

## **Section 5: Required Notices**

### ***Plan Administration***

#### **Administrator Responsibilities**

The plan administrator administers the plan in accordance with its terms for the exclusive benefit of participants and their covered spouses, domestic partners and dependents.

The plan administrator has authority to interpret or construe ambiguous, unclear or implied terms in the plan, make any findings of fact or law needed in the administration of the plan, determine eligibility of employees to participate in the plan and to receive benefits, and control and manage the operation and administration of the plan. This includes the authority to:

- Establish the method of accounting and to maintain accounts under the plan;
- Prescribe any forms to administer the plan;
- Make and enforce rules (Oregon Administrative Rule Chapter 101) and regulations needed to implement and administer the plan;
- Appoint individuals to assist in the administration of the plan;
- Furnish administrative reports to the participating employer;
- Provide information required by law to employees, governmental agencies, or other persons entitled to benefits under the plan;
- Receive, review, and keep on file reports of benefits;
- Receive information from the participating employer and from participants for the efficient administration of the plan;
- Require participants to complete and file needed applications, forms, pertinent information and documents, including receipts, and the participant's current mailing address;
- Take needed actions to satisfy IRS Code requirements;
- Review claims or claims denials under the plan;
- Sign checks or other instruments incidental to the operation of the plan;
- Make needed amendments to the plan to carry out the intent of the employer legal requirements;
- Terminate the plan unless it is required to continue under either an applicable memorandum of understanding, resolution of PEBB, or both.

Any decision the plan administrator makes in the exercise of its authority is conclusive and binding.

#### **Delegation of Authority**

The plan administrator has the discretion to delegate others to act on behalf of the plan administrator including the authority to make any benefits determination, or to sign checks or other instruments incidental to the operation of the plan.

#### **Information Required for Plan Administration**

Participants and other persons entitled to benefits must furnish the administrator with information for the purpose of administering the plan.

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**Reliance**

The administrator is entitled to rely on information furnished by a participant, participating employers, and any applicable provider or contract administrator.

**Facility of Payment**

When a person entitled to any benefits under the plan is legally disabled or unable to manage his financial affairs, the administrator may

- Direct payment of benefits to the person's legal representative or immediate relative or;
- Direct the application of the benefits for the benefit of the person as the administrator considers advisable. Any payment made will be a full and complete discharge of any liability for such payment under the plan.

**Payment**

Payment of any claim for benefits will be made to the participant unless he or she has previously authorized payment to a person rendering services, treatment, or supplies. If the participant dies before all benefits have been paid to the participant, the remaining benefits, if any, will be paid to the participant's estate or to any person or corporation that has been approved by the administrator to be entitled to payment. Such payment will fully discharge the plan's obligations with respect to that claim for benefits. If a participant is a minor, or not competent to give a valid receipt for payment of any benefit due to him under the plan and if no request for payment has been received from a duly appointed guardian or other legally appointed representative of that person, payment may be made directly to the individual or institution that has assumed the custody or the principal support of that person.

**Subrogation**

If any payment for benefits under the plan is paid, the plan will, to the extent of such payment, be subrogated to all the rights of recovery of the participant arising out of any claim or cause of action that may occur because of the negligence or willful misconduct of a third party. Each participant or his legal guardian agrees to reimburse the plan for amounts paid for such claims, out of any monies recovered from the third party, including but not limited to, any third-parties and the participant's own insurance company as the result of judgment, settlement or otherwise. In addition, each participant agrees to assist a Provider, the Contract administrator, or the plan administrator in enforcing these rights.

**Right of Recovery**

Whenever payments for a claim for benefits have been made in excess of the maximum limit for that claim under the plan, the plan will have the right to recover such amounts to the extent of the excess from whoever received the excess payment or the participant.

**Government-provided Benefits**

The plan does not provide benefits in lieu of, and does not affect any requirement for coverage by, any benefits provided under any federal, state or local government including, without limitation, any workers' compensation insurance or benefit.

**Effect of Mistake**

In the event of a mistake related to eligibility, participation, account allocations or payments, the administrator will make proper adjustments. Adjustment may include withholding amounts due to the plan or the employer from compensation paid by the employer.

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**Insurance Contracts**

PEBB has the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the plan to replace any such insurance companies or contracts.

**Miscellaneous**

**Filing of Information**

The administrator may require participants to provide pertinent information, including proof of dependency or eligibility, before providing benefits through the plan.

**Addresses**

Each participant must file the participant's contact address and any change of contact address with the administrator. The administrator will use the participant's last contact address.

**Mistake of Fact**

The administrator will correct any mistake of fact or misstatement of fact when it becomes known and when equitable and practical.

**Employee Authorization of Payroll Deductions**

The administrator may distribute and collect information or conduct transactions by means of electronic media, including electronic mail systems, Internet, or voice response system. By using electronic media, an employee consents to deductions from compensation in accordance with elections made through the systems and recording of telephone calls on the voice response system.

**No Guarantee of Tax Consequences**

Neither the plan administrator, the employer, nor any participating employer makes any warranty or other representation as to whether any payment received under the plan will be treated as excludable from the employee's gross income for federal, state, or local income tax purposes. It is the obligation of each Employee to determine whether each payment under the plan is excludable from the Employee's gross income for such purposes.

**Quality of Health Services**

The selection by the employer of the coverages that may be financed through the plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any health, dental, or vision care service provider, nor does the employer or any participating employer assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances.

**Governing Law**

The plan will be construed and enforced in accordance with the internal laws of the State of Oregon.

**Conflicting Provisions of Component Plan**

In the event of a direct conflict between the provisions of a component plan or the Summary Plan Description and the provisions of the plan, the provisions of the plan will prevail. Where terms and provisions specifically applicable to an individual component plan are not addressed in the plan document, such terms and provisions as set forth in the component plan document will govern.

**Qualified Medical Child Support Order**

The plan administrator will comply with the terms of a QMCSO.

## ***Benefit Fraud or Abuse***

### **Rights of the Medical Plans**

Your medical plan has the right to investigate fraudulent or abusive use of your plan benefits. Your plan will notify you of an investigation. If the plan identifies what may be fraud or abuse by a member, it may cancel the member's coverage. If the plan identifies what may be fraud or abuse by one of your dependents, the carrier may remove the individual from coverage.

You will receive notification prior to cancellation or removal from coverage. You have the right to appeal the plan's action through the plan's appeal process. In some cases removal from a plan may be a qualified midyear plan change, contact your payroll or benefits office for more information.

### **Rights of PEBB**

When you enroll in any PEBB benefits, you declare that you:

- Are eligible for the coverage requested on the enrollment form or in your online benefit record, as are the individuals you list for coverage
- Understand the benefit elections you make are in effect for as long as you continue to meet PEBB's eligibility requirements or until you elect to change them subject to the provisions of PEBB's plan
- Have read the benefit materials and understand the limitations and qualifications of the PEBB benefits program.
- Authorize premium payments to be deducted from your pay

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

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## ***Appeals***

### **Benefit Plan Appeal Procedure**

You must appeal benefit plan decisions directly to the plan. Follow the appeal rights and procedures in the plan's member handbook (sometimes called certificate or evidence of coverage). If you ask PEBB to review the plan's determination, PEBB will verify only that the plan's determination was within the scope of the current plan contract or request that the plan provide you more explanation of its determination. If it appears that the plan's determination is outside the scope of the contract, PEBB will ask the plan to review your appeal again.

### **Public Employees' Benefit Board Appeal**

Eligible employees may submit appeal requests to PEBB concerning PEBB policy, eligibility, or plan enrollments. PEBB staff, the Operations Subcommittee, and the Board use relevant state and federal regulations, policy, PEBB's documented Internal Revenue Code (IRC) 125 Cafeteria plan, and Oregon Administrative Rules to provide appeal decisions.

PEBB does not accept appeals related to contracted plans or plan administrators, such as but not limited to medical, dental, life, disability, COBRA, and long term care, services, decisions, or claims.

Beginning in 2011, if PEBB rescinds plan coverage due to an individual's ineligibility for coverage, the ineligible individual may appeal the rescission decision to PEBB using this rule. Until the appeal process for the rescission is exhausted, the individual's premium and claim payments will continue as if the rescission had not occurred. Upon final appeal determination, if the rescission is upheld the employee will be responsible to pay all claims and premium payments paid by the plan or PEBB during the period of ineligibility. Eligible employees, or individuals notified of coverage rescission, have four levels of PEBB appeal.

**Level One:** An eligible employee who believes he or she received an incorrect or unfair decision from PEBB, an employing agency, or retiree plan administrator, or an individual notified of a rescission may appeal the decision to PEBB within 30 days of that decision.

- The employee or individual must submit the appeal to PEBB using the correct forms and provide any supporting documentation for appeal.
- A PEBB Benefit Analyst will review the appeal documents and may request additional information from the employee, individual or the employer. PEBB must receive information requested from the employee or individual within 10 business days or the appeal is closed.
- The analyst will complete review of the appeal within 30 days of the date PEBB receives all the necessary appeal documentation or notify the employee or individual if a decision will require longer than 30 days. When complete, the analyst will provide a written explanation and determination to the employee.

**Level Two:** An eligible employee or an individual notified of rescission who is dissatisfied with a Level One appeal determination may within 30 days of the determination letter request a Level Two review from the PEBB Plan Design Manager.

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- The employee or individual must submit the request to the Plan Design Manager in writing and provide any new supporting documentation that would support the request. The manager may request additional information from the employee or the employer. Requested information from the employee or individual must be received with 10 business days or the appeal is closed.
- The Plan Design Manager will review the request and determine whether to provide a determination to the employee or move the request directly to Level Three. The Plan Design Manager may request that the Administrator or the Administrator's designee assist in the appeal review and determination.
- When the Plan Design Manager completes a review, the employee or rescission individual will receive a written explanation and determination within 30 days of PEBB receiving all the necessary appeal documentation. When the Plan Design Manager sends the appeal to Level Three without providing a determination, the employee will receive notice.

**Level Three:** An eligible employee or a plan rescission individual receiving both a first and second level denial may request that the Operations Subcommittee review the appeal. The Subcommittee may review appeals submitted directly by the Plan Design Manager.

- An employee or individual requesting a Level Three review must submit the request in writing to the Plan Design Manager within 30 days of the Level Two determination letter date.
- The Operations Subcommittee may recommend a review and determination of the appeal by the Board without providing a decision to the employee or individual. The employee or individual will receive notice of the recommendation.
- When the Subcommittee completes a review, the employee or individual will receive a written explanation and determination within 30 days after the next regularly scheduled meeting.

**Level Four:** An eligible employee dissatisfied with a determination by Operations Subcommittee or a rescission individual may request a review and determination of the appeal by the Board. The Board may review appeals submitted directly by the Operations Subcommittee.

- An employee or individual requesting a Level Four review must submit the request in writing to the Plan Design Manager within 30 days of the Operations Subcommittee determination letter date.
- When the board completes a review, the employee or individual will receive a written explanation and determination within 30 days after the next regularly scheduled meeting. Should the decision require longer than 30 days the Board will send notice to the employee.

**An individual may appeal the Board's decision as provided under the Oregon Administrative Procedures Act, ORS Chapter 183.**

## **Federally Required Notices**

### **Lifetime Limit No Longer Applies and Enrollment Opportunity**

The lifetime limit on the dollar value of benefits under PEBB-sponsored medical plans no longer applies as of Jan. 1, 2011. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice or until the end of open enrollment to request enrollment. For more information contact PEBB at 503-373-1102.

### **Opportunity to Enroll with Extension of Dependent Coverage to Age 26**

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in PEBB-sponsored medical plans. Individuals may request enrollment for such children for 30 days from Oct. 1, 2010, or until the end of open enrollment. Enrollment will be effective Jan. 1, 2011. For more information contact PEBB at 503-373-1102.

### **Notice of Women's Health and Cancer Rights**

If you or your insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, coverage will be provided for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications of all stages of mastectomy, including lymph edemas. Reconstruction benefits are subject to the same provisions as any other benefit provided under the PEBB plans.

### **Important Notice from PEBB About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Public Employees' Benefit Board (PEBB) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
  2. PEBB has determined that the prescription drug coverage offered by PEBB is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
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**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

You current PEBB group coverage pays for other health care expenses, in addition to prescription drugs. If you decide to join a Medicare drug plan, your current PEBB group coverage will not be affected. However, if you decide to join a Medicare drug plan and drop your current PEBB group coverage, be aware that you and your dependents will lose health care and prescription drug coverage through PEBB and may not be able to get this coverage back prior to open enrollment or a change-in-status event.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with PEBB and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PEBB changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325 0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

**Date: Sept. 9, 2010. Name of Entity/Sender: PEBB. Contact: Benefits Office, Ste B.  
Address:1225 Ferry St SE, Salem, OR 97301. Phone Number: 503-373-1102.**

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**Special Enrollment Rights**

Under the special enrollment provisions of HIPAA, you will be eligible, in certain situations, to enroll in a PEBB medical plan during the year, even if you previously declined coverage. This right extends to you and all eligible family members.

You will be eligible to enroll yourself (and eligible dependents) if, during the year you or your dependents have lost coverage under another plan because:

- Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility;
- Employer contributions to the plan stopped;
- The plan was terminated;
- COBRA coverage ended; or
- The lifetime maximum for medical benefits was exceeded under the existing medical coverage option.

If you gain a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the plan — again, even if you previously declined medical coverage. Coverage will be retroactive to the date of the birth or adoption for children enrolled during the year under these provisions.

You will also be eligible to enroll yourself and any eligible dependents if either of two events occur: (1) You or your dependent loses Medicaid or Children's Health Insurance Program (CHIP) coverage because of a loss of eligibility. (2) You or your dependent qualifies for state assistance in paying employer group medical plan premiums.

Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the employer medical plan.

Please note that special enrollment rights allow you to either enroll in current medical coverage; or enroll in any medical plan benefit option for which you and your dependents are eligible.

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**Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the states listed on the following page, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility. To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Ext. 61

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<b>ALABAMA – Medicaid</b>	<b>MAINE – Medicaid</b>
Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a> Phone: 1-800-362-1504	Website: <a href="http://www.maine.gov/dhhs/oms/">http://www.maine.gov/dhhs/oms/</a> Phone: 1-800-321-5557
<b>ALASKA – Medicaid</b>	<b>MASSACHUSETTS – Medicaid and CHIP</b>
Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid & CHIP Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Medicaid & CHIP Phone: 1-800-462-1120
<b>ARIZONA – CHIP</b>	<b>MINNESOTA – Medicaid</b>
Website: <a href="http://www.azahcccs.gov/applicants/default.aspx">http://www.azahcccs.gov/applicants/default.aspx</a> Phone: 1-877-764-5437	Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance Phone: 800-657-3739
<b>ARKANSAS – CHIP</b>	<b>MISSOURI – Medicaid</b>
Website: <a href="http://www.arkidsfirst.com/">http://www.arkidsfirst.com/</a> Phone: 1-888-474-8275	Website: <a href="http://www.dss.mo.gov/mhd/index.htm">http://www.dss.mo.gov/mhd/index.htm</a> Phone: 573-751-6944
<b>CALIFORNIA – Medicaid</b>	<b>MONTANA – Medicaid</b>
Website: <a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a> Phone: 1-866-298-8443	Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> Telephone: 1-800-694-3084
<b>COLORADO – Medicaid and CHIP</b>	<b>NEBRASKA – Medicaid</b>
Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> Medicaid Phone: 1-800-866-3513 CHIP Website: <a href="http://www.CHPplus.org">www.CHPplus.org</a> CHIP Phone: 303-866-3243	Website: <a href="http://www.dhhs.ne.gov/med/medindex.htm">http://www.dhhs.ne.gov/med/medindex.htm</a> Phone: 1-877-255-3092
<b>FLORIDA – Medicaid</b>	<b>NEVADA – Medicaid and CHIP</b>
Website: <a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a> Phone: 1-866-762-2237	Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900 CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a> CHIP Phone: 1-877-543-7669
<b>GEORGIA – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: <a href="http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm">http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm</a> Phone: 1-800-852-3345 x 5254
<b>IDAHO – Medicaid and CHIP</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a> Medicaid Phone: 1-800-926-2588 CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a> CHIP Phone: 1-800-926-2588	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 1-800-356-1561 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>INDIANA – Medicaid</b>	<b>NEW MEXICO – Medicaid and CHIP</b>
Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a> Phone: 1-877-438-4479	Medicaid Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> Medicaid Phone: 1-888-997-2583 CHIP Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> (Click on Insure New Mexico); CHIP Phone: 1-888-997-2583
<b>IOWA – Medicaid</b>	
Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562	
<b>KANSAS – Medicaid</b>	<b>NEW YORK – Medicaid</b>
Website: <a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a> Phone: 800-766-9012	Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831

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KENTUCKY – Medicaid	NORTH CAROLINA – Medicaid
Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	Website: <a href="http://www.nc.gov">http://www.nc.gov</a> Phone: 919-855-4100
LOUISIANA – Medicaid	
Website: <a href="http://www.la.hipp.dhh.louisiana.gov">http://www.la.hipp.dhh.louisiana.gov</a> Phone: 1-888-342-6207	

## ***Your Continuation Coverage Rights under COBRA***

### **What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health benefits offered under the Plan and not to any other benefits offered under the Plan.

The Plan provides no greater COBRA rights than what COBRA requires — nothing in this notice is intended to expand your rights beyond COBRA requirements.

### **How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

### **Continuation coverage will be terminated before the end of the maximum period if:**

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

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Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

**How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify BenefitHelp Solutions of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

**Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies.

The disability extension is available only if you notify BenefitHelp Solutions in writing of the Social Security Administration's determination of disability within the 18-month period of continuation of coverage.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed, or if the notice is not provided to BenefitHelp Solutions within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify BenefitHelp Solutions of that fact within 30 days after the Social Security Administration's determination. In providing this notice, you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures."

**Second Qualifying Event**

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

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#### **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

If your employer maintains separate plans for each health benefit component of the Plan, you may elect COBRA coverage for any one or more of the Plan components under which you were covered on the day before the qualifying event. For example, if you had the option to choose medical and/or dental and/or vision coverage, you will have the option to continue any one of the plans that you were covered under on the day before the qualifying event. However, if your employer has one health plan that covers medical, dental and vision, you must elect or decline continuation coverage for the plan as a whole.

If the health plan you are enrolled in at the time of your qualifying event is regional specific (such as a managed care plan), and you move outside the service area, and the employer has a health plan available in the area you have moved to, you may elect coverage under the other health plan. This also applies if you move after electing COBRA coverage. It is your responsibility to inform the employer of your move.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. Medicare becomes the primary payer for an age-based or disability-based Medicare beneficiary who also has COBRA coverage. If Medicare entitlement is based on ESRD, then Medicare is the secondary payer for the first 30 months of the Medicare entitlement. Carriers may assume enrollment in Medicare and estimate claims as if Medicare is the primary payer. If you haven't enrolled in Medicare Part B and are eligible, contact the Centers for Medicare and Medicaid Services (CMS) to discuss your options. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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#### **How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period defined in the law or subsequent extensions. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a no forfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

#### **Electing COBRA under the Health FSA component**

If you are currently participating in a Health FSA, and there is a positive balance of funds in your Health FSA on the termination date, you, your covered spouse and qualified beneficiaries covered under the Health FSA component are entitled to continue coverage in the Health FSA plan. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). **The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.** All qualified beneficiaries who were covered under the Health FSA component of the Plan will be covered together for Health FSA COBRA coverage.

## **When and how must payment for COBRA continuation coverage be made?**

### **First payment for continuation coverage**

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you make your first payment for continuation coverage in full later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact BHS to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

### **Periodic payments for continuation coverage**

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. As a courtesy, BHS will send monthly notices of payments due for these coverage periods if you elect to pay your premium via check. (If you do not receive a bill, it is still your responsibility to pay your COBRA premiums on time).

### **Grace periods for periodic payments**

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Send your first payment and all periodic payments for continuation coverage to:

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BenefitHelp Solutions, Inc.

P.O. Box 67240, Portland, Oregon 97268-1240

Phone: 800-556-3137 or 503-765-3581

Fax: 503-765-3453

Web: [www.benefithelpsolutions.com](http://www.benefithelpsolutions.com)

### **Important Information**

Continuation of Coverage for Spouses Age 55 or Older: Under Oregon law (ORS 743.600-743.602), if you are a spouse who is age 55 or older and your eligibility for group health plan coverage has ended due to legal separation, termination of marriage or the member's death, you may be entitled to continue your plan coverage (including coverage for dependent children) until one of the following events occur:

- the date you become covered under any other group health plan, regardless if the other plan has an exclusion or limitation period;
- the date you become eligible for federal Medicare coverage, regardless if you enroll in Medicare;
- the last day of the month that premiums were paid to us in the event of non-payment of premiums;
- the date the Plan terminates or the date the employer terminates participation under this Plan;
- a Dependent child may remain on the plan with you until he/she no longer meets the plan's definition of a dependent child.

Oregon continued coverage is available only if you (spouse age 55 or older) notify the Plan Administrator in writing of the legal separation, termination of marriage or your spouse's death within:

- thirty days of the date of the member's death;
- sixty days of the date of legal separation; or
- sixty days of the date of entry of the divorce decree.

You have 60 days from the date BHS sent this COBRA Enrollment Notice to you to exercise your Oregon continuation coverage rights.

### **For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have any questions concerning the information in this notice, your rights to coverage contact:

BenefitHelp Solutions, Inc.

P.O. Box 67240, Portland, Oregon 97268-1240

Phone: 800-556-3137 or 503-765-3581

Fax: 503-765-3453

Web: [www.benefithelpsolutions.com](http://www.benefithelpsolutions.com)

### **Keep Your Plan Informed of Address and Plan Eligibility Changes**

In order to protect your and your family's rights, you should keep BenefitHelp Solutions informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to BenefitHelp Solutions.

If you become eligible for coverage under another group health plan or Medicare, you must notify BenefitHelp Solutions of such eligibility in writing, even if you do not elect such other coverage. Failure to notify BenefitHelp Solutions of eligibility for such other coverage may subject you to a federal

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penalty equal to 110% of the premium assistance provided to you after the date you became eligible for such other coverage.

Please Note: Although BenefitHelp Solutions, Inc. has contracted with PEBB to provide various COBRA administrative services; BenefitHelp Solutions, Inc. is not the Plan Administrator. The Plan Administrator, PEBB, is the sponsor of the Plan.

### ***Notice of Privacy Practices***

This notice describes how medical information about you may be used and disclosed by PEBB and how you can get access to this information.

The Public Employees' Benefit Board (PEBB) and the PEBB sponsored benefit plans respect the privacy of personal information about all eligible employees and retirees (PEBB members), including eligible family members (together, PEBB Participants), and will maintain confidentiality in a responsible and professional manner.

PEBB sponsors various benefit plans for the benefit of PEBB Members. Some of these benefit plans fall under the definition of "Health Plans" under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. The regulations address the privacy requirements related to the use of protected health information when PEBB is acting as a Plan Sponsor in relation to a Health Plan. PEBB is providing PEBB Members with this notice explaining how it uses, discloses and protects your medical or health information as a Plan Sponsor.

A separate Notice of Privacy Practices will be provided to you by your Health Plans.

For purposes of this notice, your Protected Health Information ("PHI") is information that identifies PEBB Participants and relates to a past, present or future physical or mental health condition; the provision of health care to you; or the past, present, or future payment for health care furnished to the PEBB Participant. PEBB is required by law to maintain the privacy of PHI and to provide PEBB Members with this notice of its legal duties and privacy practices with respect to PHI.

This notice does not apply to PEBB in its capacity of administering benefits that are not for health care benefits, such as life insurance, short term or long term disability insurance, long term care insurance, or accidental death & dismemberment insurance.

### **How information is collected and protected**

As the Plan Sponsor, PEBB must collect a certain amount of PHI to provide customer service, offer new benefits, plans, products or services, administer its plans, and to fulfill legal and regulatory requirements. PEBB also collects information provided when the PEBB Member enrolls or makes changes to benefits. Examples include:

- PHI on enrollment forms and related forms, such as name, address, date of birth, gender, marital status.
- PHI about your relationship to benefit plans, including plans selected and enrollment and disenrollment information, and appeals about eligibility and contract coverage issues.
- Information from employer about eligibility dates.
- PHI from visits to PEBB's Websites, such as that provided through online forms, and online information-collecting devices known as "cookies." Cookies enable the site to remember who visits

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so navigating the site is easier. They also permit you to access your secured information and conduct secured transactions. PEBB does not record personal or sensitive information in cookies.

This information is stored in the electronic benefit system, called "pebb.benefits." Your information is provided to the Health Plans you select for benefit coverage. The Health Plans collect and use this information to administer benefits and to pay claims for services PEBB Participants receive. PEBB ensures the security of your information through physical, technical and procedural safeguards. PEBB restricts the access to and use of confidential information by employees and has established internal policies and procedures to protect member confidential information from unauthorized disclosure.

#### **How information is used or shared by PEBB**

As the Plan Sponsor, PEBB transmits enrollment information to the Health Plans selected by the PEBB Member. Information is transmitted electronically through the pebb.benefits system. Health Plans may disclose to PEBB information on whether an individual is participating in the plan, or is enrolled or has been disenrolled from the plan.

In accordance with the HIPAA privacy regulations, PEBB provides for adequate separation between the Plan Sponsor and the Health Plans with regard to the use and disclosure of PHI. For that purpose, access to PHI for use as a Plan Sponsor is limited to the following employees or classes of employees of PEBB or designated individuals:

- Director of Operations or designees
- Internal Auditors, including representatives of the Oregon Secretary of State when performing Health Plan audits, or
- The Department of Justice.

Access to PHI by the employees designated above is limited to the administrative functions that the employees perform for PEBB with regard to the member's plan.

Plan administration functions that may involve PHI being provided to PEBB include the appeals under PEBB rules, where the individual asks PEBB to review a denial of insurance coverage or a PEBB Member asks PEBB to decide if the Health Plan acted in accordance with PEBB's contract. Otherwise, PEBB is not involved in individual or member appeals.

PEBB will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit administered by PEBB.

The Health Plans may disclose summary health information to PEBB, if PEBB requests summary information for the purpose of (a) obtaining, terminating, or amending the agreements for providing coverage; or (b) modifying, terminating or amending the agreements. PEBB does not have access to your PHI held by a Health Plan. If you contact PEBB and provide PHI to PEBB, PEBB will refer that information to the Plan.

Your authorization is required for uses and disclosures of PHI other than those allowed or required by law. If you provide authorization for the use and disclosure of your information and later change your mind, you may revoke the authorization.

#### **Review and access to information**

PEBB Participants have the right to access PHI held by PEBB, receive a list of disclosures PEBB has made of PHI, request restriction on use or disclosure of PHI, or correction of incorrect information. You

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may submit a complaint if you believe PEBB has improperly used or disclosed your PHI or if you have concerns regarding PEBB's privacy policies.

- PEBB Members may access, inspect and obtain a copy of their records through the electronic benefit system, pebb.benefits.
- PEBB Participants may ask to review any information you believe may be on file at PEBB by submitting a written request with your signature to the PEBB Plan Design Manager. PEBB will respond to the request within 30 days. PEBB will either schedule an appointment for review of records on-site in the PEBB office, or will provide a photocopy of the requested record. PEBB may ask for reimbursement of copies made at your request.
- PEBB Participants may ask that PEBB restrict the use and disclosure of your individual information in the course of PEBB activities on your behalf; and to amend incorrect information held by PEBB.
- PEBB Members may correct information in their PEBB file by accessing their record in the electronic benefit system, pebb.benefits during Open Enrollment, by submitting a Qualified Status Change (QSC) to your agency or to PEBB, or by filing an appeal. Any other request to correct information or to request a restriction should be made in writing to the PEBB Plan Design Manager. PEBB will consider the request, although PEBB is not required to agree to the request.
- You may request an accounting of disclosures of your personal information in writing to the PEBB Plan Design Manager. PEBB will provide a list of disclosures within 30 days of receipt of your request; however the list does not have to include PHI disclosures made to individuals about their own PHI or prior to the HIPAA compliance date.
- PEBB Participants have a right to receive a paper copy of this notice upon request at any time. Log on to <http://oregon.gov/das/pebb/privacy.shtml> to access this notice.

**If you have any questions about this notice, contact the PEBB Plan Design Manager.**

PEBB Plan Design Manager  
1225 Ferry St SE  
Salem, Oregon 97301-3802  
Phone: 503.373.1102

**If you believe PEBB has inappropriately disclosed your confidential information, you may file a written complaint with the PEBB Administrator.**

PEBB Administrator  
1225 Ferry St SE  
Salem, Oregon 97301-3802  
Phone: 503.373.1102

You may appeal to the full Board if the issue is not resolved at the Administrator level.

**You have the right to file a complaint regarding how PEBB uses confidential information with the Privacy Officer of the State of Oregon, Department of Administrative Services (DAS).**

DAS Privacy Officer  
155 Cottage St. NE  
Salem 97301-3972  
Phone: 503.945.7296

**You may also file a written complaint with the U.S. Department of Health and Human Services; Office of Civil Rights if you believe PEBB has violated your rights. PEBB will not take any action against you for filing a complaint.**

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Office for Civil Rights, Medical Privacy Complaint Division  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW, HHH Building, Room 509H  
Phone: 866-627-7748 TTY 866-788-4989  
E-mail: OCRComplaint@hhs.gov

**Changes to Our Notice**

This notice is effective on January 1, 2008. PEBB is required to abide by the terms of this notice until it is changed. We reserve the right to change the terms of this notice and to make the new notice effective for all PHI we maintain. Once revised, we will notify you that a change has been made through the PEBB member newsletter and post the notice on our website at <http://oregon.gov/das/pebb>.