

SECTION 1: GENERAL INFORMATION

Eligible Members

Who is eligible to participate in the PEBB Benefits Program as a member?

- **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:

- Is expected to work at least 90 days
- Works at least half time or is in a position classified as job share.

Employers of eligible employees are:

- Oregon state government agencies
- The Oregon University System (OUS)
- The following semi-independent state agencies:
Appraiser Certification & Licensure Board
Board of Geologist Examiners
Oregon Board of Optometry
Oregon Board of Massage Therapists
Oregon Beef Council
Oregon Corrections Enterprises
Oregon Dairy Products Commission
Oregon Dungeness Crab Commission
Oregon Film and Video Office
Oregon Fryer Commission
Oregon Hop Commission
Oregon Patient Safety Commission
Oregon Potato Commission
Oregon Salmon Commission
Oregon State of Examiners for Engineering and Land Surveying
Oregon Tourism Commission
Oregon Wheat Commission
Physical Therapist Licensing Board
State Landscape Architects Board
State Landscape Contractors Board
Travel Information Council

- **Retirees:** Active employees enrolled in PEBB immediately prior to retirement can continue in PEBB medical and dental plans when they

retire if they are not Medicare eligible. They may also have other insurance options. The retiree must self pay the premiums.

- **COBRA Participants:** Former PEBB members who have continued their coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA participants must self-pay the premiums.

PEBB offers benefits to a variety of members.

- **Other Self-pay Participants:** The following individuals who can participate in PEBB by Oregon Revised Statute also self pay the premiums:
 - 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.

If I'm a PEBB member, are my family members covered?

Yes. Family members include the member's spouse, domestic partner and dependent children.

Who is a dependent child?

PEBB's definition of "dependent child" changed with new rules effective December 2006. If you are in doubt if a person in your family qualifies as a dependent child, contact your agency. Retiree, COBRA and other self-pay participants, contact PEBB's third-party administrator, BenefitHelp Solutions (BHS). See the contact information on page 82.

How do I participate as an eligible employee?

As an employee, you participate in the PEBB benefit program when you are eligible and you enroll for mandatory benefits. Mandatory benefits include medical and dental coverage for at least you alone (please see opt out option below). If you participate in the PEBB program, you are automatically enrolled for the required basic life insurance coverage. You may also enroll in any of the optional benefits offered.

If I don't want to participate in PEBB plans?

You may choose to **decline coverage**.

Eligible employees who decline coverage waive all rights to the employer contribution and enrollment in any of the available PEBB benefit plans. This includes all optional benefits. Employees who decline coverage do not receive any cash in lieu of benefits monthly pay as taxable income. Employees may decline all benefits within 60 days of their date of hire or eligibility, consistent with a qualified status change or during Open Enrollment. For more information about declining coverage, contact your agency.

If I have other group medical coverage, can I opt out?

Employees covered by another employer group medical plan (as defined by PEBB) may **opt out of medical insurance** (see glossary for PEBB's definition of "group medical plan"). They may do so within 60 days of their date of hire or eligibility, consistent with a qualified status change or during Open Enrollment. Members who opt out of medical insurance must enroll in a PEBB dental plan and basic life insurance. They may also choose to enroll in any of the available optional benefits.

Employees who are eligible and choose to opt out of medical coverage receive a monthly employer 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 insurance premiums is deducted from that amount pretax. They receive the remaining balance in their monthly pay as taxable income. See the opt-out calculation worksheet on page 24.

Individual medical plan coverage does not qualify an individual to opt out.

Will my PEBB benefits cover my domestic partner and my partner's children?

Yes. However, before this coverage can happen you and your partner must meet certain requirements (see page 12). Employees should also know that adding a domestic partner will increase your tax withholding, and you will take home less pay (see pages 12-13).

Benefit Options by Member Status

Benefits vary by member status (see page 1). Your member status is one of the following:

- Eligible Employees
- Retirees
- COBRA Participants
- Other Self-pay Participants.

This section will help you identify your:

- Available benefit options
- Basic enrollment information
- General effective dates
- Dependent eligibility.

This section also discusses domestic partner eligibility.

Full-time Eligible Employees of State Agencies, OUS and Semi-Independent Agencies

(Including Limited Duration Employees)

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 80 paid regular hours per month, or .5 FTE for OUS employees, 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 subsequent months.

Currently the employer contribution fully covers the premium amount for medical, dental and basic life insurance plans for full-time employees.

Benefit options vary by member status.

Benefit Options:

- All available medical plans (except for part-time and retiree plans), according to where the employee lives and/or works
- All available dental plans (except for part-time and retiree plans)
- Basic \$5,000 life insurance
- All available optional benefits.

These employees may opt out of medical coverage (if they have other group coverage as defined by PEBB). They may also decline all benefits.

Enroll online at <https://pebb.benefits.oregon.gov/members>.

Enrollment Period	Effective Dates
<p>During Open Enrollment Change, add or remove benefit plans.</p>	<p>First of the new plan year (usually January 1).</p>
<p>New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.</p>	<p><i>Generally</i>, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.</p>
<p>Midyear qualified status change event Benefit elections must be made within 60 days of the event.</p>	<p><i>Generally</i>, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.</p>

Part-Time Employees of State Agencies, OUS and Semi-Independent Agencies

(Including Limited Duration and Job Share)

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

- A minimum of 80 paid regular hours per month
- In a job share position,
- 0.5 FTE for an OUS employer, or
- As defined 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 subsequent months.

Each month, part-time employees receive a pro-rated contribution from the employer for medical, dental and basic life insurance plans. For most part-time employees, the pro-rated contribution is based on the number of hours worked in the previous month. For

Enroll online at <https://pebb.benefits.oregon.gov/members>.

job share employees, the contribution amount is fixed by their share of the FTE.

Part-time employees must pay the difference between the contribution 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.

Benefit Options:

- All available medical plans, according to where the employee lives and/or works
- All dental plans
- Basic \$5,000 life insurance
- All optional benefits.

These employees may opt out of medical coverage (if they have other group medical coverage). Also, they may decline all benefits.

Enrollment Period	Effective Dates
<p>During Open Enrollment Change, add or remove benefit plans.</p>	<p>First of the new plan year (usually January 1).</p>
<p>New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.</p>	<p><i>Generally</i>, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.</p>
<p>Midyear qualified status change event Benefit elections must be made within 60 days of the event.</p>	<p><i>Generally</i>, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.</p>

New Seasonal Employees of State Agencies, OUS and Semi-Independent Agencies

(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, or the employee moves to a position that extends employment more than 90 days without a break in service, the employee becomes benefit eligible at the time of change in employment status.

Benefit Options:

- **Full-time seasonal employees:** All available medical and dental plans (except for part-time and retiree plans), according to where the employee lives and/or works
- **Part-time seasonal employees:** All available medical and dental plans, according to where the employee lives and/or works
- Basic \$5,000 life insurance
- All optional benefits.

These employees may opt out of medical coverage (if they have other group medical coverage as defined by PEBB). They may also decline all benefits.

Enrollment Period	Effective Dates
<p>During Open Enrollment Change, add or remove benefit plans.</p>	<p>First of the new plan year (usually January 1).</p>
<p>New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.</p>	<p><i>Generally</i>, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.</p>
<p>Midyear qualified status change event Benefit elections must be made within 60 days of the event.</p>	<p><i>Generally</i>, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.</p>

Returning Seasonal Employees of State Agencies, OUS and Semi-Independent Agencies

(Returning within 12 Months)

Seasonal employees returning within 12 months without prior benefit eligibility are eligible for PEBB benefits if they are expected to work half time or more and have accumulated 60 calendar days of employment. The 60 calendar days do not need to be consecutive within the current or previous plan year.

Seasonal employees returning within 12 months who had PEBB benefits prior to starting their leave will have their benefits reinstated the first of the month following their return date.

Benefit Options

- **Full-time seasonal employees:** All available medical and dental plans (except for part-time and retiree plans), according to where the employee lives and/or works

- **Part-time seasonal employees:** All available medical and dental plans, according to where the employee lives and/or works
- Basic \$5,000 life insurance
- All optional benefits.

These employees may opt out of medical coverage (if they have other group medical coverage as defined by PEBB). They may also decline all benefits.

Most benefits are reinstated for returning seasonal employees. Reinstated means to reactivate prior medical, dental, life, and disability insurance policies, if they are provided on a guaranteed basis, when the employee returns from a leave or a termination of employment.

The exceptions are flexible spending accounts and long term care insurance. Returning seasonal employees must re-enroll if they want these plans.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefit plans.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	<i>Generally</i> , the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified status change event Benefit elections must be made within 60 days of the event.	<i>Generally</i> , the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

Non-Medicare Eligible Retirees of State Agencies, OUS and Semi-Independent Agencies

Employees who are thinking of retiring before they are eligible for Medicare have several insurance options to consider. Keep in mind that eligible retirees who enroll in PEBB benefits must self pay the premiums; the state does not contribute.

Retiree Medical and Dental Options

- PEBB retiree medical and/or dental plans
- A health plan offered by the Public Employees Retirement System (PERS)
- COBRA
- A group coverage portability plan or a plan through the Oregon Medical Insurance Pool (OMIP).

If you are a state retiree eligible for Medicare, you are no longer eligible for PEBB plans (except for those with end-stage renal disease). Your options include:

- A PERS Medicare supplement plan
- An individual Medicare supplemental plan.

For more information on these options, contact the PERS health insurance programs.

Who is a PEBB-eligible retiree?

To be eligible you must meet **both** of the following requirements:

- Be eligible to receive retirement benefits under PERS rules, and
- Be enrolled in a PEBB medical and/or dental plan.

The following individuals are eligible for retiree coverage:

- Eligible employees who will be eligible retirees
- Spouses or domestic partners, and
- Dependent children covered on active employees' plans at the time of retirement.

What PEBB retiree plans are available?

Retirees may choose from all available medical and dental plans including full-time and part-time and retiree plans available in your service area.

You may change medical or dental plans when you enroll in a PEBB retiree plan. 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.

How do I enroll for medical and/or dental coverage?

BenefitHelp Solutions (BHS) is PEBB's third-party administrator for retiree plans. Complete and submit to BHS the Medical and Dental Enrollment Form Non-Medicare Eligible Retiree and Non-Medicare Eligible Dependent. A form is included in this book. For more information contact BHS or PEBB.

How long can I continue coverage?

As long as:

- You are not eligible for Medicare (except those with end-stage renal disease)
- Premium payments are current
- PEBB continues to offer retiree coverage.

In the event of your death, your enrolled dependents may continue coverage as long as they meet the eligibility requirements.

When do I 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 group coverage will end. The enrollment deadline is 60 days from that date.

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 and then become eligible to retire, you can transfer to the retiree group during or at the end of the COBRA period.

After I enroll, can I change my choices?

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 retirees the opportunity to change plans; **it does not allow them to add coverage they did not already have.** For example, if you chose not to enroll in medical coverage when you retired, you may not enroll for medical 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 status change (see page 18).

What are the effective dates for retirees?

PEBB retiree coverage is effective immediately following the transition from PEBB employee coverage or COBRA coverage. There must be no break in coverage.

What are the enrollment time frames if I move out of the plan's service area?

When a retiree leaves a plan's service area, the retiree may enroll in a new plan. They must do so within 60 days. If they fail to enroll within 60 days, they may apply for late enrollment, which must be approved by PEBB.

What are the enrollment time frames if my dependent loses other coverage?

If an eligible dependent not enrolled on your retiree plan later loses other employer group coverage, you may enroll the dependent for coverage in the retiree plan. They must do so within 60 days. If you fail to submit the correct forms within 60 days of the event, you may apply for late enrollment, which must be approved by PEBB.

Can I continue life and long term care insurance after I retire?

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

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

Can I continue other optional benefits?

No. You cannot continue dependent life, disability, or accidental death and dismemberment insurance.

What other healthcare insurance options may I have as a retiree?

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, but you must self pay your premium. However, there are some important differences to keep in mind.

1. COBRA usually allows continuation of your participation in the active-employee group for only 18 months. If you retire because of disability, you may be eligible for an additional 11 months of COBRA coverage, for a total of 29 months.
2. COBRA coverage 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.
3. 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.

Portability Coverage or Oregon Medical Insurance

Program. The PEBB Regence and Kaiser medical plans are “portable.” Portability means that you may purchase an individual medical plan offered by your insurance

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
- Currently not be 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 individual plan carriers directly.

Samaritan and Providence medical plans are self-insured medical plans. If you leave a self-insured plan, you may 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 younger people with disabilities.

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

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 PEBB benefit-eligible position are eligible for employee 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. Reinstatement means to reactivate all previous medical, dental, life and disability insurance policies, if available, on a guaranteed basis.

NOTE: Special conditions apply to the Standard Life insurance coverage if converted or ported. Contact Standard.

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

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

Retirees enrolled in a PEBB retiree plan may suspend PEBB retiree coverage while in active employee status by notifying BenefitHelp Solutions (BHS), the third-party administrator. You must notify BHS when you are no longer an active employee meeting the half time work criterion. Your coverage must be continuous to remain eligible to participate in PEBB plans.

Non-Medicare eligible retirees have the option of declining active employee benefits. Medicare-enrolled retirees must enroll in the PEBB active employee plans because of the Medicare secondary payor rules.



*Did you know
gardening for 30 to
45 minutes burns
about 150 calories?*

Other Self-pay Participants

Other 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. Self-pay participants may also enroll their spouse or domestic partner, and eligible dependents. Self-pay participants do not receive a premium contribution. Participants are responsible to pay all premium costs.

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.

BenefitHelp Solutions (BHS) administers the Self-pay Participant program. To enroll, complete and submit the application form included in this book. If you need more information, contact BHS or PEBB.

Enrollment Period	Effective Dates
<p>During Open Enrollment Change, add or remove benefit plans.</p>	<p>First of the new plan year (usually January 1).</p>
<p>New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.</p>	<p><i>Generally</i>, the first of the month following the hire date or the receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.</p>
<p>Midyear qualified status change event Benefit elections must be made within 60 days of the event.</p>	<p><i>Generally</i>, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.</p>

COBRA Participants

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employer-sponsored group health plans to give participants the opportunity to temporarily continue their benefits in certain situations when coverage would normally end.

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 qualified status change for COBRA to apply. In general, individuals experiencing a qualifying

event must be given the opportunity to elect only the coverage they were receiving immediately before the qualifying event. You must self pay the premiums for this benefit coverage; the state does not contribute to your premium.

For more information regarding your COBRA rights and qualifying events, see page 73.

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

Domestic Partners and Their Dependents

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. A domestic partner's children are also eligible for enrollment.

The member and the domestic partner must sign and submit an affidavit declaring that both:

- Are at least 18 years of age
- Share a close personal relationship and are responsible for each other's common welfare
- Are each other's sole domestic partner
- Are not legally married to anyone* and have not had another domestic partner within the prior six months
- Are not related by blood closer than would bar marriage in the State of Oregon
- Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date of the affidavit with the intent to continue doing so indefinitely
- Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. (Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.)

If requested, you would be able to provide at least three of the following as verification of their joint responsibility, with information dated to confirm eligibility at time of enrollment:

- Joint mortgage or lease
- Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract
- Designation of the domestic partner as primary beneficiary in the covered member's will
- Durable power of attorney for health care or financial management
- Joint ownership of a motor vehicle, a joint checking account, or a joint credit account
- A relationship or cohabitation contract that obligates each of the parties to provide support for the other party.

Before enrolling a domestic partner and a partner's children, employees should know there are important tax considerations when doing so.

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
- Within 60 days of and consistent with a qualified status change event
- During Open Enrollment.

If you terminate your partnership, you must complete and submit a Termination of Domestic Partnership form and any other necessary update forms.

** Currently, opposite-gender couples of the requisite age may be legally married in Oregon. Until and unless amended by the Legislative Assembly or adjudged unconstitutional by the Oregon Supreme Court, Oregon statutes permit marriage only between one man and one woman.*

Domestic Partner Frequently Asked Questions

Will adding a domestic partner to coverage affect my take-home pay?

Yes. Before enrolling a domestic partner and a partner's children, there are important tax and pay considerations you should know.

What are the special considerations?

PEBB allows you to add a domestic partner (and/or the partner's children) to your benefit coverage. But if you do, you'll see a change in your pay. Payroll will withhold more taxes, so you will have less pay to take home.

Why will my pay be less?

The IRS doesn't view a domestic partner and children the same as a legal spouse and dependent children. The IRS sees partner coverage as a value added to your taxable income. This is called an imputed value (see glossary) on which you must pay taxes.

What is "imputed value?"

The imputed value is an estimate of the premium cost you would pay if you bought the coverage on the open market. It is not the same as the premium cost in your PEBB handbook. Each year, PEBB reviews the market cost for each of the plans and estimates an imputed value for each plan and coverage tier.

How does the imputed value affect my pay?

When you enroll a domestic partner or a domestic partner's children in PEBB coverage, your payroll adds the estimated imputed value dollar amount to your taxable wages, and then calculates and withholds the taxes. Because the new taxable total is larger than your wages alone, more taxes are withheld. So, you take home less money.

Example

Jane J. Stateworker enrolled for medical and dental coverage on the employee-only tier (see Paycheck Stub A). Payroll calculates her taxes based on her taxable wages of \$3,515.39. After payroll deductions and withholding taxes, she takes home \$ 2,665.35.

When Jane adds her domestic partner to her PEBB employee only-tier, the result is an imputed value of \$456.59 (see Paycheck Stub B). You can see the \$456.59 imputed value added to Jane's taxable wages of \$3,515.39; now payroll calculates Jane's taxes based on the total of \$3,971.98. Jane's new take home pay after payroll deductions and taxes is \$2526.94. This is a net pay difference of \$138.41.

A

STATE OF OREGON OREGON STATE PAYROLL SYSTEM				
AGENCY	DISTRIBUTION	EMPLOYEE NAME	EMP	
99900	9987	STATEWORKER, JANE J	OR99999	
EARNINGS				
DESCRIPTION	HOURS	RATE	AMOUNT	
TOTAL -REG	184.00	3,515.39	3,515.39	
GROSS PAY			3,515.39	
FED TAX			237.04	
STATE TAX			210.00	
OASDI			217.68	
MEDICARE			50.91	
WCD TAX			2.76	
EMPL DEDNS			131.65	
NET DEPOSIT			2,665.35	
NET CHECK				
EXMPTNS J 03				
YEAR TO DATE INFORMATION				
GROSS PAY	TAX DEFER INCOME	OTHER TAXABLE	TAXABLE INCOME	
31,638.51	265.41		31,373.10	2

B

STATE OF OREGON OREGON STATE PAYROLL SYSTEM				
AGENCY	DISTRIBUTION	EMPLOYEE NAME	EMP	
99900	9987	STATEWORKER, JANE J	OR99999	
EARNINGS				
DESCRIPTION	HOURS	RATE	AMOUNT	
TOTAL -REG	184.00	3,515.39	3,515.39	
GROSS PAY			3,515.39	
FED TAX			305.52	
STATE TAX			245.00	
OASDI			245.99	
MEDICARE			57.53	
WCD TAX			2.76	
EMPL DEDNS			131.65	
NET DEPOSIT			2,526.94	
NET CHECK				
EXMPTNS J 03				
YEAR TO DATE INFORMATION				
GROSS PAY	TAX DEFER INCOME	OTHER TAXABLE	TAXABLE INCOME	
31,638.51	265.41	456.59	31,373.10	2

The imputed value will increase with the addition of domestic partner children and again the result is less take-home pay. It's important to note that even though the imputed value shows as a dollar amount on Jane's pay stub, she does not receive any additional dollars nor does she pay the imputed value as a premium.

Where can I get more information on how this works?

For more information, see the PEBB Web site, or contact your agency or PEBB.



It's important to eat a variety of fruits and vegetables every day.

Important Membership Information

What happens if my provider drops out of the plan during the year?

PEBB does not guarantee that particular providers will continue to be available to participants throughout the term of the PEBB contract. The plans and insurance companies and other vendors that contract with PEBB are not employed or supervised by PEBB. They are independent businesses. Physicians, hospitals, laboratories and other healthcare providers under the contract are not selected nor supervised by PEBB. If your provider drops out, you will need to find another provider participating in your plan or pay the uncovered costs of your current provider.

What are PEBB's contract rights related to the plans?

PEBB reserves the right to specify contract terms and to amend and terminate PEBB-sponsored health plans as authorized under Oregon rule and statute. The plans may be amended from time to time or terminated in their entirety at any time by PEBB.

What should I expect when I enroll in a new healthcare plan?

When you first enroll in a medical and/or dental plan, you can expect to receive documents from the plan within a month. The documents will include a member handbook or a certificate of coverage (for Kaiser Permanente plans). You will also receive a member ID card (except for VSP).

Whom do I contact about plan specifics?

Contact the plan's customer service number (see pages 82-83) if you:

- Need help in selecting a plan provider
- Lose your ID card
- Want details about how the plan covers prescription drugs and other services
- Want information about plans exclusions or limitations
- Want to register a complaint with or grievance against the plan.

How do the medical plans handle benefit fraud or abuse?

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 benefit 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. Removal from a plan is not a qualified status change, so the member or dependent may not enroll in a different plan until Open Enrollment.

What if this handbook differs from plan documents?

This handbook is a summary only. Any discrepancy between this handbook and plan documents and/or rule or law is unintentional. In case of discrepancy, the plan document, rule or law will prevail.

How to Enroll for Benefits and Make Midyear Changes

How can I enroll in PEBB benefits?

- **Eligible employees** may enroll online during Open Enrollment.
- **Newly hired eligible employees** may enroll online 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 at the end of this handbook and online. They are also available from BenefitHelp Solutions, the third-party administrator.
- **Newly hired seasonal employees** must enroll by completing the employee enrollment forms. These forms are available from your agency and online.

May I make midyear changes to my coverage?

Yes. You may change your coverage during the year if you or your eligible dependents experience a qualified status change (see page 17).

How can I make midyear changes?

Complete the update form for the plans you wish to change. The Medical and Dental Update Form Midyear Change Request is included in this booklet. You can find all other update forms online.

Follow these steps to enroll online at <https://pebb.benefits.oregon.gov/members>.

1. Register. Provide the requested personal information to validate your identity, and create your user name and password.
2. Verify your personal information. You may change your personal information at any time.
3. Enroll in the mandatory medical and dental plans.
4. Enroll in optional life, disability and/or long term care insurance plans and/or flexible spending accounts.

NOTE: if you choose to enroll in optional plans, you must do so at the same time you enroll in mandatory plans.

5. Designate your beneficiaries.

NOTE: You may change or update your beneficiary designations at any time.

6. Review and save your selections.

NOTE: If, after you have saved your selections, you want to change them, you can do so only through your agency.

If you do not have access to a computer with Internet access, contact your agency or PEBB to obtain paper forms. The forms are online at www.oregon.gov/das/pebb.

Midyear Changes

To make changes to your PEBB benefits plan during the year, you must experience a qualified status change (QSC) event.

What is a qualified status change?

A QSC is an event that changes your work or family circumstances. The IRS requires that PEBB comply with federal regulations for midyear benefit changes. Midyear plan changes must meet the IRS "consistency rule," which means the QSC must affect eligibility and the requested change must be consistent with the way eligibility has been affected.

So, the requested benefit change must link to the event (QSC). Here are two examples.

Example 1

You adopt a child. This QSC allows you to add the dependent child to your current medical and dental insurance coverage. There is no other fact around this single event that would allow you to change to a new medical or dental plan. So you could adopt the child and add him or her to your current coverage.

Example 2

You move from an eligible full-time position to an eligible part-time position. This QSC makes you eligible to enroll in the part-time and retiree healthcare plans as well as the full-time plans and also changes the amount of the employer's contribution. So, you can change benefit plans and add or delete coverage.

What is the time frame for making benefit changes because of a QSC?

Your agency must receive the completed appropriate forms within 60 days of the QSC. Changes 60 days past the QSC event require PEBB review and approval.

What must I do to make a benefit change?

To make changes to your medical or dental coverage, complete the Medical and Dental Update form, and submit it to your agency. The agency must receive the form within 60 days of date of the QSC.

To make changes to your life or disability coverage, complete the Life and Disability Update form, and submit it to your agency. The agency must receive the form within 60 days of the QSC.

To make changes to your flexible spending account, complete the Flexible Spending Account Update form, and submit it to your agency. The office must receive the form within 60 days of the QSC.

If you have questions or need more information regarding qualified status changes, contact your agency.

What is the effective date of a change made because of a QSC?

If you are adding a dependent or a plan because of a QSC, coverage changes are effective the first of the month following the date the agency or PEBB receives the required forms, or the date of the QSC, whichever is later. Submitting an update form before the QSC will not change the effective date.

If you are removing a dependent from coverage because of a QSC, the coverage changes are effective the first of the month following the date of the QSC.

Special dependent children QSCs

Biological newborns receive plan coverage from the moment of birth through the 31st day of life. However, you must submit the update form to your agency within 60 days of birth to continue the coverage. (When forms

Qualified status changes may affect your choices.

are submitted within the 60-day period, the agency will approve coverage continuously and retroactively, so claims incurred during that time will be paid).

Dependent children 19 and up to 24 may remain under your coverage only if, during the year following each birthday, they meet one of the following criteria:

- You expect your child to attend school for at least five months (not necessarily consecutive) as a full-time student (defined by the school)
- You expect to provide more than half the support for a child who lives with you at least six months of the year
- Your dependent child is incapable of self-sustaining employment because of mental retardation or physical handicap.

It is the eligible employee's responsibility to notify the agency, or PEBB when any dependent, domestic partner or partner's child no longer qualifies for coverage. Not providing notification may cause you to have to repay claims expenses incurred when the individual no longer qualified for coverage.

Examples of QSCs

QSCs that affect eligibility for insurance benefits:

- You marry or establish a domestic partnership through affidavit
- Your spouse or domestic partner dies; you divorce, annul the marriage or legally separate; or you dissolve your domestic partnership
- 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
- You, your spouse or domestic partner, or dependent child loses other benefit coverage
- You or your spouse or domestic partner receives a national medical support order
- You or your spouse or domestic partner moves out of the plan's service area

- Your employment status changes. This may include a reduction or increase in hours of employment for you, your spouse, or domestic partner that affects eligibility. This includes changes from half-time and full-time, or commencement or return from an unpaid leave of absence, or commencement or return from a federal Family and Medical Leave Act (FMLA) leave, whether the FMLA leave is paid or unpaid or as permitted by the FMLA, and the Oregon Family Leave Act (OFLA).
- Your spouse's or domestic partner's employment status changes
- The cost or coverage of your benefit changes
- Gain or loss of Medicare or a Medicaid insurance plan.

QSCs 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.

QSCs that affect eligibility for healthcare flexible spending accounts:

- You marry
- Your spouse dies, or you divorce or have a legal separation or 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 employment status changes
- Your spouse's employment status changes.

Appeals

What types of issues can I appeal to PEBB?

You may appeal to PEBB any **eligibility decision**. You may also appeal enrollment errors or omissions, or missed enrollment timelines to PEBB.

Plan decisions must be appealed directly to the plan. Follow the appeal rights and procedures in the plan's member handbook. If you ask PEBB to review the plan's determination, PEBB will verify only if the plan's determination was within the scope of the contract, or request that the carrier 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.

What is the PEBB Appeal Process?

Step 1. If you believe you received an incorrect or unfair denial based on eligibility, you may request a review by a PEBB Benefit Analyst.

- Submit a completed Appeal Form (available from your agency, or the PEBB Web site, or PEBB) to PEBB. Include any supporting documentation.
- A PEBB Benefits Analyst will review your appeal and notify you of a decision within 45 days of receiving your request. You will receive notice if your issue will require more than 45 days.

Step 2. If you believe the decision from the Benefit Analyst is incorrect or unfair, you may request a review by the PEBB Benefits Manager.

- You must submit this request in writing within 45 days of the date of the determination letter. Include any additional supporting documentation.
- The PEBB Benefits Manager may review your case or forward your request to the PEBB Administrator or designee for review and a determination.

In either situation,

- You will receive a written determination and explanation within 30 days of the Benefits Manager receiving your case review request.

Step 3. If you believe a determination made by the Benefits Manager is incorrect or unfair, you may request a review by the PEBB Administrator or designee.

- You must submit this request in writing within 30 days of the date of the determination letter. Include any additional supporting documentation.

You may appeal eligibility decisions.

- The Administrator or designee may review your case or forward your request to the PEBB Operations Subcommittee for review and a determination.

In either situation,

- You will receive a written determination within 30 days of the Administrator or designee receiving your review request, or within 30 days after the next regularly scheduled meeting of the Operations Subcommittee.

Step 4. If you believe a determination made by the Administrator or designee is incorrect or unfair, you may request a review by the PEBB Operations Subcommittee.

- You must submit this request in writing within 30 days of the date of the determination letter. Include any additional supporting documentation.

- The Operations Subcommittee may review your case or, with approval of the Chair, may forward your request to the full Board for review and a decision.

In either situation,

- You will receive a written determination within 30 days after the next regularly scheduled meeting of the Subcommittee or the Board.

Step 5. If you believe a determination made by the PEBB Operations Subcommittee is incorrect or unfair, you may request a review by the Board.

- You must submit this request in writing within 30 days of the date of the determination letter. Include any additional supporting documentation.
- You will receive a written determination within 30 days after the next regularly scheduled meeting of the Board.

Step 6. You may appeal the Board's decision under the Oregon Administrative Procedures Act, ORS Chapter 183. You will receive notice of the status of the request for reconsideration within 15 days of receipt of the request by the reviewing entity.

What should I do if I want to appeal a denied claim?

If you receive a claim denial from a benefit plan that you believe is incorrect or unfair, you may appeal directly to the plan as described in OAR101-020-0020. See your plan's member handbook (certificate of coverage for Kaiser Permanente) for the plan's process.

In addition to eating healthy and regular exercise, getting plenty of sleep is essential to maintaining a healthy body and mind.

