DIVISION 80

OPERATIONS

111-080-0001

Payment Methods and Dates

(1) For the purpose of this rule:

(a) "ACH credit" means a payment initiated by **an Entity** ~~a Participating District~~ that is cleared through the Automated Clearing House (ACH) network for deposit to the OEBB account;

(b) "ACH debit" means a payment initiated by OEBB and cleared through the ACH network to debit ~~a Participating District's~~ **an Entity's** account and credit the OEBB account;

~~(c) "District Payment" means the monthly district payment to OEBB that includes the contributions of both Participating District and members required to pay the monthly premiums for selected OEBB benefit plans;~~

~~(d) "District Payment Invoice" means a monthly itemized statement provided by OEBB that includes the contributions of both Participating District and members required to pay the monthly premiums for selected OEBB benefit plans;~~

(**c**~~e~~) "Due date" means the seventh business day into the current month of coverage;

(**d**~~f~~) "Electronic funds transfer" refers to a payment through ACH credit or ACH debit;

(e) "Entity Payment" means the monthly entity payment to OEBB that includes the contributions of both the Entity and members required to pay the monthly premiums for selected OEBB benefit plans;

(f) "Entity Payment Invoice" means a monthly itemized statement provided by OEBB that includes the contributions of both the entity and members required to pay the monthly premiums for selected OEBB benefit plans;

~~(g) "Participating District " means a Subject District, Provisional Non-subject District and Non-subject District participating in OEBB.~~

(2) ~~Participating Districts~~ **Entities** will receive a final ~~District~~ **Entity** Payment Invoice from OEBB on the first of the month that details the payments due for that month.

(3) If the final ~~District~~ **Entity** Payment Invoice is received on a weekend or legal holiday the receipt date is recognized as the next business day.

(4) ~~Participating Districts~~ **Entities** are required to submit payment to OEBB through electronic funds transfer no later than the due date.

(5) OEBB reserves the right to issue surcharges or other appropriate measures to ~~Participating Districts~~ **Entities** that submit monthly payments after the due date.

(6) ~~Participating Districts~~ **Entities** will select an electronic funds transfer method by:

(a) Submitting an electronic funds transfer authorization form to OEBB by August 15th for payments starting October 1st of the plan year;

(b) Submitting a new electronic funds transfer authorization form to OEBB by August 15th to change the type of payment or update their account information starting October 1st of the plan year.

111-080-0005

Overpayments and Underpayments

(1) For the purpose of this rule:

(a) "Overpayment" means the amount of a ~~Participating District's~~ **Entity's** monthly payment to OEBB that exceeded the amount due.

(b) "Underpayment" means a payment submitted by ~~a Participating District~~ **an Entity** that is less than the invoiced amount.

(2) ~~Participating Districts~~ **Entities** seeking a refund of overpayments must:

(a) Notify OEBB within 90 calendar days from the date overpayment occurred;

(b) OEBB will resolve member overpayments by requesting a refund from the carrier in accordance with the law. The carrier shall refund the premium to OEBB back to the date of the termination or the date allowed by law for recoupment of paid claims.

(c) OEBB will generally reimburse ~~Participating District~~ **Entity** overpayments through adjustments to future monthly payments.

(3) The ~~Participating District~~ **Entity** shall submit any underpayment to OEBB as soon as it is discovered.

(4) OEBB reserves the right to issue surcharges or use other appropriate means for ~~Participating District's~~ **Entities** that submit underpayments.

111-080-0030

Appeals and Administrative Reviews

(1) Eligibility, enrollment issues or rescissions. OEBB has an Appeal process consisting of three levels that a member can use if they disagree with an eligibility determination or enrollment record. If the appeal is a result of a rescission, or a determination that the benefit is not a covered benefit, coverage will continue pending the outcome of the appeal. These three levels are:

(A) Appeal. An Appeal is the first level and must be received by OEBB in writing. **OEBB staff will respond to all appeals within 30 days of receipt.** OEBB staff gathers all information and sets up the Appeal file. OEBB Staff reviews the Appeal and makes a decision. The member is then notified in writing of the OEBB staff's decision. If the decision is an adverse benefit determination, the notice will include the specific reason(s) for the decision, a reference to the specific plan provision or OAR on which the determination was based a description of any additional information required and a description of the OEBB appeals process.

(B) Request for Reconsideration. A Request for Reconsideration is the second level and can be used if the member is not satisfied with the outcome on their Appeal. The request by the member must be received in writing within 31 days of receiving the Appeal decision notification. OEBB staff requests any additional information needed and includes in the Appeal file. The OEBB Management Team reviews all the information contained in the file (from the Appeal and the Request for Reconsideration) and makes a decision. The member is then notified in writing of the OEBB Management Team's decision. If the decision is an adverse benefit determination, the notice will include the specific reason(s) for the decision, a reference to the specific plan provision or OAR on which the determination was based, a description of any additional information required and a description of the OEBB appeals process.

(C) Administrative Review Request. An Administrative Review Request is the third level and can be used if the member is not satisfied with the outcome on their Request for Reconsideration. The request by the member must be in writing OEBB staff requests any additional information and adds it to the Appeal file. OEBB staff will schedule an Administrative Review Committee meeting. OEBB staff will notify the member and all applicable parties of the date, time and location. At the meeting, the Administrative Review Request will be presented to the Administrative Review Committee members and after considering all documentation and possible public comment, a decision is made. The Administrative Review Committee has the authority to grant exceptions to OEBB's Administrative Rules when there are extenuating circumstances which can be supported by documentation and verified by OEBB staff. All such documentation will be included in the member's Appeal file. The member will be notified in writing of the Administrative Review Committee's decision. If the decision is an adverse benefit determination, the notice will include the specific reason(s) for the decision, a reference to the specific plan provision or OAR on which the determination was based a description of any additional information required and a description of the OEBB appeals process.

(2) Benefit and claim issues. Following the Insurance Carrier's appeals process, a member can request an administrative review by OEBB. An Administrative Review Request can be made to OEBB if the member is not satisfied with the outcome after completing the carrier's appeal process. OEBB staff gathers all information and sets up the file. The OEBB Contracts Officer will complete an initial review of the file to ensure it is limited to a determination of whether or not a service or benefit was intended to be covered under the current contract. The initial review will assess whether there is documentation contained within the contract or member handbook relating to the benefit that was denied. If the Administrative Review request does not meet the specified criteria the Contracts Officer will refer it to the OEBB Management Team and the member will be notified in writing of the OEBB Management Team's decision. If the request does meet the specified criteria, OEBB staff will schedule an Administrative Review Committee meeting. OEBB staff will notify the member and all applicable parties of the date, time and location. At the meeting, the Administrative Review Request will be presented to the Administrative Review Committee. They will consider all documentation and public comment and make a decision in accordance with the information presented. The member will be notified in writing of the Administrative Review Committee's decision. If the decision is an adverse benefit determination, the notice will include the specific reason(s) for the decision, a reference to the specific plan provision or OAR on which the determination was based a description of any additional information required and a description of the OEBB appeals process.

111-080-0040

Eligibility and Policy Term Violations — Definitions

For the purposes of OAR 111-080-0045 and 111-080-0050, the following definitions will apply:

(1) "Eligibility or Enrollment Violations" means and includes a violation of **OEBB's** ~~the Oregon Educators Benefit Board's~~ eligibility or enrollment rules or policies including fraud or material misrepresentation. Misstatements, misrepresentations, omissions or concealments on the part of the OEBB member are not fraudulent unless they are made with intent to knowingly defraud. OEBB has primary responsibly in investigating such violations. If an Eligibility Violation is considered a violation of the insurance carrier's

policy, then the violation may also be considered a Policy Term Violation, and OAR 111-080-0050 would also apply.

(A) “Intentional Violation” is a violation that has occurred in which OEBB has electronic or written documentation that the eligible employee took action resulting in a non-eligible member being enrolled in OEBB benefits.

(B) “Unintentional Violation” is a violation that has occurred in which the eligible employee was not aware that such violation had occurred and there is no evidence of the eligible employee completing a paper form or logging in and enrolling an ineligible member in OEBB benefits.

(2) “Policy Term Violations” means and includes a violation of the insurance carrier’s policy terms. The insurance carrier has primary responsibility in investigating such violations.

111-080-0055

Eligibility Verifications and Reviews

(1) OEBB shall plan and conduct eligibility verifications and reviews to monitor compliance with OEBB administrative rules. Reviews shall include, but are not be limited to the following:

(a) Dependent eligibility;

(b) Employee eligibility;

(c) Election change limitations; and

(c) Plan enrollment limitations.

(2)(a) Employee eligibility, election change and plan enrollment reviews may occur on a random basis throughout the year, or if anomalies in data warrant a formal review.

(b) The Eligible Employee and ~~educational~~ Entity are responsible to submit documentation upon request.

(3) Dependent eligibility verifications shall be completed at least once every **five** ~~three~~ years per ~~participating~~ ~~educational~~ Entity.

~~(a) OEBB shall develop a review plan that will include an onsite verification of dependent eligibility documentation for benefit-eligible employees of each participating educational entity once every three years.~~

(**a**~~b~~) ~~Educational~~ Entities may have a formal dependent eligibility verification and review completed by a third party vendor on or after October 1, 2013. The use of a third party vendor for a dependent eligibility verification and review may meet the once every **five** ~~three~~ years requirement provided the vendor meets the standards and criteria set in the OEBB verification and review plan and agrees to report all findings ~~to OEBB~~ via a secure electronic file. All requests to substitute a third party vendor for this purpose must be pre-approved by OEBB.

(**b**~~c~~) The ~~member~~ **eligible employee, eligible early retiree or COBRA participant** is responsible to submit documentation upon request. In the event the ~~member~~ ~~does not provide the~~ required documentation **is not provided** to sufficiently prove the dependent meets eligibility requirements, or the documentation provided is insufficient, the dependent’s coverage will be terminated. Retroactive

terminations may occur if the documentation provided shows the dependent was not eligible for coverage and the member misrepresented the dependent as being an eligible dependent as defined by OAR 111-080-0045.

(4) If an eligible employee does not complete the dependent eligibility review and moves to a different entity under OEBB, their terminated dependent records will be locked in the MyOEBB benefit management system. The active eligible employee must submit documentation to OEBB to be verified before the dependent records are unlocked.

111-080-0055

Dependent Eligibility Verifications and Review Appeals

(1) Following the termination of dependents due to a dependent eligibility verification review, eligible employees, eligible early retirees, or COBRA participants may file an appeal and submit requested documentation within 60 days from the date coverage ended. If approved, coverage will be reinstated retroactively with no lapse in coverage.

(2) For eligible employees, if the appeal and submitted requested documentation is received by OEBB after 60 days from the date the coverage ended, and dependents are verified, OEBB will unlock the dependent records in the MyOEBB benefit management system. Coverage can be added back following and consistent with a Qualified Status Change (QSC) during the current plan year, or during the next open enrollment period. Adding a dependent to dental or vision coverage at open enrollment will result in the 12 month waiting period being applied where only preventive and routine services will be covered for the first 12 months of coverage.

(3) For eligible early retirees, if the appeal and submitted documentation is received by OEBB after 60 days from the date the coverage ended, and dependents are verified, OEBB will unlock the dependent records in the MyOEBB benefit management system. Coverage can be added back following and consistent with a Qualified Status Change (QSC) during the current plan year, or during the next open enrollment to the plans that they were previously enrolled in.