer; and

(b) Service credit purchases not completed at least thirty days prior to the benefit effective date.

(3) The member's employer has certified the last day for which the member will receive a salary.

(C) An estimated pension benefit shall be calculated using the accumulated contributions and service credit available in the account of the member at the time the application is received. The retirement system shall calculate the final pension benefit following the receipt of the employer's certification of final deposits and all contributions on behalf of the member.

(1) If no additional contributions are received by the retirement system, the estimated pension benefit shall be the final pension benefit.

(2) If the final pension benefit is greater than the estimated pension benefit, the retirement system shall begin paying the greater amount on the first of the month next following receipt of the additional contributions. The retirement system shall issue a retroactive payment for the difference between the total amount paid as estimated pension benefit and the amount that would have

been paid had the member received payments in the amount of the final pension benefit.

(3) If the final pension benefit is less than the estimated pension benefit, the retirement system shall begin issuing the final pension benefit on the first of the month next following receipt of the certification of the member's final contributions, and the retirant shall repay any overpayment to the retirement system pursuant to section 5505.34 of the Revised Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	5505.04, 5505.17
Rule Amplifies:	5505.16, 5505.162, 5505.17, 5505.18