AUTHENTICATED,
OHIO LEGISLATIVE SERVICE
COMMISSION
DOCUMENT #250367

Ohio Administrative Code

Rule 5505-7-04 Health care.

Effective: January 18, 2018

(A) For the purpose of this rule:

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

(2)) "Benefit recipient" shall mean an age and service retirant or disability retirant that is receiving a pension benefit as described in division (A)(1) of section 5505.17 of the Revised Code that qualifies for health care coverage pursuant to paragraph (C) of this rule. Benefit recipient does not include a member participating in the "Deferred Retirement Option Program."

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

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

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

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

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

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

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

certificate.

(10) "Eligible Plan" shall mean:

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

(b) For those benefit recipients or eligible dependents other than those described in paragraphs (A)(10)(a) and (A)(10)(c) of this rule, any medical or prescription drug plan, other than a medicare advantage plan, offered pursuant to section 5505.28 of the Revised Code.

(c) Eligible plan does not include any dental or vision plan.

(11) Service Credit shall include:

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

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

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

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

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

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

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

(4) Only benefit recipients and eligible dependents who are enrolled under state highway patrol

retirement system medical coverage are eligible for prescription drug coverage.

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

(C) The following benefit recipients shall be eligible for health care:

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

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

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

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

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

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

(b) A child for whom the benefit recipient has been appointed as guardian is eligible for healthcare if

the child is unmarried, chiefly dependent on the benefit recipient, and lives in the same household as the benefit recipient.

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

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

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

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

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

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

(a) The spouse is appointed guardian of the child within ninety days of the retirant or member's death, and the child is chiefly dependent on the spouse and lives in the same household as the spouse; and

(b) The child would be eligible pursuant to paragraph (D) of this rule.

(3) In the event a spouse remarries, health care eligibility shall continue.

Notwithstanding the foregoing, a spouse who has access to medical and/or prescription coverage through his or her new spouse must secure it as primary coverage, regardless of cost; secondary coverage may be maintained.

(4) The service credit requirements included in paragraph (C)(2) of this rule do not apply to the

dependent of a member killed in the line of duty.

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

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

(2) Qualifying events include -

(a) Marriage,

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

(c) Change in employment status,

(d) Divorce, annulment, or dissolution,

(e) Legal separation,

(f) Involuntary termination of other group coverage, or

(g) Death.

(3) The effective date of coverage will be -

(a) January first for an addition during open enrollment.

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

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

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

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

(f) The date the legal guardianship becomes effective.

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

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

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

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

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

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

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

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

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

(a) Is unmarried,

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

(c) Became disabled prior to the attainment of the limiting age for coverage of children,

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

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

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

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

(a) A physician's statement,

(b) An independent medical examination,

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

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

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

(1) A spouse who has access to medical and/or prescription coverage through employment must secure it as primary coverage, regardless of cost. Notwithstanding this provision, primary dental and

vision coverage and secondary medical and prescription coverage may be elected through the state highway patrol retirement system.

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

(3) Paragraphs (I)(1) and (I)(2) of this rule will not apply to a dependent who enrolled in both medicare part A and medicare part B coverage prior to January 1, 2018.

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

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

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

(2) The reimbursement amount for calendar year 2017 and each year thereafter shall be zero.

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

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

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

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

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

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

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