**DIVISION 10**

**DEFINITIONS**

**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 ~~Educational~~ 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 ~~Educational~~ 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 ~~district~~ **entity** policies” means ~~Educational~~ Entities’ policies and practices that apply to an employee group and are submitted to the Oregon Educators Benefit Board during the plan selection process. ~~Educational~~ 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 Educational 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 ~~Educational~~ Entity an Affidavit of Domestic Partnership form, within five business days of the electronic enrollment date or the date the ~~Educational~~ 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 ~~Educational~~ 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) ~~Educational~~ 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 ~~E~~, Moda Health **Dogwood** Plan ~~G~~, or Moda Health **Evergreen** Plan ~~H~~. Moda Health **Evergreen** Plan ~~H~~ 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 ~~Educational~~ 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.

**DIVISION 30**

**PLAN DESIGN DEVELOPMENT AND SELECTION**

**111-030-0010**

**Medical, Pharmaceutical, Dental and Vision Plan Selection Criteria**

~~Educational~~ 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** Plan ~~H~~ can only be offered to employee groups who have the option to participate in a Health Savings Account (HSA) effective October 1, ~~2013~~ **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 ~~H~~.

**111-030-0035**

**Optional Benefit Plans Selection Criteria**

(1) Basic Life Insurance — ~~Educational~~ Entities may select or allow one Basic Life plan per Employee Group unless otherwise specified in an OEBB administrative rule. Note: Employee Groups may select one Basic Life amount and offer optional life. Basic Life requires 100 percent enrollment if selected.

(2) Basic Accidental Death and Dismemberment (AD&D) — ~~Educational~~ Entities may select or allow one Basic AD&D plan per Employee Group unless otherwise specified in an OEBB administrative rule. Note: Employee Groups can select one Basic AD&D plan and offer optional AD&D if desired. The Employee Group must select Basic Life coverage to select a Basic AD&D plan. Basic AD&D requires 100 percent enrollment if selected.

(3) Optional Employee Life Insurance and Optional Employee AD&D — ~~Educational~~ Entities may select or allow Optional Employee Life and Optional AD&D for each Employee Group unless otherwise specified in an OEBB administrative rule. No minimum enrollment requirement.

(4) Optional Spouse/Partner Life Insurance and Optional Spouse/Partner AD&D — ~~Educational~~ Entities may select or allow Optional Spouse/Partner Life and Optional Spouse/Partner AD&D coverage for each Employee Group unless otherwise specified in an OEBB administrative rule. No minimum enrollment requirement. The Employee Group must offer Optional Employee Life and Optional AD&D to offer this coverage. The Optional Employee Life Insurance and Optional Employee AD&D must be greater or equal to Optional Spouse/Partner Life Insurance and Optional Spouse/Partner AD&D.

(5) Optional Child Life Insurance and Optional Child AD&D — ~~Educational~~ Entities may select or allow Optional Child Life and Optional Child AD&D coverage for each Employee Group unless otherwise specified in an OEBB administrative rule. No minimum enrollment requirement. The Employee Group must offer Optional Employee Life and Optional AD&D to offer this coverage. Optional Child Life Insurance and Optional Child Life AD&D requires enrollment in the minimum amount of Optional Employee Life and Optional AD&D by the employee.

(6) Optional Early Retiree Life Insurance and Optional Early Retiree AD&D — ~~Educational~~ Entities may select or allow Optional Early Retiree Life and Optional Early Retiree AD&D coverage unless otherwise specified in an OEBB administrative rule. No minimum enrollment requirement, but enrollment is limited to initial open enrollment period only and subject to the following restrictions:

(a) Optional Early Retiree Life and Optional Early Retiree AD&D are only available to early retirees who had this coverage as an active employee.

(b) The ~~Educational~~ Entity must offer this coverage for the early retiree to continue enrollment.

(c) When an employee moves from active to retiree status they may select coverage up to the amount they had as an active employee, or decrease coverage. Increases in coverage are not allowed.

(7) Voluntary Short Term Disability (STD) — ~~Educational~~ Entities may select or allow one Voluntary STD plan per Employee Group unless otherwise specified in an OEBB administrative rule. No minimum enrollment requirement. The employee pays all or part of the premium. An Employee Group cannot select more than one STD Plan (Voluntary, Mandatory, or Mandatory/Employee-paid).

(8) Mandatory Short Term Disability (STD) — ~~Educational~~ Entities may select or allow one Mandatory STD plan per Employee Group unless otherwise specified in an OEBB administrative rule. This plan requires 100 percent enrollment if selected and the premium is employer-paid. An Employee Group cannot select more than one STD Plan (Voluntary, Mandatory, or Mandatory/Employee-paid).

(9) Mandatory/Employee-paid Short Term Disability (STD) — ~~Educational~~ Entities may select or allow one Mandatory/Employee-paid STD plan per Employee Group unless otherwise specified in an OEBB administrative rule. This plan requires 100 percent enrollment and the premium is paid by the employee. An Employee Group cannot select more than one STD Plan (Voluntary, Mandatory, or Mandatory/Employee-paid).

(10) Voluntary Long Term Disability (LTD) — ~~Educational~~ Entities may select or allow one Voluntary LTD plan per Employee Group unless otherwise specified in an OEBB administrative rule. No minimum enrollment requirement. The employee pays all or part of the premium. An Employee Group cannot select more than one LTD Plan (Voluntary, Mandatory, or Mandatory/Employee-paid).

(11) Mandatory Long Term Disability (LTD) — ~~Educational~~ Entities may select or allow one Mandatory LTD plan per Employee Group unless otherwise specified in an OEBB administrative rule. This plan requires 100 percent enrollment and the premium is employer-paid. An Employee Group cannot select more than one LTD Plan (Voluntary, Mandatory, or Mandatory/Employee-paid).

(12) Mandatory/Employee-paid Long Term Disability (LTD) — ~~Educational~~ Entities may select or allow one Mandatory/Employee-paid LTD plan per Employee Group unless otherwise specified in an OEBB administrative rule. This plan requires 100 percent enrollment and the premium is paid by the employee. An Employee Group cannot select more than one LTD Plan (Voluntary, Mandatory, or Mandatory/Employee-paid).

**111-030-0040**

**Long Term Care (LTC) Benefit Plan Selection Criteria**

~~Educational~~ Entities may select or allow LTC options to be available for or to each Employee Group unless otherwise specified in an OEBB administrative rule. OEBB offers employer-paid and employee-paid LTC options.

(1) Employee-paid LTC is a voluntary plan where members can choose to enroll. No minimum enrollment requirement.

(2) Employer-paid LTC requires 100 percent eligible employee enrollment if selected.

**111-030-0045**

**Employee Assistance Program (EAP) Plan Selection Criteria**

(1) ~~Educational~~ Entities may select or allow an EAP option to be available to all Entity employees including, but not limited to, OEBB benefit-eligible employees and their dependents.

(2) Enrollment will happen automatically if selected by an ~~Educational~~ Entity.

**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 ~~Educational~~ Entity offers:

(A) Employer contributions to the HSA; or

(B) Pre-tax or direct deposit of employee contributions to the HSA.

(2) If an ~~Educational~~ Entity chooses to offer an employer sponsored HSA, the ~~Educational~~ Entity may offer this plan through the OEBB-contracted HSA.

(3) ~~Educational~~ 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** Plan ~~H~~ **and Kaiser 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 ~~Educational~~ 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 ~~Educational~~ Entity that offers an employer sponsored HSA must offer its employees the choice of a HDHP option, **currently Moda Health Evergreen Plan and Kaiser Permanente Plan 3**, from among OEBB's medical plans ~~(i.e., prior to the 2013-14 plan year, ODS Health Plan 9; beginning with the 2013-14 plan year, Moda Health Plan H).~~ If an employee is enrolled in an OEBB medical plan other than OEBB's HDHP, the employee may not enroll in the OEBB HSA.

**111-030-0047**

**Development of Flexible Spending Accounts**

(1) Effective October 1, 2012, OEBB will offer the use of an employer sponsored vendor for Flexible Spending Accounts (FSAs) including a Health Care Flexible Spending Account, Limited Health Care Spending Account and Dependent Care Flexible Spending Account.

(2) If an ~~Educational~~ Entity chooses to offer an employer sponsored FSA, the ~~Educational~~ Entity may offer this plan through the OEBB-contracted FSA vendor.

(3) Eligible employees who are eligible to enroll in an FSA, and choose the employer sponsored FSA vendor, do so directly through their ~~Educational~~ Entity.

(4) Eligible employees must meet requirements established by the Internal Revenue Service (IRS) to qualify for enrollment in an FSA. Once enrolled in an FSA, members are responsible to adhere to tax requirements of the IRS.

**111-030-0050**

**Premium Rate Structure Selection Process and Limitations**

(1) Educational Entities ~~and Local Governments~~ may choose a composite or tiered rate structure for each Employee Group for medical, dental and vision coverage unless otherwise specified in an OEBB administrative rule. The rate structure selected for each coverage type applies to all individuals electing to participate as active employees within an Employee Group. **Local Governments are limited to using the tiered rate structure for medical, dental and vision plans.**

(2) Educational Entities ~~and Local Governments~~ may select a composite or tiered rate structure for early retirees unless otherwise specified in an OEBB administrative rule. **Local Governments are limited to using the tiered rate structure for medical, dental and vision plans.**

(3) Educational Entities ~~and Local Governments~~ may select a composite or tiered rate structure for part-time employees of an Employee Group unless otherwise specified in an OEBB administrative rule. If a different rate structure is selected for part-time employees that structure must apply to all participating part-time employees within that Employee Group. **Local Governments are limited to using the tiered rate structure for medical, dental and vision plans.**

(4) Rate structures must be selected during the plan selection process.

(5) Once an Educational Entity ~~or Local Government~~ elects a change in rate structure for a type of coverage within an Employee Group, the rate structure selection cannot be changed for at least three plan years. The rate structure change will go into effect on the first day of the next plan year, October 1.

(6) Educational Entities or Local Governments who offered LTD on a composite rate structure prior to moving to OEBB coverages can continue to do so. Use of the composite rate structure for LTD plans is only available on a mandatory LTD plan and requires 100 percent enrollment.

(a) Employee Groups using a composite rate structure for mandatory LTD plans effective October 1, 2012, may continue to use either the employer-paid or employee-paid option.

(b) Effective October 1, 2013, OEBB will expand the availability of the composite rate structure for mandatory LTD plans only to those Employee Groups that chose to elect an employer-paid plan option.

(c) Rate structures must be selected during the plan selection period and become effective the first day of the next plan year, October 1.

Stat. Auth: ORS 243.860 to 243.886
Stats. Implemented: ORS 243.864(1)(a)

**DIVISION 70**

**HB 2557**

**111-070-0001**

**Definitions**

For the purpose of this rule:

(1) “HB 2557 eligible member” means a part time faculty who is eligible for membership in the Public Employees Retirement System (PERS) by teaching or conducting research at a single institution of higher education or in aggregate at multiple public institutions of higher education during the prior year. “HB 2557 eligible member” does not mean or include a part time faculty member who has revoked PERS membership by opting to enroll in another employer retirement plan, or a part time faculty member who is eligible for benefits through the Public Employees’ Benefit Board (PEBB).

(2) “Eligible Dependent” means a Spouse, Domestic Partner or dependent child as defined in OAR 111-010-0015.

(3) “Overpayment” means the amount of a participating HB 2557 eligible member’s monthly payment to OEBB that exceeded the amount due.

(4) “PERS” means the Oregon Public Employees Retirement System.

(5) “Plan Year” means the coverage period, usually 12 months long that is used for administration of a health benefits plan.

(6) “Public institution of higher education” means an Oregon community college or a state institution of higher education listed in ORS 352.002.

(7) “Underpayment” means a payment submitted by a participating HB 2557 eligible member that is less than the invoiced amount.

~~(8) "Electronic funds transfer" refers to a payment through an Automated Clearing House (ACH) credit or ACH debit that initiates the movement of funds from an HB 2557 eligible member’s individual banking account to the OEBB Treasury account electronically.~~

**(8) “ACH Debit” for purposes of this OAR refers to a payment through an Automated Clearing House (ACH) credit or debit that initiates the movement of funds electronically from the HB 2557 eligible member’s individual banking account within the United States to the OEBB Treasury account.**

**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 Plan 3 (limited to OEBB members in the Kaiser service area),

(b) Moda Health **Cedar** Plan ~~E~~,

(c) Moda Health **Dogwood** Plan ~~G~~,

(d) Moda Health **Evergreen** Plan ~~H~~ (limited to members who qualify for and contribute to a Health Savings Account (HSA)).

(2) If enrolling in a Moda Health medical plan, the HB 2557 eligible member may elect to enroll in the ~~Statewide~~ **PPO** option ~~(ODS Plus Network)~~ 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.

**111-070-0015**

**Enrollment**

(1) OEBB will directly provide HB 2557 eligible members notice of their eligibility, the open enrollment schedule and instructions for completing the required enrollment information prior to the beginning of the open enrollment period.

(2) HB 2557 eligible members and eligible dependents may enroll in a medical plan as specified in 111-070-0005 when one of the following occurs:

(a) During the annual open enrollment period (August 15 through September 25);

(A) Required enrollment information may be submitted by the member to the OEBB office prior to the beginning of the open enrollment period;

(B) All required enrollment information must be received **by OEBB** from the member ~~by OEBB~~ by close of business on September 25;

(C) Required enrollment information not received from the member on or before the end of the open enrollment period will be considered a declination of coverage for the Plan Year;

(D) Coverage selected will be effective at the beginning of the new Plan Year (October 1) for HB 2557 eligible member and dependent(s) who have submitted the required enrollment information by the submission deadline; or

(b) Following confirmation that an individual not initially identified as eligible for benefits is eligible for benefits:

(A) All required enrollment information must be received from the member by OEBB by close of business on the date specified in the written eligibility notice sent to the HB 2557 eligible member. Failure to meet the due date will be considered a declination of coverage for the Plan Year;

(B) Coverage selected will be effective the first day of the month following eligibility confirmation and receipt of the required enrollment information.

**111-070-0020**

**Effective Date**

(1) HB 2557 eligible members who are eligible for membership in PERS during a calendar year are eligible for medical benefits through **OEBB** ~~the Oregon Educators Benefit Board~~ for the following Plan Year.

(2) Eligibility will be determined annually within 30 days after the first quarter of the current calendar year.

**111-070-0040**

**Qualified Status Changes (QSC's)**

(1) HB 2557 eligible members experiencing a change in family status the plan year, have 31 calendar days beginning on the date of the event to make changes. If the event is gaining a child, as defined by 111-070-0040(2)(c), or results in a loss of eligibility, the eligible member has 60 calendar days after the event to make changes.

(a) The member must report the Qualified Status Change (QSC) to **OEBB** ~~the Oregon Educators Benefit Board~~ within the specified timeframe. Failure to report a QSC that would result in a removal of a spouse, domestic partner or child within the timeframe stated in 111-070-0040(1) may be considered intentional misrepresentation by OEBB and OEBB may retroactively terminate the individuals coverage back to the last day of the month in which the individual lost eligibility. If benefits are to be terminated retroactively, OEBB shall give the affected individual 30 days' notice of the termination and an opportunity to appeal before the retroactive termination takes effect.

(b) The member's failure to report timely a QSC that allows the addition of a spouse, domestic partner, or child means that the individual does not have coverage. The next opportunity the HB 2557 eligible member has to add their spouse, domestic partner, or child will be during open enrollment.

(2) The HB 2557 eligible member can only make those changes that are consistent with the event for themselves and eligible dependent(s).

(3) Qualified Status Changes which allow the member 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 a 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), 60 days from the event;

(d) Event by which dependent child satisfies eligibility requirements under OEBB plans;

(e) Event by which dependent ceases to satisfy eligibility requirements under OEBB plans;

(f) 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.

(4) Changes in cost or coverage do not constitute a Qualified Status Change. All changes resulting from a change in cost or coverage must be made during Open Enrollment.

**111-070-0050**

**Premium Payment**

(1) **HB 2557 Eligible Member Payment Methods and Due Dates**:

(a) HB 2557 eligible members will submit payment to OEBB for benefits **through Direct Payment via ACH (ACH Debit).** ~~by electronic funds transfer (EFT).~~

(b) OEBB may grant an exception from the requirement in section (1) to pay by **ACH Debit** ~~EFT~~ if the HB 2557 eligible member demonstrates their financial institution cannot accommodate an **ACH** ~~EFT~~ transfer, or the member does not maintain an account at a financial institution.

(c) Notwithstanding section (2), the **ACH Debit** ~~electronic transfer of funds~~ will occur on the 25th day of the month prior to the next month's health care coverage. All payments will be subject to this due date.

(2) If the HB 2557 member has a checking account, but submits a written letter declining to use the **ACH Debit** ~~electronic funds transfer~~ payment method, a $35.00 processing fee shall be applied to the HB 2557 member's monthly premium.

(3) HB 2557 Eligible Member Invoicing:

(a) OEBB will enroll a new HB 2557 eligible member after one of the following is completed:

(A) The required ACH **Debit Authorization Form** ~~payment agreement for electronic transfer of funds~~ is received from the member, processed and set-up with their financial institution; or

(B) The Exception Request Form is received from the member, reviewed and approved;

(b) OEBB will mail payment reminders to HB 2557 eligible members to provide notification of the amount and date the ~~automatic checking deduction~~ **ACH Debit** will occur.

(c)(A) If the payment is not received in full by the 25th calendar day of the month, the member's coverage will be terminated on the last day of the month in which a full premium payment was received. All premium payments must be paid in full before payment to the carrier will be made.

(B) OEBB shall not be responsible for any unpaid portion of premiums for coverage and will terminate the HB 2557 eligible member and dependent coverage for non-payment or underpayment of premiums due.

(4) HB 2557 Eligible Member Overpayments:

(a) OEBB will mail notification of overpayments to the HB 2557 eligible member. This written notice shall inform the member of the amount overpaid and a description of the overpayment.

(b)(A) OEBB will automatically apply any overpayments to the next month's premium due. The member may complete a Request for Reimbursement form if a refund of an overpayment is desired. However, the member may be responsible for processing fees associated with refunds less than $100.

(B) Remaining balances on coverage that has ended will be refunded in full.

(5) HB 2557 Eligible Member Underpayments:

(a) Premiums that are not paid in full by the 25th calendar day of the month prior to the coverage effective month will result in the eligible member's and dependent's coverage being terminated at the end of the last month for which premiums were paid in full.

(b)(A) HB 2557 eligible members will be notified if their coverage was terminated due to the premium not being paid in full, including payments returned by the bank for Non-Sufficient Funds (NSF), **closed bank accounts, and frozen accounts.**

(B) A check or ACH transaction that is returned for NSF**, closed bank account, or frozen account** is considered non-payment of premiums.

(c) Coverage terminated due to non-payment or underpayment cannot be reinstated until a following Plan Year in which a person is deemed a HB 2557 eligible member.

Stat. Auth: ORS 243.860 to 243.886
Stats. Implemented: ORS 243.864(1)(a)

## DIVISION 2

## POWERS OF THE BOARD

**111-002-0005**

**Powers and Duties of the Board**

(1) Pursuant to ORS 243.864, it will be within the powers and duties of the Board to study all matters connected with providing adequate benefit plan coverage for Eligible Employees, **Eligible** Early Retirees and their Dependents, with concern for the welfare of the Employees, **Eligible** Early Retirees and their Dependents and affordability for the ~~Educational~~ Entities.

(2) The ~~b~~ **B**oard will design benefit plans, devise specifications, invite proposals, analyze responses to requests for proposals, and decide on the award of contracts for benefit plan coverage of Eligible Employees, **Eligible** Early Retirees and their Dependents.

(3) The Board will work collaboratively with ~~Educational~~ Entities, members, carriers and providers to offer value-added benefit plans that support improvement in members' health status, hold carriers and providers accountable for outcomes, and provide affordable benefits and services. The board will place emphasis on:

(a) Employee choice among high-quality benefit plans;

(b) A competitive marketplace;

(c) Benefit plan performance and information;

(d) ~~Educational~~ Entity flexibility in benefit plan design and contracting;

(e) Quality customer services;

(f) Creativity and innovation;

(g) Benefit plans as part of total employee compensation;

(h) Improvement of employee health;

(i) An innovative delivery system;

(j) A focus on improving quality and outcomes;

(k) Promotion of health and wellness;

(l) Appropriate provider, health plan, and consumer incentives;

(m) Accessible and understandable information about costs, outcomes, and other health data; and

(n) Benefits that are affordable to the ~~Educational~~ Entities and Employees, **Eligible** Early Retirees and their Dependents.

(4) The Board may retain consultants, brokers, or other advisory personnel as it determines necessary and will employ such personnel as are required to perform the functions of the Board.

(5) The Board may delegate authority to the Administrator and Staff to complete duties described in (2)–(4) above.

**111-002-0010**

**Conduct of Meetings of the Board**

(1) The ~~b~~**B**oard will select one of its appointed voting members as chair and another voting member as vice chair.

(2) The chair will conduct and control meetings of the ~~b~~**B**oard. The vice chair will preside over meetings in the absence of the chair. A majority vote of the ~~b~~**B**oard will designate the member to preside over meetings in the absence of the chair and the vice chair.

(3) All meetings of the ~~b~~**B**oard will be conducted according to Oregon Public Meetings Law, ORS 192.610 to 192.690.

(4) A person must not smoke any cigar or cigarette, or use tobacco in any form in meetings of the ~~b~~**B**oard.

# 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 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.

(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 baby is added to the plan the first of the 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 baby is added to the plan 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 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.

**111-040-0015**

**Removing an Ineligible Individual from Benefit Plans**

(1) An ~~active~~ **eligible** employee who enrolls them self and/or an eligible person is responsible for removing spouses, domestic partners and children from their OEBB-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 OEBB 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) OEBB shall conduct eligibility verifications and reviews to monitor compliance with OEBB 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.

**111-040-0025**

**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.

(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.

**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 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 OEBB-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 OEBB-sponsored medical benefit plans. Eligible Employees electing to opt out must:

~~(a) Maintain coverage under another employer-sponsored group medical benefit plan;~~

**(a) Maintain minimum essential medical coverage for themselves and all other individuals for whom the employee can reasonably expect to claim a personal tax exemption deduction for. The medical coverage must be another employer-sponsored group medical benefit plan. The employee must attest to the coverage at initial enrollment and annually thereafter, or**

**(b) Be enrolled in Medicare or TRICARE coverage and be employed by an Entity that administers their benefits program in compliance with the requirements of Section 125 of the Federal Internal Revenue Code (IRC);**

(**c**~~b~~) Meet the requirements of the Entity opt out program in which they are participating;

(**d**~~c~~) Submit their election to opt out through the OEBB benefit management system; and

(**e**~~d~~) If requested, provide proof of current coverage under another employer-sponsored group medical benefit plan.

**(3) An Eligible Employee participating with or enrolled in coverage bought on the individual market, the Oregon Health Plan/Medicaid, Veterans' Administration Health Benefit Program, Student Health Insurance market may not elect to opt out of OEBB-sponsored medical benefit plans. The Eligible Employee may elect to waive benefits or enroll in an OEBB-sponsored medical benefit plan.**

(~~3~~**4**) Eligible Employees electing to opt out of the OEBB-sponsored medical benefit plans may enroll in the dental benefit plans, vision benefit plans, and optional benefit plans.

(~~4~~**5**) 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~~**6**) An Entity will provide OEBB with a written description of its opt-out program upon request.

(~~6~~**7**) 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 OEBB-sponsored benefits program, unless otherwise stated in a collective bargaining agreement or documented Entity policy.

(~~7~~**8**) 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 OEBB QSC Matrix allows this as an option.

(a) Coverage for previously OEBB-eligible employees or a previously OEBB-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 OEBB- eligible dependents to the dental and vision plans following and consistent with a QSC event will not be subject to waiting periods.

(~~8~~**9**) 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~~**10**) 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.

**DIVISION 50**

**CONTINUATION OF COVERAGE**

**111-050-0010**

**Eligibility for Retiree Insurance Coverage**

(1) Active eligible employees and their enrolled eligible dependents not yet eligible for Medicare may continue coverage in OEBB medical, dental, vision, life and accidental death and dismemberment plan options upon retirement, provided the plans are offered to Eligible Early Retirees through the ~~Educational~~ Entity or OEBB. Insurance coverage under the OEBB or non-OEBB entity active employee benefit plans, as an employee or as a dependent of an employee, and retiree benefit plans must be continuous.

(2) Active eligible employees and/or their enrolled eligible dependents that are eligible for Medicare, and therefore not eligible to continue on the OEBB medical or vision plan options, may continue coverage on OEBB dental, life, and accidental death and dismemberment plan options upon retirement, provided the plans are offered to retirees through the ~~Educational~~ Entity or OEBB.

(3) An 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.

(4) An Eligible Early Retiree may continue medical, dental, vision, optional life and accidental death and dismemberment coverage for themselves only or may continue to cover any eligible dependents who were enrolled in the employee's active plan immediately prior to the retirement as long as the coverage and plan options are included in the plans offered by the ~~Educational~~ Entity.

(5) Basic life and basic accidental death and dismemberment requires 100 percent mandatory enrollment unless otherwise specified in a collective bargaining agreement in effect on or before September 30, 2009, and the ~~Educational~~ Entity can provide documentation that supports the administration of this benefit.

(6) A former Eligible Employee who elects COBRA and is also eligible for early retiree benefits or later becomes eligible as an Eligible Early Retiree will have the right to transfer the COBRA medical, dental, and vision insurance coverage to the OEBB early retiree benefit plans at any time during COBRA or

within 30 days of the COBRA end date. Insurance coverage under the OEBB active, COBRA and early retiree benefit plans must be continuous.

**111-050-0015**

**Medical, Dental and Vision Termination Dates for Early Retirees**

(1) An Eligible Early ~~r~~**R**etiree enrolled in OEBB early retiree insurance plan that becomes eligible for Medicare coverage may not continue on an OEBB medical or vision plan, unless they are eligible as a result of end-stage renal disease. OEBB benefits end the last day of the month prior to the Medicare effective date. The retiree is responsible for reporting to their ~~Educational~~ Entity and to OEBB when the retiree is covered by Medicare within 31 days after the Medicare coverage effective date. Failure to report within this timeframe may be considered intentional misrepresentation by OEBB and OEBB may rescind OEBB coverage back to the last day of the month prior to the Medicare effective date.

(2) If an Eligible Early ~~r~~**R**etiree becomes eligible for Medicare coverage, but his or her currently-enrolled eligible dependents are not, these eligible individuals may continue OEBB medical, dental and vision insurance coverage until such time as they no longer meet OEBB eligibility requirements or become eligible for Medicare coverage for reasons other than end-stage renal disease, whichever occurs first. The eligible individuals must confirm intent to continue coverage with the retiree plan administrator within 31days after the retiree's eligibility for Medicare.

(3) Eligible dependents who were covered on a plan at the time of retirement who are eligible for Medicare, or who become eligible for Medicare, may not continue coverage on an OEBB medical or vision plan unless it is stated in a collective bargaining agreement or documented ~~district~~ **entity** policy in effect on or before February 1, 2010, that they may continue on OEBB medical plans until the retiree becomes eligible for Medicare with the following exception: OEBB coverage must end for Medicare-eligible dependents of a retiree enrolled on a Kaiser Permanente medical plan.

(4) If the Eligible Early ~~r~~**R**etiree is responsible for self-paying all or partial premiums and fails to remit the premium amount to their ~~Educational~~ Entity, all coverage will terminate on the last day of the month in which premiums are paid in full to OEBB.

(5) Dental coverage may be continued subject to the ~~Educational~~ Entity's documented ~~district~~ **entity** policy or collective bargaining agreement. Coverage is based on the OEBB dental plans that the ~~Educational~~ Entity offers to retired OEBB Medicare-eligible individuals.

**111-050-0016**

**Life and Accidental Death and Dismemberment Termination Dates for Early Retirees**

(1) Eligible Early Retirees may continue to participate in any or all coverage and plan options selected by the ~~Educational~~ Entity for his or her Employee Group until they reach age 65, unless otherwise specified in a documented ~~district~~ **entity** policy or collective bargaining agreement effective on or before February 1, 2010.

(2) Eligible Early Retirees or dependents of retirees who lose eligibility for basic or optional life insurance plans due to reaching age 65 can convert their coverage if requested within 31 days of the date the coverage ends. Requests for conversion of coverage must be made to the Life and AD&D insurance carrier.

**111-050-0020**

**Initial Enrollment**

(1) An Eligible Early Retiree has 60 calendar days from the end date of active eligible employee insurance coverage to:

(a) Continue enrollment in OEBB-sponsored medical, dental, vision, basic life, basic accidental death and dismemberment, optional life and optional accidental death and dismemberment plans with the same eligible dependents which were included on your coverage as an active employee; provided they are offered by the ~~Educational~~ Entity.

(b) Disenroll eligible dependents covered during active enrollment. Dependents cannot be re-enrolled once they are dropped from coverage, **unless a Qualified Status Change event has occurred and is reported.**

(c) Disenroll in any or all plans. Once a retiree drops **any type of** coverage the retiree cannot re-enroll **in the coverage that was dropped**.

(d) Change medical plan to a less expensive medical plan if the Eligible Early Retiree is no longer receiving a monetary contribution.

(2) All **retiree** ~~coverage~~ and dependent **coverage** ~~enrollments~~ must be continuous from the date the active coverage ends.

(3) Coverage not ~~elected~~ **continued** at the time of initial eligibility for early retiree benefits cannot be added at a later date.

(4) An Eligible Early Retiree may choose to continue enrollment in an OEBB-sponsored medical plan, dental plan, **vision plan**, basic life, basic accidental death and dismemberment, optional life, or optional accidental death and dismemberment plan, or any combination of these, unless determined otherwise by a collective bargaining agreement or documented ~~district~~ **entity** policy with the following restrictions:

~~(a) The Eligible Early Retiree must enroll in an OEBB-sponsored medical plan to continue an OEBB-sponsored vision plan; and~~

(**a**~~b~~) The Eligible Early Retiree must be enrolled in an OEBB-sponsored optional life or optional accidental death and dismemberment plan to continue optional spouse or dependent life or accidental death and dismemberment, respectively.

(**b**~~c~~) The ~~Educational~~ Entity offers the plan(s) to their retiree group.

(5) Plan Change Periods: OEBB will offer an annual plan change period for Eligible Early Retirees.

(6) An Eligible Early Retiree can change benefit plans consistent with members of their former active Employee Group.

(7) An Eligible Early Retiree may not add dependents or enroll in coverage(s) he or she did not select during the initial enrollment period, **unless a Qualified Status Change event has occurred and is reported.**

(8) An Eligible Early Retiree may choose to reduce the amount of optional life and optional accidental death and dismemberment coverage for themselves and/or their dependents, but may not increase coverage in these plans.

(9) Qualified Status Changes (QSC): An Eligible Early Retiree may make changes consistent with the OEBB QSC Matrix.

**111-050-0025**

**Effective Dates**

(1) Benefit plan changes or initial elections, unless otherwise specified in a collective bargaining agreement or documented ~~district~~ **entity** policy in effect on June 30, 2008, are effective on the first of the month following termination of the active employee coverages.

(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. Retired eligible employee must add the newborn child to their benefit plans within 60 calendar days from the date of birth 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. Retired eligible employee must add the adopted child to their benefit plans within 60 calendar days from the date of the decree or placement for the newly adopted child to be eligible for benefit coverage; and

(A) Eligible Early Retiree must submit the adoption agreement with the enrollment forms to the ~~Educational~~ 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.

**111-050-0030**

**Correcting Enrollment and Processing Errors**

(1) Enrollment Errors. Enrollment errors occur when an Eligible Early Retiree employee provides incorrect information or fails to make correct selections when making benefit plan changes. The Eligible Early Retiree is responsible for identifying enrollment errors or omissions.

(a) OEBB authorizes ~~Educational~~ Entities to correct enrollment errors reported by the Eligible Early Retiree within 45 calendar days of the original eligibility date, annual plan change period end date, or Qualified Status Change date.

(b) Enrollment errors identified after 45 calendar days of the eligibility date, annual plan change period end date or Qualified Status Change date must be submitted to OEBB for review and approval based on OAR 111-080-0030.

(2) Benefit Administrator Processing Errors. Processing errors or omissions occur when benefit plan changes are processed incorrectly in the benefit system.

(a) OEBB authorizes ~~Educational~~ Entities to correct processing errors identified within 45 calendar days of the eligibility date, annual plan change period end date, or Qualified Status Change date. The ~~Educational~~ Entities must reconcile all premium discrepancies.

(b) Processing errors identified after 45 calendar days of the eligibility date, annual plan change period end date, or Qualified Status Change date must be submitted to OEBB for review and approval based on OAR 111-080-0030. If approved, corrections are retroactive to the original effective date as identified in 111-040-0001. The ~~Educational~~ Entity must reconcile all premium discrepancies within 30 calendar days of any adjustments made in the system.

**111-050-0035**

**Late Enrollment**

(1) Late enrollment occurs when an Eligible Early Retiree fails to enroll for benefits within 60 days of retirement or fails to notify their ~~educational~~ Entity of the Qualified Status Change within 31 calendar days of:

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

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

(c) The date of birth of the retired eligible employee's biological newborn child.

(d) The date the child was adopted of the date the retiree became the legal guardian.

(2) OEBB authorizes ~~Educational~~ Entities to add and/or enroll Eligible Early Retirees and dependents within 45 calendar days of the eligibility dates referenced in sections (1)(a) and (1)(b), and within 60 calendar days of the eligibility dates referenced in (1)(c) and (1)(d).

(3) OEBB 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) and (1)(b), and more than 60 calendar days after the eligibility dates referenced in sections (1)(c) and (1)(d).

(4) Approved late enrollment requests, unless determined otherwise in a collective bargaining agreement or documented ~~district~~ **entity** policy in effect on June 30, 2008, are effective the first of the month following the date the request is received by a district benefits administrator or OEBB, 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.

**111-050-0045**

**Termination Dates**

(1) Effective October 1, 2011, if an Eligible Early Retiree 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 ~~Educational~~ Entities' reconciliation process and shall generally be within 14 days of receiving notification from the Eligible Early Retiree of the qualified status change event and requested benefit changes.

(3) Effective October 1, 2011, benefit coverage termination that is considered by OEBB to be intentional misrepresentation may be rescinded in compliance with the law. If this occurs, OEBB 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 a spouse, domestic partner, or child ends on the last day of the month that a retired eligible employee dies, unless otherwise determined by a collective bargaining agreement or documented ~~district~~ **entity** policy in effect on June 30, 2008.

**111-050-0050**

**Removing an Ineligible Individual from Benefit Plans**

(1) An Eligible Early Retiree who enrolls themselves and/or an eligible person is responsible for removing ineligible spouses, domestic partners and children from their OEBB-sponsored benefit plans by submitting completed, applicable forms to their ~~Educational~~ Entity benefits administrator within 31 calendar days after the date the individual becomes ineligible. Coverage ends on the date identified under OAR 111-050-0045.

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

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

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

(3) If coverage of an ~~e~~**E**arly ~~r~~**R**etiree's spouse, domestic partner or child is terminated retroactively then:

(a) The ~~e~~**E**arly ~~r~~**R**etire 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) OEBB shall conduct eligibility verifications and reviews to monitor compliance with OEBB 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.

(3) OEBB long term care carrier(s) will transfer the coverage from a Group Long Term Care to an Individual Long Term Care policy and premiums will be paid directly to the carrier upon request.

**111-050-0060**

**Continuation of Coverage for Eligible Employees Covered under the Federal Family Medical Leave Act**

OEBB will allow ~~Educational~~ Entities to continue medical, dental and vision coverage for Active Eligible Employees when the employee is granted leave under the Federal Family Medical Leave Act (FMLA) as required under related federal rules and regulations.

**111-050-0065**

**Continuation of Coverage for Eligible Employees Covered under the Oregon Family Leave Act**

OEBB will allow ~~Educational~~ Entities to continue medical, dental and vision coverage for Active Eligible Employees when the employee is granted leave under the Oregon Family Leave Act (OFLA) as required under related state rules and regulations.

**111-050-0070**

**Continuation of Coverage for Eligible Employees during an Approved Leave of Absence.**

OEBB will allow ~~Educational~~ Entities to continue medical, dental and vision coverage for Active Eligible Employees when the employee is granted a leave of absence based on collective bargaining agreements and/or documented ~~district~~ **entity** policies in effect on or before October 1, 2008.

**111-050-0075**

**Continuation of coverage for Eligible Employees on Active Military Service**

OEBB will allow ~~Educational~~ Entities to continue medical, dental, and vision coverage for Active Eligible Employees as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and related federal rules and regulations.

**DIVISION 65**

**OEBB ADMINISTRATION OF EARLY RETIREE GROUPS**

**111-065-0001**

**Definitions**

For the purpose of this rule:

(1) "Direct Debit" for purposes of this OAR refers to a payment through an Automated Clearing House (ACH) credit or ACH debit that initiates the movement of funds electronically from the early retiree's individual banking account within the United States to the OEBB Treasury account.

(2) "OEBB Administered Early Retiree" means an individual who meets the definition of Eligible Early Retiree in OAR 111-010-0015 and whose benefits are administered by OEBB.

(3) "Overpayment" means the amount of the ~~e~~**E**arly ~~r~~**R**etiree's monthly payment to OEBB that exceeded the amount due.

(4) "Payment in full" means payment received by OEBB which is equal to the current monthly amount due for all benefit premiums which the early retiree is currently enrolled in.

(5) "Underpayment" means a payment submitted on or before the due date by the ~~e~~**E**arly ~~r~~**R**etiree that is less than the invoiced amount.

**111-065-0005**

**Untitled**

The following administrative rules in Division 65 ~~pertain~~ **apply** to OEBB Administered Early Retirees in addition to OEBB's Division 50 rules which ~~pertain~~ **apply** to all Early Retirees.

**111-065-0010**

**OEBB Early Retiree Invoicing**

(1) OEBB will enroll the Early Retiree after OEBB has received the enrollment form and one of the following is completed:

(a) The required ACH Authorization for a recurring Direct Debit Payment is received from the ~~e~~**E**arly ~~r~~**R**etiree to initiate the setup of automated payments via ACH; or

(b) An Exception Request Form is received from the ~~e~~**E**arly ~~r~~**R**etiree and reviewed and approved by OEBB.

(2) OEBB will send payment invoices to ~~e~~**E**arly ~~r~~**R**etirees that will provide notification of the amount and payment due date or the date the automatic checking deduction will occur. OEBB will send invoices on or around the 15th of the month with payment due on the 2nd business day of the following month.

(3) Advance payments may be made only within the same Plan Year. However, any remaining balances will be carried into the next Plan Year.

**111-065-0015**

**Early Retiree Payment Methods and Due Dates**

(1) Premium payments will be made through Direct **Payment** ~~Debit~~ via ACH **(ACH Debit)** on the 2nd business day of the month unless otherwise prior authorized by designated OEBB staff.

(2) As necessary, or upon written request of a participating Early Retiree, OEBB staff will review and determine if an alternative withdrawal date is warranted to avoid future payments being returned for Non-sufficient Funds (NSF) on a recurring basis.

(3) OEBB will accept payment from early retirees by methods other than **ACH** ~~Direct~~ Debit when specific exceptions apply:

(a) The individual does not have an account with a financial institution within the United States;

(b) The individual's special circumstances, which OEBB will review on a case by case basis.

(4) ~~A~~ **An Exception Request Form** ~~request for exception~~ must be **complete** ~~made in writing and include~~ **including** the reason why or special circumstance that would not allow the member to submit payment via **ACH** ~~Direct~~ Debit.

(5) OEBB will review the request for exception, determine whether to allow or deny the exception, and notify the requesting party of its decision within 21 days of receipt of the request.

(6) Notwithstanding OAR 111-065-0010, all premium payments must be received on or before the 2nd business day of the month for the current month's health care coverage. All payments will be subject to this due date.

(7) If the Early Retiree has a checking account, but submits ~~a~~ **an Exception Request Form** ~~written letter~~ declining to use the Direct Debit payment method, a $35.00 processing fee shall be applied to the Early Retiree's monthly premium.

**111-065-0020**

**Early Retiree Overpayments**

(1) OEBB will include overpayment amounts on the monthly invoice. The invoice will include the total payment received, the date it was received, the amount of premium payment due, and any remaining balance of additional premiums paid.

(2) OEBB will automatically apply any overpayments to the next month's premium due.
The ~~e~~**E**arly ~~r~~**R**etiree may complete a Request for Reimbursement form if a refund of an overpayment is desired. The ~~e~~**E**arly ~~r~~**R**etiree may be responsible for processing fees associated with refunds less than $100. Reimbursements will be refunded via check.

(3) Remaining balances on coverage that has ended will be refunded in full within 30 days of the coverage end date or the date OEBB is notified that coverage should end, whichever occurs later.

**111-065-0025**

**Early Retiree Underpayments**

(1) Premiums must be paid in full on or before the 2nd business day of the month, unless otherwise pre-approved by OEBB under OAR 111-065-0015(2).

(2)(a) Early ~~r~~**R**etirees will be notified if their coverage was terminated due to the premium not being paid in full on the specified due date, including payments returned by the bank for Non-Sufficient Funds (NSF), closed bank accounts, and frozen accounts.

(b) A check or ACH transaction that is returned for NSF, closed bank account, or frozen account is considered non-payment of premiums.

**111-065-0035**

**Appeals**

Early ~~r~~**R**etirees have the right to use the OEBB Appeals and Administrative Review process as defined in OAR 111-080-0030.

(1) Early ~~r~~**R**etirees may appeal OEBB's eligibility decision.

(2) Early ~~r~~**R**etirees have the right to request a review of benefit and claim issues that are not resolved following the completion of the carrier appeal process. Administrative Review requests relating to denied benefits are limited to a determination of whether or not a benefit was intended to be covered under the current contract.

**111-065-0040**

**Continuation of Coverage**

(1) Early Retirees and dependents have COBRA rights consistent with 111-050-0001.

(2) Loss of coverage due to failure to make a premium payment is not a ~~qualifying event~~ **Qualified Status Change**.

**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 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.**