ANNUAL HEALTH CARE REPORT

FOR THE YEAR ENDED
JUNE 30, 2013

School Employees Retirement System of Ohio

SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO
300 E. BROAD ST., SUITE 100 • COLUMBUS, OHIO 43215-3746
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LISA J. MORRIS
Executive Director

HELEN M. NINOS
Deputy Executive Director

December 18, 2013

Bethany Rhodes, Director
Ohio Retirement Study Council
88 E. Broad St., Suite 1175
Columbus, OH 43215

Dear Ms. Rhodes:

In accordance with section 3309.21(E) of the Ohio Revised Code, please find enclosed, as of June 30, 2013, a full accounting of the revenues and costs relating to the provision of health care under sections 3309.375 and 3309.69 of the Ohio Revised Code.

Please note the following information of interest:

- The School Employees Retirement System provided health care coverage to 45,332 eligible retirees and dependents at a net cost of $54,763,945;
- The amount paid for Medicare Part B reimbursement under 3309.69(C) of the Ohio Revised Code was $26,204,777; and
- In FY2013, 0.16% of the employer contribution was allocated to the health care program. This is in addition to the 1.5% employee surcharge.

After reviewing this report, if you have any questions, please feel free to contact me.

Sincerely,

Lisa J. Morris
Executive Director

Enclosures

c: The Honorable Dave Burke, Chair, Senate Government Oversight and Reform
The Honorable Lynn Wachtmann, Chair, House Health and Aging
Members, ORSC
Timothy Keen, Director, Office of Budget and Management

SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

Annual Health Care Report

December 2013

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COST AND FUNDING SUMMARY

HEALTH CARE FUNDING

Access to health care is provided in accordance with section 3309.69 of the Ohio Revised Code (ORC), and is financed primarily through a combination of employer contributions, retiree premiums, and federal subsidies/reimbursements. In addition, investment earnings contribute to health care funding.

The System's goal is to maintain a health care reserve account with a 20-year solvency period in order to ensure that fluctuations in the cost of health care do not cause an interruption in the program. When the System is not within the 20-year solvency period goal, health care funding is on a pay-as-you-go basis.

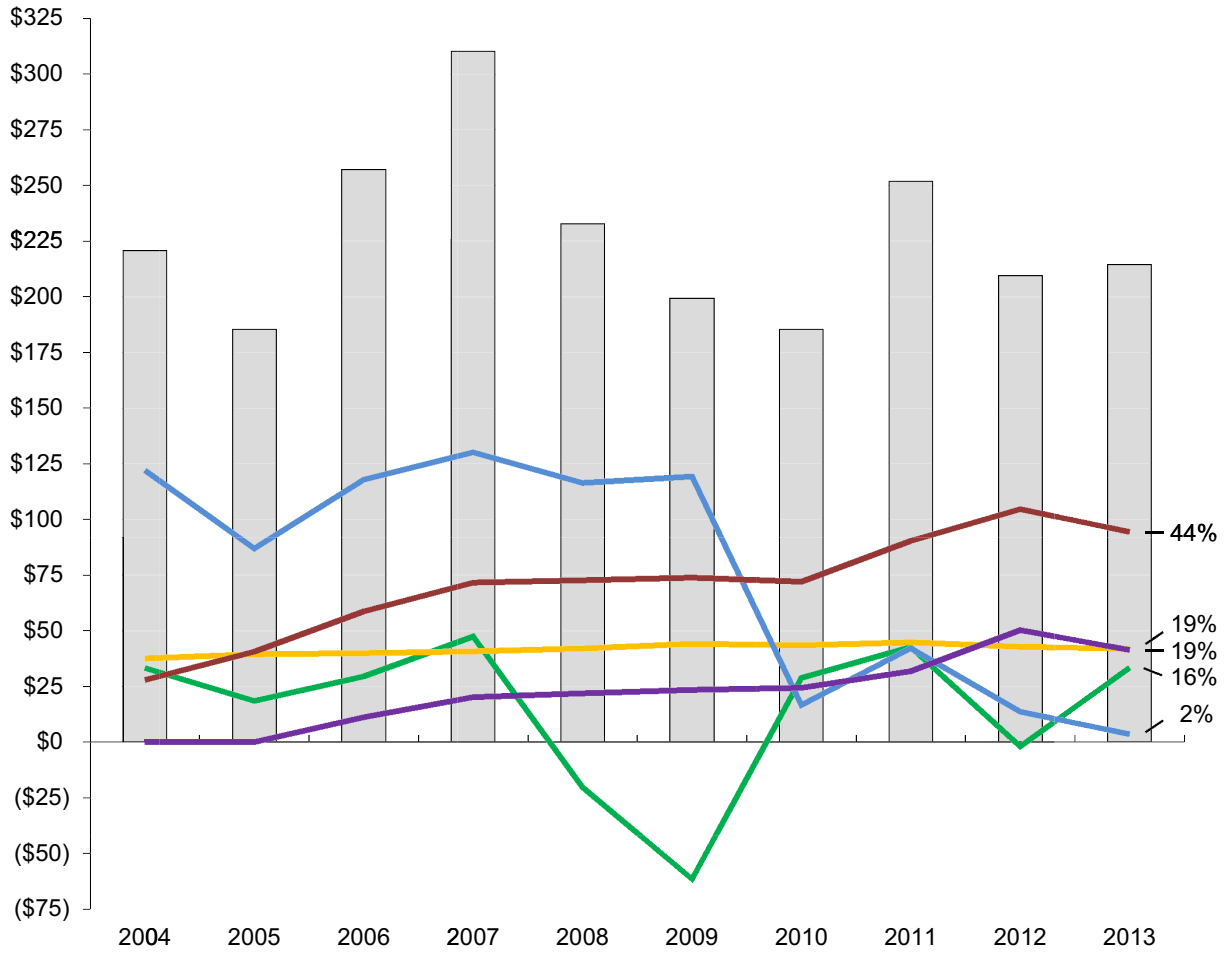
The ORC permits SERS to offer access to health care to eligible individuals receiving retirement, disability, and survivor benefits as well as access to health care for their eligible dependents.

Normal employer payroll-based contributions alone, which is that portion of the total employer contributions remaining after the funding obligations for retirement benefits, Medicare Part B reimbursement and lump sum retiree death benefits are met, are not expected to be sufficient to finance health care to the level provided by this funding policy. This is due, in large part, to the fact that the annual compensation of SERS members is frequently based on less than full-time, year-round employment.

In light of this demographic reality, a surcharge determined in accordance with ORC section 3309.491, is levied against employers whose employees earn less than a specified minimum salary. This employer surcharge is an important source of health care revenue and avoids shifting an onerous financial burden to our members and retirees, which could cause many of them to seek state assistance.

As of June 30, 2013, SERS projects health care solvency until FY2020, based on projected funding needs and expected revenue.

Health Care Fund Income
FY2004 through FY2013 (millions)

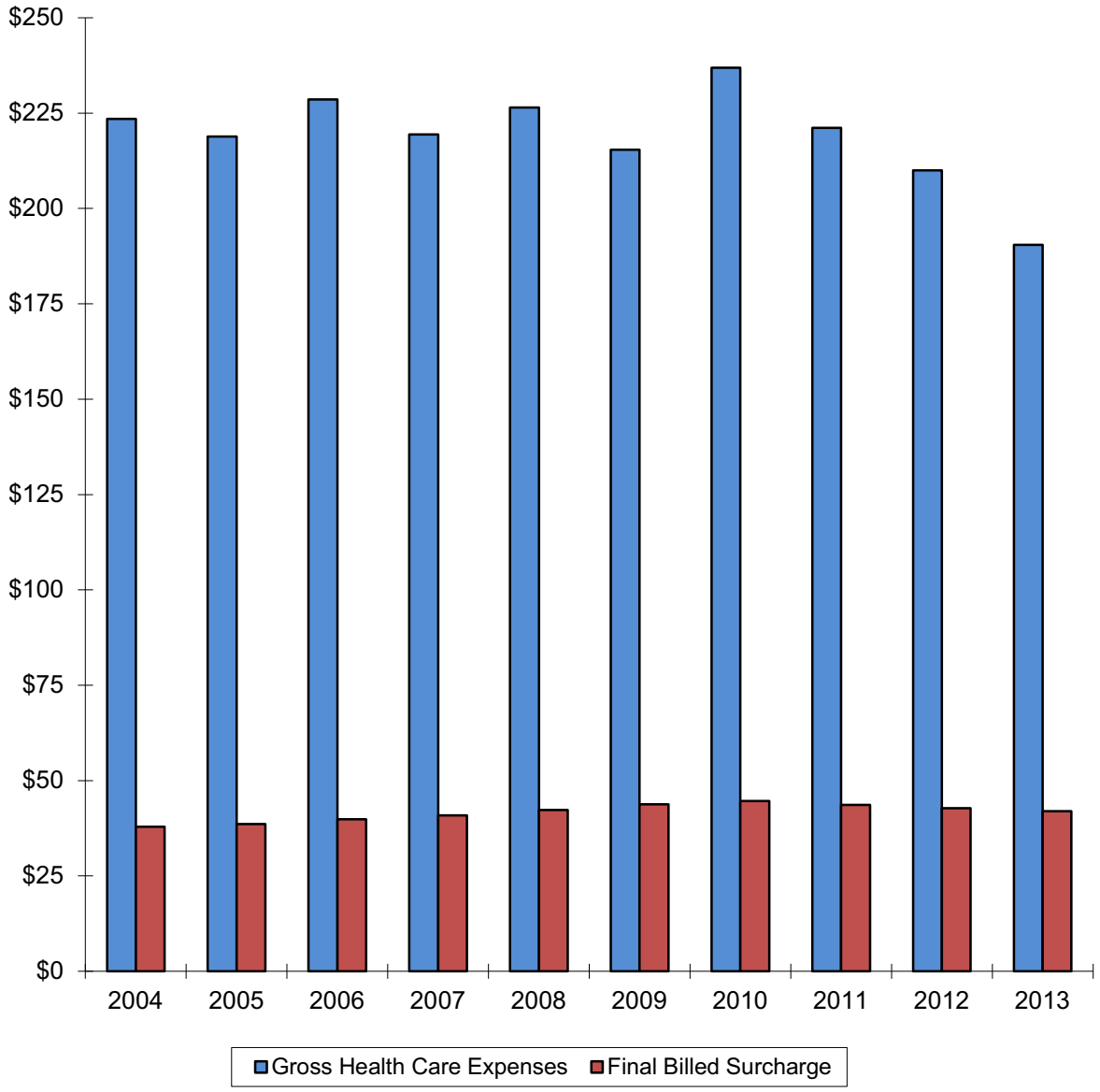


Fiscal Year	Employer Surcharge	Employer Contributions	Benefit Recipient Premiums	Investment Income/(Loss) *	Federal Subsidies/ Reimbursements	Total Income
2004	$37,566,163	$121,984,779	$27,947,708	$33,249,249	-	$220,747,899
2005	$39,446,854	$86,908,721	$40,595,447	$18,486,989	-	$185,438,011
2006	$39,909,334	$117,827,594	$58,683,818	$29,426,851	$11,135,723	$256,983,320
2007	$40,785,061	$130,163,213	$71,620,083	$47,460,777	$20,202,965	$310,232,099
2008	$42,000,617	$116,393,144	$72,707,047	($20,292,279)	$21,953,659	$232,762,188
2009	$44,134,423	$119,277,065	$73,780,246	($61,507,699)	$23,504,101	$199,188,136
2010	$43,430,538	$16,711,476	$72,034,549	$28,869,147	$24,414,855	$185,460,565
2011	$44,739,576	$42,168,707	$90,387,665	$42,728,472	$31,844,425	$251,868,845
2012	$42,769,010	$13,707,220	$104,577,662	($1,939,016)	$50,255,131	$209,370,007
2013	$41,973,356	$3,516,087	$94,353,519	$33,345,121	$41,351,527	$214,539,610

** Includes administrative expenses*

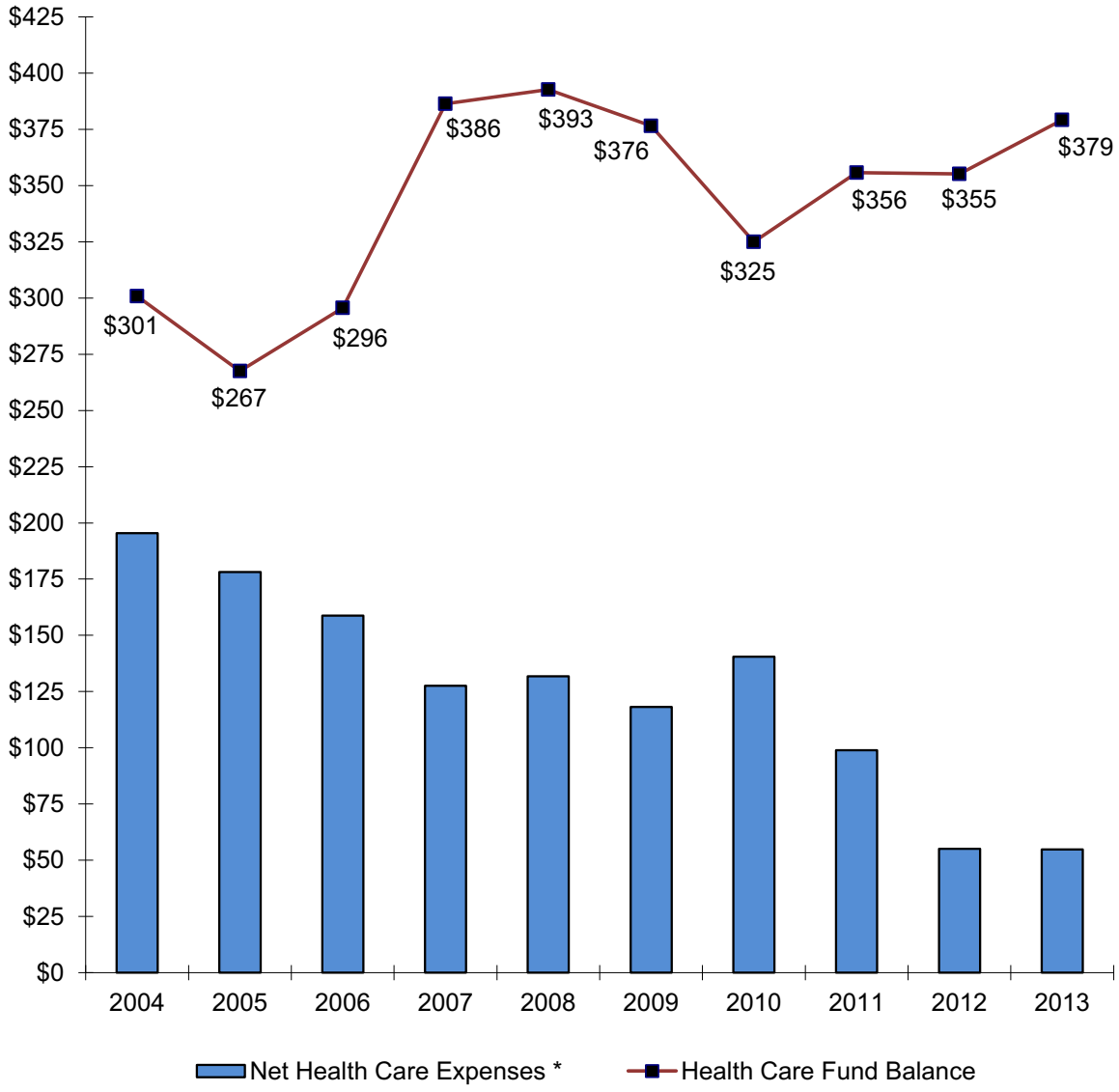
* Includes administrative expenses

Gross Health Care Expenses and SERS Surcharge
FY2004 through FY2013 (millions)



Fiscal Year	Gross Health Care Expenses	Final Billed Surcharge	As % of Payroll
2004	$223,443,805	$37,863,018	1.50%
2005	$218,816,560	$38,631,044	1.50%
2006	$228,570,748	$39,875,425	1.50%
2007	$219,438,662	$40,847,419	1.50%
2008	$226,436,827	$42,309,568	1.50%
2009	$215,409,645	$43,751,195	1.50%
2010	$236,915,618	$44,618,527	1.50%
2011	$221,167,270	$43,621,049	1.50%
2012	$209,965,344	$42,769,010	1.50%
2013	$190,468,991	$41,973,356	1.50%

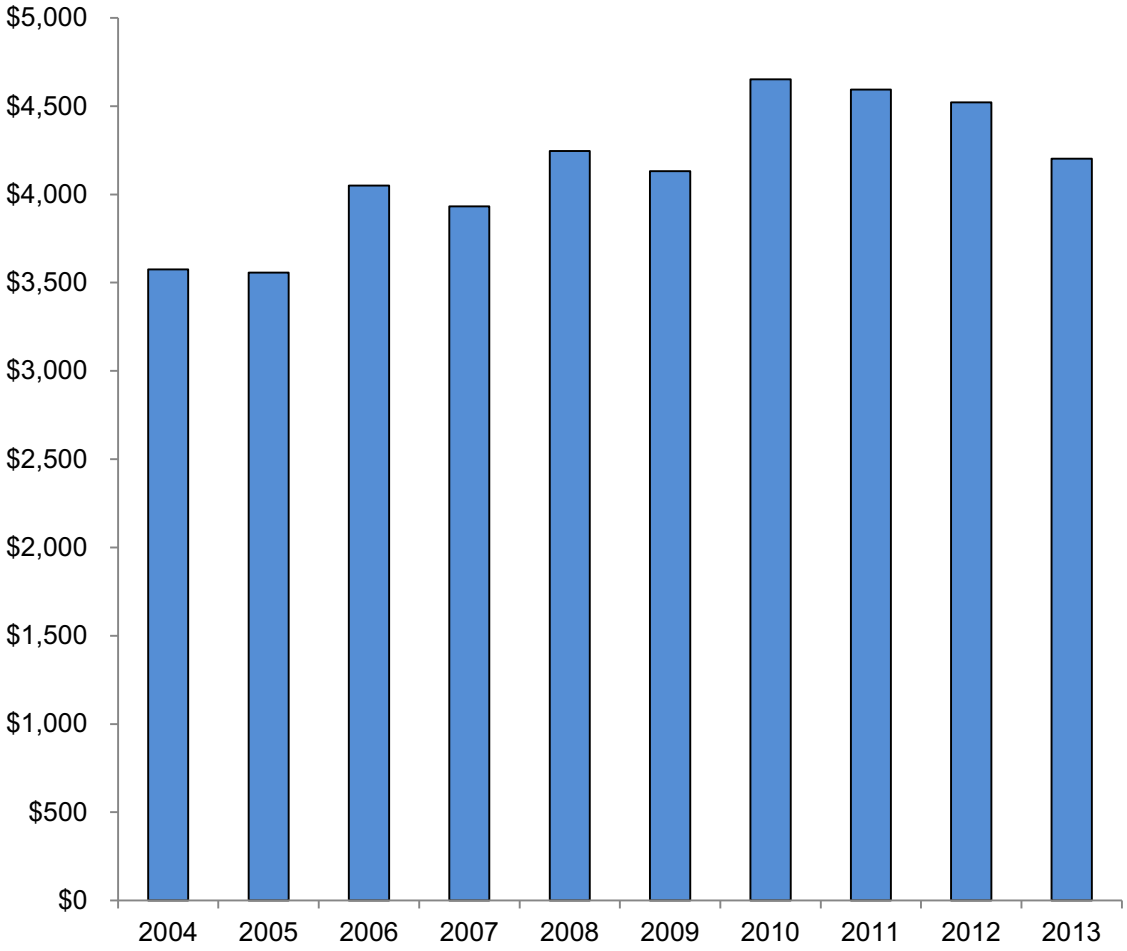
Net Health Care Expenses and Health Care Fund Balance
FY2004 through FY2013 (millions)



Fiscal Year	Net Health Care Expenses *	Health Care Fund Balance
2004	$195,496,097	$300,860,704
2005	$178,221,113	$267,482,155
2006	$158,751,207	$295,561,933
2007	$127,615,614	$386,355,370
2008	$131,776,121	$392,680,731
2009	$118,125,298	$376,459,222
2010	$140,466,214	$325,004,169
2011	$98,935,180	$355,705,744
2012	$55,132,551	$355,110,407
2013	$54,763,945	$379,181,026

* Gross expenses less benefit recipient premiums paid

Average Health Care Expense per Enrollee
FY2004 through FY2013



Fiscal Year	Number of Enrollees	Health Care Expenses *	Average Expense per Enrollee
2004	62,488	$223,443,805	$3,576
2005	61,531	$218,816,560	$3,556
2006	56,446	$228,570,748	$4,049
2007	55,818	$219,438,662	$3,931
2008	53,327	$226,436,827	$4,246
2009	52,134	$215,409,645	$4,132
2010	50,925	$236,915,618	$4,652
2011	48,151	$221,167,270	$4,593
2012	46,439	$209,965,344	$4,521
2013	45,332	$190,468,991	$4,202

* Includes prescription claims

Historical Allocation of the SERS Employer Contribution

Fiscal Year	Pension Allocation	Health Allocation	Total
1987	9.00%	5.00%	14.00%
1988	9.58%	4.42%	14.00%
1989	9.72%	4.28%	14.00%
1990	9.78%	4.22%	14.00%
1991	9.63%	4.37%	14.00%
1992	9.48%	4.52%	14.00%
1993	9.13%	4.87%	14.00%
1994	9.13%	4.87%	14.00%
1995	9.45%	4.55%	14.00%
1996	10.50%	3.50%	14.00%
1997	9.79%	4.21%	14.00%
1998	9.02%	4.98%	14.00%
1999	7.70%	6.30%	14.00%
2000	5.55%	8.45%	14.00%
2001	4.20%	9.80%	14.00%
2002	6.56%	7.44%	14.00%
2003	8.17%	5.83%	14.00%
2004	9.09%	4.91%	14.00%
2005	10.57%	3.43%	14.00%
2006	10.58%	3.42%	14.00%
2007	10.68%	3.32%	14.00%
2008	9.82%	4.18%	14.00%
2009	9.84%	4.16%	14.00%
2010	13.54%	0.46%	14.00%
2011	12.57%	1.43%	14.00%
2012	13.45%	0.55%	14.00%
2013	13.84%	0.16%	14.00%

SERS FUNDING POLICY

I. Purpose.

The purpose of this Statement of Funding Policy is to describe the funding philosophy and objectives of the Retirement Board of the School Employees Retirement System of Ohio (Board). This Statement sets forth policy and describes the organization and division of responsibilities to prudently implement the Board philosophy and objectives in accordance with sections 3309.21 and 3309.211 of the Ohio Revised Code. It also establishes the framework and specific objectives to monitor the System's funded status and to promote effective communication between the Board and SERS staff.

II. Background.

The School Employees Retirement System of Ohio (SERS or System) was initially established by the Ohio Legislature to provide retirement and disability benefits for all non-certificated persons employed by Ohio's public schools. This purpose is sustained by the member and employer contributions, and the return realized from investment of those contributions.

The System is governed by a nine-member Board, including four members elected by the general membership (those who contribute to SERS), two members elected by the retirees and three members with investment expertise appointed by the governor, treasurer of state and the legislature. The Board is responsible for managing the System in accordance with Chapter 3309 of the Ohio Revised Code, and establishing the employer and employee contribution rates (sections 3309.49 and 3309.47, respectively) in accordance with section 3309.21.

III. Funding Philosophy.

The Board realizes that its primary responsibility is to assure that, at the time benefits commence, sufficient funds will be available to provide retirement, disability and survivor benefits along with Medicare B reimbursements and lump sum retiree death benefits for the System's members. The Board also recognizes that the law governing SERS financing intends the contribution rates to remain approximately level from generation to generation (a level percentage of payroll.)

Finally, the Board is cognizant of the necessity to balance the needs of System members for proper funding of retirement, disability and survivor benefits, as well as the Medicare Part B reimbursement and lump sum retiree death benefits, with the desire to receive, where possible, an appropriate level of retiree health care coverage.

IV. Funding Objectives.

In defining funding objectives, the Board seeks to enhance the soundness of the System in order to balance as efficiently as possible the affordability and adequacy of the retirement benefits and health care coverage provided to System members. To that end, the Board establishes the following funding objectives:

A. The program of retirement benefits at SERS reflects that primary consideration is given to the career school employee. The accumulation of assets shall be for the purpose of funding retirement benefits for members who commit a significant portion of their working lives to an educational institution. Members who do not qualify for a retirement benefit shall be entitled only to a refund of contributions.

B. The System shall amortize its unfunded actuarial accrued liability over a closed period of time, decreasing one year with each annual actuarial valuation. However, the Board may approve a flat or increasing amortization period over the short term if necessary to meet the goals of affordability and adequacy of retirement benefits and health care coverage. The Ohio Revised Code section 3309.211 establishes a 30-year maximum amortization period.

C. The funded ratio, that percentage of actuarial accrued liabilities covered by actuarial assets, shall be stable or increasing each year, with a minimum of 80% unless a lower funding ratio is approved by the Board.

D. After satisfying objectives B. and C., above, and while maintaining its funding philosophy of annually reducing the amortization period, the Board may choose to pursue any of the following objectives:

1. To improve the funded ratio of the System;
2. To achieve a twenty year solvency period for the Health Care Fund; or
3. To propose legislation that provides for affordable benefit enhancements for active members and/or retirees.
4. To reduce employee and/or employer contributions.

V. Responsibilities.

In order to implement this Statement of Funding Policy, the following responsibilities are delineated:

A. To the Board.

1. After consultation with the Actuary, the Executive Director and SERS staff, the Board will determine the economic assumptions and actuarial funding method and establish the non-economic assumptions used in the annual actuarial valuation.
2. Where possible and when appropriate, the Board will provide statements of policy to direct and focus the activities of SERS' staff and outside consultants.

B. To the Staff.

1. In accordance with the Board's statements of policy, SERS' staff will implement the Mission of SERS: To provide pension benefit programs and services to our members, retirees, and beneficiaries through benefit programs and services that are soundly financed, prudently administered and delivered with understanding and responsiveness.
2. The SERS Executive Director or, in the absence of the Executive Director, the Deputy Executive Director, will report to the Board annually on SERS' actions and activities in carrying out the Board's funding policies and directives, and more often, as necessary, when Board action may be required under the terms of this Policy.
3. The staff is responsible for providing the Actuary with timely and accurate information regarding SERS' members, retirees and the benefits provided by SERS.

C. To the System Actuary.

1. In addition to preparing the various reports required by law, the Actuary will assist the Board and SERS' staff by providing education and insight regarding effective administrative practices within the community of public pension plans.

2. When requested, the System Actuary will assist in SERS' strategic planning by identifying emerging trends pertaining to benefits and health care.

VI. Review and evaluation.

In order to establish appropriate and effective policy, and to maintain the efficient, ongoing administration of the System, the System will employ the services of a qualified actuary who will prepare, at a minimum, the following:

A. Annual Reports

1. Basic Benefits Actuarial Valuation.

2. Gain/Loss Analysis of Financial Experience of Basic Benefits.

3. Basic Health Care Actuarial OPEB Valuation.

4. Report on the solvency period of the Health Care Fund.

B. Five Year Experience Study

VII. Health Care.

Access to health care is provided in accordance with section 3309.69 of the Ohio Revised Code, and is financed through a combination of employer contributions and retiree premiums, copays and deductibles on covered health care expenses, investment returns, and any funds received as a result of SERS' participation in Medicare programs. The System's goal is to maintain a health care reserve account with a twenty year solvency period in order to ensure that fluctuations in the cost of health care do not cause an interruption in the program. However, during any period in which the twenty year solvency period is not achieved, the System shall manage the Health Care Fund on a pay-as-you-go basis.

The Ohio Revised Code permits SERS to offer access to health care to eligible individuals receiving retirement, disability and survivor benefits and to their eligible dependents. Health care coverage may be changed at any time, resulting in adjustments in the required funding of the health care program.

Included within the aforementioned employer contribution is a surcharge determined in accordance with Ohio Revised Code section 3309.491. The surcharge is levied against employers whose employees earn less than a specified minimum salary. In order to avoid shifting an onerous financial burden to our members and retirees, the employer surcharge will continue to be an important source of health care revenues.

HISTORICAL REFERENCE

RESOLUTION Approved by SERS Board at the November 21, 1997 Board Meeting
Re-affirmed at the December 17, 1998 Board Meeting
Re-affirmed at the April 19, 2000 Board Meeting
RESOLUTION Approved by SERS Board at the September 19, 2008 Board Meeting
RESOLUTION Approved by SERS Board at the December 16, 2010 Board Meeting

SUMMARY OF COVERAGE

LEGAL NOTICE/DISCLAIMER

The following information is a general summary of the SERS health care program as of June 30, 2013. It is not a guarantee of a continuation of the type or amount of coverage, if any, which may be available to current or future benefit recipients.

To the extent resources permit, SERS intends to continue to offer access to health care coverage. However, it reserves the right to change or discontinue any plan or program as necessary.

ELIGIBILITY REQUIREMENTS

Eligibility for SERS' health care coverage is based on service credit. In 1981, the Ohio legislature passed H.B. 126, which requires SERS' members to earn at least 10 years of service credit, exclusive of most types of purchased credit, in order to participate in health coverage. The effective date was June 13, 1986.

Members who retire after June 1, 1986, need 10 years of service credit to qualify to participate in SERS' health care coverage. The following types of credit purchased after Jan. 29, 1981, do not count toward health care coverage eligibility: military, federal, out of state, municipal, private school, exempted, and early retirement incentive credit.

SUMMARY OF COVERAGE

The plans offered by SERS for those *without* Medicare are:

- Aetna Managed Care PPO and Express Scripts prescription drug plan
- Medical Mutual of Ohio PPO and Express Scripts prescription drug plan
- AultCare PPO in 19 Ohio counties and BioScrip prescription drug plan
- Kaiser Permanente HMO in nine Ohio counties and Kaiser prescription drug plan
- Paramount HMO in 15 Ohio and two Michigan counties and Express Scripts prescription drug plan

The plans offered by SERS for those *with* Medicare are:

- Aetna Medicare℠ Plan (PPO) and Express Scripts prescription drug plan
- PrimeTime Health Plan in 10 counties and BioScrip prescription drug plan
- Kaiser Permanente Medicare Plus in seven counties and Kaiser prescription drug plan
- Paramount Elite Medicare Advantage in four Ohio and two Michigan counties and Express Scripts prescription drug plan

The initial choice will be in effect until the next open enrollment period. If no plan choice is made on the Retirement Application, the member will be enrolled in the appropriate plan.

PLAN DESIGN

PRIMARY PLAN OFFERED FOR THOSE *WITHOUT* MEDICARE*

Medical Mutual of Ohio PPO

- Deductible: $1,000 per person; $2,000 per family
- Coinsurance limit: $1,500 per person; $3,000 per family
- Office visit co-payment: $25
- Inpatient hospital: $250 co-payment per admission; member pays 20% after deductible is met
- Durable medical equipment: 20% coinsurance after deductible is met
- All other services: member is responsible for 20% coinsurance payment after deductible is met
- Skilled nursing facility: The plan will pay 80% of the room and board charges for skilled treatment only. Also covered: physical therapy, use of special treatment rooms, drugs, casts, and dressing. These expenses will be payable for up to 365 days of confinement in any convalescent period. If private accommodations are used, the plan will cover the facility's average daily semi-private room charge.
- Home health care: member pays 20% coinsurance after deductible is met

Coordination of Benefits

The SERS plan contains a "Coordination of Benefits" (COB) provision. Payment on covered expenses will be reduced to the extent of duplicate coverage by any other group carrier determined to be the primary insurer under the model COB provisions recommended by the National Association of Insurance Commissioners and adopted by the SERS Board of Trustees.

Out-of-Pocket Maximum

The maximum out-of-pocket limit under the primary plan is $2,500 per person per calendar year, including the deductible, or $2,750 including the deductible and one hospital co-payment. The office visit co-payment of $25 for those in the managed care network does not accrue toward the out-of-pocket limit.

There is no maximum expense limit for a participant in the managed care network who does not use participating providers. There is no maximum limit under this plan.

*Other regional HMO and PPO plan designs may vary

THE PRIMARY PLAN OFFERED FOR THOSE *WITH* MEDICARE*

Aetna Medicare℠ Plan (PPO)

- Deductible: $300
- Coinsurance limit: $6,700
- Office visit co-payment: $25
- Inpatient hospital co-payment: $500 per admission
- Durable medical equipment: 20% coinsurance
- Emergency room co-payment: $50, waived if admitted
- Ambulance: member pays 20% coinsurance after deductible is met
- All other services: member may be responsible for a co-payment or coinsurance payment

- Skilled nursing facility:
  Member pays $0 for days 1-10
  Member pays $25 per day for days 11-20
  Member pays $50 per day for days 21-100 (100 days maximum)
- Home health care: 100% coverage
- Routine preventive physical exams, and pneumonia, flu, and shingles immunizations are covered at 100%.

*Other regional HMO and PPO plan designs may vary

PRESCRIPTION DRUG COVERAGE

SERS provides prescription drug coverage with all plans. Covered benefit recipients and dependents can obtain prescription drugs at retail pharmacies or by mail order.

Retail Pharmacy

Benefit recipients receive an identification card for use at retail pharmacies. Medicare benefit recipients may receive a 90-day supply at a retail pharmacy. Non-Medicare benefit recipients are limited to a 30-day supply.

Co-payments for a 30-day supply are as follows: $5 for generics; $25% preferred brand (min. $25/max. $100). For non-preferred brands, Medicare benefit recipients pay 50%. Non-Medicare benefit recipients pay 100% of SERS' cost.

There is no prescription coverage when non-network pharmacies are used. Nursing home confinements are covered.

Mail Order

Persons living in the continental U.S. can receive prescriptions by mail.

Co-payments for a 90-day supply are as follows: $12 for generics; $25% preferred brand (min. $45 / max. $200). For non-preferred brands, Medicare benefit recipients pay 50%. Non-Medicare benefit recipients pay 100% of SERS' cost.

PREMIUMS

The following are premiums for service retirees and disability recipients based on benefit date and years of service credit. Premiums for spouses and children also are listed.

Premiums are for the primary non-Medicare and Medicare health plans.

Non-Medicare Premiums

Medical Mutual of Ohio PPO					
Non-Medicare					
Service Years	**Retirement date on or before July 1, 1989**	**Aug. 1, 1989 through July 1, 1993**	**Aug. 1, 1993 through July 1, 2008**	**Retirement date on or after Aug. 1, 2008***	**Disability Recipients**
5 to 9.999	$556	Not Eligible	Not Eligible	Not Eligible	$556
10 to14.999	$230	$1,110	$1,145	$1,145	$367
15 to 19.999	$230	$556	$591	$1,145	$367
20 to 24.999	$230	$278	$313	$591	$367
25 to 29.999	$230	$230	$230	$369	$230
30 to 34.999	$230	$230	$230	$258	$230
*If you retired on or after Aug. 1, 2008 with 35 or more years of service credit, call SERS for your premium.					
Spouse premium				**Child(ren) premium**	
24.999 or less	$1,046	Spouse premium is based on the service retiree, disability recipient, or member's service credit.		$190	
25 to 29.999	$952				
30 or more years	$857				

Medicare Premiums

Aetna Medicare℠ Plan (PPO)					
PREMIUMS IF YOU HAVE MEDICARE PART A & PART B					
Service Years	**Retirement date on or before July 1, 1989**	**Aug. 1, 1989 through July 1, 1993**	**Aug. 1, 1993 through July 1, 2008**	**Retirement date on or after Aug. 1, 2008***	**Disability Recipients**
5 to 9.999	$113	Not Eligible	Not Eligible	Not Eligible	$113
10 to14.999	$84	$213	$248	$248	$84
15 to 19.999	$84	$113	$148	$248	$84
20 to 24.999	$84	$84	$99	$148	$84
25 to 29.999	$84	$84	$84	$109	$84
30 to 34.999	$84	$84	$84	$89	$84
*If you retired on or after Aug. 1, 2008 with 35 or more years of service credit, call SERS for your premium.					
Spouse premium				**Child(ren) premium**	
24.999 or less	$269	Spouse premium is based on the service retiree, disability recipient, or member's service credit.		$209	
25 to 29.999	$249				
30 or more years	$229				

All premiums are subject to change yearly.

Medicare B Reimbursement

The Medicare Part B reimbursement rate is $45.50 per month. It is paid to members who retired prior to Jan. 7, 2013, and to those who retired after that date who are enrolled in SERS' health care coverage. Medicare enrollees must pay current Medicare Part B premium to Social Security in full.

OPTIONAL DENTAL COVERAGE

MetLife Dental

Depending on if an in-network or out-of-network provider is selected, MetLife offers different levels of coverage.

	In-Network	Out-of-Network	
Preventive Care	100%	80%	No deductible
Basic Services	80%	60%	$50 deductible
Major Restorative	50%	40%	$50 deductible

The 2013 monthly premiums for the dental plan are:

Benefit recipient only	$ 26.91
Benefit recipient and one dependent	$ 51.01
Benefit recipient and two or more dependents	$ 77.18

Rev. 12/2013

2013 Non-Medicare Plan Coverage – A Deductible, Co-Pay, or Coinsurance may apply

	Aetna Managed Care	AultCare PPO	Kaiser Permanente HMO	Medical Mutual of Ohio PPO	Paramount HMO
Deductible (Annual)	$1,000/person $2,000/family	$1,000/person $2,000/family	$1,000/person $2,000/family	$1,000/person $2,000/family	$1,000/person $2,000/family
Coinsurance (Annual Limit)	$1,500/person $3,000/family	$1,500/person $3,000/family	$1,500/person $3,000/family	$1,500/person $3,000/family	$1,500/person $3,000/family
Lifetime Max	None	None	None	None	None
Office visit	$25 co-pay	$25 co-pay	$15 co-pay	$25 co-pay	$15 co-pay
Specialist	$25 co-pay	$25 co-pay	$15 co-pay	$25 co-pay	$30 co-pay
Surgeon Fee	20% coinsurance	20% coinsurance	$15 co-pay; 80% after deductible	20% coinsurance	20% coinsurance
Inpatient Hospital	20% coinsurance after $250 co-pay	20% coinsurance after $250 co-pay	20% coinsurance	20% coinsurance after $250 co-pay	20% coinsurance
Emergency Room	20% coinsurance	20% coinsurance	$50 co-pay, waived if admitted	20% coinsurance	$50 co-pay, waived if admitted
Ambulance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Outpatient Diagnostic X-ray	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Outpatient Diagnostic Lab	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Outpatient Surgery (Facility Only)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Chiropractic	20% coinsurance	$25 co-pay	Not covered	20% coinsurance	$30 co-pay
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Skilled Nursing Facility	20% coinsurance (365 day maximum)	20% coinsurance (365 day maximum)	20% coinsurance (100 day maximum)	20% coinsurance (365 day maximum)	Co-pay: $0 per day 1-15, $95 per day 16-100
Home Health Care	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Hospice	Inpatient: 100% coverage after deductible, 30 day lifetime limit. Outpatient: 20% coinsurance after deductible	20% coinsurance after deductible; 30-day inpatient lifetime maximum	100% coverage	Inpatient: 100% coverage after deductible, 30 day lifetime limit. Outpatient: 20% coinsurance after deductible	20% coinsurance
Prescription Drugs	Express Scripts **Retail** 30-day maximum: $5 generic, 25% Preferred Brand (minimum $25, maximum $100) **Mail order** 90-day maximum $12 generic, 25% Preferred Brand (minimum $45, maximum $200) Non-preferred at 100% of SERS' cost **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.	BioScrip **Retail** 30-day maximum $5 generic, 25% Preferred Brand (minimum $25, maximum $100) **Mail order** 90-day maximum $12 generic, 25% Preferred Brand (minimum $45, maximum $200) Non-preferred at 100% **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.	Kaiser Pharmacy **Retail** 31-day maximum supply $10 Co-payment **Mail order** 90-day maximum supply $25 Co-payment Non-preferred at 100%	Express Scripts **Retail** 30-day maximum: $5 generic, 25% Preferred Brand (minimum $25, maximum $100) **Mail order** 90-day maximum $12 generic, 25% Preferred Brand (minimum $45, maximum $200) Non-preferred at 100% of SERS' cost **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.	Express Scripts **Retail** 30-day maximum: $5 generic, 25% Preferred Brand (minimum $25, maximum $100) **Mail order** 90-day maximum: $12 generic, 25% Preferred Brand (minimum $45, maximum $200) Non-preferred at 100% of SERS' cost **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.

Final plan documentation prevails.
Coinsurance applies after deductibel is met.

2013 Medicare Plan Coverage – A Deductible, Co-Pay, or Coinsurance may apply

	Aetna Medicare[SM] Plan (PPO)	PrimeTime Health Plan	Kaiser Permanente Medicare Plus	Paramount Elite Medicare Advantage
Deductible (Annual)	$300	$300	None	$300
Coinsurance (Annual Limit)	$6,700 per person	$3,400 per person	$2,000/person $6,000/family	$6,700 per person
Lifetime Max	None	None	None	None
Office visit	$25 co-pay	$20 co-pay	$25 co-pay	$20 co-pay
Specialist Visit	$25 co-pay	$30 co-pay	$25 co-pay	$25 co-pay
Surgeon Fee	100% coverage	100% coverage	$100 per visit	100% coverage
Inpatient Hospital	$500 co-pay per admission	$500 co-pay per admission	$500 co-pay per benefit period	$500 co-pay per admission
Emergency Room	$50 co-pay, waived if admitted	$50 co-pay, waived if admitted	$50 co-pay, waived if admitted	$50 co-pay, waived if admitted
Ambulance	20% coinsurance	$75 co-pay	$50 co-pay	100% coverage
Outpatient Diagnostic X-ray	$25 co-pay	100% coverage	100% coverage	100% coverage
Outpatient Diagnostic Lab	100% coverage	100% coverage	100% coverage	100% coverage
Outpatient Surgery (Facility Only)	$100 co-pay per surgery	$100 co-pay per surgery	$100 co-pay per surgery	$100 co-pay per surgery
Chiropractic	$15 co-pay limited to Medicare coverage	$30 co-pay limited to Medicare coverage	$20 co-pay for manual manipulations/sublux	$20 co-pay limited to Medicare coverage
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Skilled Nursing Facility	Co-pay: $0 per day 1-10, $25 per day 11-20, $50 per day 21-100 (100 day maximum)	Co-pay: $0 per day 1-15, $20 per day 16-30, $0 per day 31-100 (100 day maximum)	100% coverage (100 day maximum)	Co-pay: $0 per day 1-15, $95 per day 16-100 (100 day maximum)
Home Health Care	100% coverage	100% coverage	100% coverage	100% coverage
Hospice	Covered per Medicare rules	100% coverage	Covered per Medicare rules	Covered per Medicare rules
Prescription Drugs	Express Scripts Medicare D PDP **Retail** 30-day supply: $5 generic, 25% Preferred Brand (minimum $25, maximum $100), 50% Non-Preferred Brand **Mail order** 90-day supply: $12 generic, 25% Preferred Brand (minimum $45, maximum $200), 50% Non-Preferred Brand **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.	BioScrip **Retail** 30-day maximum: $5 generic, 25% Preferred Brand (minimum $25, maximum $100), 50% Non-Preferred Brand **Mail order** 90-day maximum: $12 generic, 25% Preferred Brand (minimum $45, maximum $200), 50% Non-Preferred Brand **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.	Kaiser **Retail** 31-day maximum supply $15 generic, $30 Brand Formulary **Mail order** 90-day maximum supply $15 generic, $30 Brand Formulary Non-preferred at 100%	Express Scripts Medicare D PDP **Retail** pharmacies per 30-day supply $5 generic, 25% Preferred Brand (minimum $25, maximum $100), 50% Non-Preferred Brand **Mail order** 90-day maximum: $12 generic, 25% Preferred Brand (minimum $45, maximum $200), 50% Non-Preferred Brand **Insulin** (Retail) 25% or $30 maximum for preferred brand. $45 maximum for non-preferred brand. (Mail order) 25% or $60 maximum for preferred brand. $115 maximum for non-preferred brand.

Final plan documentation prevails.

Sec. 3309.375 Hospital insurance coverage for retirants.

(A) Except as otherwise provided in division (B) of this section, the board of the school employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, "Social Security Amendments of 1965," 79 Stat. 291, 42 U.S.C.A. 1395c, as amended. This coverage shall also be made available to the spouse, widow, or widower of such retirant or disability benefit recipient provided such spouse, widow, or widower has attained age sixty-five and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage only if he or she is the recipient of a monthly allowance or benefit from this system. Not less than twenty-five per cent of the cost for such coverage shall be paid from the appropriate funds of the school employees retirement system and the remainder by the recipient of the allowance or benefit.

The cost of such coverage, paid from the funds of the system, shall be included in the employer's rate provided by sections 3309.49 and 3309.51 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and shall contract for such coverage as provided in section 3309.69 of the Revised Code.

Notwithstanding sections 3309.49 and 3309.51 of the Revised Code, the employer's contribution rate shall not be increased until July 1, 1969, or later to reflect the increased costs created by this section.

(B) The board need not make the hospital insurance coverage described in division (A) of this section available to any person for whom it is prohibited by section 3309.69 of the Revised Code from paying or reimbursing the cost of such insurance.

Eff.	7/29/92	S.B. 346
	6/30/91	H.B. 382
	6/13/81	H.B. 126
	6/13/75	H.B. 1
	12/14/67	H.B. 402
OAC Reference:		3309-1-55

Sec. 3309.49 Employer's contribution rate.

Each employer shall pay annually to the school employees retirement system an amount certified by the secretary that shall be a certain per cent of the earnable compensation of all employees, and shall be known as the "employer contribution." The rate per cent of such contribution shall be fixed by the actuary on the basis of the actuary's evaluation of the liabilities of the school employees retirement system, but shall not exceed fourteen per cent, and shall be approved by the school employees retirement board. The school employees retirement board may raise the rate per cent of the contribution to fourteen per cent of the earnable compensation of all employees. In making such evaluation, the actuary shall use, as the actuarial assumptions, regular interest and such mortality and other tables as are adopted by the

school employees retirement board. The actuary shall compute the percentage of such earnable compensation, to be known as the "employer rate," required annually to fund the liability for all allowances, annuities, pensions and other benefits, and any deficiencies in the various funds, provided for in this chapter, after deducting therefrom the annuity and other benefits provided by the contributor's accumulated contributions and deposits or other applicable moneys.

Eff.	4/9/01	S.B. 270
	6/30/91	H.B. 382
OAC Reference:		3309-1-02

Sec. 3309.491 Employer minimum compensation contribution to fund future health care benefits.

(A) An actuary employed by the school employees retirement board shall annually determine the minimum annual compensation amount for each member that will be needed to fund the cost of providing future health care benefits under section 3309.69 of the Revised Code. The amount determined by the actuary under this division shall be approved by the board and shall be known as the "minimum compensation amount."

(B) (1) The secretary of the school employees retirement board shall annually determine for each employer the "employer minimum compensation contribution."

Subject to division (B)(2) of this section, the amount determined shall be the lesser of the following:

(a) An amount equal to two per cent of the compensation of all members employed by the employer during the prior year;

(b) The total of the amounts determined as follows for each member whose compensation for the prior year was less than the minimum compensation amount:

(i) Subtract the member's compensation for the prior year from the minimum compensation amount;

(ii) Multiply the remainder obtained under division (B)(1)(b)(i) of this section by one, or if the member earned less than a year's service credit for the prior year, by the same fraction as the fraction of a year's service credit credited to the member under section 3309.30 of the Revised Code;

(iii) Multiply the product obtained under division (B)(1)(b)(ii) of this section by the employer contribution rate in effect for the year the service credit was earned.

(2) If the total of the employer minimum contribution amounts determined under division (B)(1) of this section exceeds one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution, the school employees retirement board shall reduce the amount determined for each employer so that the total amount determined does not exceed one and one-half per cent of the compensation of all members employed by employers required to pay the employer minimum compensation contribution. Any reduction shall be applied to each employer in the same proportion as the employer's minimum compensation contribution bears to the total employer minimum compensation contribution.

(C) The secretary shall annually certify to each employer the employer minimum compensa-

tion contribution determined under division (B) of this section. In addition to the employer contribution required by section 3309.49 of the Revised Code, each employer shall pay annually to the employers' trust fund the amount certified to the employer under this division.

(D) Annually by the first day of August, the secretary shall submit to the superintendent of public instruction a list of the payments made by each employer under this section during the preceding fiscal year.

Eff. 4/9/01 S.B. 270
9/9/88 H.B. 290

Section 3309.69 Group hospitalization coverage; ineligible individuals; service credit; alternative use of health insuring corporation

(A) The school employees retirement board may establish a program to provide medical, hospital, surgical, prescription, or other health care coverage, benefits, reimbursement, or any combination thereof, to eligible individuals or dependents.

Any program established under this section shall be designed and administered by the board. In establishing a program, the board may do any of the following:

(1) Enter into an agreement with persons or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, prescription, surgical, or other health care benefits, or any combination thereof;

(2) Provide for self-insurance of risk or level of risk and provide through the self-insurance method specific benefits as authorized by the rules of the board;

(3) Provide reimbursements or subsidies to eligible participants;

(4) Make disbursements;

(5) Determine levels of coverage and costs for the program;

(6) Take any other action it considers necessary to establish and administer the program.

(B) If it establishes a health care program, the board shall establish eligibility criteria and any other requirements for participation. To be eligible, an individual must meet the criteria established by the board and be one or more of the following:

(1) A former member receiving benefits pursuant to section 3309.34, 3309.35, 3309.36, or 3309.381 or former section 3309.38 of the Revised Code;

(2) A disability benefit recipient receiving a disability benefit pursuant to section 3309.35, 3309.39, 3309.40, or 3309.401 of the Revised Code;

(3) A beneficiary receiving monthly benefits pursuant to section 3309.45 of the Revised Code;

(4) The beneficiary of a former member who is receiving monthly benefits pursuant to section 3309.46 of the Revised Code;

(5) A dependent, as determined under rules adopted by the board, of an individual described in divisions (B)(1) to (4) of this section.

(C) The cost paid from the funds of the system for coverage under this section shall be

included in the employer contribution under sections 3309.49 and 3309.491 of the Revised Code.

(D)(1) The board may require payment of a premium for participation in the health care program. Participation is deemed consent for the deduction of premiums from any pension, benefit, or annuity provided under this chapter to an eligible participant.

(2) An individual who fails to pay any required premium or receives any coverage or payment to which the individual is not entitled shall pay or repay any amount due the system. If an individual fails to pay or repay an amount due, the system may withhold the amount from any pension, benefit, annuity, or payment due the individual or the individual's beneficiary under this chapter or collect the amount in any other manner provided by law.

(E) A health care program participant who is eligible for coverage under medicare part B, "Supplementary Medical Insurance Benefits for the Aged and Disabled," 42 U.S.C. 1395j, as amended, shall enroll for that coverage. The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, make a monthly payment to the participant in an amount determined by the board for such coverage that is not less than forty-five dollars and fifty cents, except that the board shall make no payment to a participant who is not eligible for coverage under medicare part B or pay an amount that exceeds the amount paid by the recipient for the coverage.

(F) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 3309.375 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, Ohio police and fire pension fund, state teachers retirement system, or state highway patrol retirement system.

(G) The board shall make all other necessary rules pursuant to the purpose and intent of this section.

(H) This section does not require the board to establish, maintain, offer, or continue any health care program. This section does not require the board to provide or continue access to any health care program, or any level of coverage or costs provided under the program, if the board establishes or maintains a program under this section.

Eff.	1/1/13	S.B. 341
	10/1/02	S.B. 247
	4/9/01	S.B. 270
	11/2/99	H.B. 222
	12/8/98	H.B. 673
	6/4/97	S.B. 67
	3/6/97	S.B. 82
	7/29/92	S.B. 346
	6/30/91	H.B. 382
	5/4/92	H.B. 383
OAC Reference:		3309-1-35
		3309-1-55

Sec. 3309.691 Long term health care programs.

The school employees retirement board shall establish a program under which members of

the retirement system, employers on behalf of members, and persons receiving service, disability, or survivor benefits are permitted to participate in contracts for long-term health care insurance. Participation may include dependents and family members. If a participant in a contract for long-term care insurance leaves employment, the participant and the participant's dependents and family members may, at their election, continue to participate in a program established under this section in the same manner as if the participant had not left employment, except that no part of the cost of the insurance shall be paid by the participant's former employer.

Such program may be established independently or jointly with one or more of the other retirement systems. For purposes of this section, "retirement systems" has the same meaning as in division (A) of section 145.581 of the Revised Code.

The board may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a long-term care insurance policy or contract. However, prior to entering into such an agreement with an insurance company or health insuring corporation, the board shall request the superintendent of insurance to certify the financial condition of the company or corporation. The board shall not enter into the agreement if, according to that certification, the company or corporation is insolvent, is determined by the superintendent to be potentially unable to fulfill its contractual obligations, or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or under an order of supervision by the superintendent.

The board shall adopt rules in accordance with section 111.15 of the Revised Code governing the program. The rules shall establish methods of payment for participation under this section, which may include establishment of a payroll deduction plan under section 3309.27 of the Revised Code, deduction of the full premium charged from a person's service, disability, or survivor benefit, or any other method of payment considered appropriate by the board. If the program is established jointly with one or more of the other retirement systems, the rules also shall establish the terms and conditions of such joint participation.

Eff.	6/4/97	S.B. 67
	7/1/93	H.B. 152
	10/29/91	H.B. 180
OAC Reference:		3309-1-51

Sec. 3309.70 Overpayment of benefit; recovery.

If a person who is a member, former member, contributor, former contributor, retirant, beneficiary, or alternate payee, as defined in section 3105.80 of the Revised Code, is paid any benefit or payment by the school employees retirement system to which the person is not entitled, the benefit shall be repaid to the retirement system by the person. If the person fails to make the repayment, the retirement system shall withhold the amount due from any benefit due the person or the person's beneficiary under this chapter, or may collect the amount in any other manner provided by law.

Eff.	1/1/02	H.B. 535
	7/29/92	S.B. 346

Sec. 3305.01 Alternative Retirement Plans-Definitions.

As used in this chapter:

Sec. 3305.01 Alternative Retirement Plans-Definitions.

As used in this chapter:

(A) "Public institution of higher education" means a state university as defined in section 3345.011 of the Revised Code, the northeast Ohio medical university, or a university branch, technical college, state community college, community college, or municipal university established or operating under Chapter 3345., 3349., 3354., 3355., 3357., or 3358. of the Revised Code.

(B) "State retirement system" means the public employees retirement system created under Chapter 145. of the Revised Code, the state teachers retirement system created under Chapter 3307. of the Revised Code, or the school employees retirement system created under Chapter 3309. of the Revised Code.

(C) "Eligible employee" means any person employed as a full-time employee of a public institution of higher education.

In all cases of doubt, the board of trustees of the public institution of higher education shall determine whether any person is an eligible employee for purposes of this chapter, and the board's decision shall be final.

(D) "Electing employee" means any eligible employee who elects, pursuant to section 3305.05 or 3305.051 of the Revised Code, to participate in an alternative retirement plan provided pursuant to this chapter or an eligible employee who is required to participate in an alternative retirement plan pursuant to division (C)(4) of section 3305.05 or division (F) of section 3305.051 of the Revised Code.

(E) "Compensation," for purposes of an electing employee, has the same meaning as the applicable one of the following:

(1) If the electing employee would be subject to Chapter 145. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "earnable salary" as defined in division (R) of section 145.01 of the Revised Code;

(2) If the electing employee would be subject to Chapter 3307. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "compensation" as defined in division (L) of section 3307.01 of the Revised Code;

(3) If the electing employee would be subject to Chapter 3309. of the Revised Code had the employee not made an election pursuant to section 3305.05 or 3305.051 of the Revised Code, "compensation" as defined in division (V) of section 3309.01 of the Revised Code.

(F) "Provider" means an entity designated under section 3305.03 of the Revised Code as a provider of investment options for an alternative retirement plan.

Eff.	4/29/11	H.B. 139
	7/1/06	H.B. 478
	8/1/05	S.B. 133
	4/01/01	H.B. 535
	3/31/97	H.B. 586

3309-1-35 Health care.

(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 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.

(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 plan offered by the system including, but not limited to, the medical plan, and the prescription drug 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) "Employer" and "public employer" have the same meaning as in section 3309.01 of the Revised Code.

(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,

(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.

(2) Eligibility for health care coverage shall terminate when the person ceases to qualify as one of the persons listed in paragraph (B)(1) of this rule.

(C) 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 spouse of an age and service retirant or disability benefit recipient may only be enrolled in the system's health care coverage as follows:

(a) At the time the retirant or disability benefit recipient enrolls in school employees retirement system's health care coverage; or,

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

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

(ii) Attaining age sixty-five; or

(iii) Involuntary termination of health care coverage under another group plan, medicare advantage plan, or medicare part D plan.

(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 as follows:

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

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

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

(ii) Involuntary termination of health care coverage under another group plan, medicaid, medicare advantage plan, or medicare part D plan.

(D) Cancellation of health care coverage

(1) Health care coverage of a person shall be cancelled when:

(a) The person's eligibility terminates as provided in paragraph (B)(2) of this rule;

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

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

(d) The person's health care coverage is cancelled due to the person's enrollment in a medicare advantage plan or medicare part D plan as provided in paragraph (H) of this rule;

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

(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.

(E) Effective date of coverage

(1) 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 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, 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 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 is received within three months of the date of the member's or retirant's death, or the first 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) The school employees retirement board may establish premiums for a benefit recipient's health care coverage, including dependent coverage with the system.

(a) 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.

(b) Premium payments billed to a benefit recipient shall be deemed in default after three consecutive months of nonpayment. A benefit recipient who is in default shall be sent notice by certified U.S. mail informing 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 is received. 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.

(c) After cancellation for default, health care coverage can be reestablished and coverage reinstated as provided in paragraph (I) of this rule, or upon submission of an application 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 termination for default shall be effective on the first of the month following the date that the application for reinstatement is approved.

(2) A person enrolled in SERS' health care plan cannot receive a premium subsidy unless that person is:

(a) A dependent child.

(b) An age and service retirant:

(i) An age and service retirant with an effective retirement date before August 1, 1989; or

(ii) An age and service retirant with 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) An age and service retirant with an effective retirement date on or after August 1, 2008 who had earned twenty years of 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, 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:

(i) A disability benefit recipient with an effective benefit date before August 1, 2008; or

(ii) A disability benefit recipient with 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 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 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, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code, 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.

(iii) A surviving spouse of a deceased member who had earned twenty-five years of 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, 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 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, 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.

(e) For purposes of determining eligibility for a subsidy under paragraph (F)(2) 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.

(f) Any other individual covered under a SERS health care plan shall be eligible for a premium subsidy under the standard set forth for spouses.

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

(G) Waiver

(1) A benefit recipient may 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 waived as follows:

(a) For non-medicare eligible dependents, the benefit recipient may waive their coverage by completing and submitting a signed written request to SERS on their behalf.

(b) For medicare eligible dependents, the dependent may waive their coverage by completing and submitting a signed written request to SERS.

(H) Medicare advantage or medicare part D

(1) SERS shall cancel the health care coverage of a benefit recipient or dependent who enrolls in a medicare advantage or medicare part D plan that is not offered by the system unless SERS receives proof of cancellation within fourteen days of receipt of notice of enrollment. The cancellation shall be effective on the first day of the month after SERS notifies the benefit recipient that the coverage has been cancelled.

(I) Reinstatement to SERS health care coverage

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

(a) The application is received no later than thirty-one days after reaching age sixty-five. Health care coverage shall be effective the later of the first day of the month after reaching sixty-five or receipt of the enrollment application by the system;

(b) The application is received no later than thirty-one days after involuntary termination of coverage under another group plan, medicaid, medicare advantage plan, or medicare part D plan with proof of such termination. Health care coverage shall be effective the later of the first day of the month after termination of the other group plan or receipt of proof of termination and the enrollment application by the system.

(2) An eligible person whose coverage was cancelled pursuant to paragraph (D)(1)(f) of this rule shall be reinstated to SERS health care plan when benefit payments are reinstated.

(3) An eligible benefit recipient or dependent of a benefit recipient with health care coverage, whose coverage has been previously cancelled and who is enrolled in medicare A and B or medicare B only on December 31, 2007 may be reinstated to SERS health care coverage by filing a healthcare enrollment application during the period of time beginning October 1, 2007 and ending November 30, 2007. Health care coverage shall be effective January 1, 2008.

(4) An eligible benefit recipient or dependent of a benefit recipient with health care coverage, whose coverage has been previously cancelled pursuant to paragraph (H) of this rule and who is enrolled in medicare A and B or medicare B only on June 30, 2009 may be reinstated to SERS health care coverage by filing a health care enrollment application during the period of time beginning May 21, 2009 and ending July 15, 2009.

(5) An eligible benefit recipient who had an effective retirement or benefit date on or after August 1, 2008, who qualifies for a premium subsidy under paragraph (F)(2) of this rule, and whose coverage has previously been waived as provided in paragraph (G) of this rule, may be reinstated to school employees retirement system health care cov-

erage by submitting a complete health care enrollment application on or before December 14, 2012. Health care coverage shall be effective January 1, 2013.

(J) Medicare part "B"

(1) A person who is enrolled in SERS' health care shall enroll in medicare part B at the person's first eligibility date for medicare part B.

(2) (a) 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.

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

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

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

(3) The effective date of the medicare "B" premium 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 (J)(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.

(4) The board shall not:

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

(b) Pay a medicare "B" premium to a benefit recipient who is receiving reimbursement for this premium from any other source.

HISTORY: 3/8/13, 1/7/13 (Emer.), 9/30/12, 8/14/11, 9/26/10, 7/1/10 (Emer.), 6/11/10, 8/10/09, 5/22/09 (Emer.), 1/8/09, 8/8/08, 12/24/07, 9/28/07 (Emer.), 3/1/07, 1/2/04, 6/13/03, 11/9/98, 8/10/98, 1/2/93, 7/20/89, 3/20/80, 1/1/77

Promulgated Under: 111.15
Statutory Authority: 3309.04
Rule Amplifies: 3309.69
Review Date: 2/1/15

3309-1-51 Long-term care coverage.

(A) The school employees retirement system may contract directly with an insurer to establish a program that provides contracts for long-term care insurance for members and benefit recipients of the system and members of their families. If the program is established jointly with another retirement system, the contract shall separately establish the terms and conditions for participation through the school employees retirement system.

(B) Members of the school employees retirement system who have contributed to the system during the previous eighteen months may make application to participate in contracts effective on and after July 1, 1994 for long-term care coverage offered pursuant to section 3309.691 of the Revised Code, provided:

(1) Application for coverage shall be made directly to the insurer during enrollment periods specified by the school employees retirement system; and

(2) Determination of eligibility for participation under the terms of any such contract shall be made by the insurer with approval of the school employees retirement system.

(C) The recipient of any monthly benefit may participate in contracts for long-term care coverage, subject to the same conditions as those applicable to members under the terms of paragraph (B) of this rule.

(D) Payment for coverage shall be made by the member or benefit recipient to the insurer in such amounts and by such methods as determined under the contract for long-term care coverage.

(E) A spouse, parent or parent-in-law of any individual who has made application pursuant to paragraph (B) or (C) of this rule may apply for coverage subject to the same terms and conditions as those applicable to members under the terms of paragraph (B) of this rule, provided that in the case of a spouse, the individual participating pursuant to paragraph (B) or (C) of this rule agrees to remit the cost of such coverage along with his or her own payment.

HISTORY: 5/3/02, 6/10/94

Promulgated Under:	111.15
Statutory Authority:	3309.04
Rule Amplifies:	3309.691
Review Date:	2/1/07; 2/1/12

THE SERS HEALTH CARE PROGRAM HISTORY

1962— SERS offers its first health care plan. It is underwritten by Blue Cross/Blue Shield, and members paid 100% of the premiums.

1974— Aetna replaces the Blue Cross/Blue Shield Program. All health care participants receive coverage at no cost. The Board sets a $20,000 maximum lifetime coverage per covered person for hospital and medical coverage. Coordination of benefits ensures that total claim payment does not exceed total cost when an individual is covered by more than one health care plan.

1975— The Board increases the maximum lifetime coverage amount to $250,000. SERS offers Kaiser HMO to benefit recipients and dependents in Northeast Ohio.

1977— SERS begins reimbursing benefit recipients for the cost of Medicare Part B premiums.

1980— Aetna implements an on-site hospital billing audit program; Aetna staff audits all hospital bills over $15,000 and bills with ancillary charges greater than 70% of the total bill.

1981— The Board increases the Aetna maximum lifetime coverage amount to $500,000.

SERS introduces its first mail-order prescription drug program through National Rx Services, Inc. A 90-day supply of prescription drugs is available for a $1 co-payment.

Aetna implements individual case management to provide cost-effective alternative treatments.

The Aetna Split Funded Agreement replaces the traditional indemnity-type program, which permits detailed analysis of health care expenses and better control of claim processing costs. As a result, reserves previously held by Aetna now remain with SERS, and SERS establishes the Health Care Reserve account to receive these funds. Separate accounting insures no commingling of health care coverage funds with pension benefit funds.

1982— SERS becomes the first Ohio retirement system to publicly disclose long-term actuarial accrued liabilities of retiree health care. The actuary determines the employer contribution rate required for health care funding; SERS' staff initiates annual transfer of assets (based on this actuarially-determined rate) to the Health Care Reserve.

1983— The Board approves premium charges for spouse and dependent coverage, and establishes the annual program deductible.

1984— SERS organizes a Special Health Care Task Force. Representatives from member and employer organizations, the Retirement Study Commission, health care providers, actuaries, and accountants meet to study SERS' increasing health care costs.

1986— Effective June 13, 1986, Ohio law requires a minimum of 10 years of service to qualify for health care coverage. Previously, five years was required.

1987— SERS introduces the Kaiser Plus and United Health Plan HMOs.

Although not required by law, SERS chooses to disclose health care liabilities as part of the Pension Benefit Obligation to draw attention to the long-term nature of health care funding issues. This is accomplished by SERS' early adoption of Governmental Accounting Standards Board Statement No. 5.

1987— SERS introduces H.B. 290. Health care provisions in legislation and Board action include:

a) establish "career" vesting of health care coverage — 25 years of service required for full coverage subsidy. Coverage subsidy established at 25% (10-14 years), 50% (15-19 years), and 75% (20-24 years)

b) 40% reduction of System's subsidy of dependent health care premiums, to be phased-in over five years

c) freeze Medicare Part B reimbursement at current level

d) establish 80/20% relationship between System costs and retiree costs for mail-order drug program

e) establish an employer surcharge – an additional employer contribution – on members who earn less than an actuarially-determined minimum salary; the surcharge revenues to be used exclusively for funding health care coverage.

1988— In June of 1988, H.B. 290 becomes law.

1990— SERS implements changes to the mail-order drug program to encourage use of lower-cost generic drugs; retiree cost of brand name drugs is increased 25%, while making generic drugs available at no cost. The projected one-year savings of modification is $1 million or 6-7% of total mail-order program costs. SERS implements a retail drug program, creating significant discounts for drugs dispensed at the retail level and electronic filing of retirees' prescription drug claims.

1993— SERS adopts a new Administrative Services Only Contract agreement with Aetna, signifying what is the beginning of managed care for SERS' participants who are not eligible for Medicare. Networks are available to those who reside in the greater Cincinnati, Cleveland, and Columbus areas.

1996— The managed-care program expands and becomes available for the entire state.

2000— SERS offers Medical Mutual of Ohio as an additional choice to its HMO and Aetna PPO offerings.

2001— SERS offers a retiree-pay-all based dental plan that is administered by Delta Dental.

2004— The Board makes several changes to the SERS Health Care Plan, affecting deductibles, drug and office co-payments, and out-of-pocket maximums. SERS establishes 15% of the Plan cost as the minimum threshold a benefit recipient will pay for health care premiums. The PPO product is extended outside of Ohio for non-Medicare retirees. SERS' Medicare Coordination of Benefits methodology is changed from Government Exclusion to Maintenance of Benefits. The Board approves switching dental coverage from Delta Dental to Aetna Dental, with a two-year lock-in premium guarantee.

SERS introduces the Premium Contribution Discount Program, granting a monthly premium discount to health care participants who have a qualifying household income equal to or less than a set percentage of the federal poverty level.

2006— The Board approves the selection of LifeMasters as SERS' disease management program vendor and passes a resolution authorizing funding of a three-year contract. The program initially covers five chronic disease states: congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease, and asthma for non-Medicare SERS health plan participants.

SERS introduces the Quit-Line program to provide telephone smoking cessation counseling services and nicotine replacement therapy patches to benefit recipients. The cost of the program is shared 50/50% between SERS and the Ohio Tobacco Use Prevention and Control Foundation.

SERS receives its first Medicare Part D Retiree Drug Subsidy payment.

In late 2006, the Board approves the formation of the Health Care Preservation Task Force, assembling staff, Board members, constituents, advocacy groups, consultants, and actuaries to address the issue of long-term health care fund solvency.

2007— Several activities, all focusing on improving solvency, take place in 2007. SERS joins with Ohio Public Employees Retirement System and State Teachers Retirement System of Ohio as a founding partner in the Rx Ohio Collaborative, and is subsequently joined by The Ohio State University and the Ohio Highway Patrol Retirement System in that effort. The three founders select Express Scripts, Inc., as their pharmacy benefit manager and work toward a 2008 implementation.

The Health Care Preservation Task Force continues its work to improve the health care fund solvency.

The SERS Board approves changes to the premium subsidies available to service retirees, survivor benefit recipients, disability retirees, and spouses/dependents who are eligible for health care benefits. Although most spousal and dependent premiums increase in January 2008, premiums for retirees with Medicare decrease.

Effective in 2008, SERS selected two Medicare Advantage plans as replacements for the self-insured Medicare supplement plan currently offered. These plans provide competitive rates for retirees, improved wellness benefits, and are fully insured products.

2008— The Health Care Preservation Task Force presents its recommendations to the SERS Board. Some key components of the recommendations include increased population health management and better use of health care data as a means to control costs. Staff and the Board work in collaboration to adopt the task force recommendations.

2009— SERS issues a Request for Proposal (RFP) seeking a wellness vendor, and enters into a contract with Health Fitness to provide comprehensive wellness and health management services to under 65 Non-Medicare retirees and their adult dependents. The program includes Health Risk Assessments, member outreach in the form of wellness fairs around the state, and individual wellness coaching. A second RFP is completed, which focuses on identifying medical plan administrators. As a result, SERS elects to consolidate its two under-65 plans into one for 2010 as a means of keeping retiree premiums lower.

2010— A program to provide coverage for an over-the-counter drug is launched in an effort to reduce prescription drug spending. Following an actuarial report in which it is learned that health care funding availability will be significantly reduced by 2011, staff proposes plan design and subsidy changes to preserve the balance in the health care fund. The Health Care Preservation Task Force reconvenes to provide its input on the proposed changes.

2011— SERS extends health care coverage for adult children of health care participants up to age 26 as required by the Patient Protection Act of 2010.

SERS is approved by the Department of Health and Human Services to participate in the Early Retirement Reimbursement Program.

2012— SERS maintains premiums at 2011 levels and lowers the co-pay for insulin to encourage appropriate use.

2013— SERS expands the eligibility for a health care premium subsidy to include members who have 20 years or more of service but who are not eligible for their school employer's health care coverage upon separation of service or retirement. Members with employer health care coverage for at least three of the last five years of service are eligible for a premium subsidy if they meet the requirements.

Due to pension reform, the eligibility requirements for the Medicare Part B reimbursement from SERS change. Members retiring after Jan. 7, 2013, must be enrolled in SERS' health care coverage in order to receive the reimbursement.

Group long-term care insurance (LTC) is no longer available to new enrollees. Those currently enrolled may keep their coverage. SERS seeks new carrier but is unable to find a replacement due to the collapse of the group long-term care insurance market.

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