

SECTION 1: ELIGIBILITY, ENROLLMENT AND DATES OF COVERAGE

Who is Eligible

Eligible Employees

An eligible employee means an employee of a PEBB participating organization, and state officials in an exempt, unclassified, classified, or management position, who meet the following criteria:

- Are expected to work at least 90 days; and
- Work at least half time or in a position classified as job share.

Employers of eligible employees are:

- Oregon state government agencies
- The Oregon University System (OUS)
- Semi-independent state agencies.

PEBB's administrative rules contain its eligibility rules: 101-015. Review PEBB's administrative rules at the PEBB Web site: <http://oregon.gov/das/pebb>.

Eligible Full-time Employees

(Including Limited Duration Employees)

The current monthly benefit amount from the employer fully covers the premium amount for the core benefits of medical, dental and basic life insurance coverage for full-time employees. The amount covers these premiums on all enrollment tiers: employee only, employee and spouse or domestic partner; employee and children; and family.

Current full-time employees must work at least half time during the preceding month to be eligible for benefits the next month. Half time means employed and work or receive 80 paid regular hours per month, or 0.5 FTE for OUS employees, 80 paid regular hours per month and in a .5 FTE position for the Oregon Judicial Department, or as defined by collective bargaining agreements.

New full-time employees are not required to work at least half time in the month they are hired to be eligible for benefits the next month, but they will need to meet this requirement in following months.

Benefit Options

- All available medical and dental plans (except for part-time and retiree plans), according to where you live or work (at least 50 percent of the time)
- Basic life insurance coverage of \$25,000
- All available optional benefits.

These employees may opt out of medical coverage if they have other employer-sponsored group coverage as defined by PEBB. [*Effective Jan. 1, 2010 Employees* must provide proof this coverage to their agency within five days of enrollment.] Other group coverage does not include Medicare, TRICARE, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance. [*Effective Jan. 1, 2010 Members* who opt out will receive a monthly payment of \$233 (prorated for part-time employees according to hours worked compared with full-time).] The cost of their

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mandatory dental and basic life premiums will be deducted from that amount pretax. The balance will be added to their monthly pay as taxable income.

These employees may also decline all benefits. If you decline all benefits, you choose not to participate in the PEBB program, and you receive no portion of the monthly benefit amount from the employer.

Eligibility when on extended leave

The type of leave you take – family medical leave, active duty military leave, job-related-injury leave, etc. – and whether it is a paid or unpaid leave may affect your eligibility and how you pay for and receive benefits. Contact your payroll, human resources or benefits office, or PEBB to discuss these issues prior to taking the leave.

Eligible Part-time Employees

(Including Limited Duration and Job Share)

The current monthly benefit amount for eligible part-time employees is pro-rated based on hours worked in the month compared with full time hours.

To be eligible for benefits, part-time employees must:

- Work or receive 80 paid regular hours per month or be in a job share position;
- Hold 0.5 FTE for an OUS employer:
- Work or receive 80 paid regular hours per month and be in a .5 FTE position for the Oregon Judicial Department: or
- Fit the definition by collective bargaining agreements.

New part-time employees are not required to work at least half time in the month they are hired to be eligible for benefits the next month, but they will need to meet this requirement in following months.

Part-time employees receive a pro-rated monthly benefit amount from the employer for the core benefits of medical, dental and basic life insurance coverage. For most part-time employees, the pro-rated amount is based on the number of hours worked in the previous month. For job-share employees, the amount is fixed by their share of the FTE.

Part-time employees must pay the difference between the benefit amount they receive and the plan premium amount. They may choose to purchase either part-time and retiree, or full-time medical and dental plans. Coverage is effective at the beginning of each month. When available, part-time employees who choose a part-time and retiree plan will receive a state subsidy.

Benefit Options:

- All available medical and dental plans, according to where you live or work (at least 50 percent of the time)
- Basic life insurance coverage of \$25,000
- All optional benefits.

These employees may opt out of medical coverage if they have other employer-sponsored group coverage as defined by PEBB. [Effective Jan. 1, 2010 Employees must provide proof of this coverage to their agency within five days of enrollment] Other group coverage does not include Medicare, TRICARE, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance. [Effective Jan. 1, 2010 Members who opt out will receive a monthly payment of \$233

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(prorated for part-time employees according to hours worked compared with full-time).] The cost of their mandatory dental and basic life premiums will be deducted from that amount pretax. The balance will be added to their monthly pay as taxable income.

These employees may also decline all benefits. If you decline all benefits, you choose not to participate in the PEBB program, and you receive no portion of the monthly benefit amount from the employer.

New Seasonal Employees

(Full-time, Part-time, Job Share)

Seasonal employees may receive PEBB benefits if the employer expects them to work at least 90 consecutive days in full-time, half time, or job-share status.

Seasonal employees expected to work fewer than 90 days are not eligible for PEBB benefits. If the agency extends the length of the seasonal position, the employee is eligible for benefits retroactive to 60 days from the date of hire.

Benefit Options

- **Full-time seasonal employees:** All available medical and dental plans (except for part-time and retiree plans), according to where you live or work (at least 50 percent of the time)
- **Part-time seasonal employees:** All available medical and dental plans, according to where you live or work (at least 50 percent of the time)
- Basic life insurance coverage of \$25,000
- All optional benefits except short term and long term disability insurance.

These employees may opt out of medical coverage if they have other employer-sponsored group coverage as defined by PEBB. [*Effective Jan. 1, 2010* Beginning with enrollments for plan year 2010, employees must provide proof of this coverage to their agency within five days of enrollment.] Other group coverage does not include Medicare, TRICARE, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance. [*Effective Jan. 1, 2010* Members who opt out will receive a monthly payment of \$233 (prorated for part-time employees according to hours worked compared with full-time).] The cost of their mandatory dental and basic life premiums will be deducted from that amount pretax. The balance will be added to their monthly pay as taxable income.

These employees may also decline all benefits. If you decline all benefits, you choose not to participate in the PEBB program, and you receive no portion of the monthly benefit amount from the employer.

Returning Seasonal Employees

Previously ineligible seasonal employee who return to work are eligible for benefit plans once they accumulate 60 calendar days of employment within the current or immediately previous plan year. The 60 calendar days do not need to be consecutive. Seasonal employees who had PEBB benefits before starting leave and who return to work within 12 months will have benefits reinstated the first of the month following their return-to-work date.

Benefit Options

- Full-time seasonal employees: All available medical and dental plans (except for part-time and retiree plans), according to where you live or work (at least 50 percent of the time)

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- Part-time seasonal employees: All available medical and dental plans, according to where you live or work (at least 50 percent of the time)
- Basic \$25,000 life insurance
- All optional benefits except short term and long term disability insurance.

These employees may opt out of medical coverage if they have other employer-sponsored group coverage as defined by PEBB. [*Effective Jan. 1, 2010* Employees must provide proof of this coverage to their agency within five days of enrollment.] Other group coverage does not include Medicare, TRICARE, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance. [*Effective Jan. 1, 2010* Members who opt out will receive a monthly payment of \$233 (prorated for part-time employees according to hours worked compared with full-time).] The cost of their mandatory dental and basic life premiums will be deducted from that amount pretax. The balance will be added to their monthly pay as taxable income.

These employees may also decline all benefits. If you decline all benefits, you choose not to participate in the PEBB program, and you receive no portion of the monthly benefit amount from the employer.

Most benefits are reinstated for returning seasonal employees. Reinstated means to reactivate prior medical, dental, and life insurance enrollments within 12 months when the employee returns from a leave or a termination of employment. Exceptions are flexible spending accounts and the long term care plan. Returning seasonal employees must re-enroll if they want these plans.

Eligible Retirees

Active employees enrolled in PEBB immediately prior to retirement may continue in PEBB medical and dental plans when they retire if they are not eligible for Medicare.

Keep in mind that if you enroll in PEBB benefits as a retiree, you must self pay the premiums; the state does not provide a benefit amount.

Medical and dental options

As a PEBB retiree you may choose from all available medical and dental plans, including all full-time and part-time and retiree plans, available in your service area. You may change medical or dental plans when you enroll as PEBB retiree. You and your dependents may choose medical only, dental only, or medical and dental coverage; however, when you choose only dental coverage you cannot add medical coverage at a later time, and vice versa.

Eligibility

To be eligible for PEBB retiree coverage, you must be:

- Eligible to receive a retirement benefit through a state of Oregon retirement system, and
- Enrolled in a PEBB medical or dental plan.

You may also cover your

- Non-Medicare eligible spouse or domestic partner who is covered on your plans at the time of retirement,
- Dependent children who are covered on your plans at the time of retirement, if they are still eligible according to PEBB rules.

How to enroll

BenefitHelp Solutions (BHS) is PEBB's third-party administrator for retiree plans. Complete and submit to BHS the PEBB Enrollment Form, Eligible Retiree and Dependents.

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When to enroll as a PEBB Retiree

PEBB coverage must be continuous. **You must enroll within 60 days of when your active PEBB coverage ends.** Contact your employing agency for the date your active PEBB coverage will end. The enrollment deadline is 60 days from that date. If you enroll and pay premiums during this 60-day window, coverage is retroactive to the date your PEBB employee coverage ended.

Exceptions:

- If you have coverage under a spouse or partner's active PEBB plan, you may enroll in the PEBB retiree plan later if you lose the current coverage.
- If you choose COBRA continuation coverage, you can transfer to the retiree group during or at the end of the COBRA period.

Changing Plans

You may make plan changes only during the Plan Change Period. The Board sets the Plan Change Period for retirees.

The Plan Change Period allows you the opportunity to change plans; **it does not allow you to add coverage you did not already have.** For example, if you chose not to enroll in medical coverage when you retired, you may not enroll for medical coverage during subsequent Plan Change Periods. You may not add dependents during this period. You may add dependents only within 60 days of and consistent with a qualified midyear status change.

Effective dates

PEBB retiree coverage must be effective immediately following the transition from PEBB employee coverage or COBRA coverage.

If you relocate outside a plan's service area

If you leave a plan's service area, you may enroll in a new plan. You must do so within 60 days. If you fail to enroll within 60 days, you may apply to PEBB for late enrollment.

If a dependent loses other coverage

If a domestic partner or family member not currently enrolled on your retiree plan loses other employer group coverage, you may enroll the spouse or domestic partner, or dependent child for coverage in your plan, if they meet the PEBB eligibility. You must do so within 60 days. If you fail to submit the correct forms within 60 days of this qualified change, you may apply to PEBB for late enrollment.

Coverage Duration

Coverage continues as long as:

- You are not eligible for Medicare (except those with end-stage renal disease)
- You pay premiums timely
- PEBB continues to offer retiree coverage.

Continuing life and long term care insurance after retirement

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability if you enroll in conversion coverage or PEBB retiree life insurance portability coverage within 60 days from the date of your retirement. Please contact The Standard Insurance Company for more information about this option.

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If you have long term care insurance, you must convert the policy to an individual plan to continue the coverage. Contact UNUM Provident for more information about this option.

Continuation of other optional benefits

You cannot continue PEBB dependent life, spouse or domestic partner life, disability, or accidental death and dismemberment insurance.

Optional healthcare insurance for retirees

PERS. Contact the PERS Health Insurance Program for more information.

COBRA. The federal COBRA law allows you to continue the same coverage you had as an employee. You must self pay your premium. However, there are some important differences to keep in mind.

- COBRA usually allows continuation of your participation in the active-employee group for only 18 months. If you have a qualified Social Security disability or become qualified within the first 60 days of COBRA coverage, you may be eligible for an additional 11 months of COBRA coverage, for a total of 29 months.
- COBRA coverage for you ends if you:
 - Become eligible for Medicare in the 18-month period (except those with end-stage renal disease)
 - Become covered by another group medical plan that does not exclude or limit coverage for pre-existing conditions
 - Fail to make a timely premium payment.
- In the event of your death, COBRA coverage may continue for dependents up to 36 months from the time you began to pay your own premium. Other provisions may apply for COBRA coverage. Contact BHS for more information.

If you choose COBRA coverage, you may enroll as a PEBB retiree at any time during your COBRA coverage.

Portability Coverage or Oregon Medical Insurance Program. The [*Discontinues Jan. 1, 2010* Regence] and Kaiser HMO medical plan offers portability. Portability means that you may purchase an individual medical plan offered by the company on a guaranteed issue basis within 63 days after leaving the PEBB group. To be eligible you must:

- Have 180 days of continuous employer group medical coverage
- Be an Oregon resident
- Not be eligible for Medicare
- Not be currently enrolled in another medical plan.

In the case of your death your dependents may continue coverage if they continue to meet the eligibility requirements. For portability information and rates, call the plan directly.

The [*Effective Jan. 1, 2010* PEBB Statewide Plan] and Providence Choice medical plan are self-insured medical plans. If you leave a self-insured plan, you may be able to access coverage through the Oregon Medical Insurance Program (OMIP). To apply for coverage through OMIP, you must first exhaust your COBRA coverage. Contact OMIP for more information.

Medicare Coverage. Medicare covers:

- People 65 years of age and older
- Certain people younger than 65 with disabilities.

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When you become eligible for Medicare, you are no longer eligible to participate in PEBB retiree plans (unless you have end-stage renal disease). When you become eligible for Medicare but your spouse or partner and dependents are not, these family members may continue PEBB retiree coverage if they were enrolled in your coverage when you became eligible for Medicare.

For information about individual plans to supplement Medicare coverage, contact the Senior Health Insurance Benefits Assistance program at (800) 722-4134.

Retirees Returning to Active Employee Status

Retirees returning to work in a benefit-eligible position are eligible for PEBB benefits. You must work the equivalent of at least half time during the month to be eligible for benefits for the following month. Job-share employees are not required to work half time.

For retirees returning within 12 months of their retirement date, benefits are reinstated. You will not need to work half time the month you return to work to be eligible for benefits the following month. However, you must work at least half time each month after that to qualify for benefits the following month. Reinstatement means to reactivate all previous medical, dental, life and disability insurance policies, if available, on a guaranteed basis. You will have 60 days from the date you return to work to change your elections. Approved changes are effective the first of the month following receipt of the forms by the agency. An employee returning to paid regular status within 30 days without a break in coverage will have their previous coverage reinstated and may not make benefit plan changes.

Retirees who return beyond 12 months from their retirement date must re-enroll for all benefits.

Full-time employees are not eligible for part-time and retiree plans. Part-time employees receive a pro-rated benefit amount (based on the hours worked) and may choose from all the medical and dental plans.

Retirees returning to work and enrolled with Benefit Help Solutions (BHS), the third-party administrator, may suspend self-pay coverage while in active employee status by notifying BHS. To restart your self pay coverage, you must notify BHS when you are no longer an active employee who meets the half time work requirement. Remember, your coverage must be continuous to remain eligible to participate in PEBB plans.

Non-Medicare-eligible retirees may decline active employee benefits. Medicare-enrolled retirees cannot opt-out of the PEBB medical plans and must enroll in the PEBB active employee plans because of the Medicare secondary payer rules.

NOTE: Special conditions apply to Standard Life insurance coverage if you converted or ported coverage you had as an employee. Contact Standard and your payroll office to ensure your life insurance information is correct.

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COBRA Participants

Former PEBB members may continue their coverage in PEBB healthcare plans through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

COBRA gives employees along with their spouses, domestic partners, dependents and domestic partner's dependents a chance to continue coverage under an employer's group health plan. Participants must experience a "triggering event" for COBRA to apply. In general, individuals receive the opportunity to elect only the healthcare coverage they were receiving immediately before the event. You must self pay the premiums for this benefit coverage; the state does not provide a benefit amount.

See Section 5 for more information regarding your COBRA rights and qualifying events.

BenefitHelp Solutions (BHS) administers the COBRA program for PEBB. For more information, contact BHS.

Other Self-pay Participants

The following individuals may participate in PEBB.

- Blind Business Enterprise agents
- State-certified foster parents
- Oregon Liquor Control Commission agents
- Oregon State University and University of Oregon post doctorates and J1 Visa recipients.
- Nurses who teach or work less than half-time

These self-pay participants may enroll only in the PEBB medical and dental plans that are available to full-time state employees. The part-time and retiree plans are not an option. Blind Business Enterprise agents may enroll in a medical plan, only. All other self-pay participants may enroll in medical and dental plans. They must enroll in a medical plan to enroll in a dental plan. Self-pay participants may also enroll their spouse or domestic partner and eligible dependents for coverage.

Self-pay participants do not receive a monthly benefit amount. Participants self-pay all premium costs.

BenefitHelp Solutions (BHS) administers the Self-pay Participant program. To enroll, contact BHS.

Dependents Eligible for Coverage

Employees may enroll the following individuals for coverage:

- Spouse or domestic partner
- Dependent children
- Domestic partner's children.

Qualifying dependent children

Following is a summary of PEBB's definition of a qualifying dependent child. If you are in doubt if a person in your family qualifies as a dependent child, contact your agency or PEBB.

A qualifying dependent child must be either:

- A biological or adopted child, or a child placed for adoption with the employee or the employee's spouse or domestic partner; or
- A Child by Affidavit, which includes but is not limited to, a foster child; a child who is your legal ward by court decree; a child under the legal guardianship of the employee; or the child of a dependent.

In addition, the qualifying child:

- May not be married or have a domestic partner
- May not be in the military
- Must be a member of the eligible employee's household
- May not qualify as a qualifying child for anyone other than the eligible member. However, for the purpose of obtaining health care coverage under both parents the child may be the qualifying child of both parents that are divorced or legally separated.
- The child must be a U.S. citizen, national or resident of the U.S. or a resident of Canada or Mexico. When an adopted child or child placed for adoption fails this requirement they can still be the employees' dependent child if the child has the employee's home as his principal home and is a member of the employees' household, and the employee is a citizen or national of the U.S. Foreign students are not eligible for PEBB coverage.

Qualifying child age requirements: The child:

- Is under the age of 19 at the end of the calendar plan year; or
- Is between the ages of 19 and up to age 24 during the plan year, and is a full time student who has not attained the age of 24.

Student means an individual who during each of five calendar months during the calendar year is a full-time student at an education organization that normally maintains a regular faculty and

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curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

To be full-time, the student must be enrolled for the number of hours or courses the school considers full-time attendance. The term school includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, or schools offering courses only through the Internet. People who work "co-op" jobs in private industry as part of a school's regular course of classroom and practical training are full-time students.

[*Effective Jan. 1, 2010* Note: Seriously ill or injured full time student dependents covered under an eligible employee's plan immediately before the first day of a medically necessary leave of absence, or change in enrollment such as full-time to part-time, may continue coverage for up to one year while on a medically necessary leave of absence. "Medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any other change in enrollment at the institution that starts while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of PEBB eligibility. A physician of the dependent must provide a written certification to PEBB stating that the child is suffering from a serious illness or injury and that the leave of absence (or change in enrollment) is medically necessary. The extension of coverage continues until the earlier of one year after the first day of the leave or the date that coverage would otherwise terminate, (e.g., due to an age limitation).]

- Is age 19 up to 24 and the eligible member provides or expects to provide more than half the child's support for the year, and the child lives in the eligible member's home for at least six months of the year; or
- 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.

The attending physician must submit documentation of the disability to the eligible employee's PEBB medical insurance plan for eligibility approval. Once approved, the medical plan may review the dependent's health status at any time to determine the child's continued PEBB eligibility.

When the dependent child is 24 years of age or older, the disability must have existed before attaining age 24. The child must have had continuous medical insurance coverage, group or individual, prior to attaining age 24 and the insurance must continue until the PEBB insurance effective date.

If the child terminates from PEBB insurance coverage after age 24, the child is ineligible for future enrollment as a dependent child under PEBB coverage.

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Certifying Dependent Children Age 19 to 24

To cover dependent children age 19-24 in the next plan year,(age 19 before the new plan year starts) you must certify their continuing eligibility before the start of the new plan year. You may do so online or by submitting the required form to your agency during Open Enrollment. The yearly dependent certification excludes children approved by the insurance plan as incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

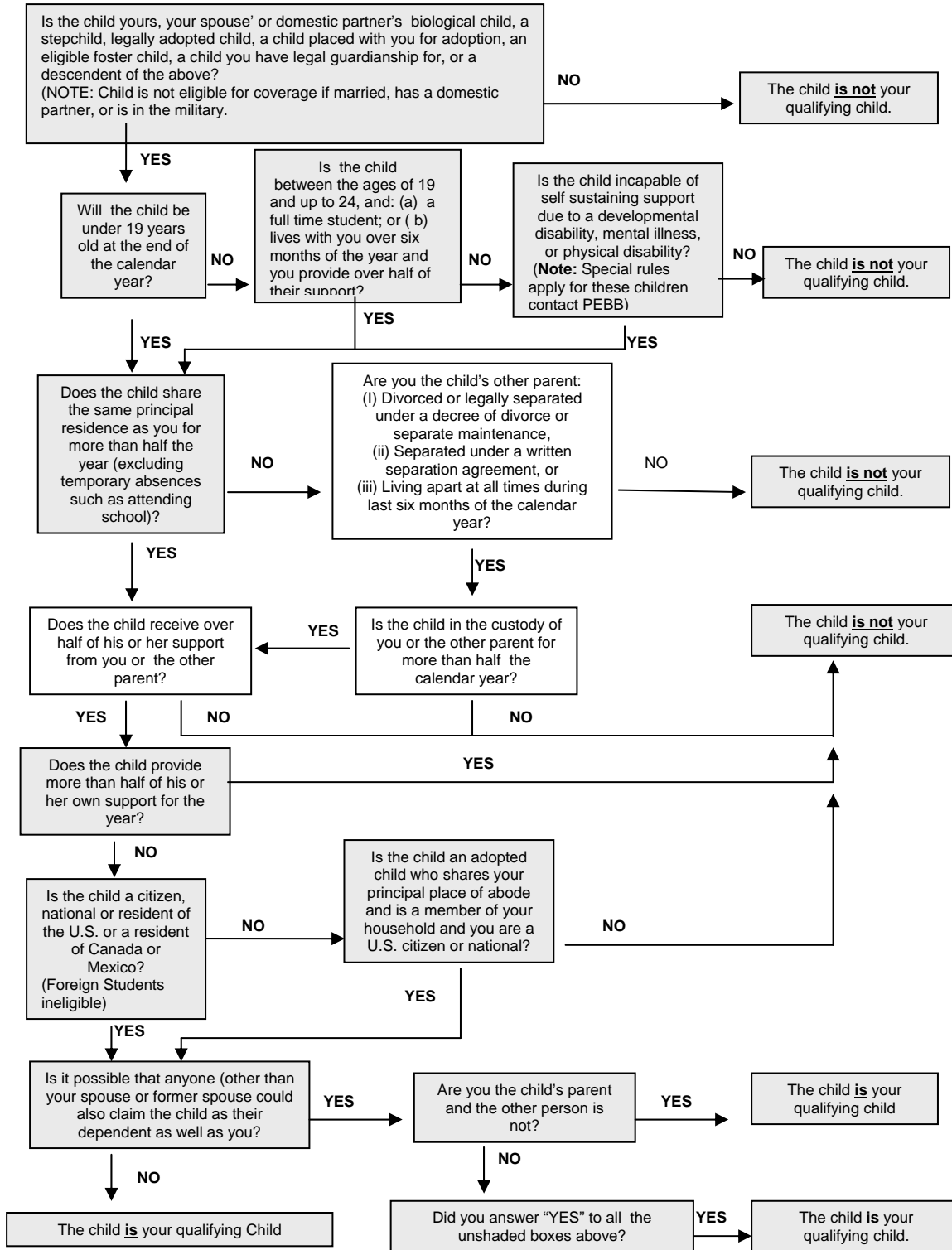
PEBB terminates all insurance coverage for dependent children the last day of the month in which the child reaches age 24. PEBB will not terminate coverage for children age 24 or older when approved by the insurance plan as incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

It is your responsibility to notify the agency when any dependent no longer qualifies for coverage. Not providing notification may cause you to have to repay claim expenses incurred when the individual no longer qualifies for coverage.

The following flow chart helps determine if a dependent child qualifies for coverage in PEBB.

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PEBB Qualifying Dependent Child Flow Chart



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Domestic partners and their dependents

You may cover a domestic partner and dependents who meet certain requirements. Adding a domestic partner who is not a tax dependent will increase your tax withholding, and you will take home less pay.

PEBB provides benefits to domestic partners that are comparable to those offered to married spouses, where legally possible. You may enroll your domestic partner in all benefit coverage available to a spouse either within 60 days of a Qualified Status Change or during the open enrollment period. A domestic partner's children are also eligible for enrollment. Federal laws may require differences in administration of benefits. For example, Medicare will pay as primary coverage for a domestic partner who becomes eligible for Medicare while covered under an employee's coverage.

The member and the domestic partner are eligible if they have

- Registered a certificate of their domestic partnership under Oregon law; or
- Signed and submitted to the member's agency a notarized Affidavit of Domestic Partnership declaring that both meet all the following criteria:
 - Are both at least 18 years of age;
 - Are responsible for each other's welfare and are each other's sole domestic partners;
 - Are not married to anyone ;
 - Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
 - Currently share the same regular permanent residence; and
 - 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.

NOTE: An employee who has a registered certificate of domestic partnership must submit only the appropriate PEBB update forms to the agency either within 60 days of meeting the qualifications or during the open enrollment period to add coverage for a domestic partner. An employee who establishes the partnership through an Affidavit of Domestic Partnership must submit both the affidavit and appropriate PEBB update forms to the agency either within 60 days of meeting the qualifications or during the open enrollment period.

Affidavit of Domestic Partnership Process

The employee must submit the completed, notarized affidavit to the agency within five business days of the electronic enrollment date or the date the agency receives the paper enrollment or update forms. If not, coverage will terminate for the domestic partner and the domestic partner's dependent children back to the effective date.

If requested, the member and domestic partner must be able to provide at least three forms of verification of their joint responsibility, with information dated to confirm eligibility at the time of enrollment.

Children of Domestic Partners

Children of eligible domestic partners may be covered by the member's plans, whether or not the enrollment includes the domestic partner. An employee who has registered a domestic partnership must submit only the appropriate PEBB update forms to the agency to add coverage for a domestic

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partner's children either within 60 days of meeting the qualifications or during the open enrollment period. If the employee does not have a registered certificate of domestic partnership, the employee must submit the completed, notarized Domestic Partner Affidavit to the agency within five business days of the electronic enrollment date or the date the agency receives the paper enrollment or update forms. If the affidavit is not received within 5 days, coverage will terminate for the domestic partner's dependent children back to the effective date.

Tax Considerations

Before enrolling a domestic partner or a partner's children for coverage, employees should know there may be important tax considerations. Payroll will add an imputed value to the eligible employee's taxable wages for the fair market value of the insurance premium for coverage of the domestic partner and domestic partner's children, unless the employee notifies payroll that the domestic partner qualifies as a tax dependent under IRS rules.

Following is information provided by the Oregon Department of Justice Attorney General's Office regarding this topic.

Domestic Partner and Domestic Partner Children as Dependents for Pre-Tax Health Benefit Purposes

Domestic Partners Eligible for Health Coverage

Group health coverage, including medical and dental benefits, is available for a domestic partner (and a domestic partner's children) of the State of Oregon's eligible employees. Refer to the applicable summary plan description (SPD) and enrollment materials for a definition of domestic partner and the procedures you must follow to enroll your domestic partner and or domestic partner children for coverage.

Tax Consequences of Domestic Partner Coverage

Under federal tax law, if your (non-spouse) domestic partner does not qualify as your tax dependent for health coverage purposes (as defined below), then the value of your domestic partner's coverage will be included in your gross income, subject to federal income tax withholding and employment taxes, and will be reported on your Form W-2. This includes any portion of the premiums that your employer pays for your domestic partner's health coverage. (The value of coverage varies, depending on the medical and dental coverage options you elect)

If your domestic partner qualifies as your tax dependent for health coverage purposes, then no portion of the premiums paid by your employer will be included in your income or be subject to federal withholding or employment taxes.

Note that if your domestic partner fails to qualify as your tax dependent for health coverage purposes for any portion of the calendar year because of a change of abode, household, or support during the year, the value of your domestic partner's coverage for the portion of the year prior to the change will be included in your gross income and related income tax and employment tax withholding will be charged to your pay as rapidly as possible. The catch-up on withholding will reduce your take-home pay and such reduction could be for some periods. The catch up on withholding to your agency payroll must be completed before the end of the current tax year.

You should also note that state tax treatment of domestic partner health coverage will differ. See OAR 150-316.007-(B) Policy -- Application of Various Provisions of Tax Law to Domestic Partners, or call the Oregon Department of Revenue at 503-378-4988 or toll-free from an Oregon prefix at 1-800-356-4222 for more information about state tax treatment.

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Although coverage is also available for children of an eligible employee's domestic partner under your employer's group health plan, a domestic partner's child is unlikely to qualify as an employee's tax dependent for health coverage purposes. Thus, the value of such coverage generally must usually be included in your gross income.

Who is a Dependent Domestic Partner for Pre-Tax Health Coverage?

IRS Publication 501 contains information on how to determine a dependent. In general, the following conditions must be met (in addition to meeting PEBB domestic partner eligibility requirements) for your same-sex or opposite-sex domestic partner to qualify as your tax dependent for pre-tax health coverage purposes under federal tax law.

- You and your domestic partner have the same principal place of abode for the entire calendar year;
- Your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law);
- During the calendar year you provide more than half of your domestic partner's total support
- Your domestic partner is not your (or anyone else's) qualifying child under Code 152 c; and
- Your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

Your domestic partner could be your federal tax dependent for health coverage purposes even if you do not claim an exemption for him or her on your Form 1040. If your tax year is a year other than the calendar year, use the other year instead. Your employer will also consider your opposite-sex domestic partner to be your federal tax dependent for health coverage purposes if he or she meets the above requirements for the first portion of the year, then you marry, and he or she remains your legal spouse for the remainder of the year.

To determine whether you provide more than half of your domestic partner's total support, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including Social Security, welfare payments, the support you provide, and the support your domestic partner provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and the like. If you believe you might provide more than half of your domestic partner's support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you complete the Certification described below.

When is a Domestic Partner's Child Considered a Dependent for Pre-Tax Health Coverage?

Determining whether a domestic partner's child is a dependent is more complicated than determining if a domestic partner is a dependent. Seeking the advice of a tax professional is recommended before certifying that a domestic partner's child(ren) is/are dependent(s). This is because in addition to PEBB's requirements for dependent children, generally all of the following must be met for your domestic partner's children to qualify as your tax dependent(s) for pretax health coverage under federal tax law:

- The child is your domestic partner's child, adopted child, child placed for adoption, or eligible foster child
- The child is a member of your household who shares your principal place of abode. (Note that the child is not a member of your household if your relationship with the child violates local law.)

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- You provide over half the child's support for the calendar year.
- **The child is NOT a Qualifying child of any other taxpayer***
- The child is a U.S. citizen, national or resident of the U.S. or a resident of Canada, or Mexico; or is an adopted child and you are a U.S. citizen or national.

***Note:** Under IRS Notice 2008-5, a domestic partner's child is not a qualifying child of the domestic partner if the domestic partner (or any other person with respect to whom the child potentially would be a qualifying child, such as child's other parent) is not required to file a federal income tax return and either (a) does not file such a return, or (b) does so solely to obtain a refund of withheld income taxes.

Filing a Certification of Dependent Domestic Partner Status

If your domestic partner qualifies as your tax dependent for health coverage purposes, you can avoid having the value of your domestic partner's health coverage treated as taxable income. To avoid taxation, you must complete and return the Certification of Dependent Domestic Partner Status, indicating that your domestic partner qualifies as your federal tax dependent for health coverage purposes. Because the determination of whether a person is a tax dependent for health coverage purposes turns on facts solely within your knowledge, your employer cannot make this determination for you. You should make this determination in consultation with your tax professional. You will be asked to complete a Certification each year at open enrollment. For any year in which your employer does not receive a Certification from you, your employer will assume that your domestic partner does not qualify as your federal tax dependent for health coverage purposes for that year.

This information is only a summary of the tax provisions governing the tax status of a domestic partner (or the domestic partner's children) for health plan purposes, and is not intended nor should it be relied upon as legal or tax advice. Due to the complexity of these tax rules and the potential impact of any imputed income you may incur, you should seek advice from a competent tax professional before certifying as to the tax status of the person being enrolled.

Removing a Domestic Partner and Domestic Partner's Children from Coverage

You may remove a domestic partner and partner's children from coverage:

- Within two weeks of receiving the first pay statement reflecting the tax implications following initial enrollment.
- Within 60 days of termination of the partnership. If you terminate a Domestic Partnership by Affidavit, you must complete and submit a Termination of Domestic Partnership form and any other necessary update forms. PEBB plan coverage ends the last day of the month in which the partnership terminates.
- Within 60 days of and consistent with a qualified mid-year change event
- During Open Enrollment.

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Enrollment Periods and Effective Dates

For Current Employees

Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Open Enrollment	First of the new plan year following online enrollment (or agency receipt of enrollment form)	First of the new plan year or first of the month in the new plan year following online enrollment (or agency receipt of enrollment form) and plan approval of medical history
Because of Qualified Status Change (QSC)	First of the month following agency receipt of update form (no earlier than date of QSC)	First of the month following agency receipt of update form and/or plan approval of medical history
Midyear		Long term care insurance only: First of the month following agency receipt of the enrollment form and plan approval of medical history (evidence of insurability)

For Newly Hired Employees

Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Within 60 days of hire	First of the month following online enrollment (or agency receipt of enrollment form)	First of the month following online enrollment (or agency receipt of enrollment form) and plan approval of medical history

For Newly Eligible Employees

Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Within 60 days of date of eligibility	First of the month following online enrollment (or agency receipt of enrollment form)	First of the month following online enrollment (or agency receipt of enrollment form) and plan approval of medical history

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How to Enroll

- **Eligible employees** may enroll online during Open Enrollment.
- **Newly hired eligible employees** may enroll online or by submitting forms within 60 days of their hire date.
- **Self-pay participants** must enroll by completing the medical and dental enrollment form identified for each group. These forms are available online or from BenefitHelp Solutions, the third-party administrator.
- **Newly eligible employees** must enroll within 60 days of meeting eligibility by electronic enrollment or by submitting the employee enrollment forms. These forms are available from your agency and online.

Failure to Enroll

Newly eligible employees who do not enroll for benefits within the 60 days of becoming eligible may not participate in the benefit program for that plan year. If you fail to enroll because of circumstances beyond your control, you may appeal to PEBB. If PEBB approves the appeal, you may enroll only for medical and dental coverage, including coverage for eligible dependents. You will also receive employee basic life insurance coverage.

Annual Enrollment

Eligible employees may make new benefit elections during Open Enrollment for the following plan year. If you do not make new elections, your current elections will continue for the following plan year (unless you experience a qualified mid-year change event that allows changes to your benefits). However, if you are required to make an enrollment and you fail to take action, your current elections may not remain in effect. Flexible spending accounts are an exception to continuation of current elections. These are annual accounts. You must enroll during Open Enrollment if you want a flexible spending account in the following plan year.

Correcting Enrollment Errors

Employees may make errors in the process of enrolling for benefits. Examples include mistakes you make when you provide information or make selections on forms or through the online system. Failure to take action is not an enrollment error.

If you make an enrollment error, contact your agency as soon as you notice it.

If you or your agency discover an enrollment error within 60 days of the original effective date of your enrollment as a newly eligible employee or for a mid year change, your agency can approve and take corrective retroactive to the original effective date.

If you make an Open Enrollment error, your agency can correct the error up to 30 days from when you receive your first paycheck of the new plan year. The correction will be retroactive to the first day of the new plan year.

Midyear Plan Changes

During the plan year, you may not revoke choices related to your participation in the benefits program, plan selections, or related salary deductions unless you experience a qualified status change.

A qualified status change (QSC) is one type of a midyear plan change event. This is an event that changes your work or family circumstances. A QSC is the most common type of midyear plan change event; however, there are several other change events allowed. The IRS requires that PEBB comply with federal regulations for midyear benefit changes. Midyear plan change events must meet the IRS "consistency rule," which means the event must affect eligibility, and the requested plan change must be consistent with the way eligibility has been affected. This means the requested benefit change must link to the event.

Here are two examples.

- **Example 1. You adopt a child.** This is a QSC event that allows you to add the dependent child to your current medical and dental insurance coverage and to add or increase other coverage related to the adoption, such as adding optional Dependent Life insurance. There is no other fact around this single event that would allow you to change to a different medical or dental plan than what you currently have. The exception to this would be if you wanted to change from a PPO to an HMO plan or vice versa.
- **Example 2. You move from an eligible full-time position to an eligible part-time position.** This change is also a QSC and makes you eligible to enroll in the part-time and retiree plans or the full-time plans. It also changes the monthly benefit amount from the employer. You may change benefit plans and add or delete coverage.

To make a change based on a mid year plan change event your agency must receive the appropriate update form within 60 days of the date of the event. Update forms are available online.

If you are removing a dependent from coverage because of a QSC, the coverage will end the last day of the month eligibility is lost.

If you experience a change in status that makes you ineligible to cover someone else, your elections will change correspondingly, whether or not you request the change within the 60-day period. For example, if a dependent becomes age 19 to 24 during the year and you do not certify that the dependent is eligible for coverage during the next plan year; the dependent coverage will automatically end December 31.

Examples of Midyear Change Events

Midyear change events that affect eligibility for insurance benefits

These changes fall into three broad categories.

1. Qualified status changes, such as changes in
 - Legal marital status – marriage, divorce or death of a spouse
 - Number of dependents, such as birth or adoption of a child
 - Your or a family member's employment status, such as the start or end of employment, or a change from part-time to full-time job status
 - Eligibility of a dependent, such as a dependent losing eligibility because of age
 - Your residence or that of a family member
 - Your domestic partnership

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2. Changes in cost or coverage, such as
 - An increase in premium cost that you pay
 - Reduction in your spouse's or domestic partner's group health insurance plan benefits
3. Changes by law or court order, such as National Medical Support Notice, Medicare, or HIPAA

Midyear changes that affect eligibility for dependent care flexible spending accounts

- You marry and gain children as dependents
- Your spouse dies, or you divorce or have a legal separation or annulment and this affects the need for dependent care
- Your biological child is born, you adopt a child, or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your employment status changes
- Your spouse's employment status changes
- You experience a change in cost or coverage of dependent care.

Midyear changes that affect eligibility for healthcare flexible spending accounts

- You marry
- Your spouse dies, or you divorce or have an annulment
- Your biological child is born. You adopt a child or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your or your spouse's employment changes, which affects your healthcare flexible spending account eligibility.

HIPAA Special Enrollment Rights

Biological newborns, adoption, or placement for adoption receive health plan coverage retroactive to the event through the first 31 days. However, you must submit the update forms to your agency within 60 days of birth to continue the coverage. When forms are submitted within the 60-day period and up to 12 months from the date of birth, the agency will approve coverage continuously and retroactively, so claims incurred during that time will be paid.

If you previously declined enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a PEBB plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Tag along rule: If you add new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents that were eligible but not enrolled. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact PEBB at (503) 373-1102, or e-mail inquiries.pebb@state.or.us.

Appendix A (<http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf>) details QSCs and consistent benefit changes that may be made.

Ending Participation in PEBB

Employees no longer participate in a PEBB plan when the PEBB plan ends or the employee is no longer eligible to participate.

When an active employee is no longer eligible, and the employee has 80 or more paid regular hours in that month, benefits will end the last day of the following month.

When an active employee is no longer eligible, is not on a protected leave and has less than 80 paid regular hours in the month, benefits will end the last day of that month.

If the employee has a flexible spending account (FSA) at the time benefits end, the account will end as described in the FSA member handbook.

Becoming Eligible after Ending Participation

PEBB will reinstate benefits an employee had on ending participation when the employee is rehired, within 30 days and again eligible for benefits. The employee may not change benefit elections until the next Open Enrollment or a midyear plan change event occurs.

An eligible employee returning to work beyond 30 days and within 12 months of the insurance coverage end date following layoff or termination of employment is not required to work at least half time in the month they return to be eligible for benefits the following month. The previous enrollments will be reinstated, if available, the first of the month following their return to work. Flexible Spending Accounts and Long Term Care benefits are not reinstated. The exception is if the individual continued participation in a healthcare FSA while on COBRA. In this case, PEBB will reinstate the FSA. The employee has 60 days from the date of rehire to change benefit elections.

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When an employee is rehired more than 12 months after ending participation and is eligible to participate, the employee must enroll as a newly eligible employee.

Returning to Work from a Leave without Pay or Reduction in Hours

An eligible employee who returns to work following a layoff, termination of employment, or leave without pay in a protected leave class (FMLA, Active Military Duty Leave, CBIW) is not required to work at least half time in the month the employee returns to work to be eligible for benefits the following month. The employee must work at least half time each month after that to qualify for benefits.

An eligible employee who returns to work from a leave without pay that is not within a protected leave class (FMLA, Active Military Duty Leave, CBIW) or a reduction in hours must work at least half time in the month the employee returns to work to be eligible for benefits the following month. The exception is job-share positions.