Affidavit of Dependency. A written document, kept on file by the agency, in which an eligible employee attests that the dependent meets the criteria set forth in OAR 101-010-0005(7) on the date the document is signed by the eligible employee. The document is available from PEBB, your agency or the PEBB Web site.

Affidavit of Domestic Partnership. A written document, kept on file by the agency, in which an eligible employee and another eligible individual attest to meeting the criteria set forth in OAR 101-010-0005(8) on the date the document is signed by the eligible employee and the eligible individual. The document is available from PEBB, your agency or the PEBB Web site.

Agency. An administrative division of Oregon government that includes a payroll, personnel or campus benefits office..

Coinsurance. The cost of a covered service that is shared by the insurance plan and by the member, typically expressed in percentages; e.g., 85% carrier and 15% member. The provider typically bills the member after the insurance plan has paid.

Co-payment (or co-pay). A fixed dollar amount (e.g., $10) paid by the member to the provider at the time of service.

Decline Benefits. In declining benefits the eligible employee waives his or her right to the employer contribution and enrollment in any of the insurance plans available through PEBB, including flexible spending accounts and all voluntary insurance plans.

Deductible. A dollar amount of expenses the member must pay before the insurance plan pays.

Dependent child(ren). Any child who meets all the criteria in (a) and at least one criterion in (b) of the following:

(a) The dependent child:

(A) Is unmarried and without a domestic partner; and

(1) Is under the age of 19 at the end of the calendar year; or

(2) Is between the ages of 19 and 24 and continues to qualify as a student or meets the gross income test set forth by the Internal Revenue Service; and

(3) Meets the criteria for a dependent child of an eligible employee, or the eligible employee's spouse or domestic partner, under Section 152 of the Internal Revenue Code, whether or not the eligible employee, or the eligible employee's spouse or domestic partner actually claims or receives a dependent exemption from federal income tax for the child. Not all individuals listed in section 152 of the Internal Revenue Code are eligible (Refer OAR 101-010-0005(13)).

(b) The dependent child(ren):

(A) Is a biological or adopted child or a child placed for adoption of the eligible employee or the eligible employee's spouse or domestic partner;

(B) Is a child living in the home of the eligible employee, or the eligible employee's spouse or domestic partner, who is a legal ward by court decree; a dependent by affidavit of dependency; or under the legal guardianship of the eligible employee, or the eligible employee's spouse or domestic partner;

(C) Is a child aged 24 or older who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. The child must have been covered by the insurance plan at the time of his or her 24th birthday, and the physical handicap or mental retardation must have existed prior to the child attaining age 24.

The dependent child of a domestic partner is entitled to the same benefit plans under these rules as the dependent child of an eligible employee or his or her spouse.

Domestic Partner. n eligible individual who attests with an eligible employee that both meet all the following criteria:

(b) Share a close personal relationship and are responsible for each other's welfare;

(c) Are each other's sole domestic partner;

(d) Are not married to anyone nor has either had a spouse or another domestic partner within the prior six months;

(e) Are not related by blood closer than would bar marriage in the State of Oregon;

(f) Have jointly shared the same regular and permanent residence for at least six months; and

(g) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household.

(h) If previously married, the six-month period begins on the final date of divorce.

Eligible Employee. An employee of a PEBB participating organization, including state officials, in exempt, unclassified, classified and management service positions who are expected to work at least 90 days, and who work at least half time or in a position classified as job share.

Eligible Individual. An eligible employee, family members of an eligible employee, domestic partner of an eligible employee and the domestic partner's dependent child(ren) provided the eligible employee lists the eligible individuals on his or her enrollment or update forms or includes the eligible individuals on the pebb.benefits electronic equivalent.

Emergency Care. Services and supplies furnished by a facility that are required to stabilize a patient with symptoms of such severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the individual's health (or the health of the fetus in the case of a pregnant woman) in serious jeopardy.

Family Member. A legally married spouse of an eligible employee or an eligible employee's dependent child.

Group Medical Plan. For purposes of opting out of medical insurance coverage:

(a) Any medical insurance plan offered or contributed to by an employer or a former employer;

(b) Medical insurance coverage provided by a federal government or other governmental entity, as an insurance plan sponsor, employer or former employer, such as Federal Employee Health Benefits or TriCare; and other group medical insurance coverage as approved by PEBB. (Refer OAR 101-020-0015)

Half time. n eligible employee who works less than full time but at least:

(a) Eighty paid regular hours per month; or
(b) 0.5 FTE for OUS eligible employees; or
(c) As defined by collective bargaining.

Health Maintenance Organization (HMO). A type of insurance plan in which members must receive all care from network providers, usually under the direction of a primary care physician (PCP), such as a family practitioner, internist or pediatrician. Members must work or reside in the HMO's service area.

Ineligible Dependent. A dependent who does not meet the definition of spouse, domestic partner, or dependent child as set forth in OAR 101-010-0005. The following individuals are not eligible:

(a) Children under age 19 who are other than biological or adopted children or a child placed for adoption with the eligible employee or the eligible employee's spouse or domestic partner and for whom the eligible employee, spouse, or domestic partner has no financial or medical responsibility.

(b) Children between the ages of 19 and 24 who are other than biological or adopted children or a child placed for adoption of the eligible employee or the eligible employee's spouse or domestic partner and for whom the eligible employee, spouse, or domestic partner has no financial or medical responsibility or do not meet the test for student status or gross income as set forth and provided to taxpayers annually by the Internal Revenue Service.

(c) Members of the eligible employee's household who may be eligible dependents under Internal Revenue Service guidelines but who are not eligible for enrollment on the PEBB benefit plans. These individuals may include the eligible employee's brother, sister, half-brother, half-sister, step-brother, stepsister, parent, grandparent, great grandparent or other direct ancestor, stepfather, stepmother, brother or sister of the eligible employee's father or mother, a son or daughter of the eligible employee's brother or sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, foster parent, or foreign students. The exception is when the eligible employee has financial and medical responsibility for a child who is under the age of 19 and who qualifies under OAR 101-010-0005(7).

Maximum Benefit. The total amount payable by an insurance plan for covered expenses. For example, the annual maximum benefit under ODS dental insurance plans is $1,500 for the year for each person covered, and the lifetime maximum for medical care in the Regence BlueCross BlueShield of Oregon medical insurance plan is $2 million.

Member. An active eligible employee, a COBRA or self-pay participant, or a retiree. Eligible employees must meet the terms of eligibility outlined in the PEBB Administrative Rules.

Non-participating Provider. For PPO insurance plans, medical care providers and facilities that have no contract or agreement with the insurance carrier. Non-participating providers generally bill members for all balances up to the billed charges that are not paid by the benefit plan.

Open Enrollment Period. A period designated by PEBB during which members are permitted to make changes to their insurance coverage and other benefit plan choices for the next plan year. During this period, members (excluding retirees) may add or delete eligible individuals from insurance coverage even if they did not experience a qualified status change event.

Opt Out. An action taken by an eligible employee to elect a form of benefit that may include a cash payment, to be determined by PEBB, in lieu of receiving medical insurance coverage through PEBB.

Out-of-Pocket Maximum. The annual amount a member must pay for deductibles and coinsurance before the insurance plan covers all remaining eligible expenses at 100 percent (referred to as "stop loss") for the remainder of the calendar year.

Participating Provider. For HMO insurance plans, a medical care provider or facility that has agreed to discounted fees and other medical care management policies with the insurance carrier.

Participating Provider (Non-preferred). For PPO insurance plans, a medical care provider or facility that has accepted the terms and conditions of the insurance carrier and agrees not to balance bill the participating members for covered services (non-preferred).

Pebb.benefits. The Web-based automated benefit management application sponsored by PEBB allowing the eligible employee to electronically convey and update demographic information and beneficiary, dependent and benefit plan selections

Plan Year. A period of 12 consecutive months currently designated by PEBB as the calendar year of January through December.

Portability of Medical Insurance. Ongoing medical insurance coverage available from the eligible employee's current medical insurance carrier after termination of insurance coverage with the state. The eligible employee must not be eligible to enroll in Medicare and must have been enrolled in an Oregon-based group medical plan for at least six months immediately prior to termination of insurance coverage; or if the eligible employee has at least 18 months of prior group medical insurance coverage with the most recent medical insurance coverage being in an Oregon-based group medical plan.

Pre-authorization. An insurance plan requirement that covered services be approved by the insurance plan prior to the date of service.

Pre-existing Condition. For medical and dental insurance coverage a physical or mental condition that was diagnosed or treated, or for which medication was prescribed or taken, in the six months prior to current insurance coverage commencing. A condition is diagnosed whenever a physician tells a person that he or she has that condition or makes an entry to that effect in the person's medical records. This diagnosis of condition applies even if the physician is examining or treating the person for a different condition. Currently, PEBB medical and dental insurance plans elected during the Open Enrollment Period impose no pre-existing condition limitations. However, specified insurance benefits in certain circumstances such as transplants may impose a waiting period or limitation. For life and disability insurance coverage, a mental or physical condition for which an individual has consulted a physician, received medical treatment or services or taken prescribed drugs or medication six months prior to the effective date of the life and disability insurance coverage.

Preferred Provider. For PPO insurance plans, a medical care provider or facility that has agreed contractually to accept discounted fees as payment in full for covered services from the insurance carrier. No billing services above usual, customary and reasonable rates.

Preferred Provider Organization (PPO). An insurance plan design that provides different benefit levels for services provided by preferred (network) providers and non-preferred providers who are not in the network. Members who choose care from preferred providers will pay less.

Qualified Status Change. Events that change the eligibility status of a PEBB member (refer PEBB Administrative Rules, Division 101, on-line) such as the following:

(a) Events that change the legal marital status of an eligible employee including marriage, death of spouse, divorce, legal separation, or annulment;

(b) Events that change the status of a domestic partner relationship, including a domestic partner initially meeting qualifying criteria, death of the domestic partner or termination of the domestic partnership;

(c) Events that change the number of an eligible employee's, or domestic partner's dependent children including birth, adoption, placement for adoption or death of a dependent child;

(d) Termination or commencement of employment by the eligible employee, spouse or domestic partner;

(e) Reduction or increase in hours of employment of the eligible employee, spouse or domestic partner that affects eligibility including a change between half time and full time, commencement or return from an unpaid leave of absence, or commencement or return from a federal Family and Medical Leave Act (FMLA) leave whether the FMLA leave is paid or unpaid or as otherwise permitted by the (FMLA) and Oregon Family Leave Act (OFLA);

(f) An event that causes an eligible employee's or domestic partner's dependent child to satisfy or cease to satisfy the eligibility requirements for benefit plan coverage due to age, student status or any similar circumstance;

(g) An increase in the eligible employee, spouse or domestic partner's out-of-pocket premium amount resulting from decisions of the employer or employee;

(h) An involuntary loss of other group medical or dental insurance coverage as specified by the federal Health Insurance Portability and Accountability Act (HIPAA);

(i) An action in compliance with a final judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody proceedings including issuance of a National Medical Support Notice (NMSN) requiring enrollment of dependent children on the existing medical and dental insurance plan;

(j) An eligible employee or an eligible employee's spouse or domestic partner moves out of the insurance plan service area, and thus loses eligibility for that insurance plan;

(k) Gain or loss of Medicare or Medicaid insurance coverage;

(l) In the dependent care flexible spending account (FSA), the dependent care contribution changes only if:

  (A) A cost change is imposed by a dependent care provider who is not a relative of the eligible employee as defined by IRC 152(a)(1)-(8); or

  (B) A change of dependent care provider, relative or not, results in a change in the cost of day care; or

  (C) A dependent child attains age 13.

  (D) There is a qualified change in employment; or

  (E) There is a change in the number of family members.

  (F) Other qualified status changes are considered except no changes are allowed with HIPAA Special Enrollment Rights, a judgement, decree or order, a change in residence or gain or loss of Medicare or Medicaid.

(m) In the healthcare flexible spending account (FSA), the healthcare contribution changes only if:

  (A) There is a qualified change in employment; or

  (B) There is a change in the number of family members.

  (C) Other qualified status changes are considered except no changes are allowed with HIPAA Special Enrollment Rights, a change in residence or a change in care cost.

(n) A change or cessation of insurance coverage, such as an overall reduction in insurance coverage, addition or elimination of benefit plan options, or changes in the dependent child's, spouses or domestic partners insurance coverage through the employer.

Referral. When a provider refers a patient to another provider. In an HMO, the primary care provider makes all referrals, including those who substitute when the primary care provider will be unavailable, as well as any specialists who are also part of the HMO.

State Contribution. The amount of money paid by the State of Oregon on behalf of eligible employees for the purchase of the benefit plans provided through PEBB. The amount of the contribution varies depending on the eligible employee's group or collective bargaining unit. Part-time and job-share positions typically receive a prorated contribution. PEBB plays no role in determining the contribution.

Usual, Customary, Reasonable (UCR) Charges. UCR applies to fees that are:

Usual. A fee that is not more than the provider's usual charge for a given service or supply.

Customary. An amount within the range of usual charges for the service or supply billed by most providers of the same or similar service or supply in the service area.

Reasonable. A usual or customary amount; or an amount that, because of unusual circumstances, inadequacy of data or other reasons is established on an individual basis.

Waiting Period. A designated period during which insurance benefits are excluded or limited.

For Dental Coverage: In PEBB insurance plans, a waiting period currently applies to dental insurance for the indemnity dental insurance plans. The waiting period applies only when the spouse, domestic partner or dependent children are not enrolled when initially eligible and continuously covered on a PEBB dental insurance plan by the eligible employee who enrolled the eligible individual when initially eligible. The waiting period also applies for those who are not covered under a PEBB dental insurance plan for 12 months or more and are subsequently enrolled during an Open Enrollment Period. The waiting period is 12 months for basic and major dental insurance benefits and 24 months for orthodontic benefits. During the waiting period, insurance coverage is provided for preventive services and relief of pain as defined by the insurance plan. The waiting period would be waived if the eligible individual is added to dental insurance coverage because of a qualified status change event such as loss of other group insurance coverage.

For Medical Coverage: The medical insurance plans may include benefit-specific waiting periods such as a 24-month exclusionary period for covered transplant procedures.

For Disability Coverage: The eligible employee must be continuously disabled for stated periods before the disability insurance benefits become payable. No disability insurance benefits are payable during the waiting period.