



PUBLIC EMPLOYEES' BENEFIT BOARD



Kate Brown, Governor

Sept. 26, 2016

Public Employees' Benefit Board
500 Summer St NE, Salem, OR 97301
Phone 503-373-1102 Fax 503-378-6584
www.oregon.gov/oha/pebb
Email inquiries.pebb@dhsos.state.or.us

Dear PEBB Self-pay Enrollee:

This is your Self-pay Participant information packet for enrolling in a 2017 PEBB health plan during Open Enrollment, Oct. 1-31, 2016.

If you are in a medical plan now and don't actively enroll during Open Enrollment, you will have the same plan in 2017 but with a \$25 surcharge (\$50 if covering spouse/partner) for not answering the tobacco-use question a \$50 surcharge (if covering spouse/partner) for not answering the spouse coverage question.

You can enroll in VSP vision coverage if you enroll in a medical plan (except Kaiser full-time plans, which include vision coverage). VSP now offer s both Basic and Plus plans.

You can enroll in a dental plan for 2017. New for 2017, some dental plans cover bite guards (see plan documents for details). Please note: The ODS (Moda) dental plans may impose waiting periods for major service and orthodontia if you enroll in these plans after you were first eligible.

Here's how to enroll in your 2016 PEBB health plans.

1. Review the health plan regions, premiums and coverage.
2. Complete the enclosed form, enrolling in the plans of your choice.
3. Mail or fax the form by Oct. 31 to:

BenefitHelp Solutions (BHS)

P.O. Box 67230

Portland, OR 97268-1230

Fax 888-249-5058 toll free

Phone 503-412-4257 toll free 877-433-6079

Please use the resource information on the reverse to contact us, the plans or BHS.

Healthier Together,
Public Employees' Benefit Board

Contact Information

How to Contact PEBB during Open Enrollment

Call PEBB at 503-373-1102 during the following times:

- Monday – Friday, 9 a.m. - 5 p.m.
- Wednesday Oct. 5, 12, 19, and 26, until 8 p.m.
- Monday Oct. 31, until 10 p.m.

Fax PEBB at 503-373-1654

Email PEBB at inquiries.pebb@dhsosha.state.or.us

How to Contact the Plans

BenefitHelp Solutions

(retiree, COBRA and self-pay administrator)

Website <http://www.benefithelpsolutions.com/pebb/pebb.shtml>

Customer service

Retiree toll free 1-855-289-6314;

COBRA toll free 1-877-433-6079

AllCare PEBB (medical plan)

Website www.AllCarePEBB.com

Customer service 541-471-4106,

toll free 1-888-460-0185

Hearing impaired 711

Kaiser Permanente NW

(medical and dental plans)

Website <https://my.kp.org/pebb/>

Customer service toll free 1-800-813-2000;

in Portland 503-813-2000

Hearing impaired 1-800-735-2900

Moda Health Plan

(medical plans and Delta Dental plans)

Website www.modahealth.com/pebb

Customer service Medical toll free 1-844-776-1593;

Pharmacy toll free 1-844-776-1594; Dental toll free

1-888-217-2365.

Hearing impaired 711

Email pebbcustomerservice@modahealth.com

Providence Health Plan

(PEBB Statewide & Providence Choice medical plans)

Website www.ProvidenceHealthPlan.com/PEBB

Log in to Personal Health Assessment

www.myProvidence.com

Customer service toll free 1-800-423-9470,

Hearing impaired 711

Willamette Dental (dental plan)

Website www.willamettedental.com/pebb

Customer service toll free 1-855-4DENTAL (433-6825)

Hearing impaired 711

Email pebb@willamettedental.com

2017 Self-pay Medical Plan Monthly Premium Rates

	Self	Self & Spouse/Partner	Self & Child(ren)	Self & Family
AllCare PEBB	\$758.36	\$1,244.59	\$1,057.57	\$1,506.41
Kaiser HMO	\$903.44	\$1,483.96	\$1,260.68	\$1,796.55
Kaiser Deductible	\$826.54	\$1,357.08	\$1,153.03	\$1,642.76
Moda Synergy, Summit	\$801.04	\$1,315.01	\$1,117.32	\$1,591.77
PEBB Statewide	\$920.81	\$1,512.63	\$1,285.01	\$1,831.31
Providence Choice	\$773.48	\$1,269.54	\$1,078.75	\$1,536.65

Medical Plans

Kaiser Permanente NW Deductible

my.kp.org/pebb

Service Area: Benton, Clackamas, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill; Clark, Cowlitz, Lewis, Skamania & Wahkiakum WA

	Full-time	Part-time
Standard deductible²	\$250/individual, \$750/family Some services not subject to deductible	\$250/individual, \$750/family Some services not subject to deductible
Additional non-HEM participant deductible³	Additional deductible: \$100/individual, \$300/family applies to all services unless otherwise noted	
Out-of-pocket max	\$1500/individual \$4500/family	\$1500/individual, \$4500/family
Providers	Kaiser Permanente network of providers	
Referrals	Referrals to non-Kaiser Permanente providers only from Kaiser provider	
Primary care visit	\$5, deductible waived	\$30, deductible waived
Chronic care visit⁵	\$5, deductible waived	\$30, deductible waived
Specialty visit	\$5 w/referral, deductible waived	\$30 w/referral, deductible waived
Outpatient mental health care	\$5, deductible waived	\$30, deductible waived
Substance abuse treatment	\$0, deductible waived	\$0, deductible waived
Prenatal, first postnatal visit	\$0, deductible waived	\$0, deductible waived
Delivery	Inpatient delivery subject to inpatient hospital charges	
Preventive	\$0, deductible waived	\$0, deductible waived
Lab & X-ray	\$15, deductible waived	\$20, deductible waived
Inpatient hospital per admission	\$50/day up to \$250 max	\$500
Emergency department⁶	\$75	\$100
Durable medical equipment	15%, deductible waived	50%, deductible waived
Insulin & diabetic supplies	\$0 or 0%, deductible waived	
Additional Cost Tier \$100 copay⁸	\$100 copay, deductible waived	\$100 copay, deductible waived
Additional Cost Tier \$500 copay	Standard copay only, applies to out of pocket maximum	Standard copay only, applies to out of pocket maximum
Alternative care provider visits¹³	\$10, deductible waived	\$30, with physician's authorization referral, deductible waived
Spinal manipulation, acupuncture services¹³	\$10, deductible waived	\$30 with physician's authorization referral, deductible waived
Prescription drugs	<ul style="list-style-type: none"> No deductible Copays accumulate to out-of-pocket maximum \$5 generic \$25 brand 50% up to \$100 max non-formulary brand \$50 Specialty Mail order (31-90 day), \$5 generic, \$25 formulary brand, 50% up to \$100 max non-formulary brand 	<ul style="list-style-type: none"> No deductible Copays accumulate to out-of-pocket maximum \$10 generic \$25 brand \$50 Specialty Mail order 2 copays for up to 90-day supply

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply. See footnotes, page 9.

Medical Plans (continued)

Kaiser Permanente NW HMO

my.kp.org/pebb

Service Area: Benton, Clackamas, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill; Clark, Cowlitz, Lewis, Skamania & Wahkiakum WA

	Full-time	Part-time
Standard deductible	\$0	\$0
Additional HEM non-participant deductible ³	Additional deductible: \$100/individual, \$300/family applies to all services unless otherwise noted	
Out-of-pocket max	\$600/individual, \$1200/family	\$1500/individual, \$3000/family
Providers	Kaiser Permanente Network of providers	
Referrals	Referrals to non-Kaiser Permanente providers only from Kaiser provider	
Primary care visit	\$5	\$30
Specialty visit	\$5, with referral	\$30, with referral
Outpatient mental health care	Same cost as physical health services	
Substance abuse treatment	\$0	\$0
Prenatal, first postnatal visit	\$0	\$0
Delivery	Inpatient delivery subject to inpatient hospital charges	
Preventive	\$0	\$0
Lab & X-ray	\$0	\$10
Inpatient hospital per admission	\$50/day, up to \$250 max	\$500
Emergency department ⁶	\$75	\$100
Durable medical equipment	\$0	50%
Insulin & diabetic supplies	\$0	
Additional Cost Tier \$100 copay ⁸	\$100 copay	\$100 copay
Additional Cost Tier \$500 copay	Does not apply in this plan	
Alternative care provider visits ¹³	\$10	\$30, with physician's authorization approval
Spinal manipulation, acupuncture services ¹³	\$10	\$30, with physician's authorization approval
Prescription drugs	<ul style="list-style-type: none"> No deductible Copays accumulate to out-of-pocket maximum \$1 generic \$15 brand \$50 Specialty Mail order (31-90 day), \$1 generic, \$15 brand 	<ul style="list-style-type: none"> No deductible Copays accumulate to out-of-pocket maximum \$10 generic \$25 brand \$50 Specialty Mail order 2 copays for up to 90-day supply

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Medical Plans (continued)

Moda Synergy, Summit

Modahealth.com/pebb

Synergy Service Area: Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, Yamhill, and Clark in Washington

Summit Service Area: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler

Providers	Full-time		Part-time	
	In Medical home ¹	Out of network ¹	In Medical home ¹	Out of network ¹
Standard deductible²	\$250/individual, \$750/family	\$500/individual, \$1500/family	\$500/individual, \$1500/family	\$1000/individual, \$3000/family
Additional non-HEM participant deductible³	\$100/individual, \$300/family applies to all services unless otherwise noted			
Out-of-pocket max (some deductibles, copays, services don't apply)	\$1500/individual, \$4500/family	\$2500/individual \$7500/family	\$2500/individual \$7500/family	\$4500/individual, \$13500/family
Primary care visit	\$5, first 4 visits deductible waived	30%	\$30, first 4 visits deductible waived	50%
Chronic care visit⁵	\$0, deductible waived	30%	\$0, deductible waived	50%
Specialty visit	\$5, with referral	30%	\$30, with referral	50%
Outpatient mental health care	\$5, deductible waived	30%	\$30, deductible waived	50%
Substance abuse treatment	\$0, deductible waived	30%	\$0, deductible waived	50%
Physician, midwife maternity services	\$0, deductible waived	30%	\$0, deductible waived	50%
Delivery	Inpatient delivery subject to inpatient hospital charges			
Preventive	\$0, deductible waived	30%	\$0, deductible waived	50%
Lab & x-ray	\$0, deductible waived	30%	\$0, Quest provider, deductible waived, or 20%	50%
Inpatient hospital per admission	\$50/day to \$250 max	30%	\$500	50%
Urgent care	\$5 in network	30%	\$30 in network	50%
Emergency department⁶	\$100	\$100	\$100	\$100
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	\$0, deductible waived			
Additional Cost Tier \$100 copay⁷	\$100	\$100 + \$30	\$100	\$100 + 50%
Additional Cost Tier \$500 copay⁹	\$500	\$500 + 30%	\$500	\$500 + 50%
Alternative care provider visits	\$5	30%	\$30	50%
Spinal manipulation, acupuncture services¹³	\$5 up to \$1,000/yr max combined. Not applied to out-of-pocket max.	30% up to \$1,000/yr max combined. Not applied to out-of-pocket max.	\$30 up to \$1000/yr max combined. Not applied to out-of-pocket max.	50% up to \$1000/yr max combined. Not applied to out-of-pocket max.
Prescription drugs	<ul style="list-style-type: none"> \$50/individual, \$150/family deductible¹⁰ \$1000 out-of-pocket maximum¹¹ \$0 Value, not subject to deductible¹² \$10 generic \$30 brand Copay x 2.5 for 90-day \$100 specialty 	<ul style="list-style-type: none"> In-network deductible, out-of-pocket max apply \$0 Value, not subject to deductible¹² \$20 generic \$50 preferred brand \$100 specialty Copay x 2.5 for 90-day Member pays difference between in-network rate and billed amount 	<ul style="list-style-type: none"> \$50/individual, \$150/family deductible¹⁰ \$1000 out-of-pocket maximum¹¹ \$0 Value, not subject to deductible¹² \$20 generic \$50 preferred brand Copay x 2.5 for 90-day \$100 specialty 	<ul style="list-style-type: none"> In-network deductible, out-of-pocket max apply \$0 Value, not subject to deductible¹² \$20 generic \$50 preferred brand \$100 specialty. Copay x 2.5 for 90-day Member pays difference between in-network rate and billed amount

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Medical Plans (continued)

PEBB Statewide

Service Area: Statewide and Nationwide

Providencehealthplan.com/PEBB

	Full-time		Part-time	
Providers	In Network	Out of Network	In Network	Out of Network
Standard deductible²	\$250/individual, \$750/family Four primary care visits not subject	\$500/individual, \$1500/family	\$500/individual, \$1500/family Four primary care visits not subject	\$1000/individual, \$3000/family
Additional non-HEM participant deductible³	\$100/individual, \$300/family applies to all services unless otherwise noted			
Out-of-pocket max (some deductibles, copays, services don't apply)	\$1500/individual \$4500/family	\$2500/individual \$7500/family	\$2500/individual \$7500/family	\$4500/individual \$13500/family
Primary care visit	15% or 10% ⁴ , deductible waived	30%	20% or 15% ⁴ , deductible waived	50%
Chronic care visit⁵	0%, deductible waived	30%	0%, deductible waived	50%
Specialty visit	15%	30%	20%	50%
Outpatient mental health care	15%, deductible waived	30%	20%, deductible waived	50%
Substance abuse treatment	0%, deductible waived	30%	0%, deductible waived	50%
Pre-natal	0%, deductible waived	30%	0%, deductible waived	50%
Delivery and postnatal	15%	30%	20%	50%
Preventive	0%, deductible waived	30%	0%, deductible waived	50%
Lab & x-ray	15%	30%	20%	50%
Inpatient hospital per admission	15%	30%	20%	50%
Urgent care	15%	15%	20%	20%
Emergency department⁶	\$100 + 15%	\$100 + 15%	\$100 + 20%	\$100 + 20%
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	0% deductible waived			
Additional Cost Tier \$100 copay⁷	\$100 + 15%	\$100 + 30%	\$100 + 20%	\$100 + 50%
Additional Cost Tier \$500 copay⁹	\$500 + 15%	\$500 + 30%	\$500 + 20%	\$500 + 50%
Alternative care provider visits	15%	30%	20%	50%
Spinal manipulation, acupuncture services¹³	15%, up to 60 services/yr max combined. Not apply to out of pocket max.	30 %, up to 60 services/yr max combined. Not apply to out of pocket max.	20%, up to 60 services/yr max combined. Not apply to out of pocket max.	50%, up to 60 services/yr max combined. Not apply to out of pocket max.
Prescription drugs	<ul style="list-style-type: none"> \$50/individual, \$150/family deductible¹⁰ \$1000 out-of-pocket maximum¹¹ \$0 Value, not subject to deductible¹² \$10 generic \$30 brand Copay x 2.5 for 90-day \$100 specialty 	<ul style="list-style-type: none"> Urgent, emergent and out-of-country In-network deductible, out-of-pocket maximum apply Reimbursed as if filled in network; member pays difference between network rate & billed amount 	<ul style="list-style-type: none"> \$50/individual, \$150/family deductible¹⁰ \$1000 out-of-pocket maximum¹¹ \$0 Value, not subject to deductible¹² \$20 generic \$50 preferred brand Copay x 2.5 for 90-day \$100 specialty 	<ul style="list-style-type: none"> Urgent, emergent and out-of-country In-network deductible, out-of-pocket maximum apply Reimbursed as if filled in network; member pays difference between network rate & billed amount

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Medical Plans (continued)

Providence Choice

Providencehealthplan.com/PEBB

Service Area: Baker, Benton, Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, Yamhill; Clark and Walla Walla, WA; Payette, ID

	Full-time		Part-time	
Providers	In Medical home ¹	Out of medical home ¹	In Medical home ¹	Out of medical home ¹
Standard deductible²	\$250/individual \$750/family, 4 visits not subject	\$500/individual \$1500/family	\$500/individual \$1500/family, 4 visits not subject	\$1000/individual \$3000/family
Additional non-HEM participant deductible³	\$100/individual, \$300/family applies to all services unless otherwise noted			
Out-of-pocket max <small>(some deductibles, copays, services don't apply)</small>	\$1500/individual, \$4500/family	\$2500/individual, \$7500/family	\$2500/individual, \$7500/family	\$4500/individual, \$13500/family
Primary care visit	\$5, first 4 visits deductible waived	30%	\$30, first 4 visits deductible waived	50%
Chronic care visit⁵	\$0, deductible waived	30%	\$0, deductible waived	50%
Specialty visit	\$5, with referral	30%	\$30, with referral	50%
Outpatient mental health care	\$5, deductible waived	30%	\$30, deductible waived	50%
Substance abuse treatment	\$0, deductible waived	30%	\$0, deductible waived	50%
Maternity, & childbirth services provider	\$0, deductible waived	30%	\$0, deductible waived	50%
Delivery	Inpatient delivery subject to inpatient hospital charges			
Preventive	\$0, deductible waived	30%	\$0, deductible waived	50%
Lab & x-ray	\$0, deductible waived	30%	20%, deductible applies	50%
Inpatient hospital per admission	\$50/day to \$250 max	30%	\$500	50%
Urgent care	\$25	\$25	\$30	\$30
Emergency department⁶	\$100	\$100	\$100	\$100
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	\$0, deductible waived			
Additional Cost Tier \$100 copay⁷	\$100	\$100 + 30%	\$100	\$100 + 50%
Additional Cost Tier \$500 copay⁹	\$500	\$500 + 30%	\$500	\$500 + 50%
Alternative care provider visits	\$5	30%	\$30	50%
Spinal manipulation, acupuncture services¹³	\$5/visit, up to \$1000/yr max combined. Not applied to out-of-pocket max.	30%, up to \$1000/yr max combined. Not applied to out-of-pocket max.	\$30/visit, up to \$1000/yr max combined. Not applied to out-of-pocket max.	50% up to \$1000/yr max combined. Not applied to out-of-pocket max.
Prescription drugs	<ul style="list-style-type: none"> \$50/individual, \$150/family deductible¹⁰ \$1000 out-of-pocket maximum¹¹ \$0 Value, not subject to deductible¹² \$10 generic \$30 brand Copay x 2.5 for 90-day \$100 specialty 	<ul style="list-style-type: none"> Urgent, emergent and out-of-country. In-network deductible, out-of-pocket maximum apply. Reimbursed as if filled in-network; member pays difference between in-network rate and billed amount. 	<ul style="list-style-type: none"> \$50/individual, \$150/family deductible¹⁰ \$1000 out-of-pocket maximum¹¹ \$0 Value, not subject to deductible¹² \$20 generic \$50 preferred brand Copay x 2.5 for 90-day \$100 specialty 	<ul style="list-style-type: none"> Urgent, emergent and out-of-country. In-network deductible, out-of-pocket maximum apply. Reimbursed as if filled in-network; member pays difference between in-network rate and billed amount.

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Medical Plans (continued)

AllCare PEBB

Service Area: Curry, Jackson, Josephine Counties; Glendale and Azalea in Douglas County.

[Allcarehealth.com/
public-employees](http://Allcarehealth.com/public-employees)

	Full-time			Part-time		
Providers	Preferred	Participating	Out-of-network	Preferred	Participating	Out-of-network
Standard deductible	\$250/individual, \$750/family	\$500/individual, \$1500/family	\$500/individual, \$1500/family	\$500/individual, \$1500/family	\$1000/ individual, \$3000/family	\$1000/ individual, \$3000/family
	Apply toward each other			Apply toward each other		
Additional HEM non-participant deductible³	\$100/individual, \$300/family (applies to all services unless otherwise noted)					
Out-of-pocket max <small>(some deductibles, copays, services don't apply)</small>	\$1500/ individual, \$4500/family	\$2500/ individual, \$7500/family	\$2500/ individual, \$7500/family	\$2500/ individual, \$7500/family	\$4500/ individual, \$13500/family	\$4500/ individual, \$13500/family
	Apply toward each other			Apply toward each other		
Primary care visit	\$5, deductible waived	\$20, deductible waived	30%	\$5, deductible waived	\$30, deductible waived	50%
Chronic care visit⁵	\$0, deductible waived	\$10, deductible waived	30%	\$0, deductible waived	\$10, deductible waived	50%
Specialty visit	\$20, w referral	\$30	30%	\$30, w referral	\$60	50%
Outpatient mental health care	\$5, deductible waived	\$20, deductible waived	30%	\$5, deductible waived	\$20, deductible waived	50%
Substance abuse treatment	\$0, deductible waived		Cost same as medical services	\$0, deductible waived		Cost same as medical services
Maternity, childbirth provider	\$0, deductible waived		30%	\$0, deductible waived		50%
Delivery	\$0, deductible waived	\$100/day up to \$500 max	30%	\$0, deductible waived	40%	50%
Preventive	\$0, deductible waived		30%	\$0, deductible waived		50%
Lab & X-ray	\$0	30%	30%	20%	40%	50%
Inpatient hospital per admission	\$50/day up to \$250 max	\$100/day up to \$500 max	30%	\$500	40%	50%
Emergency department	\$100					
Durable medical equip.	15%		30%	50%		
Insulin, diabetic supplies	\$0 or 0%, deductible waived					
Additional Cost Tier \$100 copay⁷	\$100	\$100 + 30%	\$100 + 50%	\$100	\$100 + 40%	\$100 + 50%
Additional Cost Tier \$500 copay⁹	\$500	\$500 + 30%	\$500 + 50%	\$500	\$500 + 40%	\$500 + 50%
Alternative care provider visits	\$10	\$20	30%	\$30	40%	50%
Spinal manipulation, acupuncture services¹³	\$10 up to \$1000/yr max combined. Not applied to out-of- pocket max.	\$20 up to \$1000/yr max combined. Not applied to out-of- pocket max.	30% up to \$1000/yr max combined. Not applied to out-of- pocket max.	\$30 up to \$1000/yr max combined. Not applied to out-of- pocket max.	40% up to \$1000/yr max combined. Not applied to out-of- pocket max.	50% up to \$1000/yr max combined. Not applied to out-of- pocket max.

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This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply. See footnotes, page 9.

Medical Plans (continued)

AllCare PEBB (continued)

Service Area: Curry, Jackson, Josephine, Glendale and Azalea in Douglas

Providers	Full-time			Part-time		
	Preferred	Participating	Out-of-network	Preferred	Participating	Out-of-network
Prescription drugs	<ul style="list-style-type: none"> • \$50/individual, \$150/family deductible¹⁰ • \$1000 out-of-pocket maximum¹¹ • \$0 preventive/EHB, not subject to deductible • \$10 generic • \$30 brand • \$60 non-preferred • Copay x 2 for 90-day • \$100 specialty 		Out-of-Network. Member pays full cost and may be reimbursed for AllCare PEBB share of cost.	<ul style="list-style-type: none"> • \$50/individual, \$150/family deductible¹⁰ • \$1000 out-of-pocket maximum¹¹ • \$0 preventive/EHB, not subject to deductible • \$15 generic • \$40 brand • \$75 non-preferred • Copay x 2 for 90-day • \$100 specialty 		Out-of-Network. Member pays full cost and may be reimbursed for AllCare PEBB share of cost.

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply.

Medical Plans Footnotes

¹ To receive In-Medical Home benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from providers referred by their medical home. Otherwise, benefits typically have higher costs or may not be covered. See the list of medical homes on the plan's website.

² All medical plans have a standard plan deductible (except Kaiser HMO). This is the amount a member must pay for covered services before the plan begins to pay its share for medically necessary covered services. Deductibles apply per individual, or the family deductible will apply when there are three or more individuals within a family, based on the employee's choice of coverage tier. Payments toward the deductible accumulate separately for services in-network and out-of-network, and In-Medical Home and Out-of-Medical Home (see 1 above). Certain in-network services are not subject to the deductible. Examples: first four visits per individual to a primary care provider; insulin and diabetic supplies; visits for care of asthma, diabetes, cardiovascular disease or congestive heart failure; and preventive services. On the Kaiser deductible plans, the deductible is waived on additional services; please see the benefit summary for additional details.

³ Health Engagement Model (HEM) and additional deductible do not apply to Self-pay enrollees.

⁴ PEBB Statewide plan members whose in-network provider has been recognized by the Oregon Health Authority as a Patient-Centered Primary Care Home will have the lower coinsurance.

⁵ These are visits for care of asthma, diabetes, cardiovascular disease and congestive heart failure. Not subject to deductible in-network.

⁶ Copay amounts for use of a hospital emergency department are waived if the member is admitted directly to the hospital

for inpatient treatment. This does not include admittance for observation. Copay does not apply to out-of-pocket maximum except in Kaiser plans. In-plan deductible applies.

⁷ These procedures are MRI, CT, PET and SPECT scans; sleep studies; spinal injections; upper endoscopy; bunionectomy; surgery for hammertoe and Morton's neuroma; and knee viscosupplementation. Copay does not apply to out-of-pocket maximum. Not applied to cancer-related procedures. These procedures may be overused compared with their risks and benefits.

⁸ Applies only to MRI, CT, PET and SPECT scans, and sleep studies in Kaiser plans. Additional copay applies to out of pocket maximum.

⁹ These are surgical procedures for hip or knee replacement or resurfacing; knee or shoulder arthroscopy; bariatric surgery; spine procedures; and sinus surgery. Copay does not apply to out-of-pocket maximum. Not applied to cancer-related procedures. These procedures may have alternatives that provide equal or better outcomes with lower risks and costs.

¹⁰ The prescription drug deductible is \$50 per person or \$150 for families with three or more members. It applies separately from the medical deductible.

¹¹ The prescription drug out-of-pocket maximum is \$1,000 per person, with a family maximum of \$3,000. It accrues separately from the medical out-of-pocket maximum.

¹² All plans have formularies that list covered drugs. Value drugs typically are generic drugs that are used in treating most common chronic conditions. (EHB stands for Essential Health Benefits.)

¹³ Limited to \$1,000/year (combined in Kaiser plans). Limited to 60 visits/year in PEBB Statewide plan max. Copays and coinsurance do not apply to out-of-pocket maximum.

Dental Plans



ODS (Moda) plans Modahealth.com/pebb

- When you enroll in the PPO plan, your coinsurance amount drops by 10% per year down to 0% at year three if you see your dentist at least once per year.
- Individuals who enroll for coverage in an ODS (Moda) plan during an open enrollment period after they were initially eligible may have a 12-month waiting period for basic and major services and a 24-month waiting period for orthodontia. See the ODS (Moda) plans member handbooks for details.



Willamette Dental Group plan www.willamettedental.com/pebb

- Services are provided only by Willamette Dental Group providers and only in Willamette Dental Group facilities.
- A \$5 office visit copayment is due at each visit, including visits for orthodontia.
- The copayment varies for visits related to implants.
- The plan has a \$1,500 comprehensive copayment for orthodontia.



Kaiser Plans My.kp.org/pebb

- Kaiser offers both medical and dental plans. You do not need to enroll in a Kaiser medical plan to be able to enroll in a Kaiser dental plan, and vice versa.
- You can enroll in a Kaiser dental plan if you live or work in the Kaiser service area.
- Services are provided only by Kaiser providers only in Kaiser facilities.

Dental Plans (continued)

2017 Self-pay Dental Plan Monthly Premium Rates

	Self	Self & Spouse/Partner	Self & Child(ren)	Self & Family
Kaiser Permanente	\$75.92	\$125.27	\$106.29	\$151.85
ODS (Moda) Premiere	\$66.85	\$110.29	\$93.59	\$133.70
ODS (Moda) PPO	\$61.77	\$101.91	\$86.46	\$123.53
Willamette Dental Group	\$61.70	\$101.80	\$86.37	\$123.39

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply.

2017 Dental Plans Comparison

Plan	Kaiser Dental	ODS (Moda) PPO		ODS (Moda) Premier	Willamette Dental Group
Provider	Kaiser	In-Network	Out-of-Network	Participating	Willamette
Deductible: individual/family	None	\$50/\$150	\$50/\$150	\$50/\$150	None
Annual max coverage	\$1,750	\$1,750	\$1,750	\$1,750	None
Diagnostic & preventive services	0%	0%	10%	0%, after \$5 visit copay	\$5 copay
Basic & maintenance services	20%, not applied to annual max coverage	20% year 1 10% year 2 0% year 3	30%	20%	\$5 copay
Crowns	25%	50%	50%	50%	\$190 copay
Implants	50%	50%	50%	50%	Varies
Dentures	50%	50%	50%	50%	\$190 copay
Orthodontia	50% to \$1500	50% to \$1500	50% to \$1500	50%	\$1500 copay

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply.



Vision Plan through VSP

www.vsp.com/signon.html

You don't have to be enrolled in a medical plan to enroll in VSP vision coverage. You can enroll in VSP vision coverage independent of medical coverage. The exception is full-time Kaiser plans, which include Kaiser vision coverage.

New for 2017, VSP offers the Plus plan, with better coverage for frames, coatings and progressive lenses.

2017 Self-pay Optional Vision Plan Monthly Premium Rates

	Retiree	Retiree & Spouse/ Partner	Retiree & Child(ren)	Retiree & Family	Child(ren) Only
Basic Plan	\$10.72	\$17.69	\$15.01	\$21.44	\$7.02
Plus Plan	\$16.09	\$26.53	\$22.52	\$32.16	\$10.51

VSP Basic Plan

Benefits	Description	Copay	Frequency
Well Vision Exam	Focuses on your eyes and overall wellness	\$10	Every calendar year
Prescription Glasses		\$25	See frames and lenses
Frames	<ul style="list-style-type: none"> \$150 allowance for a wide selection of frames \$170 allowance for featured frame brands 20% savings on the amount over your allowance \$80 allowance at Costco 	Included in prescription glasses	Every calendar year
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children 	Included in prescription glasses	Every calendar year
Lens Enhancements	Standard progressive lenses	\$50	Every calendar year
	Premium progressive lenses	\$80 - \$90	
	Custom progressive lenses	\$120 - \$160	
	Average savings of 35-40% on other lens enhancements		
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$200 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation) 	\$0	Every calendar year

VSP Plus Plan (includes coverage in Basic Plan)

Benefits	Description	Copay	Frequency
Frames	<ul style="list-style-type: none"> \$245 allowance for featured frame brands 20% savings on the amount over your allowance \$125 allowance at Costco 	Included in prescription glasses	Every calendar year
Lenses	Anti-reflective Coatings and Progressive Lenses	Each covered in full after \$20 copay	Every calendar year

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply.

Required Notices

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.

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? Your 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 19 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 will 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.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the 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, or call 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. 5, 2016. Name of Entity/Sender: PEBB. Contact: Benefits Manager
Address: 500 Summer St NE, Salem, OR 97301; Phone number: 503-373-1102.

Required Notices (continued)

Notice of Women’s Health and Cancer Rights Act

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator at 503-373-1102 for more information.

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 occurs: (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.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

www.dol.gov/ebsa/pdf/chipmodelnotice.pdf

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Required Notices (continued)

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	LOUISIANA – Medicaid http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ALASKA – Medicaid The AK Health Insurance Premium Payment Program: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	MAINE – Medicaid http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
ARKANSAS – Medicaid http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	MASSACHUSETTS – Medicaid and CHIP http://www.mass.gov/MassHealth Phone: 1-800-462-1120
COLORADO – Medicaid Medicaid: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	MINNESOTA – Medicaid http://mn.gov/dhs/ma/ Phone: 1-800-657-3739
FLORIDA – Medicaid http://flmedicaidtprerecovery.com/hipp/ Phone: 1-877-357-3268	MISSOURI – Medicaid http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
GEORGIA – Medicaid http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	MONTANA – Medicaid http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid: http://www.indianamedicaid.com Phone 1-800-403-0864	NEBRASKA – Medicaid http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
IOWA – Medicaid http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	NEVADA – Medicaid Medicaid: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	NEW HAMPSHIRE – Medicaid http://www.dhhs.nh.gov/oi/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW JERSEY – Medicaid and CHIP Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP : http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid	TEXAS – Medicaid
http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	https://www.gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
http://www.ncdhhs.gov/dma Phone: 919-855-4100	Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	VERMONT – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
OREGON – Medicaid	WASHINGTON – Medicaid
http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075	http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462	www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
RHODE ISLAND – Medicaid	WISCONSIN – Medicaid
http://www.eohhs.ri.gov/ Phone: 401-462-5300	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
http://www.scdhhs.gov Phone: 1-888-549-0820	https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
SOUTH DAKOTA – Medicaid	
http://dss.sd.gov Phone: 1-888-828-0059	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
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
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)



Self-Pay Participant Open Enrollment Oct. 1 – Oct. 31, 2016

- Office Use Only -

Approved by: _____ Date: _____

Effective Date: _____

This is a mandatory Open Enrollment. This means if you are currently enrolled in PEBB benefits, you must actively enroll for the 2017 plan year, even if you want the same enrollments as in 2016.

- Do not use this form to add a new dependent (new spouse, domestic partner, child) if you want the coverage in 2016. Instead, use the Midyear Change form at <http://www.oregon.gov/oha/pebb/2016Benefits/MidyearChange.pdf> to add individuals to current 2016 coverage. Use this form to enroll yourself and all eligible dependents in coverages for 2017. Blind Business Enterprise agents may enroll in medical only. All other self-pay participants may enroll in medical and dental plans

- Self-Pay participants do not enroll in the PEBB Health Engagement Model (HEM)

Complete Sections 1 through 6, and sign and date section 7. (Send completed form to BenefitHelp Solutions)

1. I am

- OLCC Agent Post Doc/J1 Visa Blind Business Enterprise
 Foster Parent (attach copy of Foster Parent Certificate) Nurse working less than half time

2. Contact Information You must complete all fields. (Please Print)

PEBB Benefit Number (P#####)

Last Name

First Name

M Agency Gender

- F M
 F M

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact Address Check if New Address Apt # City State Zip

Residence Zip Code Work Zip Code Work Email Personal Email (optional)

Date of Birth (mm/dd/yyyy) Work Phone Home Phone (Optional)

Are you Medicare Eligible? No Yes This will not affect enrollment.

Are you serving or did you ever serve in the military? No Yes

Do you authorize PEBB to send your name and address to Oregon Department of Veteran's affairs (ODVA) for the purpose of receiving benefit information? No Yes

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse

Race: Asian White Unknown Refuse Other

Black/African American American Indian Alaska Native Native Hawaiian/Other Pacific Islander

3. Family Coverage List all eligible family members you want coverage for in 2017. Attach separate sheet if necessary. **Relationship Key:** SP=Spouse, DP=Domestic Partner, CH=Employee and/or Spouse's child, DP CH=Domestic Partner's Child, AFF CH=Child by Affidavit, AFF GCH=Grandchild by Affidavit

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Spouse/Domestic Partner					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Address: Complete only if different than Address in Section 1

Is This Dependent Medicare Eligible? No Yes This will not affect enrollment.

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse

Asian Unknown Refuse Other

Black/African American American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

3a. If you listed a Domestic Partner, mark the type of Domestic Partnership

Registered Certificate of Domestic Partnership (Certificate copy not required) You have a registered certificate issued by an Oregon county clerk to two individuals of the same sex.

PEBB Domestic Partner Affidavit. You are an eligible employee in a partnership with an individual of the opposite or same sex without a Certificate of Registered Domestic Partnership. If you are **adding a new domestic partner** by affidavit you must submit the enrollment form and affidavit by Nov. 4, 2016, to your agency. The individual's enrollment will not take effect if the affidavit is not submitted. If you previously provided an affidavit for your current partnership, you don't need to provide another.

3b Eligible Dependent Children

- Children who will be 27 in 2017 are not eligible. PEBB automatically ends coverage on December 31, for children who are 26 in 2016. You do not need to do anything.
- Covering Children by Dependency or Grandchildren requires submission of the enrollment and appropriate affidavit, and may require legal documentation. Your agency must have all submissions of affidavits or legal paper work by Nov. 4 or the individual's coverage will not go into effect.

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Address: Complete only if different than Address in Section 1

Is This Dependent Medicare Eligible? No Yes This will not affect enrollment.

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse

Race: Asian White Unknown Refuse Other
 Black/African American American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Address: Complete only if different than Address in Section 1

Is This Dependent Medicare Eligible? No Yes This will not affect enrollment.

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse Other
 Asian White Unknown Refuse Other
 Black/African American American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

Last Name	First Name	M	Birth Date mm/dd/yyyy	Relationship	Gender M F	Enroll Med Den Vision
Child						

Address: Complete only if different than Address in Section 1

Is This Dependent Medicare Eligible? No Yes This will not affect enrollment.

Ethnicity: Hispanic Non-Hispanic Non-Latino Unknown Refuse

Race: Asian White Unknown Refuse Other
 Black/African American American Indian/Alaska Native Native Hawaiian/Other Pacific Islander

4. Medical Plans: Some plans have specific service areas and may not be available to you, be sure to review plan availability for your area

Medical: Check one box below for your 2017 medical plan		Dental: Check one box below for your 2017 dental plan To enroll in dental you must be enrolled in a medical plan choice.	
	Full Time		Full Time
AllCare PEBB	<input type="checkbox"/>	Kaiser Permanente	<input type="checkbox"/>
Kaiser Deductible (Kaiser vision)	<input type="checkbox"/>	MODA Premier	<input type="checkbox"/>
Kaiser HMO (Kaiser vision)	<input type="checkbox"/>	MODA PPO	<input type="checkbox"/>
Moda Summit	<input type="checkbox"/>	Willamette Dental	<input type="checkbox"/>
Moda Synergy	<input type="checkbox"/>		
PEBB Statewide PPO	<input type="checkbox"/>		
Providence Choice	<input type="checkbox"/>	<input type="checkbox"/> Decline Dental Plan Enrollment	

4a. Vision Plan: Both the full time Kaiser HMO and Kaiser Deductible plan include Kaiser vision coverage, and are not eligible for VSP. All other medical are eligible for VSP enrollment.

Enroll VSP Basic Plan	<input type="checkbox"/>	VSP Basic and VSP Plus information at: www.oregon.gov/oha/pebb/benefits/vision.pdf
Enroll VSP Plus - Includes the Basic Plan and more	<input type="checkbox"/>	
I Decline all VSP Enrollment	<input type="checkbox"/>	

5. Other Spousal/Partner Employer Group Coverage If you enroll in Medical and do not complete Section 5 a surcharge (\$50.00) will be added to your monthly premium cost

When your spouse or domestic partner is enrolled in your PEBB medical coverage and has access to medical coverage through their employer's sponsored group plan (i.e., a non-Oregon-state-agency employer) but does not enroll in it, the following amount will be added to your monthly premium for 2017 PEBB coverage: \$50.00

Check one box:

- My spouse/domestic partner has PEBB coverage as an eligible employee (Includes Opt Out) (\$-0-)
- My spouse/domestic partner has other employer group coverage available and enrolls for that coverage. (\$-0-)
- My spouse/domestic partner has other-employer group coverage available, waives that coverage and is enrolled in PEBB. (\$50)
- My spouse/domestic partner does not have other-employer group coverage available.(\$-0-)
- I do not cover a spouse or domestic partner in a PEBB medical plan. (\$-0-)
- I do not enroll in PEBB retiree medical plans.

6. Tobacco Use If you enroll in Medical and do not complete Section 6 a surcharge (\$50.00) will be added to your monthly premium cost

When you or your spouse/domestic partner currently uses tobacco, \$25 per tobacco user will be added to your monthly premium for the 2017 plan year. If both you and your spouse/domestic partner currently don't use tobacco you will not have a charge.

Check one box:

- I currently use tobacco and, my spouse/domestic partner currently does not use tobacco. (\$25)
- I currently do not use tobacco, and my spouse/domestic partner currently uses tobacco.(\$25)
- Both my spouse/domestic partner and I currently use tobacco.(\$50)
- Both my spouse/domestic partner and I currently do not use tobacco.(\$-0-)
- I currently use tobacco and do not have a spouse/domestic partner covered in PEBB. (\$25)
- I currently do not use tobacco and do not have a spouse/domestic partner covered in PEBB. (\$-0-)
- I do not enroll in PEBB medical plans.
- My spouse's or domestic partners' provider advised not to quit using tobacco (Medical Waiver). (\$-0-)

7. Participant Signature and Authorization

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay.

I understand that:

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

I also understand that if I fail to report on this enrollment form a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

Participant Signature _____

Date _____

Submit Complete form by Oct. 31, 2016 to:

**BenefitHelp Solutions
PO Box 40548
Portland, OR 97240**

**Portland: 503-765-3581
Toll Free: 1-800-556-3137
Fax: 503-765-3453 or 1-888-393-2943**

**Keep a copy of your benefit forms for your records.
Any alteration of this form may result in it being ineffective.**