# Rules

## December 4, 2018

### PERS

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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~~ shall be added to the employer's ~~quarterly~~ monthy billing summary.

(7) Service credit for the period of non-contributing service shall be granted to the member on the earlier of the date the system receives payment in full from the employer or the due date of the employer billing statement described in paragraph (D) (5) of this rule.

(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.

(c) Once the service credit is granted to the member as described in paragraph (D)(7) of this rule, a properly executed written exemption will no longer be accepted by the retirement system.

(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 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 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.

Effective:

Five Year Review (FYR) Dates: 9/29/2020

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Certification

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Date

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| Promulgated Under: | 111.15 |
| Statutory Authority: | 145.09 |
| Rule Amplifies: | 145.47, 145.48, 145.483, 145.49 |
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145-1-41 **Membership determination.**

(A) In making any determination as to whether an individual is a contract employee or independent contractor under section 145.036 of the Revised Code, the public employees retirement board shall review, including but not limited to, the elements described in paragraphs (A)(1) and (A)(2) of rule 145-1-42 of the Administrative Code to determine the degree of control or independence in the relationship between the employer and the employee or contractor based on the facts and circumstances of the relationship.

(B) If the employer fails to request a determination and the retirement board determines the individual should be a member, then the employer shall be liable for employee and employer contributions pursuant to section 145.483 of the Revised Code if no deductions have been made.

(C) If the employer fails to request a determination and the retirement board determines the individual shall not be a member, then any employee contributions received prior to the determination are unauthorized and shall be returned to the employer. Any employer contributions shall be credited against future employer liabilities.

(D) A public employer who engages or contracts with a business entity as defined in section 145.037 of the Revised Code is not required to perform the acknowledgment provisions described in section 145.038 of the Revised Code with regard to the business entity.

145-1-41

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145-1-42 **Services under a contract.**

(A) For purposes of ~~Chapter 145. of the Revised Code, and Chapter 145-1 of the Administrative Code, the following definitions apply~~ rule 145-1-41 of the Administrative Code, the board shall consider the following factors in its determination:

(1) "Contract employee" means an individual who:

(a) ~~Is~~May be a party to a bilateral agreement which may be a written document, ordinance, or resolution that defines the compensation, rights, obligations, benefits and responsibilities of the individual as an employee;

(b) Is paid earnable salary at a specific periodic rate for services personally performed for the public employer and who appears on the employer's payroll;

(c) Is eligible for workers' compensation or unemployment compensation;

(d) May be eligible for employee fringe benefits such as vacation or sick leave;

(e) Is controlled or supervised by personnel of the public employer as to the manner of work; ~~and~~

(f) Should receive an Internal Revenue Service form W-2 for income tax reporting purposes.

(2) "Independent contractor" means an individual who:

(a) ~~Is~~May be a party to a bilateral agreement which may be a written document, ordinance, or resolution that defines the compensation, rights, obligations, benefits and responsibilities of both parties;

(b) Is paid a fee, retainer or other payment by contractual arrangement for particular services;

(c) Is not eligible for workers' compensation or unemployment compensation;

(d) May not be eligible for employee fringe benefits such as vacation or sick leave;

(e) Does not appear on a public employer's payroll;

(f) Is required to provide his own supplies and equipment, and provide and pay his assistants or replacements if necessary;

(g) Is not controlled or supervised by personnel of the public employer as to the manner of work; ~~and~~

(h) Should receive an Internal Revenue Service form 1099 for income tax reporting purposes.

(3) "Personal service contract" means the same as a contract for an independent contractor.

(B)

(1)

(a) A contract employee is a public employee and shall become a contributor to the public employees retirement system.

(b) Contributions are due on the employee's earnable salary, as defined in division (R) of section 145.01 of the Revised Code and rule 145-1-26 of the Administrative Code, which is paid by the public employer to the employee for services actually performed by the employee.

(2) An independent contractor is not a public employee and shall not become a contributor to the retirement system.

(C) Notwithstanding rule 145-1-26 or 145-1-53 of the Administrative Code, if a contract employee performs services for which the employee also receives a payment, fee or commission over and above services for which the employee receives earnable salary, and for which the individual is an independent contractor , the payments for those services over and above their salary services are not earnable salary. The employee is not a member for such additional services, no contributions are due, and no service credit shall be granted.

(D) An individual who entered into a personal service contract with a public employer prior to August 20, 1976, shall be a member of the retirement system and contributions shall be remitted for the remaining period of the contract if the duties and working relationship are substantially similar to a classification position paid on the payroll of the public employer.

145-1-42

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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~~ one or more of the following methods: ~~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.~~

(a) 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;

(b) Remitting to the retirement system to a personal check or money order repaying the refund payment(s) transmitted by or on behalf of the retirement system to the member's or contributor's financial institution not later than thirty days after the institution's receipt of the refund payment(s), 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 one or more of the following methods: ~~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.~~

(a) 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;

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

(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 the health reimbursement arrangement, retiree medical account or 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.

145-1-73

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145-2-70 **Mandatory direct deposit.**

(A) For purposes of this rule, "alternate payee" has the same meaning as defined in section 3105.80 of the Revised Code.

(B) Except as provided in paragraph (C) of this rule, all benefits or payments paid in the form of a refund or monthly annuity to individuals with a United States address on file with the public employees retirement system shall be paid by direct deposit, which is an electronic fund transfer directly to an individual's account at a financial institution. ~~Benefit recipients~~ Recipients of a benefit or payment and alternate payees shall provide to the retirement system valid direct deposit account and routing numbers, the name and contact information of the financial institution, and such other information as may be required by retirement system. The retirement system may withhold a benefit or payment until the benefit recipient or alternate payee provides the information described in this paragraph.

(C) If a ~~benefit~~ recipient of a benefit or payment or alternate payee resides more than fifteen miles from a financial institution that provides direct deposit accounts, demonstrates that ~~he or she~~ the individual is the victim of fraud or identity theft, or resides in a nursing or convalescent home, the ~~benefit~~ recipient or alternate payee may submit a request for exemption from direct deposit on a form provided by the retirement system. The retirement system shall approve or deny the request.

145-2-70

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Prior Effective Dates: 03/01/2010 (Emer.), 04/05/2010, 01/01/2011, 01/01/2012, 01/07/2013 (Emer.), 03/24/2013

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

As used in this chapter:

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

(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 or the health reimbursment arrangement, 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 récipient'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 or the health reimbursement arrangement.

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

(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 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.

145-4-01

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Date

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

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

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

(C) Forfeitures shall be used to fund 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)

(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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Certification

10/10/2018

Date

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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 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, 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, 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, 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, section 145.46 or former section 145.34 of the Revised Code or sections 9.01(a) and 9.03 of the combined plan.

(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.

(3) A former member described in the 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-two qualified years of employer contributions. The former member shall be reciving benefits pursuant to division (C) of section 145.32, division (C) of section 145.332, or section 145.46 of the Revised Code or sections 9.01(c) and 9.03 combined plan.

~~(3)~~(4) 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 either 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.~~meets one of the following criteria:

(i) If, had the member retired on age and service retirement, the member would have recevied benefits described in paragraph (C)(1) of this rule, the member has accrued a least thirty qualified years of employer contributions;

(ii) If, had the member retired on age and service retiremement, the member would have received benefits described in paragraph (C)(2) of this rule, the member has accrued at least thirty-one qualifed years of employer contributions;

(iii) If, had the member retired on age and service retirement, the member would have received benefits described in paragraph (C)(3) of this

rule, the member has accrued at least thirty-two qualified years of employer contributions.

~~(4)~~(5) The spouse of the former member;

~~(5)~~(6) 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, 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 (B) or (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.

145-4-06

Effective:

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Certification

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Date

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|---|---|
| Promulgated Under: | 111.15 |
| Statutory Authority: | 145.82, 145.58, 145.09 |
| Rule Amplifies: | 145.58, 145.82, 145.584 |
| Prior Effective Dates: | 04/15/2004, 01/01/2007, 01/07/2013 (Emer.), 03/24/2013, 01/01/2014, 01/01/2015, 01/21/2015 (Emer.), 04/17/2015, 01/01/2016, 09/01/2017 |

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 described in paragraph (B) or (C) of this rule if the disability benefit recipient has been receiving a disability benefit for more than five years and meets one of the following:

(1) ~~At the time the disability benefit commenced, the~~ The disability benefit recipient ~~has thirty or more qualified years of employer contributions~~ meets one of the criteria specified in paragraph (C)(4)(b) of rule 145-4-06 of the Administrative Code;

(2) ~~At the time the disability benefit commenced, the~~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) 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.

145-4-09

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**145-4-08 Eligibility for health care coverage for years of employer contributions in traditional pension and combined plans.**

For purposes of determining eligibility for health care coverage and the monthly health care allowance, the public employees retirement system shall aggregate years of employer contributions earned and purchased in both the traditional pension plan and the combined plan if both of the following apply:

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

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

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Rule Amplifies: 145.58, 145.82
Prior Effective Dates: 01/01/2007, 01/01/2015, 01/01/2016

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

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

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TO BE RESCINDED

145-4-13 **Waiver program grandfathered.**

(A) This rule applies to a benefit recipient who irrevocably waived health care coverage under the version of rule 145-4-32 of the Administrative Code in effect prior to January 1, 2007, and an individual who irrevocably waived health care coverage in another Ohio retirement system prior to January 1, 2007.

(B)

(1) In the event that an eligible benefit recipient of this system who also was an eligible benefit recipient of another Ohio retirement system irrevocably waived health care coverage under rule 145-4-32 of the Administrative Code in order to be covered by the other Ohio retirement system, this system shall transfer to the other system annually for covered benefit recipients and dependents for each month covered an amount equal to the sum of:

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

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

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

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

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

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

(C) Where an eligible benefit recipient or dependent of an eligible benefit recipient of this system has waived health care coverage in another Ohio retirement system prior to January 1, 2007, this system shall be responsible to provide health care coverage only if the other Ohio retirement system pays annually to this system for covered benefit recipients and dependents for each month covered, an amount equal to the sum of:

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

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

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

(D) For coverage years commencing on and after January 1, 2016, eligibility for health care coverage of dependents of eligible benefit recipients described in paragraph (C) of this rule shall be determined by rule 145-4-14 of the Administrative Code. A dependent may enroll in other available coverage as defined in rule 145-4-14 of the Administrative Code or, if the dependent does not voluntarily terminate coverage, elect continuation coverage from this system as described in paragraph (H) of rule 145-4-30 of the Administrative Code.

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**145-4-14 Coordination of coverage.**

(A) This rule amplifies division (D) of section 145.58 of the Revised Code.

(B) As used in this rule, "available coverage" means health care coverage available from another Ohio retirement system. It includes any payment, stipend, funds, reimbursement, or other remuneration of any kind provided from another Ohio retirement system for the purpose of obtaining medical or prescription drug coverage.

(C) Health care coverage provided by this retirement system under sections 145.58 and 145.584 of the Revised Code shall pay covered medical expenses for benefit recipients of this retirement system prior to payment under any available coverage if the available coverage is provided to the individual as the spouse or dependent of another person.

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

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

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

(E) Except as otherwise provided in this rule, the public employees retirement system shall not be the system responsible for health care coverage for eligible benefit recipients or eligible dependents of eligible benefit recipients of this system who waive or are otherwise eligible for any available coverage after January 1, 2007.

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

145-4-14

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Rule Amplifies: 145.58, 145.584
Prior Effective Dates: 01/01/2007, 01/01/2009, 01/07/2013 (Emer.), 03/24/2013

145-4-15 **Income-based discount program.**

(A) As used in this rule, "household income" means the aggregate of all income and wages of a primary benefit recipient enrolled in health care coverage, plus the income and wages of the spouse and any individual that could be claimed as the dependent of the primary benefit recipient for purposes of federal income taxes.

(B) The public employees retirement board may offer a discount on the monthly premium for health care coverage to eligible primary benefit recipients whose household income is below an amount determined by the board. The board shall establish the requirements that must be met to qualify for the discount. Beginning January 1, 2015, a primary benefit recipient shall have at least twenty qualified years of employer contributions to be eligible for the discount. A primary benefit recipient who was receiving the discount as of December 2014 is not subject to this requirement but must meet all other eligibility requirements established by the board.

(C) If offered under paragraph (B) of this rule, an eligible primary benefit recipient must apply for the discount annually on a form provided by the public employees retirement system. The system may request documentation to validate the primary benefit recipient's eligibility for the program. Failure to accurately complete the enrollment form or provide the requested documentation will prevent enrollment in the program for that year.

(D) If the retirement system determines that the primary benefit recipient has made false or incomplete representations to qualify for the discount described in this rule, the primary benefit recipient shall reimburse the retirement system for any discounts improperly received and shall be ineligible to receive the discount at any time in the future.

145-4-15

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ACTION: No Change

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145-4-17 **Payment of health care charges and disenrollment for nonpayment.**

(A)

(1) Benefit receipients enrolled in health care coverage sponsored by the public employees retirement system shall pay all health care premiums and associated costs through deduction from the benefit.

(2) If the benefit does not satisfy the amounts due, the public employees retirement system or designated third party shall bill the benefit recipient for the amount due or the remainder of the amount due after partial deduction from the available benefit.

(B) A benefit receipient who fails to timely remit payment for amounts due pursuant to paragraph (A)(2) of this rule shall be disenrolled from all health care coverage as provided in this rule.

(1) A benefit recipient may prevent disenrollment only by remitting all amounts due prior to the due date.

(2) A benefit recipient who has failed to remit the amount due by the due date shall be notified of disenrollment from health care coverage not less than fifteen days prior to the date on which the retirement system will process the disenrollment.

(3) The effective date of disenrollment shall be the last day of the month following the month the benefit recipient failed to remit the amount due, in coordination with the centers for medicare and medicaid services, as necessary.

(4) Any unpaid amounts due through the effective date of disenrollment shall be deducted from the benefit following disenrollment.

(5) Disenrollment of a benefit recipient pursuant to this rule applies to all enrolled dependents and coverage options.

(C) A benefit receipient whose coverage was terminated pursuant to this rule may re-enroll in coverage once during the annual open enrollment period if full payment of all amounts due is received by the first day of December of the year preceding the coverage period.

(D) A second termiantion of coverage pursuant to this rule is permanent and ends all eligibility to participate in this plan.

145-4-17

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

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

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

145-4-24

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Rule Amplifies: 145.83
Prior Effective Dates: 04/15/2004, 10/27/2006, 07/01/2016 (Emer.), 09/01/2016

ACTION: Original

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145-4-26 **Dental and vision coverage.**

(A) The public employees retirement system may offer dental or vision coverage that is administered by a third party administrator(s) to individuals who are receiving a benefit from the system and eligible dependents. For purposes of this rule, "benefit" includes monthly amounts paid to an individual pursuant to section 145.32, 145.33, 145.331, 145.332, 145.35, 145.36, 145.361, 145.37, 145.384, 145.45, or 145.46 of the Revised Code, or section 9.02, article X, or article XI of the combined plan document.

(B) The dental and vision coverage offered by the system shall be administered consistent with health care coverage as follows: enrollment in the coverage as described in paragraphs (B), (E), and (F) of rule 145-4-30 of the Administrative Code and paragraph (D) of rule 145-4-62 of the Administrative Code; effective dates of coverage as described in rule 145-4-32 of the Administrative Code; and enrollment of dependents as described rules 145-4-30, 145-4-34, 145-4-36, 145-4-62, 145-4-62, and 145-4-66 of the Administrative Code; and payment of charges and disenrollment for nonpayment as described in rule 145-4-17 of the Administrative Code.

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

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

~~(1)~~(2) An individual enrolled in dental or vision coverage can voluntarily terminate ~~his or her~~ the individual's enrollment in the coverage or a dependent's enrollment in the coverage only at the end of each calendar year by filing the notice of cancellation ~~on~~ in a form ~~provided~~ and manner approved by the system during the annual open enrollment period.

~~(2)~~(3) The system may require the automatic withholding of coverage premiums from the benefit paid to the enrolled individuals or, if necessary, may require the direct payment of premiums by the individual to the system or the third party administrator(s).

(D) 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 U.S.C.A. 300gg-1.

145-4-26

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Rule Amplifies: 145.58, 145.584
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**145-4-28 Health care plan provisions regarding the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").**

(A) As used in this rule:

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

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

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

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

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

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

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

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

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

(D)

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

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

(E)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F)

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

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

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

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

145-4-28

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CERTIFIED ELECTRONICALLY

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Rule Amplifies: 145.58, 145.584
Prior Effective Dates: 01/01/2009, 01/01/2011, 01/07/2013 (Emer.), 03/24/2013, 01/01/2014, 01/01/2016

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 thirty days after the benefit recipient's initial benefit payment. During this thirty-day period, the applicant may make one change to the filed application. If the application is received more than 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 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 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.

(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.

(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 or dependent 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 paragraph (C) or (D) of 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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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 thirty days after the initial benefit payment. An election under this paragraph shall be made not later than 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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145-4-34 **Eligibility for pre-medicare health care coverage for the dependents and survivors of this system's members and retirants.**

(A) Health care coverage may be available to an eligible survivor benefit recipient or an eligible dependent upon application on a form provided by the public employees retirement system.

(B) An eligible survivor benefit recipient may enroll in health care coverage if the survivor benefit recipient is an eligible dependent, as defined in rule 145-4-09 of the Administrative Code.

(C) The primary benefit recipient, or surviving spouse of an age and service retirant or member, who is enrolled in health care coverage or participating in the health reimbursement arrangement, may enroll an eligible dependent in pre-medicare health care coverage while the dependent continues to be eligible under this rule and rule 145-4-09 of the Administrative Code. A survivor benefit recipient who is a surviving child of the member may enroll in health care coverage regardless of a surviving spouse's enrollment, provided the child continues to be eligible under this rule and rule 145-4-09 of the Administrative Code.

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

(E) An eligible dependent described in paragraph (B) of rule 145-4-09 of the Administrative Code shall cease to be eligible for health care coverage on the first day of the month following the dependent's twenty-sixth birthday. An eligible dependent described in paragraph (C) of rule 145-4-09 of the Administrative Code shall cease to be eligible for health care coverage on the first day of the month following the eighteenth birthday of the primary benefit recipient's child who is the parent of the primary benefit recipient's enrolled grandchild.

(F) Upon the death of a primary benefit recipient, any individual who would have been treated as an eligible dependent of the primary benefit recipient but for the recipient's death shall be treated as an eligible dependent of the primary benefit recipient for purposes of this chapter until the individual reaches the age limitation set forth in rule 145-4-09 of the Administrative Code.

(G) A benefit recipient shall inform the retirement system, in writing, not later than thirty days after an eligible dependent no longer meets the requirements of this rule.

(H) The retirement system may require a benefit recipient to certify the status of an individual as an eligible dependent for purposes of health care coverage. Failure to

provide certification within sixty days of the request by the retirement system shall result in the denial or withdrawal of health care coverage for such individual until the next annual health care open enrollment period.

145-4-34

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145-4-36 **Enrollment of eligible dependents outside of open enrollment period.**

(A) A benefit recipient may enroll an eligible dependent in pre-medicare health care coverage at any time outside of the annual health care open enrollment period if any of the following apply:

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

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

(3) The benefit recipient may enroll an eligible dependent who has involuntarily lost health care coverage from another source;

(4) The primary benefit recipient is ordered to enroll a child pursuant to a national medical support order;

(5) The dependent first achieves an eligibility threshold described in rule 145-4-09 of the Administrative Code.

(B) Enrollment of an eligible dependent under this rule shall be made on an application provided by the public employees retirement system and must be received not later than sixty days after of the occurrence of the event described in paragraph (A) of this rule.

145-4-36

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Rule Amplifies: 145.58
Prior Effective Dates: 01/01/2007, 01/01/2011, 01/01/2015, 01/01/2016

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 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 thirty days after the issuance of the initial benefit payment, the termination is effective on the first day of the 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 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.

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

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

~~(2)~~(1) A benefit recipient whose disenrollment occurred under rule 145-4-17 of the Administrative Code;

~~(3)~~(2) 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)~~(3) A benefit recipient who is eligible for medicare.

145-4-38

Effective:

Five Year Review (FYR) Dates: 10/10/2018

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Date

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|---|---|
| Promulgated Under: | 111.15 |
| Statutory Authority: | 145.09, 145.58 |
| Rule Amplifies: | 145.58, 145.584 |
| Prior Effective Dates: | 01/01/2014 (Emer.), 01/10/2014, 01/01/2016, 09/01/2017 |

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~~ remaining medical ~~expenses~~ claims cost not paid or reimbursed by the comparable or employer's coverage; up to the systems's limits in 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.

145-4-40

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| Statutory Authority: | 145.09, 145.58 |
| Rule Amplifies: | 145.38, 145.58, 154.584 |
| Prior Effective Dates: | 09/01/2017 |

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 account. 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~~ pays secondary to 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 : (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.

145-4-60

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| Rule Amplifies: | 145.58, 145.584 |
| Prior Effective Dates: | 01/01/2016, 09/01/2017 |

145-4-62 **Coverage for medicare-eligible benefit recipient during public employment.**

(A) Public employer or other coverage

(1) As used in section 145.38 of the Revised Code, “comparable coverage” does not include medicare coverage.

(2) 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 retirement system of the status of health care coverage for the employed benefit recipient.

(3) If the benefit recipient is covered under the public employer's health care coverage and the benefit recipient is also enrolled in coverage that ~~supplements~~ pays secondary to medicare that is sponsored by the public employees retirement system, this system’s coverage shall pay only the ~~covered qualified~~ remaining medical ~~expenses~~ claims costs not paid or reimbursed by the employer’s coverage or medicare up to the system's limits in coverage.

(B) Except as provided in rule 145-4-68 of the Administrative Code, this system's health care coverage that ~~supplements~~ pays secondary to medicare may be available to medicare-eligible benefit recipients who are public employees upon application on a form provided by the system and received by the system not later than sixty days after public employment commences. A primary benefit recipient enrolled in the coverage described in this paragraph may enroll an eligible dependent as defined in rule 145-4-09 of the Administrative Code.

(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 described in paragraph (B) of this rule.

(D)

(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 (E)(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~~, 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 remains effective until the first day of the second month following receipt of the application~~.

(E) Except as provided in rule 145-4-68 of the Administrative Code, a benefit recipient is eligible for the health care coverage described in this rule while the recipient is a public employee. Eligibility for this coverage shall extend through the earlier of thirty days after the date a benefit recipient is notified of ineligibility for this coverage due to termination of public employment or the benefit recipient is a participant in the health reimbursement arrangement. The benefit recipient is eligible for participation in the health reimbursement arrangement on the first day of the month following termination of public employment.

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| Rule Amplifies: | 145.38, 145.58, 145.584 |
| Prior Effective Dates: | 01/01/2016 |

145-4-64 **Eligibility for health care coverage for the medicare-eligible dependents and survivors of this system's members and retirants during public employment.**

(A) Except as provided in rule 145-4-68 of the Administrative Code, the health care coverage described in paragraph (B) of rule 145-4-62 of the Administrative Code may be available to medicare-eligible survivor benefit recipients who are public employees upon application on a form provided by the system and received by the system not later than sixty days after public employment commences.

(B) The primary benefit recipient, or surviving spouse of an age and service retirant or member, who is enrolled in the health care coverage described in paragraph (A) of this rule, may enroll an eligible dependent in the coverage while the dependent continues to be eligible under rule 145-4-09 of the Administrative Code.

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

(D) An eligible dependent described in paragraph (B) of rule 145-4-09 of the Administrative Code shall cease to be eligible for health care coverage on the first day of the month following the dependent's twenty-sixth birthday. An eligible dependent described in paragraph (C) of rule 145-4-09 of the Administrative Code shall cease to be eligible for health care coverage on the first day of the month following the eighteenth birthday of the primary benefit recipient's child who is the parent of the primary benefit recipient's enrolled grandchild.

(E) Upon the death of a primary benefit recipient, any individual who would have been treated as an eligible dependent of the primary benefit recipient but for the recipient's death shall be treated as an eligible dependent of the primary benefit recipient for purposes of this chapter until the individual reaches the age limitation set forth in rule 145-4-09 of the Administrative Code.

(F) A benefit recipient shall inform the retirement system, in writing, not later than thirty days after an eligible dependent no longer meets the requirements of this rule.

(G) The retirement system may require a benefit recipient to certify the status of an individual as an eligible dependent for purposes of health care coverage. Failure to provide certification within sixty days of the request by the retirement system shall result in the denial or withdrawal of health care coverage for such individual until the next annual health care open enrollment period.

145-4-64

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145-4-66 **Enrollment of eligible dependents outside of open enrollment period.**

(A) A benefit recipient enrolled in coverage described in paragraph (B) of rule 145-4-62 of the Administrative Code may enroll an eligible dependent in health care coverage at any time outside of the annual health care open enrollment period if any of the following apply:

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

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

(3) The benefit recipient may enroll an eligible dependent who has involuntarily lost health care coverage from another source;

(4) The primary benefit recipient is ordered to enroll a child pursuant to a national medical support order;

(5) The dependent first achieves an eligibility threshold described in rule 145-4-09 of the Administrative Code.

(B) Enrollment of an eligible dependent under this rule shall be made on an application provided by the public employees retirement system and must be received not later than sixty days after of the occurrence of the event described in paragraph (A) of this rule.

145-4-66

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145-4-68 **Return to HRA following termination of public employment and reenrollment.**

Regardless of the coverage options exercised by a benefit recipient during a period of public employment, a benefit recipient who terminated public employment, became eligible for participation in the health reimbursement arrangement, and entered a second period of public employment during the same plan year shall not be eligible for participation in the health reimbursement arrangement for the remainder of the plan year.

If eligible, such benefit recipient may enroll in or remain enrolled in the coverage described in paragraph (B) of rule 145-4-62 of the Administrative Code until the later of the end of the plan year or termination of public employment, at which time the recipient is eligible for participation in the health reimbursement arrangement.

145-4-68

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| Prior Effective Dates: | 01/01/2016 |

145-4-69 **Reenrollment following voluntary termination of health care coverage for medicare-eligible benefit recipients.**

(A) An eligible benefit recipient enrolled in health care coverage under paragraph (D) of rule 145-4-60 of the Adminstrative 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 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 (D)(1) of rule 145-4-62 of Administrative Code.

(2) If the termination of coverage is received by the retirement system more than thirty days after the issuance of the initial benefit payment, the termination is effective on the first day of the 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 at the time of application; or

(2) Within sixty days of involuntary termination of health care coverage under another plan, the benefit recipient submits an application for health care coverage and provides proof of creditable coverage in the prior plan.

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

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

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

145-4-69

Effective:

Five Year Review (FYR) Dates:

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Certification

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| Promulgated Under: | 111.15 |
| Statutory Authority: | 145.09, 145.58 |
| Rule Amplifies: | 145.58, 145.584 |

145-4-70 **Reimbursement of medicare part "A" premium.**

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

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

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

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

(3) One of the following are in effect: coverage described in paragraph (B) of rule 145-4-62 of the Administrative Code or a medicare supplemental plan that is not sponsored by the system and that would allow for participation in the health reimbursement arrangement.

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

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

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

~~(E) A benefit recipient or spouse who enrolls in medicare part A during the 2016 general enrollment period may receive reimbursement of the July 2016 medicare part A~~

~~premium in accordance with this rule, except that the coverage or plan described in paragraph (B)(3) of this rule does not yet need to be in effect.~~

145-4-70

Effective:

Five Year Review (FYR) Dates: 10/10/2018

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Date

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|---|---|
| Promulgated Under: | 111.15 |
| Statutory Authority: | 145.09, 145.58 |
| Rule Amplifies: | 145.584 |
| Prior Effective Dates: | 01/01/2016 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The effective date of health care coverage under rule 145-4-04 or 145-4-62 of the Administrative Code or an allowance under paragraph (C) of rule 145-4-60 of the Administrative Code;

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

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

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

Five Year Review (FYR) Dates: 10/10/2018 and 09/29/2023

CERTIFIED ELECTRONICALLY

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Certification

10/10/2018

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Date

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| Promulgated Under: | 111.15 |
| Statutory Authority: | 145.09, 145.58 |
| Rule Amplifies: | 145.58 |
| Prior Effective Dates: | 08/20/1976, 09/06/1988, 03/22/2002, 01/01/2003, 01/01/2007, 01/01/2009, 04/05/2010, 01/07/2013 (Emer.), 03/24/2013, 01/01/2016 |

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

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

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

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

742-4-11

Effective:

Five Year Review (FYR) Dates: 9/7/2018

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Certification

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Date

Promulgated Under: 111.15
Statutory Authority: 742.10, 742.43
Rule Amplifies: 742.444
Prior Effective Dates: 12/31/2002 (Emer.), 04/06/2003, 08/28/2008

ACTION: Original

DATE: 09/07/2018 2:18 PM

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

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

(B) ~~For members who are DROP participants, but elect~~If a DROP participant elects to exercise his/her rights under the Family Medical Leave Act~~ (FMLA)~~, ~~an~~such election ~~to exercise his/her rights under FMLA~~ shall not extend the time during which the DROP participant can participate in DROP.

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

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

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

Effective:

Five Year Review (FYR) Dates: 9/7/2018

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Certification

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Date

Promulgated Under: 111.15
Statutory Authority: 742.10, 742.43
Rule Amplifies: 742.443
Prior Effective Dates: 12/31/2002 (Emer.), 04/06/2003, 08/22/2013

ACTION: No Change

DATE: 11/07/2018 10:21 AM

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

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

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

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

742-4-15

Five Year Review (FYR) Dates: 11/7/2018 and 11/07/2023

CERTIFIED ELECTRONICALLY

Certification

11/07/2018

Date

Promulgated Under: 111.15
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Rule Amplifies: 742.444
Prior Effective Dates: 12/31/2002 (Emer.), 04/06/2003, 08/28/2008, 12/12/2013

ACTION: No Change

DATE: 11/07/2018 10:21 AM

742-4-16 **Selection of distributions.**

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

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

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

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

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

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

742-4-16

Five Year Review (FYR) Dates: 11/7/2018 and 11/07/2023

CERTIFIED ELECTRONICALLY

Certification

11/07/2018

Date

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|---|---|
| Promulgated Under: | 111.15 |
| Statutory Authority: | 742.10 |
| Rule Amplifies: | 742.444 |
| Prior Effective Dates: | 12/31/2002 (Emer.), 04/06/2003, 12/27/2005 (Emer.), 03/20/2006, 08/28/2008, 12/12/2013 |

**742-5-07 Service credit purchases and transfers.**

(A) For purposes of sections 742.21 and 742.251 of the Revised Code, a "purchase" shall mean that the Ohio police and fire pension fund ("OP&F") member withdrew his/her contributions from the applicable retirement system or out-of-state or local government and a "transfer" shall mean that the OP&F member maintained his/her contributions with the applicable retirement system.

(B) For purposes of divisions (B)~~(1)~~ and (C)~~(1)(a)~~ of section 742.21 of the Revised Code, "amount withdrawn" shall mean contributions paid by the member to the applicable retirement system for service credit, which are later withdrawn from that retirement system by the member, but shall not include interest paid to the member on such contributions by the withdrawing retirement system. In no event, however, shall this definition impact OP&F's right to the payment of interest according to ~~divisions (B), (C), (H) and (I) of section 742.21 of~~ the Revised Code.

(C) For purposes of determining whether an OP&F member is not receiving a pension or benefit payment, as outlined in sections 742.21 and 742.251 of the Revised Code, OP&F will rely upon its books and records.

(D) For purposes of determining "full-time service," OP&F shall request the employer and the member to certify the full-time service, but in any event, OP&F will determine that the contributing credit was for "full-time service." In order for the service to be "full-time", as provided for in divisions (A) and (B) of section 742.01 of the Revised Code: (1) the service credit to be purchased or transferred must have been rendered while employed in a full-time public position; and (2) the individual must meet the criteria for "full-time contributing service," as outlined in rule 742-5-03 of the Administrative Code. As a result, any pay period in which the member failed to work the equivalent of thirty-seven and one half or more hours per week does not qualify as "full-time" and, in such event, OP&F will pro-rate such credit.

(E) As required by section 742.21 of the Revised Code, in no event can credit be purchased or directly transferred for employment in a part-time position. For purposes of meeting the definition of "full-time service" in section 742.21 of the Revised Code and this rule, periods of service in part-time positions cannot be combined to equal "full-time service."

(F) Credit may not be purchased or directly transferred for periods of employment concurrent with any employment for which the member has already received OP&F service credit.

(G) Subject to the other provisions of this rule, an OP&F member who is not receiving a pension or benefit payment from OP&F may purchase qualifying service credit for periods of full-time service in a full-time public position as a member of a state or

municipal retirement system in the state of Ohio, provided that such service credit has been canceled by the system in which it was earned.

(H) Subject to the provisions of section 742.251 of the Revised Code and the other provisions of this rule, an OP&F member who is not receiving a pension or benefit payment from OP&F may purchase qualifying service credit for periods of full-time service in a full-time public position as an employee of an entity of an out-of-state or local government, or of an entity of the United States government, provided that such service credit is not used in the calculation of any public or private retirement benefit, other than federal social security benefits.

A member who chooses to purchase service credit under this paragraph rather than transferring the qualifying service credit under paragraph (I) of this rule is entitled to be granted service credit for periods of active duty military service, as provided for in section 742.521 of the Revised Code.

(I) To initiate the transfer of eligible service credit to OP&F under section 742.21 of the Revised Code, the member shall initiate the request with the transferring retirement system. Within a reasonable time from OP&F's receipt of the ledger of contributions and the employer address from the transferring system, OP&F will send a transfer packet to the member containing a certification to be completed and signed by the member and a certification to be completed by the employer where the service credit that is being transferred was earned. The certification forms should be returned together to OP&F. Upon receipt of this information, OP&F will then review the certifications and ledger information and notify the transferring system of the eligible service credit that should be transferred pursuant to section 742.21 of the Revised Code. In the event that the transferring system transfers monies to OP&F without OP&F's review and approval, OP&F reserves the right to reject service credit that does not meet the criteria for "full-time," as outlined in this rule.

(J) To initiate the purchase of eligible service credit from OP&F, the member shall notify OP&F to request a cost to purchase the service credit. Within a reasonable time period of such notice, OP&F will send the member a purchase packet containing a certification to be completed and signed by the member and a certification to be completed by the member's employer(s) where the purchasable service credit was earned. The certification forms should be returned together to OP&F. Notwithstanding these certifications, OP&F will review the documentation and determine if the service is "full-time," as required by section 742.21 of the Revised Code, and as more fully outlined in this rule. Once OP&F determines the service credit meets the statutory and administrative requirements, OP&F will provide the eligible member with a cost statement. Once the member purchases the service credit, OP&F will bill the former system for monies associated with the purchase, as required by section 742.21 of the Revised Code. In the event that the former system pays the

monies to OP&F without OP&F's review and approval, OP&F reserves the right to reject service credit that does not meet the criteria for "full-time," as outlined in this rule.

(K) For purposes of division (K) of section 742.21 of the Revised Code, purchased service credit not only includes purchased service credit, but it shall also include service credit transferred by the Cincinnati retirement system, a non-uniform retirement system, or the other uniform retirement system to OP&F.

(L) The interest rate charged for the purchase of civilian service credit shall be the actuarial interest assumption adopted by the board.

Effective:

Five Year Review (FYR) Dates: 11/19/2018

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| Promulgated Under: | 111.15 |
| Statutory Authority: | 742.10 |
| Rule Amplifies: | 742.21, 742.251 |
| Prior Effective Dates: | 07/24/1986 (Emer.), 10/16/1986, 07/17/1993, 08/05/1996, 02/22/2002, 11/03/2003, 01/16/2014 |

ACTION: Original

DATE: 09/07/2018 2:18 PM

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

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

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

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

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

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

(C) If the member wishes to complete the payroll plan referenced in paragraph (B) of this rule, the member must sign, and cause his or her employer to sign, the ~~completed~~authorization form ~~in the format prescribed~~prepared by OP&F ~~or substantially similar thereto, the member shall cause the employer to sign the completed form in the format prescribed by OP&F or substantially similar thereto for members purchasing service credit with amounts designated by the employer as picked-up contributions under section 414(h)(2) of the Internal Revenue Code of 1986, 26 U.S.C.A. 414(h)(2),~~ and return the ~~fully executed original~~ form to OP&F. ~~, with a copy being given by the member to the~~ The ~~member's~~member shall provide his or her employer with a copy of the authorization form~~on a timely basis in order~~

~~for~~ in a timely manner so that the employer ~~to~~can properly implement the payroll deduction plan elected by the ~~OP&F~~ member.

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

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

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

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

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

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

OP&F shall assess the penalties prescribed by section 742.352 of the Revised Code.

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

(a) Non-conforming payroll deduction report. OP&F shall initially give verbal notice to the employer of the non-conforming nature of the report and allow the employer to have an opportunity to take corrective actions to cure such deficiencies within thirty days of OP&F's verbal notice of deficiency. If the employer has not submitted a writing to OP&F that properly addresses the noted deficiencies by Friday of the week in which OP&F gave the verbal notice, OP&F shall then send a written notice to the employer of the non-conforming nature of the report and allow the employer to still have an opportunity to take the corrective actions identified in the written notice from OP&F within thirty days of OP&F's initial verbal notice (referred to herein as the "cure period"), and the following shall apply:

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

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

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

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

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

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

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

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

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

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

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

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

(L) ~~Beginning from and after September 16, 1998,~~ OP&F will not treat a member who is purchasing credit pursuant to this rule with amounts designated by the employer as picked-up contributions under section 414(h)(2) of the Internal Revenue Code of 1986, 26 U.S.C.A. 414(h)(2) unless the employer certifies in writing the tax deferred status of the payroll deduction plan as part of the employee's enrollment in the payroll deduction plan ~~or within ninety days of OP&F's request.~~. ~~and~~ OP&F will rely upon

certification in determining the taxability of benefits due the member, as outlined in rule 742-9-14 of the Administrative Code. In the event that the employer fails to provide such certification, then OP&F will treat the payroll deduction plan as a regular non-tax deferred payroll deduction plan. In all events, it shall be the responsibility of the employer to establish the tax deferred payroll deduction plan, as required by the applicable terms of the Internal Revenue Code. Employers that wish to pay all or part of the voluntary contributions for the purchase of service credit through payroll deductions shall submit the standard resolution in the form adopted by OP&F's board of trustees, as required by rule 742-7-14 of the Administrative Code.

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

(1) Decrease or increase the payroll deduction;

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

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

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

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

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

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

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

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

(P) On early termination of the payroll deduction plan, the member will be credited with a proportion of the service to be purchased equal to the proportion of time the payroll deduction plan ~~was in effect~~became effective to the time the payroll deduction plan was scheduled to complete the purchase. In addition, OP&F will provide written notice of such termination to the member. ~~Beginning January 1, 2007, for employers who wish to pay all or part of the voluntary contributions for the purchase of service credit through payroll deductions, the employers shall submit the standard resolution in the form adopted by OP&F's board of trustees.~~

Effective:

Five Year Review (FYR) Dates: 9/7/2018

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Certification

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Date

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| Promulgated Under: | 111.15 |
| Statutory Authority: | 742.10 |
| Rule Amplifies: | 742.10, 742.21, 742.221, 742.23, 742.24, 742.27, 742.32, 742.371, 742.375, 742.376, 742.52, 742.521, 742.56 |
| Prior Effective Dates: | 12/29/1986, 06/24/2001, 10/26/2006, 05/22/2008, 08/19/2013 |

742-9-10 **Employer reporting requirements.**

(A) For purposes of this rule, "required penalties" shall mean the penalties prescribed by section 742.352 of the Revised Code, as modified by rule 742-8-07 of the Administrative Code.

(B) For purposes of section 742.32 of the Revised Code, the "report of employeee deductions" that employers must transmit to Ohio police & fire pension fund ("OP&F") shall be on the report of retirement deductions form provided by OP&F and found on OP&F's website, www.op-f.org, and shall be consistent with the requirements outlined in this rule.

(C) For purposes of section 742.32 of the Revised Code, the term "employee" shall refer to a "member", as such term is defined in divisions (A)(2)(a) and (B)(2)(a) of section 742.01 of the Revised Code.

(D) For purposes of section 742.32 of the Revised Code, the deduction shall be taken on "salary" paid by the employer to the employee for the month covered in that report, pursuant to the terms of division (L) of section 742.01 of the Revised Code and the rules of the Administrative Code adopted pursuant to that section.

(E) The form of the employer's report of employee deductions shall be deemed properly filed with OP&F if all of the following occurs:

(1) The completed form of the report that is filed with OP&F by the statutory deadline is consistent with the report of retirement deductions form and meets all the following requirements:

(a) A separate report for the report of deductions for firefighter members and a separate report for the report of deductions for police officer members;

(b) For electronic filings, it meets the technical specifications provided to the employers by OP&F, as may be amended from time to time with prior notice to the employer;

(c) The reporting of "salary" is consistent with the requirements outlined in this rule; and

(d) The reporting of picked-up contributions, whether done through a salary reduction or paid on behalf of the member, must be consistent with the requirements outlined in rule 742-7-14 of the Administrative Code.

(2) The report and/or payment is accompanied by a completed OP&F recap form as referenced in rule 742-9-17 of the Administrative Code, and is received by OP&F by the statutory deadline. It is OP&F's preference that the recap form

is sent along with the payment, rather than the report. For electronic filers, the recap form must still be received by OP&F by the statutory deadline.

(3) The contributions due under section 742.32 of the Revised Code must be paid to OP&F by the statutory deadline, must match the amount outlined in the recap form referenced in rule 742-9-17 of the Administrative Code, and must match the total amount reported on the report referenced in paragraph (E)(1)(a) of this rule. As referenced in paragraph (E)(2) of this rule, it is OP&F's preference that the recap form accompany this payment.

(4) For newly hired members, the report and payment is accompanied by a completed OP&F personal history record in the form provided by OP&F and documentation showing the member's appointment to a full-time position as a police officer or firefighter to the extent that it exists.

(F) In order to verify the reporting of "salary" consistent with the provisions of division (L) of section 742.01 of the Revised Code and section 742.32 of the Revised Code and the corresponding rules of the Administrative Code, OP&F may request detailed pay records involving the member's wages and/or service credit from the employer at any time.

(G) For purposes of assessing the required penalties for all filings due OP&F under section 742.32 of the Revised Code, OP&F shall take the following course of action:

(1) No report/no payment. If the required payment prescribed by section 742.32 of the Revised Code is not made in accordance with the deadline outlined in such section and no report of employee deductions is filed with OP&F in accordance with the deadline outlined in such section, which includes the recap form, OP&F shall assess the required penalties.

(2) Report/no payment. If the required report of employee deductions prescribed by section 742.32 of the Revised Code and more fully outlined in this rule is filed with OP&F in accordance with the deadline outlined in such section, but the proper payment is not paid to OP&F in accordance with the deadline outlined in such section, OP&F shall assess the required penalties.

(3) No report/payment. If the required report of employee deductions prescribed by section 742.32 of the Revised Code and more fully outlined in this rule is not filed with OP&F in accordance with the deadline outlined in such section, but a payment is made with OP&F in accordance with the deadline outlined in such section, OP&F shall assess the required penalties.

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

(a) Non-conforming payroll report. OP&F shall give notice to the employer of the non-conforming nature of the report and allow the employer to have an opportunity to take corrective actions to cure such deficiencies within thirty days of OP&F's notice of deficiency (referred to herein as the "cure period"), and the following shall apply:

(i) If the employer files a correct report of employee deductions in OP&F's approved format and such report is received by OP&F on or before the expiration of the cure period, no penalties will be assessed by OP&F against the employer.

(ii) If OP&F does not receive from the employer the proper report of employee deductions on or before the expiration of such cure period, then OP&F will assess the required penalties beginning the day after the expiration of the cure period.

(b) In all other situations, OP&F will notify the employer of the employer's failure to comply with the provisions of section 742.32 of the Revised Code and shall allow the employer to still have an opportunity to take the corrective actions identified in the notice from OP&F within thirty days of OP&F's notice (referred to herein as the "cure period"), and the following shall apply:

(i) If the employer files a correct report of employee deductions in OP&F's approved format and such report is received by OP&F on or before the expiration of the cure period, no penalties will be assessed by OP&F against the employer.

(ii) If OP&F does not receive from the employer the proper report of employee deductions on or before the expiration of such cure period, then OP&F will assess the required penalties, beginning the day after the expiration of the cure period.

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

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

(H) The provisions of this rule will not change the amounts of the required penaltied.

Five Year Review (FYR) Dates: 11/7/2018 and 11/07/2023

CERTIFIED ELECTRONICALLY

Certification

11/07/2018

Date

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

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

Five Year Review (FYR) Dates: 11/7/2018 and 11/07/2023

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11/07/2018

Date

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