

**DEPARTMENT OF ADMINISTRATIVE SERVICES, OREGON EDUCATORS
BENEFIT BOARD**

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 OEGB 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 OEGB Treasury account electronically.

111-070-0005

Plan Selections

(1) HB 2557 eligible members may enroll in medical plans only in the tiered rate structure. The plan selections will be determined on an annual basis, included in our policies and communicated **to those individuals identified by PERS as being eligible under HB 2557** to enroll in OEGB medical benefits the next Plan Year.

111-070-0015

Enrollment

(1) OEGB 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 15);

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

(B) All required enrollment information must be received **from the member** by OEGB by close of business on September 15;

(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 OEGB 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 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.

111-070-0030

Termination

(1) OEGB coverage will be terminated under the following circumstances:

(a) Premiums are not paid in full by the due date. Coverage is contingent upon the receipt of the full monthly premium payment.

(A) Coverage will be terminated on the last day of the month in which premiums were paid in full; or

(b) Eligibility for PERS membership is lost during the previous calendar year.

(A) Coverage will be terminated on the September 30th following the calendar year in which PERS membership is lost.

(c) Upon notification and confirmation that an individual is not eligible for benefits due to adjustments that affect the individual's PERS membership.

(A) Coverage will be terminated on the last day of the month in which ineligibility is confirmed.

(d) Upon notification and confirmation that an individual is not eligible for benefits due to not being a teaching or research faculty member during the calendar year upon which eligibility determination was based.

(A) Coverage will be terminated retroactively to the original coverage effective date. Refunds of premiums are limited to 90 days.

(2) Upon loss of OEGB coverage due to a qualifying event, HB 2557 eligible members and their eligible dependents will have COBRA rights. Cancellation due to failure to make a premium payment does not constitute COBRA rights.

111-070-0040

Qualified Status Changes (QSC's)

- (1) HB 2557 eligible members experiencing a change in family status during the plan year have 31 calendar days from the date of the event to make allowed changes.
- (2) The HB 2557 eligible member may make only those changes that are consistent with the event for themselves and eligible dependent(s).
- (3) Qualified Status Changes which allow the subscriber to make changes to his or her coverage are:
 - (a) Gain 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, 60 days from the event;
 - (c) Gain dependent by birth, placement for/or adoption, affidavit of dependency 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 OEGB plans (for a list of requirements see 111-010-0015);
 - (e) Event by which dependent ceases to satisfy eligibility requirements under OEGB plans (for a list of requirements see 111-010-0015), 60-days from the event;
 - (f) 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.
 - (g) Related laws or court orders. For example: Qualified Medical Child Support Order (QMCSO), Medicare, or HIPAA. Changes are determined by the applicable law or court order, and the Family Health Insurance Assistance Program (FHIAP).

111-070-0050

Premium payment

HB 2557 Eligible Member Payment Methods and Due Dates

- (1) HB 2557 eligible members will submit payment to OEGB for benefits by electronic funds transfer (EFT).
- (2) OEGB may grant an exception from the requirement in section (1) to pay by EFT if the HB 2557 eligible member demonstrates their financial institution cannot accommodate an EFT transfer, or the member does not maintain an account at a financial institution.

(3) Notwithstanding section (2), the 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.

HB 2557 Eligible Member Invoicing

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

(a) The required ACH 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

(2) OEGB will mail payment reminders to HB 2557 eligible members to provide notification of the amount and date the automatic checking deduction will occur.

(3) 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.

(a) OEGB 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.

HB 2557 Eligible Member Overpayments

(1) OEGB 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.

(2) OEGB 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.

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

HB 2557 Eligible Member Underpayments

(1) 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.

(2) 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)

(a) A check or ACH transaction that is returned for NSF is considered non-payment of premiums.

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

111-070-0060

Appeals and Administrative Reviews

(1) HB 2557 eligible members have the right to use the OEGB Appeals and Administrative Review process.

(a) HB 2557 eligible members may appeal OEGB's eligibility decision.

(b) HB 2557 eligible members 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.

111-070-0070

Continuation of Coverage

(1) HB 2557 eligible members and dependents have COBRA rights consistent with 111-050-0001 and 111-070-0030.