# Ohio Administrative Code

## Rule 3309-1-64 Supplemental health care coverage.

Effective: June 5, 2020

(A) Definitions

(1) "Benefit recipient," "Member," "Age and service retirant," "Disability benefit recipient," and Dependent shall have the meanings set forth in paragraph (A) of rule 3309-1-35 of the Administrative Code.

(2) "Supplemental health care coverage" means any dental or vision plan offered by the school employees retirement system.

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

(B) Eligibility

(1) A person is eligible for supplemental health care coverage under this rule so long as the person meets the eligibility requirements in section 3309.69 of the Revised Code and rule 3309-1-35 of the Administrative Code for the retirement systems health care coverage.

(2) Eligibility for supplemental health care coverage shall terminate when the person ceases to qualify as one of the persons listed in paragraph (B)(1) of rule 3309-1-35 of the Administrative Code. A person described in paragraph (B)(4) of rule 3309-1-35 of the Administrative Code shall remain eligible for supplemental health care coverage under this rule.

(C) Enrollment

(1) An eligible benefit recipient may only enroll in one or more supplemental health care plans as follows:

(a) At the time the benefit recipient applies for an age and service retirement, disability benefit, or monthly benefit pursuant to section 3309.45 of the Revised Code;

(b) At the time the benefit recipient reinstates previously waived or cancelled health care coverage as provided in paragraph (I) of rule 3309-1-35 of the Administrative Code;

(c) Within thirty-one days after involuntary termination of another dental or vision plan; or,

(d) During the retirement systems open enrollment period.

(2) An eligible dependent of an age and service retirant or disability benefit recipient may only enroll in one or more supplemental health care plans as follows:

(a) At the time the age and service retirant or disability benefit recipient enrolls in the supplemental health care plan;

(b) During the retirement systems open enrollment period so long as the age and service retirant or disability benefit recipient is also enrolled in the supplemental health care plan; or

(c) Within thirty-one days after involuntary termination of another medical, dental, or vision plan, so long as the age and service retirant or disability benefit recipient is also enrolled in the supplemental health care plan.

(D) A persons supplemental health care coverage shall be cancelled when:

(1) The person's eligibility for health care coverage terminates as provided in paragraph (B)(2) of rule 3309-1-35 of the Administrative Code;

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

(3) The persons supplemental health care coverage is cancelled for default as provided in paragraph

(F) of this rule;

(4) 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;

(5) The benefit recipient elects to cancel the supplemental health care coverage for the following calendar year during the open enrollment period; or

(6) The benefit recipient elects to cancel health care coverage under paragraph (D) of rule 3309-1-35 of the Administrative Code.

(E) Effective date of coverage

(1) When a benefit recipient elects to enroll in supplemental health care coverage during an open enrollment period, the effective date of coverage shall be the first day of the calendar year following the open enrollment period.

(2) When a benefit recipient elects to enroll in supplemental health care coverage upon receipt of a benefit, the effective date of coverage shall be as follows:

(a) For a disability benefit recipient or dependent of a disability benefit recipient, the supplemental health care coverage shall be effective on the first day of the month following approval of the benefit or the benefit effective date, whichever is later.

(b) For an age and service retirant or dependent of an age and service retirant, the supplemental health care coverage shall be effective on the first day of the month following the date that the retirement application is filed with the retirement system or 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, the supplemental health care coverage shall be effective on the effective date of the benefit if the appropriate application is received within three months of the date of the

member's or retirant's death, or the first day of the month following the date that the appropriate application is received if not received within three months of the date of the member's or retirant's death.

(F) Premiums

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

(2) Premium payments billed to a benefit recipient shall be deemed in default after the unpaid premiums for coverage under this rule and health care coverage under rule 3309-1-35 of the Administrative Code reach a total cumulative amount of at least three months of billed premiums. The retirement system shall send written notice to the benefit recipient that payments are in default and that coverage will be cancelled on the first day of the month after the date of the notice unless payment for the total amount in default is received prior to the date specified in the notice. If coverage is cancelled due to a recipients failure to pay premium amounts in default, the recipient shall remain liable for such amounts due for the period prior to cancellation of coverage. The benefit recipient shall be ineligible for reinstatement of coverage until payment for the total amount in default is received.