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ARCHIVES DIVISION
MARY BETH HERKERT
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

TEMPORARY ADMINISTRATIVE ORDER

INCLUDING STATEMENT OF NEED & JUSTIFICATION

OEBB 1-2018

CHAPTER 111
OREGON HEALTH AUTHORITY
OREGON EDUCATORS BENEFIT BOARD

FILED
09/24/2018 11:27 AM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amendments clarify current OEBB processes and address changes related to the new benefit plan year

EFFECTIVE DATE: 09/25/2018 THROUGH 03/23/2019

AGENCY APPROVED DATE: 09/04/2018

CONTACT: April Kelly
503-378-6588
april.kelly@state.or.us

500 Summer Street NE
Salem,OR 97301

Filed By:
April Kelly
Rules Coordinator

NEED FOR THE RULE(S):

The rule amendments are needed to keep OARs updated and current with OEBB and it's contracted carrier's policies and processes.

JUSTIFICATION OF TEMPORARY FILING:

The amendments to these rules need to be in effect with the start of the OEBB plan year, October 1st. The decisions on the rule changes were not made until late August, and approved by the OEBB Board on September 4. By filing temporary, this will allow OEBB staff time to go through the permanent rule making process. A permanent rule will be filed to replace this temporary rule prior to the temporary expiration date.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

ORS 243.860 to 243.886, 2007 Oregon laws available online or by request of the OEBB staff.
OEBB Board Public Meeting minutes from September 4, 2018 are available online at https://www.oregon.gov/oha/OEBB/Pages/OEBB-Board-Meetings.aspx

RULES:
111-010-0015, 111-030-0010, 111-030-0046, 111-040-0001, 111-040-0020, 111-040-0025, 111-040-0040, 111-070-0005

AMEND: 111-010-0015

RULE SUMMARY: Removing the Health Savings Account (HSA) requirement from the Moda Health Evergreen medical plan.

CHANGES TO RULE:

111-010-0015

Definitions ¶

Unless the context indicates otherwise, as used in OEBB administrative rules, the following definitions will apply:¶
(1) "Actuarial value" means the expected financial value for the average member of a particular benefit plan.¶
(2) "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on but not limited to:¶
(a) A determination of a member's eligibility to participate in the plan;¶
(b) A determination that the benefit is not a covered benefit; or¶
(c) A rescission of coverage, whether or not, in connection with rescission, there is an adverse effect on any particular benefit.¶
(3) "Affidavit of Domestic Partnership" means a document that attests the eligible employee and one other eligible individual meet the criteria in section (15)(b).¶
(4) "Benefit plan" includes, but is not limited to, insurance or other benefits including:¶
(a) Medical (including non-integrated health reimbursement arrangements (HRAs));¶
(b) Dental;¶
(c) Vision;¶
(d) Life, disability and accidental death;¶
(e) Long term care;¶
(f) Employee Assistance Program Plans;¶
(g) Supplemental medical, dental and vision coverages (including Integrated General Purpose and Integrated Post-Deductible health reimbursement arrangements (HRAs); and Limited Purpose, Post-Separation/Retiree, and Premium Only health reimbursement arrangements (HRAs));¶
(h) Any other remedial care recognized by state law, and related services and supplies;¶
(i) Comparable benefits for employees who rely on spiritual means of healing; and¶
(j) Self-insurance programs managed by the Board.¶
(5) "Benefits" means goods and services provided under Benefit Plans.¶
(6) "Board" means the ten-member board established in the Department of Administrative Services as the Oregon Educators Benefit Board under chapter 00007, Oregon Laws 2007.¶
(7) "Child" means and includes the following:¶
(a) An eligible employee's, spouse's, or domestic partner's biological son or daughter; adopted child; child placed for adoption; or legally placed child, who is 25 or younger on the first day of the month. An eligible employee must provide the required custody or legal documents to their Educational Entity showing proof of adoption, legal guardianship or other court order if enrolling a child for whom the employee, spouse, or domestic partner is not the biological parent. Grandchildren are only eligible when the eligible employee is the legal guardian or adoptive parent of the grandchild.¶
(b) A person who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. There is no age limit for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. When the dependent child is 26 years of age or older all the following requirements must be met:¶
(A) The disability must have existed before attaining age 26.¶
(B) The employee must provide evidence to the Entity or OEBB that (1) the person had health plan coverage, group or individual, prior to attaining age 26, and (2) health plan coverage continued without a gap until the OEBB health plan effective date.¶
(C) The person's attending physician must submit documentation of the disability to the eligible employee's OEBB health insurance plan for review and approval. If the person receives health plan approval, the health plan may review the person's health status at any time to determine continued OEBB coverage eligibility.¶
(D) The person must not have terminated from OEBB health plan coverage after attaining the age of 26.¶
(c) Eligibility for coverage under this rule includes people who may not be dependents under federal or state tax

law and may require an Entity to adjust an eligible employee's income based on the imputed value of the benefit.¶
(8) "Comparable cost (Medical, Dental and Vision)" means that the total cost to a district for enrollment in OEBB plans comparable in design to the district's plan(s) do not exceed the total cost to a district for enrollment in the district's plan(s) using the rate(s) in effect or proposed for the benefit plan year.¶
(9) "Comparable cost (Basic and Optional Life Insurance, Accidental Death & Dismemberment, and Short and Long Term Disability)" means that the premium rates of an OEBB plan design option do not exceed the average, aggregate premium rates of a district's pre-OEBB plan design in effect the year prior to implementation.¶
(10) "Comparable plan design (Medical, Dental and Vision)" means that the actuarial values of two plan designs are within 2.5 percent higher or lower of each other.¶
(11) "Comparable plan design (Basic and Optional Life Insurance and Accidental Death & Dismemberment)" means that 90 percent of district employees can obtain a maximum benefit through an OEBB plan design that is within $2,500 of the maximum benefit obtained through a pre-OEBB plan design in effect the year prior to implementation.¶
(12) "Comparable plan design (Short and Long Term Disability)" means 90 percent of the district employees can obtain the same elimination period, percentage of covered compensation, definition of covered compensation, coverage period duration, and maximum payment per benefit period through an OEBB plan design as through a pre-OEBB plan design in effect the year prior to implementation.¶
(13) "Dependent" means and includes the eligible employee's spouse or domestic partner, or child as defined by OAR 111-010-0010(7), unless otherwise defined in another OEBB rule.¶
(14) "Documented entity policies" means Entities' policies and practices that apply to an employee group and are submitted to the Oregon Educators Benefit Board during the plan selection process. Entities' policies and practices must be identified and submitted with the applicable employee group plan selections.¶
(15) "Eligible Domestic partner," unless otherwise defined by a collective bargaining agreement or documented district policy in effect on January 31, 2008, means and includes the following:¶
(a) An unmarried individual of the same sex who has entered into a "Declaration of Domestic Partnership" with the eligible employee that is recognized under Oregon law; or¶
(b) An unmarried individual of the same or opposite sex who has entered into a partnership that meets the following criteria:¶
(A) Both are at least 18 years of age;¶
(B) Are responsible for each other's welfare and are each other's sole domestic partners;¶
(C) Are not married to anyone and have not had a spouse or another domestic partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;¶
(D) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;¶
(E) Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date the Affidavit of Domestic Partnership is signed and submitted to the Entity; and¶
(F) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.¶
(G) The eligible employee and domestic partner must jointly complete and submit to the Entity an Affidavit of Domestic Partnership form, within five business days of the electronic enrollment date or the date the Entity received the enrollment/change form. If the affidavit is not received, coverage will terminate for the domestic partner retroactive to the effective date.¶
(c) The eligible employee must notify the Entity within 31 days of meeting all criteria as defined in 111-010-0015 (15)(b) or obtaining the "Declaration of Domestic Partnership" which is recognized under Oregon law.¶
(d) Entities' must calculate and apply applicable imputed value tax for domestic partners covered under OEBB benefit plans.¶
(16) "Educational Entity" means public school districts (K-12), education service districts (ESDs), community colleges and public charter schools participating in OEBB.¶
(17) "Eligible employee" means and includes an employee of an Educational Entity or Local Government who is

actively working or on paid or unpaid leave that is recognized by federal or state law, and:¶
(a) Is employed in a half time or greater position or is in a job-sharing position; or¶
(b) Meets the definition of an eligible employee under a separate OEBB rule or under a collective bargaining agreement or documented district policy in effect on January 31, 2008; or¶
(c) Is an employee of a community college who is covered under a collectively bargained contract and has worked a class load of between 25 percent and 49 percent for a minimum period of two years and is expected to continue to work a class load of at least 25 percent. Coverage is limited to medical to include Kaiser Medical Plan 2, Kaiser Medical Plan 3 (where available), Moda Health Cedar Plan, Moda Health Dogwood Plan, or Moda Health Evergreen Plan. ~~Moda Health Evergreen Plan can only be elected if the eligible employee is eligible for and actively contributing to a Health Savings Account (HSA).~~ The tiered rate structure will apply to all medical plans.¶
(18) "Eligible Early Retiree" means and includes a previously eligible employee who is:¶
(a) Not Medicare-eligible; or¶
(b) Under 65 years old; and¶
(A) Receiving a service or disability retirement allowance or pension under the Public Employees Retirement System (PERS) or under any other retirement or disability benefit plan or system offered by an OEBB participating organization for its employees;¶
(B) Eligible to receive a service retirement allowance under PERS and has reached earliest retirement age under ORS Chapter 238;¶
(C) Eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or¶
(D) Eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by an OEBB participating organization and has reached earliest retirement age under the plan or system.¶
(19) "Employee Group" means employees and early retirees of a similar employment type, for example administrative, represented classified, non-represented classified, confidential, represented licensed, or non-represented licensed, within an Entity. If one or more collective bargaining unit exists within an employee group, each unit will be considered a separate employee group.¶
(20) "Entity" means an Educational Entity, Local Government or Special district.¶
(21) "Flexible benefit plan" includes plans that allow contributions on a tax-favored basis including health savings accounts.¶
(22) "Health Reimbursement Arrangement (HRA)" means an account established and funded solely by the employer that can be used to pay for qualified health care expenses for eligible employees and their spouses and federal tax dependents, up to a maximum dollar amount for a coverage period, and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods. This definition should be interpreted to comply with the guidelines established by the IRS for treatment of HRAs on a tax-favored basis in Technical Release No. 2013-03, IRS Publication 969 and IRS Notice 2002-45. HRA includes, but is not limited to, the following:¶
(a) "Integrated General Purpose HRA" is an HRA that allows participants to be reimbursed for all IRS qualified expenses and is available only to eligible employees who are enrolled in an OEBB medical plan as the primary subscriber, or as an eligible dependent.¶
(b) "Integrated Post-Deductible HRA" is an HRA that allows participants to be reimbursed for expenses up to a certain amount, but only after the participants have met the annual deductible on an OEBB medical plan in which the employee participant is enrolled as the primary subscriber, or as an eligible dependent.¶
(c) "Limited Purpose HRA" is an HRA that allows participants to be reimbursed for only standard dental, vision, and orthodontia expenses and does not require the employee participant to be enrolled in an OEBB medical plan as the primary subscriber, or as a dependent.¶
(d) "Non-integrated HRA" is an HRA that allows participants to be reimbursed for all IRS qualified expenses when the employee participant is not enrolled in an OEBB medical plan as the primary subscriber, or as an eligible dependent.¶
(e) "Post-Separation/Retiree HRA" is an HRA that allows participants to be reimbursed for qualified expenses only

after the employee separates/retires and does not require the employee participant to be enrolled in an OEBB medical plan as the primary subscriber, or as a dependent.¶
(f) "Premium Only HRA" is an HRA that allows participants to be reimbursed only for insurance premiums paid on an after tax basis, where the employee participant has no ability to pay the premium on a pre-tax basis and the HRA does not require the employee participant to be enrolled in an OEBB medical plan as the primary subscriber, or as a dependent.¶
(23) "Health Savings Account (HSA)" means a tax-exempt trust or custodial account that is set up with a qualified HSA trustee to pay or reimburse certain incurred medical expenses, as defined in 26 U.S.C. Sec. 223(d) and IRS Publication 969.¶
(24) "High Deductible Health Plan (HDHP)" means a health plan that meets the criteria for a "high deductible health plan" as outlined in 26 U.S.C. Sec. 223(c)(2). Enrollment in an HDHP is one of the requirements that must be met in order to qualify to contribute to a health savings account (HSA).¶
(25) "Local Government" means cities, counties and special districts in Oregon.¶
(26) "Members" means and includes the following:¶
(a) "Eligible employee" as defined by OAR 111-010-0015(17).¶
(b) "Child" as defined by OAR 111-010-0015(7).¶
(c) "Domestic Partner" as defined by OAR 111-010-0015(15).¶
(d) "Spouse" as defined by OAR 111-010-0015(34).¶
(27) Newly-hired and newly-eligible employee means a benefit-eligible employee who is being hired at an Entity and has not been employed or eligible for benefits through the hiring Entity in the past six months, or within the same benefit Plan Year.¶
(28) "Non-subject District" means a community college not yet participating in benefit plans provided by the Oregon Educators Benefit Board, or a charter school whose employees are not considered employees of a school district.¶
(29) "Oregon Educators Benefit Board or OEBB" means the program created under chapter 00007, Oregon Laws 2007.¶
(30) "OEBB participating organization" means a Subject District, Non-subject District, or Provisional Non-subject District that participates in benefit plans provided by the Oregon Educators Benefit Board (OEBB).¶
(31) "Provisional Non-subject District" means a common school district, a union high school district, or an education service district that:¶
(a) Was self-insured on December 31, 2006;¶
(b) Had an independent health insurance trust established and functioning on December 31, 2006; or¶
(c) Can provide comparable plan designs at a comparable cost as defined by sections (8) and (10) of this Rule.¶
(32) "Qualified Status Change (QSC)" means a change in family or work status that allows limited mid-year changes to benefit plans consistent with the individual event. Outside of open enrollment, a QSC is the only time a change in enrollments can occur.¶
(33) "Special district" means any district listed in ORS chapter 198 "Special Districts Generally," or as determined by the Board.¶
(34) "Spouse" means a person who is married under the laws of the State of Oregon or under the laws of any other state or country. The definition of spouse does not include a former spouse and a former spouse does not qualify as a dependent.¶
(35) "Subject District" means a common school district, a union high school district, or an education service district that:¶
(a) Did not self-insure on January 1, 2007;¶
(b) Did not have a health trust in effect on January 1, 2007; or¶
(c) Does not provide comparable plan designs at a comparable cost as defined by sections (8) and (10) of this rule.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: ORS 243.864(1)(a)

AMEND: 111-030-0010

RULE SUMMARY: These amendments remove the requirement previously in place where the Health Savings Account (HSA) was required to enroll in Moda Health Evergreen medical plan. Additionally, the amendments specify which plans are compatible with certain types of accounts.

CHANGES TO RULE:

111-030-0010
Medical, Pharmaceutical, Dental and Vision Plan Selection Criteria ¶

Entities may choose or allow all medical, dental and vision plans available in the service area to be available to some or all Entity Employee Groups with the following exceptions:¶
(1) The HMO vision plan offered through Kaiser Permanente is only available if the HMO medical plan offered through Kaiser Permanente is available.¶
(2) Moda Health Evergreen Medical Plan ~~ean onld~~ Moda Health Fir Medical Plan may be offered ~~to employee groups who have the option to participate in a Health Savings Account (HSA) effective October 1, 2016. (Previously Moda Health Plan H) Eligible employees must qualify and contribute to an HSA during the plan year to enroll in Moda Health Evergreen Plan~~as a stand-alone medical plan, or may be paired with a Health Savings Account (HSA). These plans are incompatible with any type of Health Reimbursement Arragement (HRA).¶
(3) Kaiser Permanente Medical Plan 3 may be offered as a stand-alone medical plan, or may be paired with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).
Statutory/Other Authority: ORS 243.860-243.886
Statutes/Other Implemented: ORS 243.864(1)(a))

AMEND: 111-030-0046

RULE SUMMARY: These amendments add Moda Health Fir Medical plan to the list of HSA compatible plans in this section.

CHANGES TO RULE:

111-030-0046
Development of Health Savings Accounts (HSA) ¶

(1) Effective October 1, 2011, OEBB will offer the use of an employer sponsored vendor for Health Savings Accounts (HSA). For purposes of this rule, an HSA vendor will be considered employer sponsored if the Entity offers:¶
(A) Employer contributions to the HSA; or¶
(B) Pre-tax or direct deposit of employee contributions to the HSA.¶
(2) If an Entity chooses to offer an employer sponsored HSA, the Entity may offer this plan through the OEBB-contracted HSA.¶
(3) Entities may select or allow the HSA option to be available to eligible employees who enroll in OEBB's high-deductible health plan (HDHP) option (currently Moda Health Evergreen Medical Plan, Moda Health Fir Medical Plan and Kaiser Permanente Medical Plan 3).¶
(4) Eligible employees who are eligible to enroll in an HSA, and choose the employer sponsored HSA vendor, may do so directly through the HSA vendor or their Entity.¶
(5) Eligible employees must meet requirements established by the Internal Revenue Service (IRS) to qualify for enrollment in an HSA. Once enrolled in an HSA, members are responsible to adhere to tax requirements of the IRS.¶
(6) Because IRS requirements for an individual to qualify for enrollment in an HSA include concurrent enrollment in a high-deductible health plan (HDHP), an Entity that offers an employer sponsored HSA must offer its employees the choice of a HDHP option, currently Moda Health Evergreen Medical Plan, Moda Health Fir Medical Plan and Kaiser Permanente Plan 3, from among OEBB's medical plans. If an employee is enrolled in an OEBB medical plan other than OEBB's HDHP, the employee may not enroll in the OEBB HSA.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: ORS 243.8~~7~~64(~~5~~1)(a)

AMEND: 111-040-0001

RULE SUMMARY: The amendment to this rule is to clarify OEBB's current process regarding approval letters and the effective date of approved coverage.

CHANGES TO RULE:

111-040-0001
Effective Dates ¶

(1) Effective Dates for Newly Eligible Employees. Initial benefit elections, unless otherwise specified in a collective bargaining agreement or documented Entity policy in effect on June 30, 2008, are effective on the later of:¶
(a) The first of the month following a completed online enrollment in the OEBB benefit management system or submission of a paper enrollment or change form, or¶
(b)(A) The first of the month following the date of hire or the date of eligibility; with the following exception:¶
(B) The first of the month following approval of Evidence of Insurability for Optional Life Insurance above the guarantee issue amount, Long Term Disability, or Long Term Care insurance. The approval letters sent to the member are not official until entered into OEBB's benefit management system.¶
(2) Effective Dates for Qualified Status Changes. Covered dependent changes are effective the first of the month following the date of the event causing the dependent to be eligible under OEBB administrative rules with the following exceptions:¶
(a) Coverage for a newborn child is effective on the date of birth. The active eligible employee must add the newborn child to their benefit plans within 60 calendar days from the date of birth in order for the newborn child to be eligible for benefit coverage. If the newborn is born between the first and the fifteenth of the month, the eligible employee is billed for any applicable premium beginning the first month in which the baby is born. If the newborn is born between the sixteenth of the month and the end of the month, the eligible employee is billed for any applicable premium beginning the first of the following month. With a newborn, the baby begins incurring their own expenses from their date of birth and since premiums are not pro-rated, this balances premiums.¶
(b) Coverage for a newly adopted child is effective the date of the adoption decree or date of placement for adoption. The eligible employee must add the adopted child to their benefit plans within 60 calendar days from the date of the decree or placement in order for the newly adopted child to be eligible for benefit coverage; and¶
(A) The eligible employee must submit the adoption agreement with the enrollment forms to the Entity.¶
(B) Claims payments will not be made for expenses incurred prior to the date of decree or placement.¶
(c) Coverage for an eligible grandchild is as follows:¶
(A) If the legal guardianship is finalized within the first 60 days following the birth of the grandchild, coverage will be effective retroactive to the date of the birth.¶
(B) If the legal guardianship is finalized 61 or more days from the date of birth of the grandchild, the coverage will be effective the first of the month following the date the guardianship documents are finalized.¶
(C) If the legal guardianship is finalized 61 to 180 days from the date of birth of the grandchild, and the effective date of legal guardianship is retroactive to the grandchild's date of birth, coverage will be effective retroactive to the date of birth. If legal guardianship is finalized after 180 days coverage will be effective the first of the month following the date the guardianship documents are finalized.¶
(d) The first of the month following approval of Evidence of Insurability for Optional Spouse/Domestic Partner Life insurance above the guaranteed issue amount, if applicable, or Long Term Care Insurance.¶
(3) Elections made during an open enrollment period are effective on the first day of the new plan year. There will be a 12-month waiting period for services other than preventive dental exams and cleanings for coverage added during the open enrollment period if enrolling in a dental plan in which the employee and/or dependents were previously eligible.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: ORS 243.864(1)(a)

AMEND: 111-040-0020

RULE SUMMARY: The amendments to this rule clarify OEBB's current process on the time frame for which the Evidence of Insurability must be submitted to OEBB's contracted life insurance company, should a member request additional life insurance during open enrollment. In addition, there is one small housekeeping amendment. Effective October 1, 2017, OEBB removed the 12 month waiting period from vision coverage. This was missed in this section of our rules when they were previously amended.

CHANGES TO RULE:

111-040-0020
Open Enrollment ¶

(1) Eligible employees may make benefit plan changes or elections and add or remove eligible dependents during open enrollment periods as designated by OEBB.¶
(2) Coverage under OEBB-sponsored benefits plans for an eligible individual added during open enrollment begins on the first day of the new plan year. Dental ~~and vision~~ coverage added during the open enrollment period will be limited to preventive dental exams and cleanings ~~and routine vision exams~~ for the first 12 months of coverage, if the eligible individual and/or their eligible dependents were eligible for the coverage directly prior to the beginning of the new plan year. Coverage for an individual terminated during open enrollment ends on the last day of the month of the current plan year.¶
(3) Benefit plan elections are irrevocable for the new plan year except as specified in OAR 111-040-0040.¶
(4) If optional life insurance is requested beyond the guarantee issued amount, Evidence of Insurability must be submitted to the OEBB life insurance carrier(s) by December 31.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: ORS 243.864(1)(a)

AMEND: 111-040-0025

RULE SUMMARY: The amendments to this rule clarify OEBB's current policy and process when the approval for optional coverage is not entered into OEBB's benefit management system. In addition, OEBB allows for an open enrollment correction period and the amendment clarifies this in rule.

CHANGES TO RULE:

111-040-0025
Correcting Enrollment and Processing Errors ¶

(1) Employee Enrollment Errors. Enrollment errors occur when an Eligible Employee provides incorrect information or fails to make correct selections when making benefit plan elections. The Eligible Employee is responsible for identifying enrollment errors or omissions.¶
(a) OEBB authorizes Entities to correct enrollment errors reported by the Eligible Employee within 45 calendar days of the original eligibility date, open enrollment period end date, or Qualified Status Change date.¶
(b) Enrollment errors identified after 45 calendar days of the eligibility date, open enrollment period end date or Qualified Status Change date must be submitted to OEBB for review and approval based on OAR 111-080-0030.¶
(c) If an Eligible Employee receives an approval notice for additional optional coverage, and discovers it was not updated in OEBB's benefit management system, the member may:¶
(A) Pay all premiums owed retroactive to the original effective date, or¶
(B) Re-apply for the additional optional coverage during the next Open Enrollment period, or following and consistent with a Qualified Status Change. Evidence of Insurability may be required.¶
(2) Benefit Administrator Processing Errors. Processing errors or omissions occur when benefit plan elections are processed incorrectly in the benefit system or when a newly eligible employee does not receive correct enrollment information.¶
(a) OEBB authorizes Entities to correct processing errors identified within 45 calendar days of the eligibility date, open enrollment period end date, or Qualified Status Change date. The Entity must reconcile all premium discrepancies.¶
(b) Processing errors identified after 45 calendar days of the eligibility date, open enrollment period end date, or Qualified Status Change date must be submitted to OEBB for review and approval based on OAR 111-080-0030. The ~~Educational~~ Entity must reconcile all premium discrepancies within 30 calendar days of any adjustments made in the system.¶
(3) The effective date for the correction of either an employee enrollment error or benefit administrator error is retroactive to the original effective date as identified in OAR 111-040-0001.¶
(4) The OEBB Administrator 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.¶
(5) Eligible Employees have a right to an Open Enrollment correction period through the last calendar day in October of the same plan year the error was made.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: ORS 243.864(1)(a)

AMEND: 111-040-0040

RULE SUMMARY: The amendments to this rule clarify OEBB's current process on the time frame for which the Evidence of Insurability must be submitted to OEBB's contracted life insurance company, should a member request additional life insurance following and consistent with a Qualified Status Change (QSC).

CHANGES TO RULE:

111-040-0040
Qualified Status Changes (QSCs) ¶

(1) An Eligible Employee experiencing a change in family or work status as noted below after an annual open enrollment, or anytime during the plan year, has 31 calendar days beginning on the date of the event to make allowable changes. If the event is gaining a child, as defined by 111-040-0040(4)(c), or results in a loss of eligibility, the Eligible Employee has 60 calendar days after the event to make allowable changes.¶
(2) An Eligible Employee can only make changes that are consistent with the event for them self and/or dependents.¶
(3) An Eligible Employee must report the Qualified Status Change (QSC) to the employee's Entity within the specified timeframe. Failure to report a QSC that will result in removal of a spouse, domestic partner, or child within the timeframe stated in 111-040-0040(1) may be considered intentional misrepresentation, and OEBB may rescind the individual's coverage back to the last day of the month in which the individual lost eligibility. Please refer to the QSC matrix for details on what changes can occur with each event.¶
(4) Qualified Status Changes which allow an employee to make changes to his or her coverage are:¶
(a) Gaining a spouse by marriage or domestic partner by meeting domestic partner eligibility;¶
(b) Loss of spouse or domestic partner by divorce, annulment, death or termination of domestic partnership,¶
(c) Gaining a child by birth, placement for/or adoption, or Domestic Partner's children (by affidavit of domestic partnership),¶
(d) Change in employee group which affects plan option availability;¶
(e) Spouse, domestic partner or child starts new employment or other change in employment status which affects eligibility for benefits;¶
(f) Spouse, domestic partner's or child's employment ends or other change in employment status resulting in a loss of eligibility for benefits under their employer's plan;¶
(g) Event by which a child satisfies eligibility requirements under OEBB plans;¶
(h) Event by which a child ceases to satisfy eligibility requirements under OEBB plans;¶
(i) Changes in the residence of the active eligible employee, spouse, domestic partner, or child (i.e., moving out of the service area of an HMO or limited network service area plan);¶
(j) Significant changes in cost of the Eligible Employee's or Early Retiree's current plan and tier level that result in a negative or positive impact of 10 percent or more to:¶
(A) The amount an Eligible Employee or Early Retiree must contribute toward benefits.¶
(B) The amount a spouse or domestic partner must contribute toward his or her group health insurance plan cost.¶
(k) Different Open Enrollment/Plan Year under a spouse/domestic partner's employer plan.¶
(l) Related laws or court orders. For example: Qualified Medical Child Support Order (QMSCO), Entitlement to Medicare or Medicaid, HIPAA, or Children's Health Insurance Program (CHIP) Changes are determined by the applicable law or court order.¶
(5) Changes in coverage, or contribution amounts that result in a reduced amount that an employee or eligible dependent must contribute toward benefits, do not constitute a Qualified Status Change.¶
(6) The following applies to the Long Term Care benefit plans only:¶
(a) Cancel the plan at any time without a QSC event.¶
(b) Plan additions or changes require a QSC event as defined 111-040-0040(2). The addition of a plan or change in plans with a QSC is subject to a medical evidence review by the LTC carrier.¶

(7) If optional life insurance is requested beyond the guarantee issued amount, Evidence of Insurability must be submitted to the OEBB life insurance carrier(s) within 90 calendar days of the QSC event.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: ORS 243.864(1)(a)

AMEND: 111-070-0005

RULE SUMMARY: Removing the Health Savings Account (HSA) requirement from the Moda Health Evergreen medical plan and other housekeeping amendments.

CHANGES TO RULE:

111-070-0005
Plan Selections ¶

(1) HB 2557 eligible members will use the tiered rate structure and may elect to enroll in the following medical plans:¶
(a) Kaiser Permanente Medical Plan 3 (limited to OEBB members in the Kaiser service area),¶
(b) Moda Health Cedar Medical Plan,¶
(c) Moda Health Dogwood Medical Plan,¶
(d) Moda Health Evergreen ~~Plan (limited to members who qualify for and contribute to a Health Savings Account (HSA))~~Medical Plan.¶
(2) If enrolling in a Moda Health medical plan, the HB 2557 eligible member may elect to enroll in the PPO option or the Synergy or Summit network plan option if the HB 2557 member lives or works in an area where the Synergy or Summit network is available.
Statutory/Other Authority: ORS 243.860 - 243.886
Statutes/Other Implemented: 243.864(1)(a)