AUTHENTICATED,
OHIO LEGISLATIVE SERVICE
COMMISSION
DOCUMENT #511648

Ohio Administrative Code

Rule 3309-1-35 Health care.

Effective: March 6, 2026

(A) Definitions

As used in this rule:

(1) "Benefit recipient" means an age and service retirant, disability benefit recipient, or a beneficiary as defined in section 3309.01 of the Revised Code, who is receiving monthly benefits due to the death of a member, age and service retirant or disability benefit recipient.

(2) "Member" has the same meaning as in section 3309.01 of the Revised Code.

(3) "Age and service retirant" means a former member who is receiving a retirement allowance pursuant to section 3309.34, 3309.35, 3309.36 or 3309.381 of the Revised Code. A former member with an effective retirement date after June 13, 1986 must have accrued ten years of qualified service credit.

(4) "Disability benefit recipient" means a member who is receiving a benefit or allowance pursuant to section 3309.35, 3309.39, 3309.40 or 3309.401 of the Revised Code.

(5) "Dependent" means an individual who is either of the following:

(a) A spouse of an age and service retirant, disability benefit recipient, or member;

(b) A biological, adopted or step-child of an age and service retirant, disability benefit recipient, member, deceased age and service retirant, deceased disability benefit recipient, or deceased member or other child in a parent-child relationship in which the age and service retirant, disability benefit recipient, member, deceased age and service retirant, deceased disability benefit recipient, or deceased member has or had custody of the child, so long as the child:

(i) Is under age twenty-six; or

(ii) Regardless of age is permanently and totally disabled, provided that the disability existed prior to the age and service retirant's, disability benefit recipient's, or member's death and prior to the child reaching age twenty-six. For purposes of this paragraph "permanently and totally disabled" means the individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve months.

(6) "Health care coverage" means any of the following group plans offered by the system:

(a) A medical and prescription drug plan;

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

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

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

(8) "Premium subsidy" means a monthly amount paid by the system on the benefit recipient's or recipient's dependent's behalf in order to reduce the health care coverage premium amount.

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

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

(11) "Marketplace plan" means an individual health plan available through either a state or federal health insurance marketplace.

(12) "Qualified service credit" means a member's total service credit excluding credit obtained after January 29, 1981 pursuant to sections 3309.021, 3309.301, and 3309.33 of the Revised Code. Credit obtained pursuant to section 145.201 of the Revised Code is excluded for those members who establish eligibility for SERS health care coverage on or after July 1, 2025.

(B) Eligibility

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

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

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

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

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

(C) Counseling

(1) An age and service retirant or disability benefit recipient who is not eligible for medicare shall complete counseling with a SERS approved marketplace counselor to review marketplace plan options before they are eligible to enroll in health care coverage. Those who do not complete counseling as specified by this rule shall be deemed to have waived SERS health care coverage and cannot enroll in SERS health care coverage until they meet the reinstatement requirements as outlined in paragraph (J) of this rule.

(2) An age and service retirant or disability benefit recipient, who is not eligible for medicare and

whose initial SERS health care coverage eligibility date is on or after June 1, 2023, shall complete counseling with a SERS approved marketplace counselor to review marketplace plan options before the later of the following:

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

(b) Within three months of initial health care coverage eligibility.

(3) An age and service retirant or disability benefit recipient, who is not eligible for medicare and whose reinstatement to SERS health care coverage is established under paragraph (J) of this rule on or after June 1, 2023, shall complete counseling with a SERS approved marketplace counselor to review marketplace plan options before the later of the following:

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

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

(4) The age and service retirant or disability benefit recipient shall provide the marketplace counselor with all information required to determine the cost of available marketplace plans. The marketplace counselor shall notify SERS when such counseling has been completed.

(5) Counseling shall not be required to establish eligibility prior to enrollment if the marketplace counselor is unable to determine available marketplace plans based on the age and service retirant's or disability benefit recipient's address or other demographic information. The marketplace counselor shall notify SERS when a marketplace plan cannot be determined based on the circumstances.

(D) Termination of eligibility

(1) Eligibility for SERS health care coverage shall terminate under the following circumstances:

(a) When the person ceases to qualify as one of the persons listed in paragraph (B)(1) of this rule, except that a dependent described in paragraph (A)(5)(b)(i) of this rule shall cease to qualify on the

first day of the calendar year following the dependent's twenty-sixth birthday.

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

(c) When a person listed in paragraph (B)(1) of this rule on or after January 1, 2021, becomes eligible for medicaid and ineligible for medicare.

(i) For purposes of this rule, a benefit recipient and their dependent(s) shall be presumed to be eligible for medicaid if their gross monthly SERS benefit is less than the percentage of the federal poverty level used by the Ohio department of medicaid to determine medicaid eligibility under agency 5160 and division 5160:1 of the Administrative Code.

(ii) Upon request, a benefit recipient presumed to be eligible for medicaid must provide SERS with satisfactory proof of ineligibility for medicaid in their state of residence within ninety days from the date of SERS' request.

(d) When a person eligible for medicare part B fails to:

(i) Enroll in medicare part B during the person's initial enrollment period or special enrollment period under 42 U.S.C. 1395p that includes a date on or after January 1, 2019; or

(ii) Enroll in medicare part B during the general enrollment period available under 42 U.S.C. 1395p immediately following a loss of medicare part B coverage that began on or after January 1, 2019.

(iii) Maintain enrollment in medicare part D.

(e) When an age and service retirant or disability benefit recipient, who is not eligible for medicare and whose initial SERS health care coverage eligibility date or reinstatement to SERS health care coverage under paragraph (J) of this rule is on or after June 1, 2023, fails to complete counseling as required under paragraph (C) of this rule.

(E) Enrollment

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

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

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

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

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

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

(c) Within ninety days of the eligible spouse, age and service retirant or disability benefit recipient becoming eligible for medicare.

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

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

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

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

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

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

(F) Cancellation of health care coverage

(1) Health care coverage of a person shall be cancelled under the following circumstances:

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

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

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

(d) The person enrolls in a medicare advantage or medicare part D plan that is not offered by the system;

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

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

(g) The person's benefit payments are suspended for failure to submit documentation required to

establish continued benefit eligibility under division (D) of section 3309.392 of the Revised Code; or

(h) The enrolled eligible dependent of a deceased member, deceased disability benefit recipient or deceased age and service retirant fails to submit the appropriate application to continue health care coverage to the system within three months of the death of the member, disability benefit recipient or age and service retirant.

(G) Effective date of coverage

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

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

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

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

(2) The effective date of coverage for a person described in paragraphs (C)(2) and (C)(3) of this rule shall be the later of the following:

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

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

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

(H) Premiums

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

(2) If the retirement system determines that any premium has been calculated incorrectly, the system will recalculate the premium to the correct amount. The recalculated premium will begin on the next payment date.

(a) If the recalculation results in a decreased premium, the retirement system shall pay the recipient the cumulative difference between the original calculation and the recalculation in a one-time lump-sum.

(b) If the recalculation results in an increased premium, the recipient shall pay to the retirement system the cumulative difference between the original calculation and the recalculation.

(c) The following standards shall apply if the recipient was not the source of the information or records that caused the incorrect calculation and did not commit fraud, misrepresentation, or other misconduct resulting in the incorrect calculation.

(i) For any amounts owed to the system under paragraph (H)(2)(b) of this rule, the retirement system will waive collection of:

(a) The first two hundred dollars, and

(b) Any portion of the amount due that accrued more than two years before the date of the determination made in paragraph (H)(2) of this rule.

(ii) In seeking payment under paragraph (H)(2)(b) of this rule, the system shall deduct up to ten per cent of the gross amount of any periodic benefit due the person until the payment due has been paid in full.

(3)

(a) Premium payments billed under paragraph (H)(1) of this rule shall be deemed in default after the unpaid premiums for coverage under this rule and supplemental health care coverage under rule 3309-1-64 of the Administrative Code reach a total cumulative amount of at least three months of billed premiums.

(b) Premium payments billed under paragraph (H)(2)(b) shall be deemed in default if the benefit recipient does not agree to a payment plan or if the benefit recipient misses scheduled payments under a payment plan in a total cumulative amount of at least three months of billed premiums.

(c) The retirement system shall send written notice to the benefit recipient that payments are in default and that coverage will be cancelled on the first day of the month after the date of the notice unless payment for the total amount in default is received prior to the date specified in the notice. If coverage is cancelled due to a recipient's failure to pay premium amounts in default, the recipient shall remain liable for such amounts due for the period prior to cancellation of coverage.

(4) After payment for the total amount in default is received, health care coverage cancelled for default can be reinstated as provided in paragraph (J) of this rule, or upon submission of a written request for reinstatement supported by medical evidence acceptable to SERS that demonstrates that the default was caused by the benefit recipient's physical or mental incapacity. "Medical evidence" means documentation provided by a licensed physician of the existence of the mental or physical incapacity causing the default. Health care coverage reinstated after cancellation for default shall be effective on the first of the month following the date that the written request for reinstatement is approved.

(5) A person enrolled in SERS health care coverage may be eligible to qualify for a premium subsidy. A person enrolled in SERS' health care coverage cannot receive a premium subsidy unless that person is:

(a) A dependent child.

(b) An age and service retirant who:

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

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

(iii) Has an effective retirement date on or after August 1, 2008 who had earned twenty years of qualified service credit and who:

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

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

(c) A disability benefit recipient, except as provided in paragraph (H)(5)(d) of this rule who:

(i) Has an effective benefit date before August 1, 2008; or

(ii) Has an effective benefit date on or after August 1, 2008 who:

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

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

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

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

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

(iii) Has an effective benefit date on or after August 1, 2008 who had earned twenty years of qualified service credit and who:

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

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

(e) A spouse:

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

(ii) A spouse or surviving spouse of an age and service retirant or disability benefit recipient with an effective retirement date or benefit date on or after August 1, 2008 who had earned twenty-five years of service credit;

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

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

five years of service preceding retirement or separation from SERS service.

(iii) A surviving spouse of a deceased member who had earned twenty-five years of qualified service credit, with an effective benefit date before August 1, 2008; or

(iv) A surviving spouse of a deceased member who had earned twenty-five years of qualified service credit, with an effective benefit date on or after August 1, 2008, and the member;

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

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

(f) For purposes of determining eligibility for a subsidy under paragraph (H)(5) of this rule, when the last contributing service of an age and service retirant, disability benefit recipient, or member was as an employee as defined by division (B)(2) of section 3309.01 of the Revised Code the health care plan participation requirement shall be if the individual would have been eligible for the public employer's health care plan if the individual were an employee as defined by division (B)(1) of section 3309.01 of the Revised Code.

(g) Any other individual enrolled in SERS health care coverage shall be eligible for a premium subsidy under the standard set forth for spouses.

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

(I) Waiver

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

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

(a) For a currently enrolled non-medicare eligible dependent child, the benefit recipient may voluntarily waive the dependent child's coverage by completing and submitting a signed written request to SERS on the dependent child's behalf.

(b) For a currently enrolled non-medicare eligible dependent spouse, the benefit recipient may voluntarily waive the dependent spouse's coverage by completing and submitting a written request to SERS, signed by the benefit recipient and dependent spouse.

(c) For a currently enrolled medicare eligible dependent, the dependent may voluntarily waive their coverage by completing and submitting a signed written request to SERS.

(J) Reinstatement to SERS health care coverage

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

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

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

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

(2) An eligible person whose coverage was cancelled pursuant to paragraphs (F)(1)(f) and (F)(1)(g)

of this rule shall be reinstated to SERS health care coverage when the required documents have been received and benefit payments are unsuspended.

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

(K) Medicare part B

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

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

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

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

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

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

(i) January 1, 1977; or

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

satisfactory proof of coverage.

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

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

(ii) The effective date of SERS health care coverage.

(4) The board shall not:

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

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