Rules

June 8, 2017

PERS

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145-2-22 **Receipt of disability benefits.**

(A) After the board has acted on a member's application, it shall notify, by regular mail, the member and the member's last employer reporting to the retirement system or other retirement system, as applicable, of its action.

(B) The board may require a member to submit to ~~subsequent~~ medical examination(s) by an examining physician(s) provided the medical consultant recommends such examination(s) in order to evaluate continued eligibility for disability benefits. The board's consideration shall remain limited to the disabling condition(s) described in paragraph (B)(2) of rule 145-2-21 of the Administrative Code or as described in paragraph (G) of this rule.

(C) The board may waive the ~~annual~~ periodic medical examination as described in section 145.362 of the Revised Code upon the recommendation of the board's medical consultant or when the recipient of a disability allowance is within twelve months of becoming eligible for a benefit under section 145.331 of the Revised Code. A waiver of the ~~annual~~ periodic medical examination does not prohibit the board from requiring the member to submit to ~~subsequent~~ future medical examinations.

(D) Continued medical treatment

(1) A member whose disability benefit is approved with the requirement of continued medical treatment must submit required medical treatment reports on a form provided by the retirement system. If the member fails to submit a required report or does not continue the required treatment, the member's disability benefit shall be suspended until such report is received by the retirement system or the member resumes treatment. If such failure continues for one year, the disability benefit shall be terminated in accordance with section 145.35 of the Revised Code and is not subject to appeal to the public employees retirement board.

(2) The medical consultant may waive the requirement for continued medical treatment if the medical consultant determines that the treatment is no longer helpful or advisable.

(3) A disability benefit recipient enrolled in the rehabilitative services program shall comply with the continued medical treatment as described in paragraph (F) of this rule.

(E) Reemployment of or public service provided by a disability benefit recipient

(1) If a disability benefit recipient is restored to service by a public employer as defined in this rule, the disability benefit shall cease in accordance with section 145.362 of the Revised Code and is not subject to appeal to the public employees retirement board.

(2) Subject to paragraph (E)(3) of this rule, "restored to service" means holding elective office or service as a public employee with any public employer covered by Chapter 145. of the Revised Code, regardless of whether the service is similar or dissimilar to the public employment from which the recipient was found disabled, the amount or type of compensation, if any, or whether the compensation is earnable salary.

(3) "Restored to service" does not include either of the following:

(a) On and after July 1, 2015, service the disability benefit recipient terminates immediately upon notice from the retirement system as described in this paragraph.

Upon receipt of notice that the disability benefit recipient has been restored to service, the system shall notify the recipient on a form provided by the system. The form shall require an affirmation by the recipient that either the service will be terminated in order to continue to receive a disability benefit or the service will continue, which will cause the disability benefit to be terminated. The recipient shall return to the retirement system the signed and notarized form not later than forty-five days after the date it was mailed by the retirement system. If the recipient affirms a continuation of service or the recipient fails to return the form to the retirement system within forty-five days, the disability benefit shall be terminated on the date the recipient was restored to service and any overpayment of disability benefits shall be collected as authorized in Chapter 145. of the Revised Code. If the recipient affirms a termination of service, the termination of service shall be effective on receipt of the notice from the retirement system and any employee contributions remitted for the service shall be unauthorized and returned to the employer. The corresponding employer contributions shall be unauthorized and shall be credited against future employer liabilities.

(b) Service performed as an election worker, as defined in rule 145-1-44 of the Administrative Code, who is not a public employee pursuant to section 145.012 of the Revised Code.

(4) The retirement board shall review the employment of a disability benefit

recipient who seeks employment or is employed or compensated by an employer other than a public employer in a position similar to the position the recipient held as a public employee to determine if the recipient must undergo a medical examination to determine if the disability is ongoing or whether the benefit should be terminated.

(F) Rehabilitative services program

(1) A disability benefit recipient whose application for a disability benefit was received by the retirement system on or after January 7, 2013, and who was not a law enforcement officer at the time contributing service terminated, may elect to participate in the rehabilitative services program. If the recipient withdraws from the rehabilitative services program, the recipient is eligible to make one additional election to participate. A recipient may elect to participate in the rehabilitative services program under this paragraph not later than six months prior to the beginning of the third year following the benefit effective date.

(2) For a disability benefit recipient who has elected to participate in the rehabilitative services program, the continued treatment requirement will be satisfied by the recipient's participation in the case management treatment plan through the rehabilitative services program. Prior to the conclusion of the third year following the benefit effective date, non-compliance with the case management treatment plan shall be treated as described in paragraph (D) of this rule. After the conclusion of the third year following the benefit effective date, non-compliance with the case management treatment plan irrevocably terminates the disability benefit recipient's participation in the rehabilitative services program and thereafter the medical examination of the recipient shall be conducted under the standard described in division (B) of section 145.362 of the Revised Code.

(3) If the recipient has been receiving the benefit for less than five years and the medical consultant determines that there are no rehabilitative services acceptable to the board's medical consultant, the recipient shall be considered on leave of absence and the standard for termination of the benefit is that the recipient is not physically or mentally incapable of resuming the service from which the recipient was found disabled.

(G) Disability from the duties of any position

(1) Consideration of a recipient's ability to perform any position that meets the criteria in division (B) of section 145.362 of the Revised Code shall include the recipient's physical and mental functionality as based on the recipient's

disability record.

(2) For purposes of evaluating the ability to perform the duties of any position described in division (B) of section 145.362 of the Revised Code, all criteria described in that division shall be determined at the beginning of each review.

(H) Information gathered or obtained regarding the disabling condition(s) under this rule becomes part of the disability record that is available for review by the medical examiner and medical consultant.

Effective:

Five Year Review (FYR) Dates: 09/29/2021

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	145.09
Rule Amplifies:	145.35, 145.36, 145.361, 145.362, 145.37
Prior Effective Dates:	6/30/61, 2/1/93, 10/4/93, 9/27/98, 1/5/01, 1/1/03, 12/24/04, 1/1/07, 2/1/11 (Emer.), 4/18/11, 12/10/12, 1/7/13 (Emer.), 3/24/13, 7/7/13 (Emer.), 9/16/13, 11/6/14, 3/23/15 (Emer.), 6/6/15, 1/1/17

145-2-33 **Educational benefits.**

(A) For the purpose of this rule and division (B)(2) of section 145.45 of the Revised Code:

(1) "Qualified student" means a qualified child as defined in division (B)(2)(b)(i) of section 145.45 of the Revised Code;

(2) "School year" means the twelve-month period commencing on the first date of instruction at the institution of learning or training program and ending on that date twelve months later;

(3) "Two-thirds of the full-time curriculum" means that in any one school year, the number of semester or credit hours required to maintain two-thirds of the full-time status for the entire school year with one semester or quarterly break.

(B)

(1) Benefits payable to a qualified student shall be paid to the qualified student for the month in which eligibility is attained or terminated, providing the child is over eighteen years of age and under age twenty-two and a student in a school pursuing a program designed to complete at least two-thirds of the full-time curriculum in each school year.

(2) If a qualified spouse is eligible for a monthly benefit as provided in division (B)(2)(a) of section 145.45 of the Revised Code solely due to the qualified spouse's care of a qualified student, the qualified spouse's benefits shall be suspended or terminated for any period that the qualified student is not eligible for a monthly benefit.

(C) Benefits to a qualified student shall be paid during a school vacation period that does not exceed four calendar months provided the child:

(1) Was qualified to receive benefits before the vacation period began;

(2) Intends to, and subsequently does, return to qualified attendance after the end of the vacation period, unless the child has otherwise met the two-thirds of the full-time curriculum requirement for the school year; and,

(3) Does not receive such benefits for more than one vacation period during any one school year.

(D) Not later than the last day of the month next following the public employees retirement system's request, a qualified student shall provide proof of registration and completion of all courses for which monthly benefits are paid.

(E) Any overpayment of benefits may be recovered by withholding the amount of the overpayment from any benefits due to the beneficiary(ies) who accrued the overpayment. If no benefits are due to the beneficiary(ies) who accrued an overpayment, the amount may be collected pursuant to section 145.563 of the Revised Code.

(F) At no time shall a child be eligible for a monthly benefit as a qualified student for the period following completion of the course of study or graduation from the institution of learning or training program, unless the qualified student continues in the qualified attendance of an institution of learning or training program while under the age of twenty-two.

(G) This rule applies only to eligibility requirements under section 145.45 of the Revised Code as it existed immediately prior to April 6, 2017.

Effective:

Five Year Review (FYR) Dates: 09/29/2021

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	145.09
Rule Amplifies:	145.45, 145.563
Prior Effective Dates:	8/27/70, 9/27/98, 1/1/03, 7/1/04, 1/1/09

145-2-39 **Survivors of law enforcement officers with ~~non-law~~ non-law enforcement service.**

(A) Definitions

(1) "Law enforcement officer" means a member described in division ~~(VV)~~(YY) of section 145.01 of the Revised Code.

(2) "Law enforcement service" means service as a law enforcement officer or public safety officer.

(3) "~~Non-law~~ Non-law enforcement service" means service covered by the public employees retirement system that is other than law enforcement service.

(4) "Public safety officer" means a member described in division ~~(XX)~~(AAA) of section 145.01 of the Revised Code.

(B) If a member who has both law enforcement service credit and ~~non-law~~non-law enforcement service credit dies prior to retirement, the member's qualifying beneficiary or beneficiaries as determined in accordance with section 143.43, 145.431, or 145.45 of the Revised Code may elect to have benefits paid pursuant to section 145.33, 145.332, 145.43, or 145.45 of the Revised Code. If the benefit is calculated pursuant to division (I)(2) or (I)(3) of section 145.332 of the Revised Code, the beneficiary shall be paid a lump sum payment discounted to present value for the ~~non-law~~ non-law enforcement service.

Effective:

Five Year Review (FYR) Dates: 09/29/2021

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	145.09
Rule Amplifies:	145.01, 145.33, 145.332, 145.43, 145.431, 145.45
Prior Effective Dates:	8/20/76, 7/31/89, 12/30/91, 12/6/93, 2/3/00, 4/5/01, 1/1/03, 1/1/07, 1/1/10, 1/7/13 (Emer.), 3/24/13

145-2-49 **Retirement benefits for law enforcement officers.**

(A) Definitions

(1) "Law enforcement officer" means a member described in division ~~(VV)~~(YY) of section 145.01 of the Revised Code.

(2) "Law enforcement service" means service as a law enforcement officer or public safety officer.

(3) "Non-law enforcement service" means service covered by the public employees retirement system that is other than law enforcement service.

(4) "Public safety officer" means a member described in division ~~(XX)~~(AAA) of section 145.01 of the Revised Code.

(B) If a law enforcement or public safety officer is eligible, applies for, and elects to receive retirement benefits pursuant to division (I)(2) or (I)(3) of section 145.332 of the Revised Code, the law enforcement or public safety officer shall elect to receive the benefit amount for the non-law enforcement service as provided in that section. If the monthly annuity would be less than twenty-five dollars per month, the law enforcement or public safety officer shall receive a lump sum payment. If, at the time of the retirant's death, the retirant has received a total amount of monthly benefits that were less than the retirant would have received as a lump sum payment discounted to the present value of the non-law enforcement service benefit, the difference between the amount the retirant received and the amount the retirant would have received shall be paid to the retirant's beneficiary in a lump sum payment.

Effective:

Five Year Review (FYR) Dates: 09/29/2021

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	145.09
Rule Amplifies:	145.332
Prior Effective Dates:	8/20/76, 7/31/89, 12/30/91, 12/6/93, 2/30/00, 4/5/01, 1/1/03, 1/1/06, 1/1/07, 1/1/10, 1/7/13 (Emer.), 3/24/13

145-4-06 **Eligibility for health care in traditional pension and combined plans.**

(A) For effective dates of benefits before January 1, 2014, "ineligible individual" means all of the following:

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.332, or 145.46 or former section 145.34 of the Revised Code or section 9.03 of the combined plan ~~document~~ for whom eligibility is established after June 13, 1986, and who, at the time of establishing eligibility, has accrued less than ten years of service credit, exclusive of credit obtained pursuant to section 145.297 or 145.298 of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 or 145.301 of the Revised Code, credit obtained after May 4, 1992, pursuant to section 145.28 of the Revised Code, and credit obtained in the combined plan after January 1, 2003, pursuant to section 145.28, 145.293, or 145.301 of the Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code or section 9.03(e) of the combined plan ~~document~~, as amended on January 7, 2013.

(B) For effective dates of benefits on and after January 1, 2014, but before January 1, 2015, "ineligible individual" means any individual who does not meet any of the following:

(1) A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.332, or 145.46 or former section 145.34 of the Revised Code or section 9.03 of the combined plan ~~document with an effective date of benefits on and after January 1, 2014, but before January 1, 2015~~, and who has accrued at least ten years of qualified years of employer contributions.

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code or section 9.03(e) of the combined plan ~~document~~, as amended on January 7, 2013.

(C) For effective dates of benefits on or after January 1, 2015, "ineligible individual" means any individual who does not meet any of the following:

(1) A former member described in this paragraph who has attained age sixty and has accrued at least twenty qualified years of employer contributions or is any age and has accrued at least thirty qualified years of employer contributions. The former member shall be receiving benefits pursuant to division (A) of section 145.32, section 145.33, division (A) of 145.332, ~~or~~ section 145.46 or former section 145.34 of the Revised Code or ~~section~~ sections 9.01(a) and 9.03 of the combined plan ~~document with an effective date of benefits on and after January 1, 2015, and who has attained age sixty and has accrued at least twenty qualified years of employer contributions or is any age and has accrued at least thirty qualified years of employer contributions~~.

(2) A former member described in this paragraph who has attained age sixty and has accrued at least twenty qualified years of employer contributions or is any age and has accrued at least thirty-one qualified years of employer contributions. The former member shall be receiving benefits pursuant to division (B) of section 145.32, section 145.33, division (B) of 145.332, or section 145.46 of the Revised Code or sections 9.01(b) and 9.03 of the combined plan.

~~(2)~~(3) A former member receiving benefits pursuant to section 145.331 of the Revised Code who is one of the following:

(a) Had an effective date of benefits under section 145.361 of the Revised Code prior to January 1, 2015, and had accrued at least ten qualified years of employer contributions; or

(b) Had an effective date of benefits under section 145.361 of the Revised Code on or after January 1, 2015, and attained age sixty and has accrued at least twenty years of qualified employer contributions or is any age and has accrued at least thirty qualified years of employer contributions.

~~(3)~~(4) The spouse of the former member;

~~(4)~~(5) The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code or section 9.03(e) of the combined plan ~~document~~, as amended on January 7, 2013.

(D) Beginning January 1, 2014, as used in section 145.58 of the Revised Code, an "ineligible individual" includes a disability benefit recipient who has an effective date of benefits that is on or after January 1, 2014, and has been receiving a disability benefit for more than five years unless the recipient meets one of the

following:

(1) The recipient has met the eligibility requirements described in paragraph (C) of this rule;

(2) The recipient qualifies for federal hospital insurance benefits under the Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395c, on the basis of a disability and has not attained age sixty-five;.

(3) The recipient is not eligible to participate in medicare part A at no cost to the recipient and has not attained age sixty-five.

(E) A member participating in the combined plan shall be a member of the traditional pension plan for purposes of the coverage described in sections 145.58 and 145.584 of the Revised Code.

Effective:

Five Year Review (FYR) Dates: 09/29/2018

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	145.09, 145.58, 145.82
Rule Amplifies:	145.58, 145.584, 145.82
Prior Effective Dates:	4/15/04, 1/1/07, 1/7/13 (Emer.), 3/24/13, 1/1/14, 1/1/15, 1/21/15 (Emer.), 4/17/15, 1/1/16

145-4-09 **Definition of "eligible dependent" for health care coverage.**

"Eligible dependent" is a dependent for purposes of sections 105 and 106 of the Internal Revenue Code of 1986, 26 U.S.C.A. 105, 106, and is described as one of the following:

(A) The spouse of a primary benefit recipient.

(B) The biological or legally adopted child of a primary benefit recipient who is under the age of twenty-six or is permanently and totally disabled prior to age twenty-two. 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.

(C) The grandchild of a primary 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 for the health care coverage.

(D) For effective dates of disability benefits on and after January 1, 2014, an eligible dependent ~~of a disability benefit recipient~~ described in paragraph (B) or (C) of this rule ~~who~~ if the disability benefit recipient has been receiving a disability benefit for more than five years ~~if the disability benefit recipient~~ and meets one of the following:

(1) At the time the disability benefit commenced, the disability benefit recipient has thirty or more qualified years of employer contributions; ~~or~~

(2) At the time the disability benefit commenced, the disability benefit recipient has attained age sixty and has twenty or more qualified years of employer contributions~~.~~; or

(3) The disability benefit recipient qualifies for federal hospital insurance benefits under the Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395c, on the basis of disability before the age of sixty-five.

(E) ~~For coverage periods commencing on and after January 1, 2018~~Except as provided in paragraph (D) of this rule, for benefit effective dates on and after January 1, 2015, an eligible dependent described in paragraph (B) or (C) of this rule may be newly enrolled in health care coverage only if the primary benefit recipient had at least twenty qualified years of employer contributions at the time the benefit commenced.

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Date

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Rule Amplifies:	145.58, 145.584
Prior Effective Dates:	1/1/05, 10/27/06, 1/1/09, 1/1/11, 1/1/15, 1/1/16

145-4-30 **Pre-medicare coverage sponsored by the system.**

(A) This rule applies to health care coverage sponsored by the Ohio public employees retirement system to eligible recipients and dependents who are not yet eligible for coverage under medicare. Health care coverage for an eligible primary benefit recipient may be available upon application on a form provided by the public employees retirement system. A primary benefit recipient may enroll an eligible dependent as defined in rule 145-4-09 of the Administrative Code. Except as provided in paragraph (G) of this rule, eligibility for coverage described in this rule terminates upon the individual's attainment of eligibility for coverage under medicare.

(B)

(1) Except as provided in this paragraph, applications for health care coverage must be received by the public employees retirement system not later than ~~sixty~~ thirty days after the benefit recipient's initial benefit payment. During this ~~sixty~~thirty-day period, the applicant may make one change to the filed application. If the application is received more than ~~sixty~~ thirty days after the initial benefit payment or the benefit recipient fails to file an application within that period, the benefit recipient shall be treated as described in paragraph (E) of this rule.

(2) The system may accept and process an application received more than ~~sixty~~ thirty days after the benefit recipient's initial benefit payment if either of the following occur:

(a) The system determines that a physical or mental incapacity prevented the benefit recipient from making application within the initial ~~sixty~~ thirty-day benefit period. The effective date of coverage shall be determined in accordance with rule 145-4-32 of the Administrative Code.

(b) The benefit recipient did not apply for coverage and later submits an application due to involuntary termination of coverage under another group plan. The benefit recipient shall submit the application within thirty-one days of the involuntary termination together with proof of such termination. ~~If the application is received on or before the tenth day of a month, the coverage is effective on the first day of the month following receipt of the application. Otherwise, the coverage is effective on the first day of the second month following receipt of the application.~~

(C) Upon the recommendation of the actuary retained by the board, the board shall

determine annually the portion of the self-supporting rate it may pay for eligible benefit recipients and eligible dependents enrolled in health care coverage.

(D) An ineligible individual, as defined in rule 145-4-06 of the Administrative Code, may remain enrolled in a health care plan administered by a third party health care administrator(s). Such ineligible individual shall pay all required premiums directly to the health care administrator in the time and manner prescribed by the third party health care administrator. New enrollments to this plan shall not be permitted on or after January 1, 2014. Except to the extent required under paragraph (I) of this rule, the retirement system shall not be responsible for any premiums, claims, or withholding of premiums for such health care plan.

(E)

(1) An eligible benefit recipient may defer enrollment in health care coverage. The deferral applies to both the benefit recipient and the benefit recipient's dependents.

(2) A benefit recipient who is described in paragraph (E)(1) of this rule or who waived coverage under a version of this rule in effect prior to January 1, 2014, may enroll by filing an application for enrollment in health care coverage during one of the following:

(a) The annual open enrollment period for health care coverage, except that the deferral or waiver remains effective until January first of the next year;

(b) Within sixty days of involuntary termination of coverage under another group plan, and with proof of such termination~~, except that the deferral or waiver remains effective until the first day of the month following receipt if the application is received by the tenth day of the preceding month, otherwise the deferral or waiver remains effective until the first day of the second month following receipt of the application~~.

(F) An individual who is eligible for health care coverage from more than one benefit may not enroll for health care coverage simultaneously under more than one benefit.

(G)

(1) Except as provided in paragraph (G)(2) of this rule and regardless of the reason for eligibility, all enrolled benefit recipients and dependents shall enroll in

medicare parts A and B at the benefit recipient or eligible dependent's first eligible date.

(2) A benefit recipient approved for early medicare coverage shall enroll in and provide the retirement system with evidence of the medicare coverage not later than thirty days after the recipient is notified of coverage by the centers for medicare and medicaid services. The system may cover or coordinate the benefit recipient's retroactive claims with medicare and continue the coverage or coordination for not more than four months following the date the recipient was notified of coverage by the centers for medicare and medicaid services.

When the coordination period described in this paragraph or other medicare coordination period required for end-stage renal disease expires, the benefit recipient is no longer eligible for participation in pre-medicare coverage sponsored by the retirement system and may be eligible to participate in the plans described in rule 145-4-60 of the Administrative Code.

(H) The retirement system shall offer continuation coverage, as applicable, in accordance with the requirements of the Consolidated Omnibus Budget and Reconciliation Act of 1985 ("COBRA"), 42 United States Code 300gg-1.

(I) Benefit recipients under this rule are not eligible for coverage during any period of benefit suspension or forfeiture.

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Five Year Review (FYR) Dates: 09/29/2018

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Certification

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Date

Promulgated Under:	111.15
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Rule Amplifies:	145.58, 145.584
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145-4-32 **Effective date of pre-medicare health care coverage.**

(A) Except as otherwise provided in this rule or rule 145-4-30 of the Administrative Code, the effective date of health care coverage shall be the later of the following:

(1) The effective benefit date of the benefit that is the basis of the health care coverage, or

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

(B) For benefit receipients of survivor benefits under section 145.45 of the Revised Code and article XI of the combined plan document, the effective date of health care coverage shall be the effective date of the survivor benefit, but shall not exceed more than one year prior to the date on which the system receives an application for enrollment in health care coverage.

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

(D) The effective date of health care coverage shall be on the first day of a month.

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145-4-38 **Reenrollment following voluntary termination of pre-medicare health care coverage.**

(A) An eligible benefit recipient enrolled in health care coverage under rule 145-4-30 of the Administrative Code may voluntarily terminate coverage. The termination of coverage applies to both the benefit recipient and the benefit recipient's dependents. The effective date of the termination of coverage shall be determined as follows:

(1) If the termination of coverage is received by the retirement system not later than ~~sixty~~ thirty days after issuance of the initial benefit payment and the public employees retirement system has not paid claims for health care coverage of the benefit recipient or dependent, the termination is effective on the effective date of benefits. The benefit recipient shall be treated as an individual who did not enroll in coverage under paragraph (E)(1) of rule 145-4-30 of the Administrative Code.

(2) If the termination of coverage is received by the retirement system more than ~~sixty~~ thirty days after the issuance of the initial benefit payment ~~but not later than the tenth day of a month~~, the termination is effective on the first day of the month following receipt of the termination.

~~(3) If the termination of coverage is received by the retirement system more than sixty days after the issuance of the initial benefit payment and after the tenth day of a month, the termination is effective on the first day of the second month following receipt of the termination.~~

(B) A benefit recipient who voluntarily terminated coverage as described in paragraph (A) of this rule on or after January 1, 2014, may reenroll in coverage by one of the following actions:

(1) During the annual open enrollment period, the benefit recipient applies for health care coverage and provides proof of creditable coverage in another health care plan that is effective ~~through December thirty-first of the plan year immediately preceding participation in this plan~~at the time of application; or

(2) Within sixty days of involuntary termination of health care coverage under another plan, the benefit recipient submits and application for health care coverage and provides proof of creditable coverage in the prior plan. ~~This enrollment will become effective on the first day of the month following receipt of the application if the application is received not later than the tenth day of the month; otherwise, the enrollment becomes effective on the first day of the second month following receipt of the application.~~

(C) This rule does not apply to any of the following:

(1) Rule 145-4-13 of the Administrative Code;

(2) A benefit recipient whose disenrollment occurred under rule 145-4-17 of the Administrative Code;

(3) A benefit recipient whose health care coverage has been suspended for failure to submit the documentation necessary to administer the individual's enrollment in the coverage.

(4) A benefit recipient who is eligible for medicare.

Effective:

Five Year Review (FYR) Dates: 09/29/2018

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	145.09, 145.58
Rule Amplifies:	145.58, 145.584
Prior Effective Dates:	1/1/14 (Emer.), 1/10/14, 1/1/16

145-4-40 **Pre-medicare health care coverage during public employment.**

(A) Public employer and other coverage available

(1) A public employer that employs a primary benefit recipient shall provide health care coverage for such benefit recipient consistent with the provisions of section 145.38 of the Revised Code. At the time the employer provides notice of employment under section 145.38 of the Revised Code, the employer shall also notify the public employees retirement system of the status of health care coverage for the employed benefit recipient.

(2) If the primary benefit recipient should be covered under the employer's health care plan as required by section 145.38 of the Revised Code but fails to enroll in the employer's health care plan or other comparable coverage, the recipient is ineligible to participate in a plan provided by the retirement system during public employment.

(3) If the benefit recipient is covered under the public employer's health care coverage or other comparable coverage, this system's coverage shall pay only the covered qualified medical expenses not paid or reimbursed by the comparable or employer's coverage.

(B) The retirement system may offer health care coverage for pre-medicare benefit recipients during public employment. The benefit recipient shall apply for coverage on a form provided by the retirement system and received by the retirement system not later than sixty days after public employment commences. If applicable, a primary benefit recipient must provide evidence of enrollment in the employer's or other comparable coverage. A benefit recipient enrolled in the coverage described in this paragraph may enroll an eligible dependent in the appropriate coverage determined by the retirement system.

(C)

(1) An eligible benefit recipient may defer enrollment in health care coverage under paragraph (B) of this rule. The deferral applies to both the benefit recipient and the benefit recipient's dependents.

(2) A benefit recipient who is described in paragraph (C)(1) of this rule may enroll by filing an application for enrollment in health care coverage during one of the following:

(a) The annual open enrollment period for health care coverage, except that the deferral or waiver remains effective until January first of the next year;

(b) Within sixty days of involuntary termination of coverage under another group plan, other than a public employer's coverage described in paragraph (A) of this rule, and with proof of such termination.

(D) In all other regards, the coverage provided under this rule shall be administered substantially similar to other pre-medicare coverage sponsored by the retirement system and may differ or coordinate with such coverage as determined by the retirement system. For enrolled recipients, the retirement system shall transfer enrollment to the coverage described in rule 145-4-30 of the Administrative Code effective the first day of the month following termination of the public employment.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Rule Amplifies:	145.38, 145.58, 145.584

145-4-60 **Plans offered to medicare-eligible benefit recipients.**

(A) Rules 145-4-60 to 145-4-68 of the Administrative Code apply to the plans sponsored by the public employees retirement system and offered to medicare-eligible benefit recipients and their dependents.

(B) "Public employee" and "public employer" have the same meanings as in section 145.01 of the Revised Code.

(C) Upon a benefit recipient or dependent becoming eligible for medicare, the system may provide an eligible benefit recipient with access to a monthly allowance through a health reimbursement arrangement. A benefit recipient who is a public employee shall not participate in the health reimbursement arrangement sponsored by the system during any month that the recipient is a public employee.

(D) The system may provide to a medicare-eligible benefit recipient who is a public employee health care coverage that supplements medicare as described in rules 145-4-62 to 145-4-68 of the Administrative Code. In its sole discretion, the system may also make this coverage available on a temporary basis to eligible benefit recipients who are not public employees until such time as the benefit recipient ~~completes an initial enrollment in a medicare supplemental plan that is not sponsored by the system and that allows for~~ : (1) begins participation in the health reimbursement arrangement or (2) becomes medicare-eligible based on age following a medicare coordination period.

(E) Medicare-eligible benefit recipients are not eligible for coverage or allowances described in paragraph (C) or (D) of this rule during any period of benefit suspension or forfeiture.

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

Effective:

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Certification

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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 that qualifies for health care coverage pursuant to paragraph (C) of this rule. Benefit recipient does not include a member participating in the Deferred Retirement Option Program.

(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 (D) or (E) 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.

(11) "Service Credit" shall include:

(a) Credit earned as an employee as defined by division (A) of section 5505.01 of the Revised Code;

(b) Military service credit purchased pursuant to division (D) of section 5505.16 of the Revised Code; and

(c) Credit granted under section 5505.201 of the Revised Code.

(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 following benefit recipients shall be eligible for health care:

(1) Except as provided in division (C)(3) of this rule, a benefit recipient that began receiving a pension pursuant to division (A)(1) of section 5505.17 or elects to participate in the deferred retirement option plan pursuant to section 5505.51 before January 1, 2020;

(2) Except as provided in division (C)(3) for this rule, a benefit recipient that began receiving a pension pursuant to division (A)(1) of section 5505.17 of the Revised Code or elects to participate in the deferred retirement option plan pursuant to section 5505.51 of the Revised Code on or after January 1, 2020 shall be eligible for health care coverage only if he or she has twenty or more years of service credit;

(3) A benefit recipient granted a disability pursuant to division (B)(1) of section 5505.18 of the Revised Code.

(D) 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) Effective January 1, 2018, a child who is 18 up to 26 years of age is not an eligible dependent if he or she has access to any medical and/or prescription coverage through employment, a biological or step-parent, a spouse, military service, or a college or university regardless of cost. For the purpose of this division, access to medical and/or prescription coverage includes receiving a payment, stipend, or other remuneration of any kind.

(b) 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.

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

(1)

(a) the retirant or member was eligible to be a benefit recipient at the time of death;

(b) if the retirant or member was not eligible to be a benefit recipient at the time of death, the date in which the member would have been eligible to enroll pursuant to division (C) of this rule; and

(c) the dependent is eligible to enroll pursuant to division (D) of this rule.

(2) A child for whom a retirant or member has been legally appointed as guardian, who would have been eligible to enroll pursuant to division (C) of this rule, may obtain or continue coverage, provided the spouse elects to continue coverage if:

(a) 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; and

(b) the child would be eligible pursuant to division (D) of this rule.

(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.

(4) The service credit requirements included in division (C)(2) of this rule do not apply to the dependent of a member killed in the line of duty.

(F) 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 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.

(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.

(G) 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.

(H)

(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 disabled prior to the attainment of the limiting age for coverage of children.

(d) The child met the eligibility requirements included in division (D) of this rule at the time the disability occurred; and

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

(f) 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,

(d) Proof that the disabled child applied for Medicare insurance, and

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

(I)

(1) 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.

(2) 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.

(3) Divisions (H)(1) and (H)(2) of this rule will not apply to a dependent who enrolled in both medicare part A and medicare part B coverage prior to

January 1, 2018.

(4) If the cost of primary coverage pursuant to division (H)(1) or (H)(2) 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.

(J) 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) 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.

(K) 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.

(L) 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.

(M) 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.

(N) 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.

Replaces: 5505-7-04

Effective:

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