Rule Amendment Synopsis:

This rule outlines the powers and duties of the Board, as well as Board conduct. The rule amendments are "housekeeping". We are aligning rule language throughout all rule divisions. There are no substantial changes.

No public comment received.

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.

Rule Amendment Synopsis:

This rule outlines all OEBB enrollment rules. Most rule amendments are "housekeeping" in nature, or they clarify policy or procedures that are already in place.

"Wash rule" on newborns. Since OEBB began, we have been applying the wash rule. If a baby 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 baby 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. All other allowable mid-year Qualified Status Change events to add dependents become effective 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 is a way to balance premiums. This reflects the flow of money between OEBB and the entities. This language existed in our QSC Matrix until December 2013 at which time it was determined that the placement of this language in the matrix was not the most appropriate place. Because this is a process we have in place, we are proposing to include language in our rule, and file permanent.

Opt-out. The IRS proposed new regulations for opting out of employer-sponsored medical coverage in exchange for taxable cash. The regulations allow employees to opt-out of medical coverage when they provide an attestation around minimum essential coverage. MyOEBB benefit management system was updated for open enrollment so that each employee wanting to opt out must attest that they and all other individuals for whom they are reasonably expect to claim on a personal exemption deduction during the taxable year have or will have "minimum essential coverage". We are proposing OEBB rule language be updated to reflect new IRS regulations, and file permanent.

TRICARE and Medicare. Allowing TRICARE and Medicare as other group coverage for medical opt-out. Department of Health and Human Services representatives have informally indicated that they believe that no violation of the Medicare Secondary Payer rule occurs if employees entitled to Medicare are given the same cash-out rights as are employees who are not entitled to Medicare under a cafeteria plan that meets the requirements of Code §125.

PEBB, the Public Employee's Benefit Board allows their members to opt-out of medical coverage if they maintain coverage under Medicare, TRICARE or other employer sponsored group coverage.

OEBB staff received guidance from Department of Justice regarding this topic.

In addition, we wanted to clarify through rule that the following are not eligible for medical opt out:

- Coverage bought on the individual market
- Oregon Health Plan/Medicaid
- Veterans' Administration Health Benefit Program
- Student Health Insurance

We are proposing OEBB rule language be updated to reflect this new interpretation for medical opt out, and file permanent.

No public comment received.

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 eligible employee is billed for any applicable premium beginning the first month in which the baby is born. If the newborn is born between the sixteenth of the month and the end of the month, the eligible employee is billed for any applicable premium beginning the first of the following month. With a newborn, the baby begins incurring their own expenses from their date of birth and since premiums are not pro-rated, this balances premiums.**

(b) Coverage for a newly adopted child is effective the date of the adoption decree or date of placement for adoption. The ~~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**s** enrolling in ~~the~~ **a** dental ~~and/or vision~~ plan~~s~~ 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~~ **a** dental ~~or vision~~ plan~~s~~, or adds previously OEBB- eligible dependents to ~~the~~ **their** dental ~~and vision~~ plan~~s~~ following and consistent with a QSC event will not be subject to **the 12 month** waiting period~~s~~.

(~~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.

Rule Amendment Synopsis:

This rule outlines the rules on continuation of coverage under COBRA, as a retiree or on leave. The rule amendments are "housekeeping" in nature, or they clarify policy or procedures that are already in place. There are no substantial changes.

No public comment received.

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.

Rule Amendment Synopsis:

This rule outlines OEBB's administration of early retiree groups. The rule amendments are "housekeeping" in nature, or they clarify policy or procedures that are already in place. There are no substantial changes.

No public comment received.

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**.

Rule Amendment Synopsis:

This rule outlines OEBB's operations and processes, including financial and eligibility reviews. The rule amendments are "housekeeping" in nature, or they clarify policy or procedures that are already in place. There are no substantial changes.

Under Eligibility Verifications and Reviews, additional information specific to Dependent eligibility verification and appeals is added. This is our current process.

No public comment received.

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 responsibility in investigating such violations. If an Eligibility Violation is considered a violation of the insurance carrier’s policy, then the violation may also be considered a Policy Term Violation, and OAR 111-080-0050 would also apply.

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

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

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

111-080-0055

Eligibility Verifications and Reviews

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

(a) Dependent eligibility;

(b) Employee eligibility;

(c) Election change limitations; and

(c) Plan enrollment limitations.

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

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

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

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

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

(**b**~~c~~) The ~~member~~ **eligible employee, eligible early retiree or COBRA participant** is responsible to submit documentation upon request. In the event the ~~member does not provide the~~ required documentation **is not provided** to sufficiently prove the dependent meets eligibility requirements, or the documentation provided is insufficient, the dependent's coverage will be terminated. Retroactive terminations may occur if the documentation provided shows the dependent was not eligible for coverage and the member misrepresented the dependent as being an eligible dependent as defined by OAR 111-080-0045.

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

111-080-0060

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.