

DIVISION 40
ENROLLMENT

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 OEBC 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.

(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 OEBC 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.

(b) Coverage for a newly adopted child is effective the date of the adoption decree or date of placement for adoption. The active 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 active 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 and/or routine vision exams for coverage added during the open enrollment period if enrolling in a dental or vision plan in which the employee and/or dependents were previously eligible.

111-040-0005

Termination Dates

(1) Effective October 1, 2011, if an active eligible employee requests a termination of coverage for them self, a spouse, a domestic partner, or a child, coverage ends on the last day of the month that eligibility is lost. Requests for coverage termination must be made consistent with a Qualified Status Change as defined by 111-040-0040.

(2) Retroactive termination of coverage may be made in the event of a delay in the Entities' reconciliation process and shall generally be within 14 days of receiving notification from the employee of the Qualified Status Change event and requested benefit changes.

(3) Effective October 1, 2011, benefit coverage termination that is considered by OEGB to be intentional misrepresentation may be rescinded in compliance with the law. If this occurs, OEGB shall give the affected individual 30 days' notice of the rescission of benefit coverage and an opportunity to appeal before the rescission takes effect.

(4) Benefit coverage for active eligible employees ends on the last day of the month that they retire, unless otherwise determined in a collective bargaining agreement or documented Entity policy in effect on June 30, 2008. Benefit coverage may be continued based on the requirements and limitations in OARs 111-050-0001 through 111-050-0050.

111-040-0010

Newly-hired and Newly-eligible Employees

(1) Newly-hired and newly-eligible employees must enroll in OEGB-sponsored benefit plans through the OEGB benefit management system or paper equivalent within 31 calendar days of the date of hire or date of gaining eligibility, unless determined otherwise in a separate OEGB administrative rule or in a collective bargaining agreement or documented Entity policy in effect on June 30, 2008.

(2) An employee enrolling in OEGB-sponsored benefit plans and terminating employment before the effective date of benefit coverage is not eligible to receive benefits.

111-040-0011

Returning to Benefit Eligible Status

(1) A former Eligible Employee returning to benefit-eligible status with the same Entity following an unpaid leave of absence, or termination of employment, or returning from a strike, lock-out, layoff, within six months of the date eligibility was lost will have their benefit plans and coverages reinstated.

(a) All coverages and plans previously enrolled in will be effective the first of the month following the date eligibility is regained, unless otherwise stipulated in a collective bargaining agreement or documented Entity policy in effect on or before May 1, 2013.

(b) The 12-month late enrollment waiting period for dental and/or vision coverage will only apply if it was in effect at the time coverage was initially lost.

(c) Plan changes or changes to covered dependents may only be made if:

(A) A Qualified Status Change occurred during the period of ineligibility, consistent with OAR 111-040-0040, and requested within 31 days of returning to benefit-eligible status, or

(B) Benefits are being reinstated in a new plan year from which benefits were initially lost.

(2) If reinstatement occurs within the same plan year, medical, dental and vision coverage will be reinstated at the same level as was in effect immediately prior to the loss of eligibility. (i.e., dental incentive levels, amounts applied toward deductibles, annual maximum out-of-pockets and benefit maximums, and benefits beyond routine and basic dental and vision), if applicable.

(3) The Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA gives an employee and previously covered dependents the right to reinstate

coverage upon returning to employment with the Entity in a benefit eligible position with no waiting period.

111-040-0015

Removing an Ineligible Individual from Benefit Plans

(1) An active employee who enrolls them self and/or an eligible person is responsible for removing spouses, domestic partners and children from their OEGB-sponsored benefit plans by submitting completed, applicable forms to their Entity benefits administrator within 31 calendar days after the date the individual becomes ineligible. Coverage ends on the date identified under OAR 111-040-0005.

(2) An Entity is responsible for removing ineligible individuals from the OEGB benefits management system. The Entity must complete such removal within 14 calendar days after:

(a) An event resulting in loss of the employee's eligibility, or

(b) The receipt of notification of an event resulting in loss of eligibility of the employee's spouse, domestic partner or child.

(3) If coverage of an employee's spouse, domestic partner or child is terminated retroactively then:

(a) The employee may be responsible for claims previously paid by the benefit plans to the providers during the period of ineligibility at the carrier's discretion; and

(b) Premium adjustments will be made retroactively based on the coverage end date.

(4) OEGB shall conduct eligibility verifications and reviews to monitor compliance with OEGB administrative rules governing eligibility and enrollment. Eligibility reviews may occur at different times throughout the plan year. The member is responsible to submit documentation upon request. In the event the member does not provide the required documentation in a timely manner 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.

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 OEGB.

(2) Coverage under OEGB-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.

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) OEGB 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 OEGB for review and approval based on OAR 111-080-0030.

(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) OEGB 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 OEGB 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 OEBC Administrator has the authority to grant exceptions to OEBC's Administrative Rules when there are extenuating circumstances which can be supported by documentation and verified by OEBC staff.

111-040-0030

Late Enrollment

(1) Late enrollment occurs when an active eligible employee fails to notify their Entity of the Qualified Status Change within 31 calendar days, or unless otherwise specified in rule, of:

(a) The date of hire or other benefit eligibility date as identified in OAR 111-040-0001;

(b) The date a spouse, domestic partner, or child gains eligibility;

(c) The date of marriage to a spouse who was most recently enrolled as a domestic partner; or

(d) The date of birth of the employee's biological newborn child;

(e) The date the child was adopted or the date the employee became the legal guardian.

(2) OEBC authorizes Entities to add and/or enroll employees and dependents within 45 calendar days of the eligibility dates referenced in sections (1)(a), (1)(b), and (1)(c) and within 60 calendar days of the eligibility dates referenced in (1)(d) and (1)(e).

(3) OEBC must review and approve all late enrollment requests based on OAR 111-080-0030 when the request and enrollment is made more than 45 calendar days after the eligibility dates referenced in sections (1)(a), (1)(b), and (1)(c), and more than 60 calendar days after the eligibility dates referenced in sections (1)(d) and (1)(e).

(4) Approved late enrollment requests, unless determined otherwise in a collective bargaining agreement or documented district policy in effect on June 30, 2008, are effective the first of the month following the date the request is received by an Entity benefits administrator or OEBC, except for approved requests to add newborn children or newly adopted child which are retroactive to the month the child was born or adopted along with any premium adjustments.

111-040-0040

Qualified Status Changes (QSC's)

111-040-0040

Qualified Status Changes (QSC's)

(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 OEGB 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 OEGB plans;

(h) Event by which a child ceases to satisfy eligibility requirements under OEGB 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 impact of 10 percent or more to:

(A) The amount an active 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.

111-040-0050

Declination of Coverage

(1) As used in this section:

(a) "Opting out of coverage" means that an otherwise Eligible Employee elects not to enroll in a medical plan and is eligible to receive a portion of the cash contribution or other type of remuneration as provided for under a collective bargaining agreement, documented Entity policy, or employment contract.

(b) "Waiving benefits" means that an otherwise Eligible Employee elects not to enroll in any one of the benefit plans available under the OEBC-sponsored benefits program and is not eligible to receive any portion of a cash contribution or other type of remuneration.

(2) Unless otherwise specified in a collective bargaining agreement, documented Entity policy or employment contract in effect on July 1, 2008, an Eligible Employee may opt out of the OEGB-sponsored medical benefit plans. Eligible Employees electing to opt out must:

- (a) Maintain coverage under another employer-sponsored group medical benefit plan;
- (b) Meet the requirements of the Entity opt out program in which they are participating;
- (c) Submit their election to opt out through the OEGB benefit management system; and
- (d) If requested, provide proof of current coverage under another employer-sponsored group medical benefit plan.

(3) Eligible Employees electing to opt out of the OEGB-sponsored medical benefit plans may enroll in the dental benefit plans, vision benefit plans, and optional benefit plans.

(4) The level and type of funds and allowances retained by Eligible Employees and Entities as a result of opt out programs are determined through collective bargaining agreements and documented Entity policies.

(5) An Entity will provide OEGB with a written description of its opt out program upon request.

(6) An otherwise Eligible Employee may opt-out of medical if the criteria above are met, decline dental and/or vision, or elect any combination of benefits provided under the OEGB-sponsored benefits program, unless otherwise stated in a collective bargaining agreement or documented Entity policy.

(7) Elections to opt out of the medical benefit plans or waive benefits must be made at the time of hire, when initially meeting eligibility, during an open enrollment period, or following a QSC event whereby the OEGB QSC Matrix allows this as an option.

(a) Coverage for previously OEGB-eligible employees or a previously OEGB-eligible dependent enrolling in the dental and/or vision plans during an open enrollment period will be limited to routine and preventive care for the first 12 months and subject to a 12-month waiting period for orthodontia coverage.

(b) An Eligible Employee who enrolls in the dental or vision plans, or adds previously OEGB-eligible dependents to the dental and vision plans following and consistent with a QSC event will not be subject to waiting periods.

(8) An Eligible Employee electing to not enroll when initially eligible for optional insurance plans, or enrolling for more than the guarantee issue amount, will have to go through a medical review. Failure to remit a medical history statement or complete other

requirements will result in a declination of requested amounts, or the amount above the guaranteed amount, if applicable.

(9) An Eligible Employee electing to not enroll when initially eligible for optional short term disability will be subject to a late enrollment penalty upon enrollment.