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 (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~~).

(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)