



SUMMARY PLAN DESCRIPTION

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State of Oregon
Public Employees' Benefit Board Summary Plan Description

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SECTION 1: ELIGIBILITY, ENROLLMENT AND DATES OF COVERAGE

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 are expected to work at least 90 continual calendar days and work at least half time or in a position classified as job share. The term active eligible employee can apply to a permanent employee appointed to a benefit eligible position or a temporary or impermanent worker who becomes benefit eligible due to work expectations or becomes benefit eligible following an initial measurement period.

Employers of eligible employees are:

- Oregon state government agencies
- Oregon's seven public universities
- Local Governments
- Semi-independent state agencies

Oregon Administrative Rules (OARs) determine application of eligibility for PEBB benefits.

The rules are available on the Secretary of State's website, which are linked from PEBB's webpage: www.pebinfo.com Refer to Chapter 101, Divisions 10, 15, 20, 30, 50, 60 and 70.

Employer Shared Responsibility in the Patient Protection and Affordable Care Act (ACA)

This section applies to employees paid through the Oregon State Payroll System (OSPS). If you are paid through another system (e.g., University, Lottery), contact your employer's benefits office for ACA shared responsibility policy and definitions.

The following ACA employer shared responsibility definitions apply to all OSPS employees.

- Initial Measurement Period means the 12 consecutive month period starting with the first day of the employee's employment.
- Hours of Service means each hour for which an employee is paid or entitled to payment for duties performed for the state. Hours of service also include each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity, being on call, or military duty Note that three types of special unpaid leave also count as hours of service: OFLA/FMLA leave, USERRA leave, and jury duty leave.
- New Employee means an employee who has not been employed in state service for at least one complete Standard Measurement Period.

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- Ongoing Employee means an employee who has been employed in state service for a least one complete Standard Measurement Period.
- Stability Period means the 12 consecutive month period after any Standard or Initial Measurement Period and Administrative Period during which employees are entitled to keep coverage, no matter what their hours of service are.
- Standard Measurement period for the OSPS employee means a 12 consecutive month period starting November 1 and ending October 31.
- Variable Hour Employee means a New Employee if, based on the facts and circumstances at the New Employee's start date, the agency cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period.
- An initial measurement period applies to all new employees to state employment, regardless if their appointment is to a permanent position or temporary position. During the initial measurement period and until meeting the requirements of a stability period, benefit eligible employees must be in regular paid status a minimum of 80 hours each month to earn benefits for the following month.

Note: PEBB's employee benefits are in whole month increments.

Stability period:

- To reach a stability period an employee must have recorded 1,560 hours of service, accrued during the initial or each standard measurement period.
- If an employee's measurement period does not meet the hours-of-service requirement the employee does not enter a stability period. A measurement period starts over.

An employee who terminates state employment during a current stability period, and returns to work as either a permanent or temporary employee:

- In less than 13 weeks remains in the current stability period.
- After a break of service for 13 weeks or longer, is no longer in a stability period and an initial measurement period from the new date of hire starts.

Eligible Full-time Permanent Position Employees (Includes Limited Duration Employees)

The employer and employee each provide a share of the monthly premium amount for the core benefits of medical (includes prescription drug) vision, dental, and basic life insurance coverage for full-time employees. The employee share is determined by the employing agency or collective bargaining agreements. Employees should check with their HR, payroll or benefits office for the share of premium that is their responsibility. PEBB is not the source for this information.

Current full-time permanent employees (as classified by the Human Resources system) who are not in a current "stability period" must work or be in paid regular status at least half time

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during the preceding month to be eligible for benefits the next month. Half time means employed and:

- Work or receive 80 paid regular hours per month; or
- 0.5 FTE for Oregon University employees; or
- 80 paid regular hours per month and in a documented 0.5 FTE position for the Oregon Judicial Department; or
- Fits the definition in an applicable collective bargaining agreement.

Employees in a current benefit eligible “stability period” are not required to work 80 hours each month to remain benefit eligible the following month.

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

Benefit Options for Full-time Employees

Core Benefits – Core benefits are:

- All available full-time medical plans, and dental plans according to where you live or work (at least 50 percent of the time) and a vision plan. You must be enrolled in a choice of medical plan (which includes Opt-Out) to enroll in dental or vision coverage.
- Basic employee life insurance coverage of \$10,000.

Note: Employees choosing core benefits may also enroll in all available optional benefit plans, for which they pay the premiums.

Opt-Out – Opting out is a choice of medical plans. Employees may opt out of PEBB medical coverage if they have other employer group coverage (which does not include for Oregon Health Plan/Medicaid, Student Health Insurance, and individual health insurance). All employees who opt-out will receive a monthly taxable opt-out amount determined by the Board. All employees who opt-out must pay a share of the premium for employee basic life coverage. Employees who choose to opt-out of PEBB medical coverage may enroll in vision and dental coverage. The employee cost of basic life premiums, and enrolled dental or vision coverage is deducted pretax. Employees who opt-out may enroll in optional benefit plans, for which they pay the full premium amount. Opt-Out money is not paid during a leave without pay.

Decline – Employees may decline core benefits. If they decline core benefits, they choose not to participate in the PEBB program. They will not receive a portion of the employer’s premium share and they cannot enroll in any of the optional benefit plans.

Eligible Permanent Position Part-time Employees (Includes Limited Duration and Job Share positions)

Permanent position part-time employees (as classified by the Human Resources system) who are not in a current “stability period” must work or be in paid regular status at least half time during the

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preceding month to be eligible for benefits the next month. Half time means the individual is employed and:

- Works or receives 80 paid regular hours per month or is in a job share position; or
- Is 0.5 FTE for unclassified Oregon University employees; or
- Works or receives 80 paid regular hours per month and is in a 0.5 FTE position for the Oregon Judicial Department; or
- Fits the definition in an applicable collective bargaining agreement.

NOTE: For job share positions only: Employees in a job share position need only work one hour in the preceding month to be eligible for benefits the following month.

Employees in a current benefit eligible “stability period” are not required to work 80 hours each month to remain benefit eligible the following month.

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

The monthly employer share of premium for core benefits for most eligible part-time employees is pro-rated based on hours worked in the month when compared with the month's available full-time hours less the employee's premium share. Employees should check with their payroll for premium share they are responsible to pay. PEBB is not a source for that information.

For job-share employees, the amount is fixed by their share of the position.

Part-time employees must pay the difference between the employer share and the plan total premium amount. They may choose to purchase either part-time or full-time medical and dental plan coverage. Coverage is effective at the beginning of each month. Part-time employees who choose a part-time plan will receive a premium subsidy, when available.

Benefit Options for Part-time Employees

Core Benefits - Core benefits are:

- All full time medical and dental plans available according to where you live or work (at least 50 percent of the time)
- All medical and dental plans labeled “part time” plans, according to where you live or work (at least 50 percent of the time)
- Vision coverage
- You must be enrolled in a choice of medical plan (which includes Opt-Out) to enroll in dental or vision coverage
- Basic employee life insurance coverage of \$10,000

Note: Employees who enroll in core benefits may also enroll in all available optional benefit plans, for which they pay the premiums

Opt-out – Opting out is a choice of medical plans. Employees may opt-out of PEBB medical coverage if they have other coverage (which does not include for Oregon Health Plan/Medicaid, Student Health Insurance, and individual health insurance). All employees who opt-out will receive a monthly taxable opt-out amount determined by the Board and

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prorated for part-time employees according to hours worked when compared with full-time hours in the month. All employees who opt out must pay a share of the premium for employee basic life coverage. Employees who choose to opt out of PEBB medical coverage can enroll in vision and dental coverage. The employee cost of basic life premium, and enrolled dental or vision coverage is deducted pretax. Employees who opt out may enroll in optional benefit plans, for which they pay the full premium amount. Opt-out money is not paid during a leave without pay.

Decline – Employees may decline core benefits. If they decline core benefits, they choose not to participate in the PEBB program. They will not receive a portion of the employer's premium share and they cannot enroll in any of the optional benefit plans.

New Permanent Seasonal Employees

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

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

See full-time employee and part-time employee descriptions regarding employer and employee premium share.

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 to 90 days or longer, the employee is eligible for retroactive enrollment in benefits effective 30 days from the date of hire.

Benefit Options for Seasonal Employees

- **Full-time seasonal employees:** Full-time seasonal employees may enroll in any of the benefit plans as stated under Eligible Permanent Full-time Employees, with the exception that seasonal employees may not enroll in short term or long-term disability insurance.
- **Part-time seasonal employees:** Part-time seasonal employees may enroll in any of the benefit plans as stated under Eligible Permanent Part-time Employees, with the exception that seasonal employees may not enroll in short term or long-term disability insurance.

Returning Permanent Seasonal Employees

Previously benefit-eligible employees returning to work:

Seasonal employees who had PEBB benefits before starting leave and who return to work within 12 months will have most benefits reinstated the first of the month following their return-to-work date. Reinstatement means to reactivate all previous enrollments in medical, dental, and life insurance plans, if available, on a guaranteed basis when the employee is returning from an approved leave or a termination of employment within 12 months of the coverage end date. Employees have 30 days from the date of their return to change reinstated benefits. Employees returning within 30 days without a break in coverage will have their previous coverage reinstated but cannot make benefit plan changes.

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Plans that are exceptions to reinstatement are flexible spending accounts (FSAs), commuter fringe benefit accounts and the long-term care plan. Returning seasonal employees must re-enroll if they want these plans.

Returning reinstated seasonal benefit eligible employees do not need to work more than 80 hours in the return month to be eligible for benefits the following month. However, if they are not in a current benefit eligible stability period, they must work at least half time each month after that to qualify for benefits the following month.

Previously ineligible seasonal employee returning to work:

Seasonal employees returning to work who were previously not eligible for benefits will be benefit eligible once they accrue 60 calendar days of employment between the current year and the previous plan year. The 60 days do not need to be consecutive. The employee has 30 days from the date of eligibility to enroll in PEBB benefits.

Temporary, Impermanent or Variable Hour Employees

With the passage of ACA, employees hired on a temporary, impermanent, or variable hour status may become eligible for employee health benefits offered through the PEBB. Each employee's employment varies; for that reason, employees should contact their agency Human Resources office for additional information regarding eligibility and enrollment for PEBB benefits.

When benefit eligible:

- Employees can enroll in any of the benefit plans as stated under Eligible Permanent Full-time Employees, with the exception of short term or long-term disability insurance.
- See the full-time employee descriptions regarding employer and employee premium share contributions.

Eligibility when on extended leave

The type of leave employees takes – family medical leave, active duty military leave, job-related-injury leave, etc. – and whether it is a paid or unpaid leave may affect eligibility and benefits. Contact your agency payroll, human resources, or benefits office to discuss these issues prior to taking the leave. **This applies to all active benefit eligible employees.**

Active Employees and Medicare Eligibility

An active employee, spouse, or domestic partner of an active employee, who gains Medicare eligibility remains eligible for active employee PEBB medical plan coverage. PEBB medical plans will generally continue to pay claims as primary, and Medicare will pay claims as secondary coverage. Medicare provides a booklet entitled "Who Pays First." Employee's and family members may find this publication helpful. The booklet can be found here:

<http://www.medicare.gov>

You may also find additional information regarding Medicare helpful on the Oregon Shiba site at: <http://healthcare.oregon.gov/shiba/Documents/or-medicare-guide.pdf>

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Eligible Retirees

Active employees and eligible dependents enrolled in PEBB immediately prior to the active enrollee's retirement may continue in PEBB medical, dental and vision plans if they are not eligible for Medicare (due to age or disability) and meet eligibility for retiree coverage.

Note: Employees who enroll in retiree PEBB benefits must self-pay the premiums to the retiree program administrator; the state does not provide a benefit amount and does not administer premium payments.

Medical, dental and vision options

As a PEBB retiree, you may choose from all available medical, dental and vision plans, including plans labeled "Part time," available in your service area. You may change medical, dental or vision plans when you enroll as PEBB retiree. You and your eligible dependents (if you and your dependents are not Medicare eligible) may choose medical only, dental only, vision only or medical and dental coverage or medical and vision coverage; however, when you choose only dental or vision coverage you cannot add medical coverage at a later time, and vice versa.

Eligibility

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

- Eligible to receive a retirement benefit through a State of Oregon retirement system, and
- Enrolled in a PEBB medical (includes Opt-Out) dental plan or vision plan, and
- Non-Medicare eligible due to age or disability

You may also cover your:

- Non-Medicare eligible (due to age or disability) spouse or domestic partner and/or dependent children who is covered on your plans at the time of retirement

If you are unable to enroll to cover yourself in a retiree plan because you are Medicare eligible due to age or disability, but you meet all the other criteria, you may enroll your spouse, domestic partner, and dependent children if they meet eligibility criteria.

How to enroll as a PEBB Retiree

Benefit Help Solutions (BHS) is PEBB's third-party administrator for retiree plans. Complete and submit to BHS the PEBB Eligible Retiree & Dependents enrollment form. This can be obtained by contacting BHS and requesting the form.

When to enroll as a PEBB Retiree

PEBB coverage must be continuous. **You must enroll for medical, dental and vision benefits within 30 days of when your active PEBB coverage ends.** Contact your employing agency for the date your active PEBB coverage will end. The enrollment deadline is 30 days from that date. If you enroll and pay premiums during this 30-day window, coverage is retroactive to the date your PEBB employee coverage ended.

Exceptions:

- If you have coverage under a spouse or partner's active PEBB plan, you may enroll in the PEBB retiree plan later if you lose the current coverage.

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- If you choose COBRA continuation coverage, you may transfer to the retiree group anytime during or at the end of the COBRA period.

Changing Plans

You may make plan changes only during the **Plan Change Period**. The Board sets the Plan Change Period for retirees; it generally coincides with Open Enrollment for active employees.

- The Plan Change Period allows you the opportunity to change plans. **The Plan Change Period does not allow you to add coverage you did not already have.** For example, if you chose not to enroll in medical coverage when you retired, you may not enroll in medical coverage during subsequent Plan Change Periods.
- **During the plan year, you may not change plan choices related to your participation in the PEBB benefits program, unless you experience a qualified midyear plan change event. You must request the plan change within 30 days of the event.**

Effective dates

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

Coverage Duration

Coverage continues as long as:

- You are not eligible for Medicare due to age or disability (except those with end-stage renal disease).
- Coverage for eligible family members can continue even if you are not eligible
- You pay premiums timely
- PEBB continues to offer retiree coverage

Continuing life and long-term care insurance after retirement

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability if you enroll in a conversion coverage or the PEBB retiree life insurance portability coverage **within 30 days from the date of your retirement**. Please contact The Standard Insurance Company (<https://www.standard.com/mybenefits/pebb/>) 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. Contact UNUM (<http://unuminfo.com/pebb/enrollment.aspx>) for more information about this option.

Continuation of other optional benefits

You cannot continue PEBB dependent life, spouse or domestic partner life, disability, or accidental death and dismemberment insurance. This coverage ends upon your retirement.

Retirees Returning to Active Employee Status

Retirees returning to work in a **permanent benefit-eligible position** are eligible for PEBB benefits.

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A retiree returning within 12 months from the date of their loss of active employee PEBB coverage, will have benefits reinstated and will not need to work half time in the month of return to be eligible for benefits the following month.

- A retiree returning to work who is not within a current stability period upon return, must work at least half time each month after the month of return to qualify for benefits the following month, a new initial measurement period starts from date of hire.
- A retiree returning to work with less than a 13 week break in service and within their current stability period remains in the stability period. Benefits are reinstated the first of the month following the return-to-work month.

Reinstatement means to reactivate all previous medical, dental, vision, life and disability insurance policies, if available, on a guaranteed basis. Employees will have 30 days from the date of return to work to change reinstatement elections. Approved changes are effective the first of the month following receipt of the forms by the agency. An employee returning to paid regular status within 30 days without a break in coverage will have their previous coverage reinstated and may not make benefit plan changes.

Retirees who return beyond 12 months from their retirement date must enroll in any benefits as a newly eligible employee. If enrolled in PEBB retiree coverage, they may suspend the retiree coverage by notifying the third-party administrator, Benefit Help Solutions. When they are no longer an active employee and remain eligible for the retiree plan, they may restart the retiree coverage with BHS. ***This is necessary to maintain continuous PEBB coverage and eligibility.***

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

Retirees returning to work as a Temporary Employee should contact their agency Human Resource Office or Payroll office for benefit eligibility information.

COBRA Participants

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

COBRA gives employees along with their spouses, domestic partners, dependents, and domestic partner's dependents a chance to continue coverage under an employer's group health plan. Participants must experience a "triggering event" for COBRA to apply. You must self-pay the premiums for this benefit coverage; the state does not provide a benefit amount.

See Section 6 for more information regarding your COBRA rights and qualifying events.

BenefitHelp Solutions (BHS) administers the COBRA program for PEBB. For more information, contact BHS at 888-387-5440 or visit their website at:

<https://www.benefithelpsolutions.com/members/group-members/pebb>

Other Self-pay Participants

The following individuals may participate in PEBB:

- Blind Business Enterprise agents

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- State-certified foster parents
- Oregon Liquor Control Commission agents
- Oregon State University and University of Oregon post doctorates and J1 Visa recipients
- Nurses who teach or work less than half-time for a PEBB participating organization

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

Self-pay participants do not receive a monthly benefit amount. Participants self-pay all premium costs. **BenefitHelp Solutions (BHS)** administers the Self-pay Participant program.

To enroll, contact BHS at 888-387-5440;

<https://www.benefithelpsolutions.com/members/group-members/pebb>

Individuals Eligible for Coverage

Employees may enroll the following individuals for coverage:

- Spouse or domestic partner (an ex-spouse or former domestic partner is not eligible for coverage)
- Dependent children
- Domestic partner's children

For full definitions of eligibility please access information at:

www.pebbinfo.com and click on **Administrative Rules**.

Spouse

A spouse means an individual who is legally married. A marriage or relationship recognized as a legal marriage between two individuals in Oregon, or another state or foreign country, will be recognized in Oregon even though such a relationship would not be a marriage if the same facts had been relied upon to create the marriage in Oregon. Spouse does not include a former spouse and a former spouse does not qualify as a dependent.

Dependent Children

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

An eligible dependent child must be an eligible employee's, spouses, or domestic partner's:

- Son, daughter, stepson, stepdaughter, or adopted child who has not reached age 26. The exception is a child who meets all the requirements of a child with a disability as stated under *Disabled Dependent Children*. Marital status, tax dependency, or residency does not affect this eligibility; or
- A biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a Grandchild by Affidavit) and meets all the following criteria:

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1. The child's parent will not be older than age 26, is unmarried and without a domestic partner.
2. Both the child's parent and the child live in the household of the eligible employee, and both the child and grandchild are the eligible employee's IRS dependent and must claim both child and grandchild on their most recent years tax return.
3. The child's parent has PEBB health coverage through the eligible employee.
4. An eligible employee may not add a grandchild age 18 or older to their PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18.

NOTE: Once the eligible child is no longer eligible (i.e., turns age 26), then the grandchild is no longer eligible to remain on coverage.

- A Child by Affidavit (Child by Affidavit of Dependency) which includes but is not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child and meets all the following criteria:
 1. The child lives in the household of the eligible employee and is the eligible employee's IRS dependent.
 2. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first.
 3. An eligible employee may not add a child by affidavit age 18 or older to PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18.

In the event where a spouse or domestic partner passes away, the dependents (i.e., child of domestic partner, stepchild, grandchild) may continue PEBB health plan coverage provided they are currently enrolled, and eligibility is still being met. For biological, stepchildren or children of domestic partners, coverage ends the last day of the month in which they turn 26. For Child by Affidavit of Dependency, coverage ends the last day of the month in which the court ordered guardianship ends, or age 18. For Grandchild by Affidavit, eligibility ends when the grandchild no longer meets the definition of Grandchild by Affidavit.

When are Special Forms and Documentation Required for Children?

An employee must complete and submit the correct PEBB enrollment forms, notarized affidavit, and any required legal documents to provide coverage or the child's coverage will not take effect for the following children:

- A foster child
- A child placed for adoption, an affidavit and court documents for the placement or guardianship are required.
- A ward of the court
- A child under legal guardianship or other court order
- For some eligible grandchildren
- Disabled Children over the age of 26

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End of coverage: Coverage for a child ends the last day of the month in which the child turns 26. In some cases, such as for foster children or wards of the court, coverage may end the last day of the month of legal responsibility or 18, whichever comes first.

Example: Jack's foster child Joe is receiving PEBB coverage. Jack's legal documentation used at the time of Joe's enrollment stated that Jack will no longer be responsible for Joe when Joe turns 18. Joe's birth date is November 11. If there is no change to the legal responsibility or the documented responsibility end date, Joe's PEBB coverage will terminate November 30 the year he turns 18.

Disabled Dependent Children

There is no age limit for medical plan coverage for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. **All the criteria in this section must be met for the child to remain eligible.**

When an employee requests to enroll a disabled child over the age of 26 or establish the disability for a dependent already covered under a PEBB medical plan:

- The employee must submit to PEBB an appeal and enrollment form to enroll a disabled child age 26 or older. The employee must also provide evidence to PEBB that the child has had continuous health plan coverage, group or individual, prior to attaining age 26 and the coverage remains in effect.
 - The other medical coverage must continue until the employee's PEBB medical plan approves the child's health status as disabled and other eligibility is met, and the PEBB plan is effective.
 - The employee must complete the Affidavit of Disabled Dependent (MSC 5570) and return it to PEBB. This form verifies that the child is the employee's or spouse's **qualifying IRS tax dependent and is claimed on the eligible employees' most recent years tax return, the child files their own tax return and demonstrates that their adjusted gross income does not exceed 150% of the federal poverty level (FPL), or the employee is the legal guardian of the disabled child.** **Note:** Imputed taxes may apply, per IRC provisions, when an employee enrolls and covers dependents on their PEBB coverage that are not claimed on their federal taxes, and thus are not tax dependents.
 - The child's attending physician must submit to the employee's health plan verification and documentation of the child's disability.
 - The physician must verify to the health plan that:
 1. The disability existed before the child attained age 26, and;
 2. The child is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.
- Note:** The child must be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.
- The health plan provides a medical review of the physician's documentation and will notify PEBB of the plan's disability determination.
 - If the child has not had continuous coverage, the child is not eligible for PEBB coverage.

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PEBB will notify the subscriber of the child's medical determination and request verification for eligibility, if both medical and eligibility are met, PEBB will notify the subscriber of the effective date.

When a disabled child is receiving coverage beyond the age of 26, the employee's health plan may review the health status at any time to determine if the child continues to meet the criteria for coverage. PEBB will require verification of eligibility with each recertification by the medical plan.

If a disabled dependent child's PEBB coverage terminates for any reason after the age of 26, the child is ineligible for future enrollment as a dependent child under PEBB coverage. The exception is termination of the child's coverage due to the employee's termination of employment. If the employee is later rehired into a PEBB benefit eligible position, the child may be enrolled again if all PEBB criteria for disabled child are met.

Termination of Coverage When a Child Ages Out of PEBB Coverage

PEBB terminates all health plan coverage at midnight on the last day of the month in which a child reaches age 26. PEBB will not terminate coverage for a dependent child age 26 or older when the medical plan determines the child meets all the criteria for a disabled child and the dependent meets PEBB eligibility.

Domestic partners and their dependents

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

PEBB provides benefits to domestic partners that are comparable to those offered to married spouses, where legally possible. You may enroll your domestic partner in all benefit coverage available to a spouse either within 30 days of a Qualified Status Change or during the open enrollment period. A domestic partner's children are also eligible for enrollment.

The member and the domestic partner are eligible if they have

- Registered a certificate of their domestic partnership under **Oregon law**; or
- Signed and submitted to the member's agency a notarized Affidavit of Domestic Partnership declaring that both meet all the following criteria:
 - Are both at least 18 years of age;
 - Are responsible for each other's welfare and are each other's sole domestic partners;
 - Are not married to anyone;
 - Share a close intimate and committed relationship of mutual caring and are not related by blood closer than would bar marriage in the State of Oregon;
 - Currently share the same regular permanent residence, and;
 - Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

NOTE: An employee who has an Oregon registered certificate of domestic partnership must submit only the appropriate PEBB update forms to the agency either within 30 days of meeting the qualifications or during the open enrollment period to add coverage for a domestic partner. An employee who establishes the partnership through an Affidavit of Domestic Partnership must submit both the affidavit and appropriate forms to the agency either within 30 days of meeting the qualifications or during the open enrollment period.

Affidavit of Domestic Partnership Process

Eligible employees must submit an enrollment or midyear change form along with the notarized affidavit to enroll domestic partners and children within the allowable time for the enrollment type. Agencies will not process a domestic partner or a partner's children enrollment until the enrollment documentation submission is complete. If requested, the member and domestic partner must be able to provide at least three forms of verification of their joint responsibility, with information dated to confirm eligibility at the time of enrollment.

Children of Domestic Partners

Children of eligible domestic partners may be covered by the member's plans, whether or not the enrollment includes the domestic partner.

- An employee who has an Oregon registered domestic partnership must submit only the appropriate form to the agency to add coverage for a domestic partner's children either within 30 days of meeting the qualifications or during the open enrollment period.

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- If the employee does not have a registered certificate of domestic partnership, the employee must submit the completed, notarized Affidavit of Domestic Partnership to the agency with the paper enrollment or midyear change form.

Tax Considerations

Before enrolling a domestic partner or a partner's children for coverage, employees should know there may be important tax considerations. Payroll will add an imputed value to the eligible employee's taxable wages for the fair market value of the insurance premium for coverage of the domestic partner and domestic partner's children, unless the employee notifies payroll that the domestic partner qualifies as a tax dependent under IRS rules. Following is information provided by the Oregon Department of Justice Attorney General's Office regarding this topic.

Domestic Partner and Domestic Partner's Children as Dependents for Pre-tax Health Benefit Purposes

Domestic Partners Eligible for Health Coverage

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

Tax Consequences of Domestic Partner Coverage

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

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

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

Although coverage is also available for children of an eligible employee's domestic partner under your employer's group health plan, a domestic partner's child is unlikely to qualify as an

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employee's tax dependent for health coverage purposes. Thus, the value of such coverage generally must be included in your gross income.

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

IRS Publication 501 contains information on how to determine a dependent.

Filing a Certification of Dependent Domestic Partner Status

If your domestic partner and/or domestic partner's child qualifies as your tax dependent for health coverage purposes, you can avoid having the value of your domestic partner's health coverage treated as taxable income. To avoid taxation, you must complete and return the Certification of Dependent Domestic Partner Status, indicating that your domestic partner qualifies as your federal tax dependent for health coverage purposes. Because the determination of whether a person is a tax dependent for health coverage purposes turns on facts solely within your knowledge, your employer cannot make this determination for you. You should make this determination in consultation with your tax professional.

You will be asked to complete a Certification each year at open enrollment. For any year in which your employer does not receive a Certification from you, your employer will assume that your domestic partner does not qualify as your federal tax dependent for health coverage purposes for that year.

Removing a Domestic Partner and Domestic Partner's Children from Coverage On dissolution of a domestic partnership, you must remove the domestic partner and partner's children from coverage within 30 days of the date of dissolution. If you terminate a Domestic Partnership by Affidavit, you must complete and submit a midyear change form to your payroll/benefit office.

An employee's failure to notify PEBB or their agency/university benefit office of a domestic partner's loss of eligibility may result in civil or criminal charges against the employee for fraud or the intent to misrepresent the material facts of enrollment. PEBB may rescind coverage back to the last day of the month in which eligibility was lost or retroactively to the effective date of coverage if eligibility criteria were never met.

Dependent Eligibility Verification (DEV) Review

PEBB has implemented a Dependent Eligibility Verification (DEV) Review. The purpose of this review is to ensure that only eligible dependents are receiving core benefit (medical, dental and vision) coverage. As a Section 125 Cafeteria Plan, PEBB has a fiduciary responsibility to manage health care costs and to ensure that health plans offered through PEBB cover only those who meet the eligibility criteria.

All active employees, retirees and self-pay participants who have a dependent(s) enrolled in the PEBB benefit management system will be required to complete and return the required verification documents **when** they are selected for the review process. It is mandatory that members verify and submit the acceptable documentation by the review deadline in order to continue benefit coverage for their dependents. Dependents identified as ineligible will be

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terminated from all PEBB benefit plans effective the last day of the month in which the determination was made and no later than the last day of the month in which the review is completed.

COBRA continuation information will be mailed indicating the exact date coverage ends and COBRA eligibility begins.

Enrollment Periods and Effective Dates

Notice on Irrevocability of Plan Elections PEBB provides an Internal Revenue Service (IRS) Code 125 Cafeteria plan of benefits. This plan allows employees to receive health benefits pre-tax. To maintain the Cafeteria plan status, PEBB follows Code 125 federal regulations, which mandate that participant elections are irrevocable for the plan year. The federal regulations provide only limited circumstances in which the elections may change (e.g., qualified midyear plan change events or possible administrative correction).

Three types of events allow a participant to make plan elections during a plan year.

1. When an employee first meets the eligibility requirements.
2. At the annual open enrollment, this is when new elections can be substituted for old ones.
3. The occurrence of certain events identified by the IRS as permitting election changes.

In general, all elections must be prospective---that is, employees must make their benefit elections before the cash that they could otherwise receive is available to them. However, some retroactive enrollments such as special enrollment rights required under HIPAA for birth, adoption, or placement for adoption apply. The chart on the following page explains effective dates for benefit enrollments or changes.

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Current Employees		
Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Open Enrollment (Generally held each October)	First day of the new plan year (January 1) following either online enrollment or the agency processing of all required enrollment forms or documentation during open enrollment.	First day of the new plan year (January 1), or for enrollments requiring approval of medical history first of the month in the new plan year following plan approval (e.g., increases to life insurance).
Qualified Midyear Change Event , including special enrollment events. Subscribers have 30 days from the date of the event to submit forms.	The later of the first day of the month following agency receipt of update form or the event date. Ineligible individual coverage termination dates are retroactive to the last day of the month in which the individual lost eligibility.	First day of the month following agency receipt of midyear change form and plan approval of medical history if medical history is required. Termination – retroactive to the last day of the month in which eligibility was lost.
		Long term care insurance only: First of the month following agency receipt of the enrollment form and the plan's approval of medical history (evidence of insurability).
Newly Hired Employees		
Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Within 30 days of hire.	After initial hire date: First day of the month following online enrollment or agency receipt of all necessary enrollment forms including any required documentation	First of the month following online enrollment (or agency receipt of completed enrollment forms) and plan approval of medical history if medical history is required.
Newly Eligible Employees		
Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Within 30 days of date of eligibility.	After initial Eligibility date: First day of the month following online enrollment or agency receipt of all necessary enrollment forms including any required documentation.	First of the month following online enrollment (or agency receipt of enrollment form) and plan approval of medical history if medical history is required.

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Enrolling

It's important for you to be confident in your annual plan choices when you enroll because in most cases you will not be able to make changes after your benefits go into effect for the benefit plan year.

To comply with federal regulations, PEBB must ensure that employee plan elections, regardless of the type of enrollment (e.g., open enrollment, new hire), are irrevocable for the plan year. (See Appendix A Midyear Plan Changes for limited exceptions to this rule.)

- **Newly hired or newly eligible employees** may enroll online or by submitting required forms and any necessary documentation to their agency within 30 days of their eligibility or hire date. Enrollment elections for Opt-Out, Dependent Child by Affidavit, Grandchild by Affidavit, and Domestic Partner by Affidavit require submission of enrollment forms and other legal documentation to the agency. Employees can enroll electronically for these elections; however, the agency must receive all required forms within 5 business days to complete the enrollment. Employees submitting printed enrollment forms and documentation to the agency must ensure that the submissions are complete, or the agency will not process the enrollment.
- **Open Enrollment Period: The Board may require all eligible employees to actively enroll for core benefits during Open Enrollment for the following plan year. This is called a Mandatory or Required Open Enrollment. The Board also may require this of COBRA, Retiree, or Self-pay subscribers.** Employees who take no enrollment action during a mandatory open enrollment period may default in some programs and plans. **An enrollment action means to enroll, add to, save current enrollment, or change benefit plan enrollment elections or to enroll, add to, save current enrollment, or change coverage for an individual.**
 - The agency must provide an opportunity for open enrollment elections to an employee who becomes newly eligible or hired after the open enrollment period but before the start of the new plan year. The employee must submit required enrollment forms and documentation to the agency before the start of the new plan year.
 - During the open enrollment period, the eligible employee is accountable for enrolling and providing coverage to only those individuals who will meet PEBB eligibility criteria for coverage the **first day in the new plan year**. Certain enrollment elections require the submission of documentation to the employing agency before the enrollment will go into effect or the individual's enrollment will not go into effect.
 - Employees should not use the open enrollment period to remove individuals who have lost eligibility or will lose eligibility. Employees should remove individuals from their coverage and benefit record by submitting a midyear change form to their agency or to PEBB.
 - During open enrollment employees may terminate coverage for an individual electronically or by using a form if they know the individual will be ineligible for

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coverage the first day of the plan year or if the employee no longer wants to provide coverage to the individual even though the individual will continue to meet eligibility. **The individual's coverage will not end until the last day of the last month of the current plan year.**

- Before the start of the new plan year the agency must provide an opportunity for open enrollment elections to eligible employees away from work because of an employer-approved leave status and the employee's core benefits are continuing. Examples include but are not limited to FMLA, CBIW, and Active Military Duty.
- **Some Self-pay participants** (COBRA) must enroll by completing the enrollment forms identified by enrollment group type on the PEBB forms site. All Self-pay participants (including Retirees) send forms to BenefitHelp Solutions (BHS), PEBB's third-party administrator.
- PEBB's annual open enrollment requires all employees to review their current benefits and answer questions for the upcoming plan year. Employees who fail to log in during open enrollment are defaulted to specific enrollments because important questions have gone unanswered. Specific questions are asked each year that must be answered, or the default occurs. Examples of the questions requiring answering range from double coverage in other PEBB or OEGB coverage, tobacco use, spouse/domestic partner access to other employer coverage, and enrollment in the Health Engagement Model (HEM). Employees who do not take action during open enrollment are subject to the following actions, according to their coverage tier (i.e. employee only, employee and spouse etc.):
 - Tobacco use default – employee, or employee and spouse or domestic partner. Surcharge of \$25/person/month will be applied.
 - Standard Insurance higher premium rate default for tobacco use during the past 12 months default (if enrolled in optional employee or spouse or partner life insurance) will be applied.
 - Spouse or partner has other group coverage and waives the coverage default – if the employee has a spouse or partner. Surcharge of \$50 per month will be applied.

The above defaulted surcharges are correctable once a correction form is submitted and processed by PEBB staff. The correction is effective prospectively. There is no HEM correction opportunity for employees who do not complete open enrollment.

Failure to Enroll

Newly benefit eligible employees who do not enroll for benefits within the 30 days of becoming eligible may not participate in the benefit program for that plan year. However, if you fail to enroll you may appeal to PEBB. If PEBB approves the appeal, you may enroll **only** for core benefit coverage for the plan year, this includes coverage for eligible family members. Oregon Administrative Rules (OARs) on late enrollment can be found in Division 20. To find the rules, go to www.pebbinfo.com and click on Administrative Rules.

Correcting Enrollment Errors

Employees may make benefit enrollment errors when they provide information, make selections on paper forms, or through the online benefit management system.

An employee's failure to take an enrollment action during a period of required enrollment action, such as Open Enrollment, is not considered an enrollment error. An enrollment action means to enroll, add to, save current enrollment or change benefit plan enrollment elections or to enroll, add to, save current enrollment, or change coverage for an individual.

If you or your agency discovers an enrollment error within 30 days of the original effective date of your enrollment as a newly eligible employee or for a midyear change, your agency may take corrective action for a prospective date.

Certain Open Enrollment errors may be correctable. Your agency can correct these errors from the close of Open Enrollment up to the designated correction period. Once a medical, dental or vision plan becomes effective a correction to change to a different plan shall be prospective only.

PEBB must review all employee requests for a midyear change when received beyond 30 days from the original date of eligibility or the date that qualifies for a midyear plan change event.

Midyear Plan Changes

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

A qualified status change (QSC) is one type of midyear plan change event. This is an event that changes your work or family circumstances. A QSC is the most common type of midyear plan change event; however, several other change events are allowed.

The IRS requires that PEBB comply with federal regulations for midyear plan changes. Midyear plan change events must meet the IRS "general consistency rule." **Under the general consistency rule, an election change satisfies the consistency requirement for changes in status "if the election change is *on account of and corresponds with* a change in status that affects eligibility for coverage under an employer's plan."** Some qualified midyear events do not apply to all the benefits offered under the plan.

To make a change based on a midyear plan change event your agency must receive all the appropriate forms within 30 days of the date of the event. Midyear change form is available online at www.pebinfo.com and click on forms. PEBB must receive all midyear plan change requests when they are submitted beyond 30 days from the event date.

Qualifying Midyear Change Events

Midyear change events that affect eligibility for insurance benefits fall into three broad categories. Each event is detailed in federal regulation and criteria for the event must be met. See the appendix A chart on the recognized qualifying events under PEBB at: <http://www.oregon.gov/oha/PEBB/Benefits/SPD/AppendixA.pdf>

The eligible employee is responsible for identifying enrollment errors and maintaining a valid and accurate enrollment.

Individuals No Longer Eligible for Coverage

An employee can experience a qualified midyear change event that will permit, or require, the employee to request a termination of coverage for other individuals on their healthcare coverage. The employee's request for any coverage termination for an individual must be submitted within 30 days of the qualifying midyear event date to the employee's agency on the appropriate forms.

NOTE: PEBB will not terminate a spouse's or domestic partner's coverage due to a separation.

- (a) **When an employee experiences a qualifying midyear change that permits the employee to remove an eligible individual from coverage, agencies will terminate the coverage retroactive to the last day of the month of the event date.** Submission of the forms beyond 30 days requires an appeal to PEBB and will result in termination of the coverage retroactive to the last day of the month of the event date.
- (b) Employees must request termination of coverage for an individual receiving PEBB coverage under their enrollments when the individual becomes ***ineligible for the coverage***. Examples of individuals who no longer meet eligibility and require termination from coverage include but are not limited to an ex-spouse, an ex-domestic partner, a child by affidavit no longer eligible due to age limitation within the responsibility of a legal document, and a disabled child who no longer meets criteria.

Agencies will terminate an ineligible individual's coverage retroactive to the last day of the month of the event date (i.e., divorce date). PEBB, not the agency, processes retroactive terminations.

A COBRA notice of eligibility is sent to all individuals terminated as ineligible when the agency is notified within 60 days of the event date.

Late Requests for Terminations: PEBB must receive all employee requests for termination of coverage of ineligible individuals beyond the allowable 30 days.

An employee's failure to notify PEBB or their agency/university benefit office of a family member's or domestic partner's loss of eligibility may result in civil or criminal charges against the employee for fraud or the intent to misrepresent the material facts of enrollment. PEBB may rescind coverage back to the last day of the month in which eligibility was lost or retroactively to the effective date of coverage if eligibility criteria were never met. Rescission of coverage can occur to an employee, or an individual for whom the employee provides coverage.

Examples of fraud include, but are not limited to, a member's failure to notify PEBB or their agency/university benefit office of their divorce, termination of a domestic partnership, an individual losing eligibility or an individual who never meet eligibility criteria for enrollment in PEBB plans.

The following actions will occur during a rescission of coverage action taken by PEBB:

- The agency may request premium refunds from PEBB or the Plan based on the current contract.

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- An agency may determine that an employee must repay to the agency the state-funded premiums paid for coverage during the ineligible period.
- As contractually agreed to, a plan may determine that an employee must repay insurance claims paid by a plan for the ineligible individual during the ineligible period.
- An employee's agency may take disciplinary action against the employee for the employee's failure to remove an ineligible individual from coverage.
- The employee may have imputed value added to taxable income for premiums not refunded by the plans or repaid by the employee to the agency.

A benefit plan may remove from coverage or deny the claims of an eligible employee, a family member, domestic partner, or domestic partner's dependent child because of fraud, intentional misrepresentation of a material fact as prohibited by the terms of the plan, eligibility violations, or policy term violations. When a plan removes an employee from coverage for violations:

- a) The employee may choose, as a midyear plan change, an alternative PEBB plan to replace the terminated plan. If no alternative PEBB plan is available in the employee's service area, there is no coverage.
- b) The plan may retain all premiums paid and has the right to recover from the employee the benefits paid because of such wrongful activity that are in excess of the premiums.
- c) The plan may deny future enrollments of the individual.

HIPAA Special Enrollment Rights

Biological newborns, and children by adoption or placed for adoption receive health plan coverage retroactive to the event through the first 31 days. However, enrollment forms must be submitted to the agency within 30 days of birth, adoption, or placement to continue the coverage. When you submit forms within the 30-day period and up to 12 months from the date of birth of a biological child, the agency will approve coverage continuously and retroactively to the birth date, adopted, or placed for adoption date. Claims incurred during that time will be paid. A change in plans to a different plan type is prospective.

If you previously declined enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a PEBB plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Your coverage will be effective from the first day of the month of the other coverage loss. If the request is outside the 30 days from the loss of coverage, if approved the effective date will be prospective only to the first day of the month following submission of forms.

Tag along rule applies. If you add a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents that were eligible but never enrolled previously. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Individuals added within 30 days as tag along will have a prospective date.

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To request special enrollment or obtain more information, contact PEBB at (503) 373-1102, or email inquiries.pebb@odhsoha.oregon.gov

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

Ending Participation in PEBB

- Employees no longer participate in a PEBB plan when the PEBB plan ends or the employee or a covered individual is no longer eligible to participate.
- When an employee terminates employment and:
 - The employee accrues less than 80 hours paid regular hours in the month that employment terminates, coverage ends the last day of that month.
 - The employee accrues 80 or more paid regular hours in the month that employment terminates, coverage ends the last day of the month following the employment termination month.
- When an employee is within a stability period, in an approved leave without pay, and a nonpayment of premium occurs with a letter of non-payment sent to the employee from the agency, payroll will retroactively terminate coverage to the date specified in the letter. Generally, this is the last day of the last period for which the required premium contribution was paid.
- When terminating employment, flexible spending accounts and commuter accounts terminate on the last day of the last month that the employee is credited with paid regular status hours.
- Benefits for self-pay individuals and retirees terminate the last day of the last period for which the required premium contribution is paid.
- Optional plan coverage ends according to the optional plan's policy or certificate directives.
- Returning to Work Employees returning from a protected leave such as FMLA, CBIW, Military or other protected leave should contact their agency for specific enrollment and eligibility information.

Returning to Work

An eligible employee with a break in employment status returning to paid regular status within 30 days without a break in core benefit plan coverage will have all previous coverage reinstated and cannot make benefit plan changes.

Note: Exceptions is for Flexible Spending Accounts (FSAs), Commuter Accounts and Long-Term care coverage through UNUM. Check with your payroll or Human Resources office on enrollment in these accounts.

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Generally:

- An active eligible employee who is returning from a leave without pay (LWOP), but who has not been in a protected leave status such as FMLA, OFLA etc., and isn't in a current benefit eligible stability period must work at least half-time in the month of return to be eligible for benefits in the following month. The exception is an eligible employee in job share positions.
- An active eligible employee not in a current stability period returning from a reduction in hours below eligibility criteria must work at least half-time in the month of return to be eligible for benefits in the following month. The exception is an eligible employee in job share positions.
- A previous permanent, benefit eligible employee returning to a permanent benefit eligible position in paid regular status within 12 months of a core benefit coverage termination date following a layoff or termination of employment, is not required to work at least half time in the month they return to be eligible for benefits the following month. The agency will reinstate the previous plan enrollments, if available, effective the first of the month following the employee's return to work. The employee has 30 days to change reinstated benefit elections. Reinstatement excludes Flexible Spending Accounts, Long-Term Care insurance, and Commuter accounts.
Note: A stability period ends when there is a break in employment longer than 13 weeks. The employee's initial measurement period will start over.
- Flexible Spending Accounts, Long-Term Care insurance, and Commuter accounts are never reinstated. The employee has 30 days from the date of rehire, or return to work, to change benefit elections. Long-Term Care insurance may be reinstated as a payroll deduction if the employee continued the plan through portability. An exception occurs if the individual continued participation in a healthcare FSA while on COBRA, prepaid or made arrangements with the agency to pay the FSA prior to taking a FMLA leave. In this case, PEBB will reinstate the FSA.
- A previously benefit eligible employee returning to paid regular status in a benefit eligible position after a termination of core benefits of 12 months or longer must enroll as a newly eligible employee.

For Stability or Measurement Period Purposes: When any employee is employed immediately prior to his or her break in service for a period of less than 13 weeks, the agency may treat the employee as a new employee upon rehire for purposes of stability or measurement period, as long as the period during which the employee did not accrue any hours of service was at least four weeks long. For example, an employee who works for five weeks and then has no hours of service for six weeks may be treated as a new employee.

SECTION 2: MEDICAL BENEFITS

Medical Plan Options

Each of PEBB's medical plans provides a member handbook (evidence of coverage in the case of Kaiser Permanente) and a summary of benefits and coverage (SBC). They are incorporated in this Summary Plan Description by reference and are available for download as printable documents on the plans' websites. Carefully review the plans' member handbooks, SBCs and service areas to see which one best fit you and your family's healthcare needs.

Prescription Drug Coverage. All medical plans offered by PEBB include coverage for prescription drugs.

Routine Vision Care. Employees and others who enroll in a medical plan offered by PEBB may enroll in coverage for routine vision care. The exception is Kaiser Permanente full-time medical plans, which include routine vision care. See the Kaiser Permanente Evidence of Coverage for information on routine vision care in those plans. See VSP Routine Vision Care for the summary of benefits in the other plans.

Healthcare Service Contractor

Healthcare Service Contractor (HCSC) plans offer a high level of service and benefits with low out-of-pocket copayments. To get benefits, you must use the providers and facilities that are part of the plan. You select a primary care provider within Kaiser Permanente who guides your care. If you seek care elsewhere, the plan may not pay or may pay a reduced amount. PEBB sponsors the **Kaiser Permanente Traditional** and **Kaiser Permanente Deductible** plans for those who live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the plan's member handbook (evidence of coverage) for details on these plans and coverage. Contact Kaiser Permanente Member Services for the ZIP codes in the service area.

Medical-home and PCP 360 Plans in the Coordinated Care Model

A medical home is a clinic staffed by health care professionals who work together as a team. Led by your primary provider, this team coordinates all of your health care, including referrals to outside providers or specialists when necessary. The team gives you connected health care by staying informed about and actively participating in all aspects of your care. PEBB offers **Providence Choice** as a medical-home model plan. In this plan, you need to establish your medical home clinic and inform the plan of your selection of medical home to ensure you have access to the full benefits of your plan, including claims paid at the medical home benefit level and not the out-of-network level. You may select different medical homes for yourself and your dependents.

PEBB offers **Moda Health Synergy** as a coordinated care plan. In this plan, you need to establish your PCP 360 and inform the plan of your selection to ensure you have access to in-network benefits for primary care services. A PCP 360 is a primary care provider who has been certified by the Oregon Patient-Centered Primary Care program. This means that a PCP 360 has to meet certain quality standards and will be accountable for delivering high quality care that is centered on

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you. If you do not select a PCP 360, all primary care services will be paid at the out-of-network benefit level. You may select the same or a different PCP 360 for each member of your family. However, referrals from your PCP 360 are not required to see a specialist.

Preferred Provider Organization Plans

Preferred provider organization (PPO) plans offer services and benefits at two coverage levels — from preferred providers and from non-preferred providers. PEBB offers the **Providence Statewide PPO** plan in all parts of the state. You may use any doctors you wish. If you use doctors who are preferred (in-network), you pay less. If you use providers who are not preferred (out of network), you pay more. If you use providers who do not participate in the plan, the providers may bill you for amounts greater than allowed in the plan. If you use a state-recognized patient centered primary care home (PCPCH) that is in the Statewide Plan's network, your coinsurance rate for primary care services drops from 15% to 10%.

Links to the medical plans' customer service contacts and member handbooks can be found on the PEBB website at www.pebinfo.com

Medical Plan Premium Rates

Medical plan rates are located on the PEBB website: www.pebinfo.com

Medical Plan Comparisons

Medical plans comparisons are located on the PEBB website: www.pebinfo.com

Health Improvement and Cost Containment Programs

The Board may institute health improvement and cost containment programs in the design of health plans. The goal of these programs is to assist the employer and employees to improve employee health and contain costs for health benefits.

SECTION 3: DENTAL BENEFITS

Dental Plan Options

You are not required to enroll in a dental plan, but to enroll in a dental plan you must be enrolled in a medical plan. You may enroll yourself, your spouse/domestic partner, and your dependents individually or in any combination. Full-time plans are available to both full-time and part-time employees. Part-time plans are available only to part-time employees. If you enroll in Medical Opt-Out, you may enroll in a Dental plan.

Delta Dental plans

- Delta Dental, one of the largest dental networks in Oregon and nationwide, offers two plan choices: PPO and Premier.
- All preventive services (i.e., cleanings and x-rays) do not apply to the annual benefit maximum. You can use those additional dollar savings for basic and major services.

Willamette Dental Group plan

- Services are provided only by Willamette Dental Group providers and only in Willamette Dental Group facilities.

Kaiser Permanente Plans

- You do not need to enroll in a Kaiser Permanente medical plan to enroll in a Kaiser Permanente dental plan, and vice versa.
- You can enroll in a Kaiser Permanente dental plan if you live or work in the Kaiser Permanente Service area at least 50% of the time.
- Services are provided by Kaiser Permanente dental group providers in Kaiser Permanente dental offices.

Each of PEBB's dental plans provides a member handbook (also called certificate or evidence of coverage) and benefit summary. They are incorporated in this Summary Plan Description by reference and are available for download as printable documents on each plan's website. Carefully review the plans' member handbooks and service areas to see which one best fits you and your family's dental care needs. Links to the dental plans' customer service contacts and member handbooks are on the PEBB website: www.pebinfo.com

Dental Plans Rates

Dental plan rates are located on the PEBB website: www.pebinfo.com

Dental Plans Comparisons

Dental plan rates are located on the PEBB website: www.pebinfo.com

SECTION 4: VISION BENEFITS

The full-time Kaiser Permanente Traditional and Kaiser Permanente Deductible medical plans include coverage of routine vision services. If you enroll in another medical plan, including a part-time plan or Opt-Out, you may (but are not required to) enroll in vision coverage provided by VSP. You may enroll yourself and any combination of your spouse or partner, and dependents.

You pay a share of premium if you enroll in the VSP Basic Plan. Your premium share is the same percentage rate as your medical coverage percentage which includes Opt-Out.

VSP Plus plan has better coverage for frames, coatings, and progressive lenses. For this plan, you pay the employee premium share for the Basic plan plus the difference in premium cost between the Basic and Plus plans.

SECTION 5: OPTIONAL BENEFITS

PEBB offers eligible employees the opportunity to enroll in optional benefits. This section summarizes the following plans.

- **Optional Employee and Spouse or Domestic Partner Life Insurance** (beyond the employer-provided \$10,000 basic employee insurance) for the employee, the employee's spouse or domestic partner
- **Dependent Life Insurance** for the employee's spouse or domestic partner, and eligible children
- **Short Term and Long-Term Disability Insurance** for the employee only. (This option is not available for seasonal or temporary/intermittent employees.)
- **Accidental Death and Dismemberment Insurance** for the employee, or the employee and eligible dependents
- **Healthcare and Dependent Care Flexible Spending Accounts (FSAs)**
- **Long Term Care Insurance** for the employee, spouse or domestic partner, dependents and certain extended family members
- **Commuter Account Fringe Benefits** for employee only

The employer provides no benefit amount toward the cost of optional benefits. Optional benefits are voluntary choices you purchase on your own. Monthly premium payments or contributions for these benefits are your responsibility. When optional benefits become effective, your payroll

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deducts the insurance premium or contribution from your pay. Your pay stub or statement shows the monthly deductions.

Life Insurance

This subsection summarizes the group Optional Life Insurance plan available through PEBB. This is a summary only. For full details, see the [Certificate of Insurance](#). The controlling provisions of the plan are in the group policy issued by Standard Insurance Company (The Standard). The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Life insurance, you must be one of the following:

- An active employee of the State of Oregon who is regularly scheduled to work and who meets the terms of eligibility outlined in the PEBB Oregon Administrative Rules (OARs).
- A retiree of the State of Oregon who:
 - Retired under the employer's retirement plan during the month of December 2001 and whose insurance under the group policy as an active employee terminated on or after January 1, 2002, or;
 - Retired under the Employer's retirement plan on or after January 1, 2002 and was insured as an active employee under the group policy on the day before retirement.

The following dependents are eligible for coverage if they meet eligibility requirements of the PEBB Oregon Administrative Rules (OARs):

- Spouse
- Domestic partner
- Your PEBB eligible child or your spouse's or domestic partner's PEBB eligible child

Life coverage can be continued for activated reservists, subject to continued payment of premium, for the longest leave period allowed under the group policy (12 months).

Amounts of Life Insurance for Active Employees

Basic Life Insurance for Active Employees: \$10,000. This coverage is part of core benefits for which employees pay a share of premium.

Optional Life Insurance for Active Employees and their Spouse or Domestic Partner:

- *Employee:* Any multiple of \$20,000, up to \$600,000. You pay the entire premium. Newly eligible employees have a guaranteed issue (medical history not required) of \$20,000 up to \$100,000 if enrolled within 30 days of eligibility.

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- *Spouse or domestic partner:* Any multiple of \$20,000, up to \$400,000. You pay the entire premium. Newly eligible spouse or domestic partners have a guaranteed issue (medical history not required) of \$20,000 if enrolled within 30 days of eligibility.

Note: If you are covered as both an employee and a spouse or domestic partner, the combined maximum amount is limited to \$600,000.

Dependent Life Insurance for Spouse or Domestic Partner and Eligible Children of Active Employees: \$5,000. You pay the entire premium. The rate is the same, regardless of the number of eligible dependents.

Evidence of Insurability

Evidence of insurability is required when you apply for:

- Any amount of coverage requested more than 30 days after becoming eligible
- More than the guaranteed issue amount of \$100,000 for Employee Optional Life coverage when you are first eligible to apply.
- More than the guaranteed issue amount of \$20,000 of Spouse or Domestic Partner Optional Life coverage when you are first eligible to apply.
- An elective increase in coverage.
- Any amount during annual open enrollment, unless you are within your 30-day eligibility period

A Medical History Statement (MHS) should be submitted to The Standard within 5 business days of the request or December 31 if the amount is requested during open enrollment. A MHS can be submitted online to [The Standard](#).

Coverage during Retirement

If you are insured for life insurance under this program immediately prior to your retirement under the State of Oregon's retirement plan, you may elect to continue up to 50 percent of the total amount of your Employee Basic and Optional Life insurance in effect on the day before your retirement (in increments of \$2,500 not to exceed \$200,000). You must apply to the plan for coverage within 30 days after your retirement and agree to pay the cost of coverage.

At age 65 and older, the amount available to you as a retiree decreases to a percentage of the amount determined above, as follows:

<u>Your Age</u>	<u>Percentage</u>
65 – 69	65%
70 – 74	50%
75 or older	35%

Your spouse or domestic partner and any children are not eligible for coverage during your retirement.

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Note: If you return to work and become eligible for coverage as an active employee within 12 months, your previous active coverage may be reinstated at your choice. If you choose to do so you must notify The Standard to cancel the retirement life insurance coverage. Please also note, should you cancel your retirement coverage, you will not be offered another opportunity to re-enroll.

Effective Date of Coverage

Basic Life Insurance for Employees: The day when your PEBB medical or dental coverage becomes effective.

- **Optional Life Insurance for Employee and Spouse or Domestic Partner:**
- **For amounts that do not require evidence of insurability:** The first day of the calendar month following the date you enroll for the coverage.
- **For amounts subject to evidence of insurability:** The first day of the calendar month following the date The Standard approves evidence of insurability.
- **Amounts requested during open enrollment require evidence of insurability:** January 1 of the new plan year or the first day of the calendar month following the date The Standard approves the evidence of insurability in the new plan year.

Dependent Life Insurance for Spouses/Domestic Partners and PEBB eligible Children: The first day of the calendar month following the date you enroll for the coverage.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective (including coverage for your spouse, domestic partner and children). If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively at Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively At Work on your last scheduled work day before the date of your absence; and 3. You were capable of Active Work.

Designating a Beneficiary

When you enroll for coverage, you should name a beneficiary or beneficiaries to receive death benefits. You may do this online through the [PEBB enrollment system](#). If you name more than one

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beneficiary, they will share equally unless you specify otherwise. You may change beneficiaries at any time through the PEBB enrollment system without the consent of the beneficiary.

If you do not name a beneficiary or your named beneficiary dies before you, The Standard will pay benefits in equal shares to the first surviving of the following: your spouse; your children; your parents; your estate. You are the beneficiary of benefits paid on the death of your spouse or domestic partner or child.

Additional Benefits

Travel Assistance: The Standard includes a travel assistance program that provides a full range of 24-hour medical, legal, and travel assistance services to you and your dependents when you travel more than 100 miles from home or in a foreign country. For more information, download the [brochure](#).

Life Service Toolkit: To address important life matters, PEBB members and their beneficiaries have access to The Standard's [Life Services Toolkit](#). As a participant, you will have access to services such as estate planning assistance (including will preparation), financial planning, funeral arrangements, and identity theft prevention. Beneficiaries can access services such as grief support, legal assistance, support services, and other online resources.

Other Benefits: For information on Repatriation Benefit for Employees, Coverage during Total Disability (waiver of premium) and Accelerated Benefit, please see the [Certificate of Insurance](#).

Continuation of Insurance if Employment Ends (Portability)

If your employment ends you may be eligible to continue your Optional Life coverage. You must apply to The Standard within 60 days following the date your employment ends.

You may continue any multiple of \$20,000, up to the amount of your Optional Life Insurance in effect on the date your employment ends. If you elect to continue your Optional Life, you also may elect to continue any multiple of \$20,000 of your spouse or domestic partner Optional Life insurance coverage, up to the amount in effect on the date your employment ends. You may not continue coverage under this provision if you are retiring or are totally disabled, or if you convert your coverage to an individual policy.

Coverage continued under this provision will be subject to all terms of the group policy.

Note: If you die, your spouse or domestic partner may continue his or her Optional Life Insurance.

Right to Convert

If your coverage or a dependent's coverage ends or is reduced, you may be eligible to convert the terminated amounts to certain types of individual life insurance policies without providing evidence of insurability. You must apply and pay premiums within 60 days after group coverage ends or is reduced.

You may not convert coverage amounts for which you have received an accelerated benefit.

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Suicide Exclusion

The suicide exclusion applies to Optional Life insurance for yourself and your spouse or domestic partner. If the death results from suicide or other intentionally self-inflicted injury while sane or insane, The Standard will not pay amounts that have not been continuously in effect for at least two years on the date of death.

When Coverage Ends

Your Basic and Optional Life coverage ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid (except if premiums are waived while you are totally disabled)
- The date you cease to meet the terms of eligibility outlined in PEBB Oregon Administrative Rules (OARs)
- The date you become a full-time member of the armed forces
- The date the group policy ends

Optional life insurance for your spouse or domestic partner and dependent life insurance ends automatically on the earliest of the following:

- The date you cease to be insured
- Five months after the date you die (no premiums are charged for this period of coverage)
- The date the last period ends for which a premium was paid for the coverage
- The last day of the month in which a dependent loses eligibility under PEBB Oregon Administrative Rules (OARs)
- For your spouse, the last day of the calendar month in which you are divorced
- For a domestic partner, the termination date of your domestic partner relationship
- For a child who is disabled, 90 days after you receive a request for proof of disability and you do not provide this proof

Payment of Benefits

For amounts less than \$10,000, The Standard issues a check to the beneficiary. The Standard pays amounts of \$10,000 or more to the beneficiary by depositing funds into Standard Secure Access – a no fee, interest bearing draft account. The beneficiary receives a personalized checkbook and has complete control of the account. Beneficiaries can write checks as needed or for the full amount. The arrangement allows beneficiaries to earn interest on the benefit while they consider financial decisions.

Claims

To make a claim, the claimant must submit to The Standard proof that a death or total disability occurred and any other information The Standard may reasonably require in support of the claim. For a claim for continued coverage during total disability (waiver of premium), The Standard may have you examined by a specialist of The Standard's choice at reasonable intervals. For death

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claims, The Standard may have an autopsy performed at The Standard's expense, except where prohibited by law.

The Standard will provide the claimant a written decision on the claim within a reasonable time after The Standard receives the claim. If the claimant does not receive a decision from The Standard within 90 days, the claimant can request a review as if the claim were denied.

If The Standard denies any part of the claim, The Standard will provide the claimant a written notice of denial containing the reasons for the decision, reference to the parts of the group policy supporting the decision, a description of any additional information needed to support the claim, and information on the claimant's right to a review of the decision.

If the claimant wants The Standard to conduct a review of the denial, the claimant:

- Must request the review in writing within 60 days after receiving notice of the denial (or within 180 days with respect to a claim for continued coverage during total disability).
- May include written comments or other items to support the claim.
- May review any non-privileged information that relates to the request for review.

The Standard will review the claim promptly after receiving the request. The Standard will send the claimant a notice of the final decision within 60 days after receiving the request for review, or within 120 days if special circumstances require an extension. The notice will include the reasons for the decision and will refer to the relevant parts of the group policy that support the decision.

Monthly Premium Rates

Monthly premiums can be found on the PEBB website at: www.pebinfo.com

Short Term Disability (STD) Insurance

This subsection summarizes the group Short Term Disability Insurance plan available through PEBB. It is a summary only. For full details, see the [Certificate of Insurance](#). The controlling provisions of the plan are in the group policy issued by Standard Insurance Company (The Standard). The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Short-Term Disability (STD) Insurance, you must be an active employee of the state of Oregon who is regularly scheduled to work and who meets the terms of eligibility in PEBB Administrative Rules.

You are not eligible if you are: a seasonal or intermittent employee; an employee scheduled to work fewer than 90 days; a temporary employee; a full-time member of the armed forces of any country.

Effective Date of Coverage

Your STD Insurance becomes effective:

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- The first day of the calendar month following the date you enroll, if you enroll within 30 days after becoming an eligible employee.
- January 1 of the following year if you enroll during the annual open enrollment period.
- The first day of the calendar month following the date you enroll, if you enroll within 30 days following a qualified status change (as determined by your employer).

Note: You pay the entire monthly premium.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective. If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible

Member. Active Work and Actively at Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively at Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work.

Benefit Amount

The Standard pays benefits at the end of each week in which you qualify. The weekly amount is 60 percent of the first \$2,770 of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit, before reduction by deductible income, is \$1,662. The weekly minimum benefit, after reduction by deductible income, is \$25.

Benefit Waiting Period

If The Standard approves your claim, it will pay benefits only after the benefit waiting period. The benefit waiting period is a specified number of days for which you must remain continuously disabled. This is seven days if the disability is caused by physical disease, pregnancy or mental disorder. There is no benefit waiting period if the disability is caused by accidental injury.

However, if your disability begins while you are scheduled to be away from work under the terms of your employment, your benefit waiting period is the longer of the date determined above and the period ending on the day before you were scheduled to return to work.

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Maximum Benefit Period

Benefits may continue for any one period of disability up to the maximum benefit period of 13 weeks unless the pre-existing condition limitation applies. In that case, the maximum benefit period is four weeks.

If you are eligible to receive benefits under any other disability plan, your STD benefits will end when the other disability benefits become payable. This applies even if you become eligible for the other benefits before the end of the STD maximum benefit period.

Definition of Disability

The Standard deems you disabled if, because of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation. The Standard deems you partially disabled if you work for the state of Oregon but are unable to earn more than 80 percent of your pre-disability earnings. You are no longer disabled when your earnings from any occupation exceed 80 percent of your pre-disability earnings.

Return to Work Incentive

You may work for the State of Oregon during the benefit waiting period and while you are receiving benefits. The Standard will reduce your weekly benefit amount to the extent your earnings exceed 100 percent of your pre-disability earnings when added to your gross benefit.

Reasonable Accommodation Benefit

If you return to work in any occupation for any employer (except self-employment) through the employer's workplace accommodation, The Standard will reimburse the employer for the incurred expenses to an amount agreed upon in advance and in writing by The Standard and the employer.

Temporary Recovery

If you temporarily recover and then become disabled again from the same cause or causes after benefits are payable, and the recovery period does not exceed 14 days, The Standard will

- Not impose a new benefit waiting period
- Resume paying benefits as if no break in coverage had occurred
- Use the same pre-disability earnings to determine your benefit
- Reduce the maximum benefit period by the previous period or periods of disability

Pre-disability Earnings

Pre-disability earnings are your weekly earnings from the state of Oregon in effect on the last full day of active work. They include:

- Salary
- Grant assistance wages
- Stipends

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- Contributions you make through a salary reduction agreement with your employer to an IRC Section 401(k), 403(b) or 457 deferred compensation arrangement, or an executive nonqualified deferred compensation arrangement
- Amounts contributed to fringe benefits according to salary reduction agreements under an IRC Section 125 plan

Pre-disability earnings exclude: bonuses; overtime pay; your employer's contribution to a deferred compensation arrangement or pension plan; state-paid benefit amounts in excess of your premiums for medical insurance, dental insurance and the first \$50,000 of group life insurance; or any other extra compensation.

If you are paid hourly, pre-disability earnings are determined by multiplying your hourly pay rate by the average number of hours you worked per week during the preceding 13 weeks (or during your period of employment if less than 13 weeks), but not more than 40 hours.

Deductible Income

The Standard considers the following deductible income and deducts any amounts from your benefit:

- Work earnings, as described in Return To Work Incentive
- Benefits you are eligible to receive under any other short term disability plan that, when added to your benefit under this plan, exceed 75 percent of your pre-disability earnings
- Amounts received by compromise, settlement, or other method as a result of a claim for the above, whether disputed or undisputed
- Sick pay or other salary continuation (including donated leave) paid to you by your Employer, but not including vacation pay

Exclusions and Limitations

You are not covered for a disability:

- Caused or contributed to by an intentionally self-inflicted injury, while sane or insane
- Arising out of or in the course of any employment for wage or profit

No benefits will be paid for any period you are:

- Not under the on-going care of a physician
- Eligible to receive workers' compensation or similar benefits
- Working for any employer other than the state of Oregon or are self-employed
- Confined for any reason in a penal or correctional institution

Pre-existing Condition: The Standard limits your maximum benefit period to four weeks if your disability is caused or contributed to by a pre-existing condition. A pre-existing condition is a mental or physical condition for which, during the 90 days immediately preceding the date you became insured, you consulted a physician or other licensed medical professional, received

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medical treatment or services, undergone diagnostic procedures, or took prescribed drugs or medications. The Standard will not apply this limitation to a disability that begins after you have been insured under the group policy for 12 months and have been actively at work for at least one day after those 12 months.

When Benefits End

Benefits end on the earliest of:

- The date you are no longer disabled
- The end of the maximum benefit period
- The date you die
- The date you begin working for any employer other than the state of Oregon, or are self-employed
- The date long term disability benefits become payable to you
- The date you fail to provide proof of continued disability and entitlement to benefits

When Coverage Ends

This coverage ends automatically on the earliest of the following dates:

- End of the period for which a premium was paid for your coverage
- The last day of the calendar month in which your employment terminates
- You cease to be eligible under PEBB Oregon Administrative Rules (OARs)
- You become a full-time member of the armed forces
- The group policy ends

Claims

To file a claim, please call The Standard at (800) 242-1888. You can find more information about filing a claim, including what information you will need to provide, on the [Frequently Asked Questions](#) document.

The Standard may:

- Investigate your claim at any time
- Have you examined at reasonable intervals by specialists of their choice
- Deny or suspend benefits if you fail to attend an examination or cooperate with the examiner

The Standard will send you a written decision on your claim within a reasonable time after receiving your claim. If you do not receive the decision within 90 days, you can request a review as if your claim were denied.

If The Standard denies any part of your claim, it will send you written notice of denial. The notice will give the reasons for the decision and refer to the parts of the group policy supporting the decision. It will describe any additional information needed to support your claim and information concerning your right to a review of the decision.

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If you want The Standard to conduct a review of denial of all or part of your claim, you must request the review in writing within 180 days after you receive notice of the denial. When you request a review, you may include written comments or other items to support your claim. You also may review any nonprivileged information that relates to your request for review. The Standard will review your claim promptly after receiving your request. The Standard will send you a notice of the final decision within 45 days after receiving your request, or within 90 days if special circumstances require an extension. This notice will state the reasons for the decision and refer you to the relevant parts of the group policy that support the decision.

Monthly Premium Rates

Monthly premiums can be found on the PEBB website at: www.pebinfo.com

This insurance may replace a portion of your monthly income should you become disabled. You must self-pay for this coverage; the state does not provide a benefit amount for this benefit.

Long Term Disability (LTD) Insurance

This subsection summarizes the group Long Term Disability Insurance plan available through PEBB. It is a summary only. For full details, see the [Certificate of Insurance](#). The controlling provisions of the plan are in the group policy issued by The Standard Insurance Company (The Standard). The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Long Term Disability (LTD) Insurance, you must be an active employee of the state of Oregon who is regularly scheduled to work and who meets the terms of eligibility in PEBB Administrative Rules.

You are not eligible if you are: a seasonal or intermittent employee; an employee scheduled to work fewer than 90 days; a temporary employee; a full-time member of the armed forces of any country.

Effective Date of Coverage

Your LTD Insurance becomes effective:

- The first day of the calendar month following the date you enroll, if you enroll within 30 days after becoming an eligible employee
- January 1 of the following year if you enroll during the annual open enrollment period
- The first day of the calendar month following the date you enroll, if you enroll within 30 days following a qualified status change (as determined by your employer)

Note: You pay the entire monthly premium.

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Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective.

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively at Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively at Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work.

Benefit Amount

The Standard pays benefits at the end of each month in which you qualify. When you apply for coverage, you elect one of the following monthly benefits:

- An amount equal to 60 percent of the first \$12,000 of your pre-disability earnings. The monthly maximum benefit, before reduction by deductible income, is \$7,200.
- An amount equal to 66 2/3 percent of the first \$12,000 of your pre-disability earnings. The monthly maximum benefit, before reduction by deductible income, is \$8,000.

The monthly minimum benefit, after reduction by deductible income, is \$50. Your monthly benefit will be no less than \$50 while you qualify.

If you are disabled for less than a full month, The Standard will pay you one-thirtieth (1/30) of the benefit for each day of disability.

Note: If you initially elect the 60% benefit and later increase to the 66 2/3% benefit, The Standard will apply a new pre-existing condition exclusion to the change. In this case, if you become disabled and the increased benefit is not payable because of the new pre-existing condition exclusion, The Standard will administer your claim as if you had not elected to change your benefit percentage.

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Benefit Waiting Period

The benefit waiting period is the number of days for which you must remain continuously disabled and during which benefits are not payable. When you apply for coverage, you elect a benefit waiting period of either 90 or 180 days. If The Standard approves your claim, it will pay benefits after the end of the benefit waiting period.

Note: If you initially elect a 180-day benefit waiting period and later reduce your benefit waiting period to 90 days, The Standard will apply a new pre-existing condition exclusion. If you become disabled and benefits are not payable because of the new pre-existing condition exclusion, The Standard will administer your claim as if you had not elected to change your benefit waiting period.

Maximum Benefit Period

LTD benefits may continue during Disability up to the end of the maximum benefit period, determined by your age when Disability begins. Please consult the [Certificate of Insurance](#) to determine the maximum benefit period applicable to you.

Additional Benefits for Severely Disabled and Family Care Expenses

Please see the [Certificate of Insurance](#) for a description of the additional benefits available to you under the Assisted Living Benefit and Family Care Expenses Adjustment provisions.

Definition of Disability

The Standard deems you disabled if, during the benefit waiting period and the next 24 months, you are unable to perform with reasonable continuity the material duties of your own occupation as a result of physical disease, injury, pregnancy or mental disorder.

Thereafter, The Standard deems you disabled if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

Return to Work Incentive

You may work for any employer while receiving LTD benefits, provided you meet the definition of Disability described above. Earnings from work are used to reduce the amount of your LTD benefit, as follows:

- During the first 12 months of working, your work earnings are used to reduce the LTD benefit to the extent that they exceed 100% of your pre-disability earnings when added to your gross LTD benefit.
- Thereafter, your LTD benefit is reduced by one-half of your work earnings.

Rehabilitation Plan

You may apply to participate in a Rehabilitation Plan by submitting a form or letter to The Standard. If they approved your Rehabilitation Plan, The Standard may reimburse you for some or

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all of the following expenses you incur in connection with the plan, including training and education expenses; family care expenses; job-related expenses; job search expenses.

Reasonable Accommodation Benefit

If you return to work in any occupation for any employer (not including self-employment) because of a workplace accommodation made by the employer, The Standard will reimburse the employer for the expenses incurred, up to an amount agreed upon in advance and in writing.

Temporary Recovery

If you temporarily recover and then become disabled again from the same cause or causes, you will not be required to serve a new benefit waiting period, provided the period of recovery does not exceed the following applicable periods:

- During the benefit waiting period: a total equal to 5 days for every 30 days of the benefit waiting period
- During the maximum benefit period: 180 days for each period of recovery

Benefits will resume as if no break in coverage had occurred (the pre-disability earnings used to determine your LTD benefit remain the same, and the maximum benefit period, own occupation period and maximum period for benefits under the Mental Disorder limitation will be reduced by the previous period or periods of Disability).

Pre-disability Earnings

Pre-disability earnings are your monthly earnings from the State of Oregon in effect on **the last full day of active work**, and include:

- Salary
- Grant assistance wages • Stipends
- Contributions you make through a salary reduction agreement with your employer to an IRC Section 401(k), 403(b) or 457 deferred compensation arrangement, or an executive nonqualified deferred compensation arrangement
- Amounts contributed to fringe benefits according to salary reduction agreements under an IRC Section 125 plan

Pre-disability earnings exclude bonuses; overtime pay; your employer's contribution to a deferred compensation arrangement or pension plan; your state-paid benefit amounts in excess of your premiums for medical insurance, dental insurance and the first \$50,000 of group life insurance; or any other extra compensation.

If you are paid hourly, pre-disability earnings are determined by multiplying your hourly pay rate by the average number of hours you worked per month during the preceding three calendar months (or during your period of employment if less than three months), but not more than 173 hours.

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Deductible Income

The following amounts will be considered deductible income, and used to reduce the amount of your LTD benefit:

- Work earnings, as described in the Return To Work Incentive
- Sick pay or other salary continuation (including donated leave) paid to you by your Employer, but not including vacation pay
- Amounts for which you are eligible under a workers' compensation law or similar law
- Amounts you, your spouse, or your children under age 18 are eligible to receive because of your disability or retirement under the Federal Social Security Act or any similar plan or act
- Amounts you are eligible to receive under any state disability income benefit law or similar law
- Amounts you are eligible to receive because of your disability under any other group insurance coverage
- Disability or retirement benefits you are eligible to receive under your employer's retirement plan, including PERS, STRS and any plan arranged and maintained by a union or employee association for the benefit of its members

If any of these plans has two or more payment options, the option which comes closest to providing you a monthly income for life with no survivors' benefit will be Deductible Income, even if you choose a different option.

- For employees of the Oregon University System, benefits you are eligible to receive under an employer-sponsored individual disability policy arranged for individuals in a common group
- Amounts received by compromise, settlement or other method as a result of a claim for the above, whether disputed or undisputed

Survivors Benefit

If you die while receiving LTD benefits, a lump sum benefit equal to 3 times your LTD benefit (before reduction by deductible income) will be paid to the first of the following eligible survivors:

- Your spouse or domestic partner
- Your children under age 24 who meet the terms of eligibility outlined in the PEBB Oregon Administrative Rules (OARs)
- Your spouse or Domestic Partner's children under age 24 who meet the terms of eligibility outlined in the PEBB Oregon Administrative Rules (OARs)
- Any person providing care and support for any of the above
- A spouse is a person to whom you are legally married. A domestic partner is a person who meets the eligibility requirements outlined in the PEBB Oregon Administrative Rules (OARs)

Exclusions and Limitations

You are not covered for a disability caused or contributed to by:

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- An intentionally self-inflicted injury, while sane or insane
- A Preexisting Condition. A Preexisting Condition is a mental or physical condition for which, during the 90 days immediately preceding the date you became insured, you consulted a physician, received medical treatment or services, or took prescribed drugs or medications. This exclusion will not apply to a Disability which begins after you have been insured under the group policy for 12 months and have been actively at work for at least one day after those 12 months

Note: A new Preexisting Condition exclusion will apply to an increase in benefit percentage and/or decrease in benefit waiting period.

No LTD benefits will be paid for any period:

- You are not under the on-going care of a physician
- You are confined for any reason in a penal or correctional institution

Mental Disorder Limitation: Payment of LTD benefits will be limited to 24 months for each period of continuous Disability caused or contributed to by a mental disorder. However, if you are confined in a hospital* at the end of the 24 months, this limitation will not apply while you are continuously confined.

*Hospital includes only legally operated hospitals providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Hospital does not include rest homes, nursing homes, and convalescent homes, homes for the aged or facilities primarily affording custodial, educational, or rehabilitative care.

When LTD Benefits End

LTD benefits will end on the earliest of the following dates:

- The date you are no longer disabled
- The end of the maximum benefit period
- The date you die
- The date benefits become payable to you under any other group long term disability insurance policy under which you become insured during a period of temporary recovery
- The date you fail to provide proof on continued Disability and entitlement to LTD benefits

When Coverage Ends

Your Long-Term Disability coverage ends automatically on the earliest of the following dates:

- The date the last period ends for which a premium was paid for your coverage
- The date you cease to meet the terms of eligibility outlined in the PEBB Administrative Rules
- The last day of the calendar month in which your employment terminates
- The date you become a full-time member of the armed forces
- The date the group policy terminates

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Claims

To file a claim, please call The Standard at (800) 242-1888. You can find more information about filing a claim, including what information you will need to provide, on the [Frequently Asked Questions](#) document.

The Standard may:

- Investigate your claim at any time
- Have you examined at reasonable intervals by specialists of their choice
- Deny or suspend benefits if you fail to attend an examination or cooperate with the examiner

You will receive a written decision on your claim within a reasonable time after The Standard receives your claim. If you do not receive their decision within 90 days, you can request a review as if your claim had been denied.

If The Standard denies any part of your claim, you will receive a written notice of denial containing the reasons for their decision, reference to the parts of the group policy supporting their decision, a description of any additional information needed to support your claim, and information concerning your right to a review of their decision.

If you want The Standard to conduct a review of denial of all or part of your claim, you must request the review in writing within 180 days after you receive notice of the denial. When you request a review, you may include written comments or other items to support your claim. You also may review any nonprivileged information that relates to your request for review. The Standard will review your claim promptly after receiving your request. The Standard will send you a notice of the final decision within 45 days after receiving your request, or within 90 days if special circumstances require an extension. This notice will state the reasons for the decision and refer you to the relevant parts of the group policy that support the decision.

Monthly Premium Rates

Monthly premiums can be found on the PEBB website at: www.pebinfo.com

This insurance may replace a portion of your monthly income should you become disabled. You must self-pay for this coverage; the state does not provide a benefit amount for this benefit.

Accidental Death and Dismemberment (AD&D) Insurance

This subsection summarizes the group Optional Accidental Death and Dismemberment (AD&D) insurance plan available through PEBB. It is a summary only. For full details, see the [Certificate of Insurance](#). The controlling provisions of the plan are in the group policy issued by Standard Insurance Company. The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

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Eligibility for Coverage

To be eligible for Optional Accidental Death and Dismemberment (AD&D) insurance, you must be an active employee of the State of Oregon who is regularly scheduled to work and who meets the terms of eligibility outlined in the PEBB Oregon Administrative Rules (OARs).

Dependents eligible for coverage are:

- Spouse: A person to whom you are legally married
- Domestic Partner: A domestic partner who meets the eligibility requirements outlined in the PEBB Oregon Administrative Rules (OARs)
- Child: Your child or your spouse's or domestic partner's child who meets the eligibility requirements outlined in the PEBB Oregon Administrative Rules (OARs)

Employees and dependents who are full-time members of the armed forces of any country are not eligible for coverage.

Amounts of Optional AD&D Insurance

Optional AD&D Insurance for you:

You may apply for any multiple of \$50,000 up to \$500,000. Enrollment is either for employee only or for employee & eligible dependents.

Optional AD&D Insurance for your Spouse or Domestic Partner and Children:

If you elect employee and dependent coverage, the AD&D insurance amounts for each of your dependents is equal to a percentage of your AD&D insurance amount, determined as follows:

- If on the date your spouse or domestic partner dies or suffers a loss you do not have any eligible children, your spouse's or domestic partner's AD&D insurance amount is 50 percent of your AD&D insurance amount
- If on the date your spouse or domestic partner dies or suffers a loss and you have both a spouse or domestic partner and eligible children, your spouse or domestic partner's AD&D insurance amount is 40 percent of your AD&D insurance amount
- If your eligible child dies or suffers a loss, the child's AD&D insurance amount is 15 percent of your AD&D insurance amount

Covered Losses

With Optional AD&D insurance, benefits are payable in the event of an employee's or insured dependent's death or covered loss resulting from an accident. The amount payable is a percentage of the AD&D insurance amount in effect for the person who suffers the loss on the date of the accident.

The loss must occur due to an accident (or accidental exposure to the natural elements), independently of all other causes, and within 365 days after the accident.

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If you or your dependent disappears in an accident that could have caused loss of life and is not located within one year despite reasonable search efforts, death will be presumed.

Additional Benefits

The AD&D coverage includes the following additional benefits when an AD&D insurance benefit is payable:

- **Seat Belt Benefit**
- **Higher Education Benefit**
- **Career Adjustment Benefit**
- **Occupational Assault Benefit**
- **Public Transportation Benefit**
- **Line of Duty Benefit**

Please see the AD&D [Certificate of Insurance](#) for more information about these benefits.

Effective Date of Coverage - Coverage for Employee and Dependents

Your AD&D Insurance becomes effective on the first day of the calendar month following the date you enroll, provided you apply within 30 days after becoming an eligible employee. If you wish to enroll for employee and dependent coverage, you must apply within 30 days after becoming an eligible employee with eligible dependents.

If you do not enroll within 30 days after becoming eligible, you may enroll only during the annual open enrollment period or within 30 days following a qualified status change, as determined by your employer. The effective date of coverage for which you enroll during the annual open enrollment period is the following January 1. The effective date of coverage for which you enroll following a qualified status change is the first day of the calendar month following the date you enroll.

You pay the entire cost of coverage. While employee and dependent coverage is in effect, each new dependent becomes insured automatically.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective. If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively at Work mean performing the material duties of your own occupation at your Employer's usual place of business.

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You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively at Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work

Designating a Beneficiary

When you enroll for coverage, you should name a beneficiary or beneficiaries to receive death benefits. You may do this online or by completing the appropriate form. Your designation must be dated and delivered to your employer during your lifetime. If you name more than one beneficiary, they will share equally unless you specify otherwise. You may change beneficiaries at any time without the consent of the beneficiary.

If you don't name a beneficiary or your named beneficiary dies before you, death benefits will be paid in equal shares to the first surviving of the following: your spouse; your children; your parents; your estate.

Benefits payable for losses other than loss of life are paid to the person suffering the loss. You are the beneficiary of benefits paid due to the death of your spouse, domestic partner or child.

Payment of Benefits

For amounts less than \$25,000, The Standard issues a check to the claimant. The Standard pays amounts of \$25,000 or more to the claimant by depositing funds into Standard Secure Access — a no fee, interest bearing draft account. The claimant receives a personalized checkbook and has complete control of the account. Claimants can write checks as needed or for the full amount. This arrangement allows claimants to earn interest on the benefit while they consider financial decisions.

Exclusions

AD&D insurance benefits are not payable for death or dismemberment caused or contributed to by:

- War or act of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Suicide or other intentionally self-inflicted injury while sane or insane
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot (except while performing official duties)
- Voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above

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- Travel or flight in or descent from any kind of aircraft, as a pilot or crew member, except in employer owned, leased or operated aircraft while on state business

When Coverage Ends

AD&D insurance ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid for coverage
- The last day of the calendar month in which your employment terminates
- The date you cease to meet the terms of eligibility outlined in the PEBB Oregon Administrative Rules (OARs)
- The date you become a full-time member of the armed forces
- The date the group policy terminates

AD&D insurance for your spouse or domestic partner and children ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid for the coverage
- The date your AD&D insurance ends
- The last day of the month in which a dependent loses eligibility under the PEBB plans
- For a child who is disabled, 90 days after we mail you a request for proof of disability, if proof is not given

Claims

A person wishing to make a claim must, at the claimant's expense, submit to The Standard proof that a death or other loss occurred, and any other information The Standard may reasonably require in support of the claim. The Standard may have you or your dependents examined by a specialist of The Standard's choice at reasonable intervals. The Standard may have an autopsy performed at The Standard's expense, except where prohibited by law.

The claimant will receive a written decision on the claim within a reasonable time after The Standard receives the claim. If the claimant does not receive a decision from The Standard within 90 days, the claimant can request a review as if the claim had been denied.

If The Standard denies any part of the claim, the claimant will receive a written notice of denial containing the reasons for the decision, reference to the parts of the group policy supporting the decision, a description of any additional information needed to support the claim, and information concerning the claimant's right to a review of the decision.

If the claimant would like The Standard to conduct a review of the denial, the claimant must request the review in writing within 60 days after receiving notice of the denial. When requesting a review, the claimant may send The Standard written comments or other items to support the claim. The claimant also may review any non-privileged information that relates to the request for review. The Standard will review the claim promptly after receiving the request. They will send the claimant a notice of their final decision within 60 days after receiving the request for review, or within 120

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days if special circumstances require an extension. In the notice they will state the reasons for their decision and refer to the relevant parts of the group policy that support their decision.

Monthly Premium Rates

Monthly premiums can be found on the PEBB website at: www.pebinfo.com

Flexible Spending

PEBB offers healthcare and dependent care flexible spending accounts (FSAs) for eligible employees.

FSAs

An FSA is a tax-free account that allows you to use pre-tax dollars to pay for eligible out-of-pocket healthcare or dependent care expenses. You choose an annual amount to contribute to your account, and your payroll deducts your salary contribution before calculating your taxes. Paying for eligible expenses with these pre-tax dollars saves money.

Here are things you should know about these accounts.

- FSAs operate according to IRS regulations
- FSAs are subject to non-discrimination testing
- Enrollment in an FSA terminates at the end of each plan year. To have an FSA in the following plan year, you must actively enroll before the start of the new plan year. Generally, this enrollment occurs during the Open Enrollment period
- When you enroll, you enroll for the entire plan year. Your enrollment is irrevocable except for limited situations so you should plan accordingly
- You may change your contribution amount midyear only within 30 days of a qualified midyear change event
- You forfeit any funds that you don't use and claim for valid expenses by the end of the grace period (use it or lose it)
- There are no refunds of contributions without an eligible expense
- There are no transfer of monies from one account to another.
- Your payroll will deduct even portions of your annual election amount each month over the course of the year. You can only have one contribution per month to your FSA account
- Expenses for a Domestic Partner cannot be reimbursed
- The Health Care and Dependent Care FSA period of coverage is the plan year (calendar year 12 months). PEBB has a Grace Period plan which allows the previous plan year contributions to be used through March 15 of the following plan year. Claims must be filed by March 31 or the previous plan year funds will be forfeited
- If you terminate participation mid plan year you can claim reimbursement only for the time period you were an active participant. Active participation in an FSA ends the last day of the month in which the last contribution is deducted by payroll for that month

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- a. If you are an Oregon State Payroll System employee and you terminate employment you will not have a contribution taken from your final paycheck
 - b. If you are an employee of an Oregon University and you terminate employment and you meet the 80-hour work termination rule you will have a contribution taken from your final paycheck Reimbursement of eligible expenses may occur only for the period of coverage (including the grace period) in which your participation was active, provided the claim is filed by the claims deadline (March 31). The exception is a dependent care FSA from which you request reimbursement of expenses: 1) incurred in the month following the end of participation, 2) in the current plan year (not the grace period) and 3) made within 90 days of the participation end date
- You cannot use your FSA funds as reimbursement for expenses you incur after you leave employment with the state. The exception is a health care FSA, which you may be eligible to continue by enrolling in COBRA
 - The FSA administrator may require additional documentation for a submitted claim to be in accordance with IRS regulations

PEBB contracts with ASIFlex to administer the FSA program under PEBB Oregon Administrative Rules (OARs) and in keeping with IRS code.

Healthcare Flexible Spending Account (HCFSA)

A Healthcare Flexible Spending account is an allowable benefit of a Cafeteria Plan as defined in Section 125 of the Internal Revenue Code. It permits eligible employees to contribute pre-tax to an account for reimbursement of certain healthcare expenses. Deductions from your paycheck to the plan are exempt from federal and state income tax and Social Security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns. Note that reducing your taxable income may have the effect of reducing your total Social Security benefit earnings.

You may elect to have up to an annual maximum of \$3,050 for the calendar year deducted from your pay during the year. The minimum monthly contribution amount is \$20.00.

Claims Administrator

ASIFlex administers claims for PEBB's healthcare flexible spending account program. The customer service department is open from 5 a.m. to 5 p.m. Pacific Time, Monday through Friday, and from 7 a.m. to 11 a.m. on Saturday. Contact: (800) 659-3035; TTY (866) 908-6043; fax (877-879-9038); email asi@asiflex.com. Website <http://asiflex.com/orpebb/>

Mailing Address: ASIFlex PO Box 6044 Columbia, MO 65203	Physical Address: ASIFlex 201 W. Broadway #4C Columbia, MO 65203
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To Participate:

1. **Estimate your family's annual out-of-pocket medical expenses.** You may include expenses for your spouse, your tax dependents, and your adult child (ren) who have not reached age 26. Include predictable expenses only. Divide your annual out-of-pocket medical expense estimate by the number of months you expect to receive paychecks during the Plan Year.
2. **Enroll in the healthcare FSA.** Enroll online during Open Enrollment or by submitting a paper form to PEBB. If you become eligible to enroll midyear submit your forms to PEBB.
3. **Receive healthcare services.** You incur an expense when you receive the services or supplies that create the expense. You can file a claim for healthcare services only after you receive the services.
4. **File claims.** After you receive the healthcare services and know the amount of your responsibility for the bill, submit a claim (with required substantiation) for those expenses to ASIFlex, the plan administrator. See the ASIFlex web site for additional information about eligible reimbursements.
5. **Receive reimbursements.** ASIFlex will review your claim. If ASIFlex approves the claim, ASIFlex will reimburse you for the healthcare expenses within one to three business days of receipt of the claim.

Qualifying Healthcare Expenses include only those expenses that are defined as medical expenses in Internal Revenue Code §213 and are not reimbursed by any other insurance or another plan. As stated in §213, qualifying Medical Care Expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. All insurance premiums, long-term care expenses, and cosmetic expenses are not eligible for reimbursement.

Refer to IRS Publication 502 for further details on qualifying expenses. This publication is accessible via ASIFlex's Website. The purpose of Publication 502 is to assist people with income tax filing. The publication does not address healthcare flexible spending account plans. However, most of the items listed as deductible in Publication 502 can be claimed through your healthcare FSA. You cannot deduct on your income tax return expenses reimbursed by the healthcare flexible spending account plan. You cannot file for healthcare FSA expense reimbursements for expenses you deduct on your income tax return or reimbursed by a third party (including other insurance plans).

You can only claim expenses based on the date incurred or date of service (not "paid" as stated in IRS Publication 502). Contact ASIFlex at: <http://asiflex.com/orpebb/> (800) 659-3035 if you have any questions regarding particular expenses.

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Debit Card

The FSA administrator, ASIFlex, offers a debit card for use in the healthcare flexible spending account program. Use of this debit card may reduce the amount of paperwork required in substantiating some claims. The card does not eliminate the need to substantiate all claims. There is no cost to you for the card. You will receive two cards. Additional or replacement cards are \$5 per set, billed to your account. See the ASIFlex website at <http://asiflex.com/orpebb/>

Coverage Continuation

COBRA. To the extent required by COBRA, participants may continue the Health Care FSA under COBRA if there is a positive balance in the account. Contributions made under COBRA are post tax. Continuation of coverage will not extend beyond the end of the current Plan year or Grace Period. Continuation of coverage may terminate earlier if the premiums are not paid.

Payment for expenses incurred during any period of continuation will not be made until the administrator receives the contributions for that period. An administrative charge of two percent is assessed for each premium paid for continuation coverage.

FMLA Leave: Employees approved for a Family Medical Leave Act (FMLA) may continue their FSA during the leave if the employee and agency agree to one of the following options for employee contribution.

Prepay – The employee is given the opportunity to prepay their share due during the leave period before the leave begins. Submit a request for the prepay option to PEBB. The prepay option cannot be the sole option offered to employees on approved protected leave.

Pay as you go – The employee pays the cost of coverage in installments during the leave. Contributions are paid with after-tax dollars or with pre-tax dollars to the extent that the employee receives compensation (e.g. unused sick or vacation days) during the leave.

Catch-up – The employer and employee agree in advance that the employer will advance payment of the employee's share of the contribution during the leave and the employee will repay the advance amounts when the employee returns to work.

QRD - Qualified Reservist Distribution

Conditions. You must meet the following conditions to elect a qualified reservist distribution (QRD) from your healthcare flexible spending account (FSA):

- You have made contributions to your FSA that exceed plan-year reimbursements on the date of your QRD request.
- You are ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- You have provided the Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.
- You are ordered or called to active military duty on or after the beginning of the plan year that began January 1, 2009.
- You submit to the Administrator a QRD election form during the period beginning on the date of your order or call to active duty and ending on the last day of the Plan Year (or grace period) during which the order or call occurred. For example, if you are called to active duty on September 13, 2019, you must request the QRD between September 13, 2019, and March 31, 2020 (for the 2019 plan year only).

Amount. If you meet these conditions, you will receive a QRD equal to your plan-year contributions to your FSA as of the date of your request, minus any reimbursements you already received as of that date. Example: You elected FSA benefits of \$1,000 for the plan year. During the first six months of the plan year, you make FSA contributions of \$500 and receive reimbursements of \$200 for substantiated medical care expenses. If you request a QRD upon being called to active duty for an indefinite period on June 30, you would receive a distribution of \$300.

Further Reimbursement and Account Status. When you request a QRD, you forfeit the right to receive reimbursements for medical care expenses incurred during the period that begins on the date of your request and ends on the last day of the plan year. Your FSA terminates as of the date you request a QRD.

Tax Treatment. Your QRD will be included in your gross income and will be reported as wages on your Form W-2 for the year in which it is paid to you.

Dependent Care Flexible Spending Account (DCFSA)

A Dependent Care Flexible Spending Account (FSA) is an allowable benefit of a Cafeteria Plan as defined in Section 125 of the Internal Revenue Code. It permits eligible employees to contribute pre-tax to an account for reimbursement of certain dependent care expenses provided to a qualifying individual by a qualified provider. A Dependent Care FSA is not used for Health Care reimbursement.

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A qualifying individual is:

- Your dependent who is under the age of 13 who lives with you at least one half of the year
- Your spouse or an older dependent who is mentally or physically incapable of self-care who resides with you for more than one half of the year and is a qualifying child or relative under Section 152 of the IRS Code

A qualified provider can provide care in your home or outside your home. If the care is provided outside your home by a facility that cares for more than five individuals, it must be licensed by the state. The expenses may not be paid to your spouse, a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred, or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

Deductions from your paycheck to the plan are exempt from federal and state income tax and Social Security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns. Note that reducing your taxable income may have the effect of reducing your total Social Security benefit earnings.

You may contribute up to \$5,000 per year to a dependent care flexible spending account if you are married and filing jointly. The minimum monthly contribution is \$20.00. If you and your spouse (not Domestic Partner) both contribute to an account, your **combined** yearly contribution maximum may not exceed \$5,000.

You may contribute up to \$2,500 per year if you to a dependent care flexible spending account if you are single, or married filing separately. The minimum monthly contribution is \$20.00.

A dependent care flexible spending account is an alternative to taking a tax credit allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the tax credit or the dependent care flexible spending account. The IRS will not allow you to receive two tax breaks on the same expenses.

Generally, employees with a higher income have a higher percentage tax break through the dependent care flexible spending account. Contact your tax advisor if you have questions about which is best for you.

Claims Administrator

ASIFlex is the claims administrator for PEBB's Dependent Care Flexible Spending account program. The customer service department is open from 5 a.m. to 5 p.m. Pacific Time, Monday through Friday, and from 7 a.m. to 11 a.m. on Saturday. Contact: (800) 659-3035; TTY (866) 908-6043; fax (866) 381-9682; email asi@asiflex.com

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Mailing Address: ASIFlex PO Box 6044 Columbia, MO 65203	Physical Address: ASIFlex 201 W. Broadway #4C Columbia, MO 65203
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To Participate:

1. **Estimate your total dependent care expenses for the Plan Year.** Include predictable expenses only. Divide your yearly dependent care expenses estimate by the number of months you expect to receive paychecks during the Plan Year.
2. **Enroll in the dependent care flexible spending account.** Enroll online during Open Enrollment or by submitting a paper form to PEBB. If you become eligible to enroll midyear submit the form to PEBB.
3. **Receive Dependent care services.** You incur expenses when you receive the services that create the expense. You can file a claim for dependent care services only after you receive the services.
4. **File claims.** After you have received the dependent care services, submit a claim for those expenses (with required substantiation) to ASIFlex.
5. **Receive reimbursements.** ASIFlex will review your claim. If ASIFlex approves the claim, it will reimburse you for the dependent care expenses within one to three business days of receipt of the claim up to the amount you have on deposit in your account. If your claim exceeds your available funds, ASIFlex will record the difference and will pay as funds become available from payroll.

Commuter Accounts (Fringe Benefit)

Commuter Accounts are **Fringe Benefit** accounts to which employees can make a monthly contribution through a pre-tax salary reduction. These accounts are regulated by the federal Internal Revenue Code (IRC).

Commuter accounts allow employees to claim tax free reimbursement of certain employment-related commuter expenses. Deductions from your paycheck to the account are exempt from federal and state income tax, and Social Security tax. These deductions reduce your taxable income reported on your W-2 and on your income tax returns. Note that reducing your taxable income may have the effect of reducing your total Social Security benefit earnings.

The Commuter benefit includes two types of accounts: a Transportation account and a Parking account. PEBB-enrolled employees may contribute to one or both accounts on a pretax basis to pay for work-related commuting expenses. These accounts are administered by ASIFlex, a third party administrator.

Here are things you should know about these accounts:

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- Commuter accounts operate according to IRS regulations
- Enrollment in a commuter account does not require annual enrollment during open enrollment
- When you enroll, your enrollment will not terminate or change until you submit the request for the change or termination of enrollment
- You may change your contribution amount at any time and does not require a qualified midyear change
- Changes are effective the first of the month following receipt of the midyear change form
- There are no refunds of contributions without an eligible expense
- There are no transfer of monies from one account to another
- You have 180 day window to use contributions before you forfeit remaining money in the account
- Your payroll will deduct even portions of your annual election amount each month
- Expenses for the year must be submitted before March 31 of the following plan year in order to be eligible for reimbursement
- Employees who terminate participation can claim reimbursement only for the time period they were active participants:
 - a. Employee terminates employment – the employee has access to the account balance only by submitting reimbursement requests for qualified claims that occurred before the employment termination. The account forfeits 180 days after the employment termination date
 - b. Employee ceases to contribute or cancels the account but remains an employee – the account forfeits if no activity (contribution or claims), for 180 days. Reimbursement request for qualified claims that occur after the monthly contribution ceases or cancellation of the account are valid and will be paid
 - c. An Oregon State Payroll employee terminating employment will not have final contribution taken from their final paycheck
 - d. An employee of an Oregon University terminating employment who meets the 80 hour work termination rule will have a contribution taken from their final paycheck

PEBB contracts with ASIFlex to administer the Commuter Fringe Benefits program under PEBB Oregon Administrative Rules (OARs) and in keeping with IRS code.

Eligibility and Accounts

All active employees enrolled in PEBB benefits are eligible for these accounts. The accounts are employee-only accounts. Two types of accounts are available: Transportation and Parking. You may enroll in one or both.

Transportation Account

This is a pretax account to pay for work-related commuting expenses for bus, ferry, rail, monorail, streetcar, train, subway or vanpooling expenses. **(If you purchase vouchers through payroll,**

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DO NOT enroll in this account. Your agency deducts the fees for vouchers pre-tax each month from your paycheck.)

The maximum monthly contribution amount to the Transportation Account is \$300.

The account reimburses for the following qualified expenses:

- **Transit Pass Expenses.** These are expenses incurred for a pass, token, fare card, voucher, or similar item for transportation using Mass Transit Facilities. These include public or commercial facilities. Commercial facilities are those provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).
- **Commuter Highway Vehicle (Vanpool) expenses.** The transportation must be in connection with travel between your residence and place of employment. A commuter highway vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver). At least 80% of the mileage must be for purposes of transporting employees in connection with travel between the employees' residences and the employees' places of employment. The number of employees transported for such purposes must be, on average, at least half of the adult seating capacity of the vehicle.

Parking Account

(If you park in a state parking lot, DO NOT enroll in this account for your monthly state parking lot fee. Your agency deducts state lot fees pre-tax each month from your paycheck.)

This is a pretax account to pay for certain parking expenses incurred to work. The expenses are those for parking at the following:

- At or near the business premise of your employer
- A location from which to commute to work by mass transit facilities or commuter highway vehicle (carpool)

The maximum monthly contribution amount to the Parking Account is \$300. State parking lot fees are deducted pretax from the employee's monthly pay. The Commuter Parking account is not used to pay the monthly state-parking fee.

Monthly Contribution Limits

The minimum monthly contribution is \$20 for each account. The monthly maximum limits are set each year by the Internal Revenue Service (IRS) and are subject to change, the Board reviews and approves changes to the contribution amounts. The current maximum monthly contribution amount is \$300.

To estimate what you should contribute each month, review your expenses for commuting to and from work in the previous year. Make note of what you spend on a regular monthly basis. You can make changes to an existing account at any time during the year.

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Account Changes

You can enroll, change, or cancel your Commuter accounts at any time. You must submit a Commuter account form to your agency changes are effective the first of the month following receipt of the form.

Reimbursement

To be reimbursed for commuter expenses incurred or paid, submit a completed claim form along with appropriate supporting documentation. See the ASIFlex website for forms and instructions: <http://asiflex.com/orpebb/>.

IMPORTANT: All current year claims for reimbursement must be submitted by March 31 of the following plan year, submission after that date will result in a claim denial. However, unlike the FSA account Commuter funds do not forfeit and remain in your account and can be used during the current year if your eligibility and the account eligibility continues. Always review and adjust your monthly contribution amount if needed in order to avoid a loss.

- You can submit claims for reimbursement to ASIFlex via toll-free fax or mail.
- You cannot be reimbursed for more than the cash balance in your account.
- You may make changes and adjust future contributions to avoid having an excess balance.
- Expenses must be “incurred or paid” before being reimbursed. Reimbursement cannot be made before the date an expense has been incurred or paid.
- Excess account balances will be carried over to the following month/year
- You can be reimbursed only for the monthly amount in effect during the timeframe you are requesting reimbursement for.

ASIFlex Card (debit card): You can order an ASIFlex Card (debit card) for use with Transportation accounts. In some cases, transportation expenses may require documentation; ASIFlex will notify you when this is required. If you do not provide the documentation timely, the card will be temporarily inactivated.

- If you are currently using an ASIFlex card in your health care FSA, ASIFlex will add the transportation account to your existing benefit debit card. If you don't have a health care FSA, or do not have a health FSA card, you can order a transportation account card by completing and submitting an order form. There is no cost to you for the card. You will receive two cards. Additional or replacement cards are \$5 per set, billed to your account.

End of plan year

Commuter accounts are a month-to-month benefit; there is no plan year. Commuter Accounts will not terminate as long as they are “active” and do not require re-enrollment each year. You may terminate your account by submitting a form to your agency or university benefits or payroll office.

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If six months lapse without making a contribution or submitting a reimbursement claim, any funds in your account will be forfeited.

Terminating Employment

- If you terminate employment you have access to your Commuter funds for a limited time (six months) for reimbursement of valid claims incurred while you were an active employee.
- The Internal Revenue Code (IRC) does not permit any funds remaining in your account to be refunded. If you terminate employment your account cannot be refunded to you, *unless you file a claim for expenses incurred before you terminated employment.*

IMPORTANT: You forfeit your account funds if six months lapse without a contribution being made or a reimbursement claim processed.

Long Term Care Insurance

All Long Term Care insurance information can be found on UNUM's website at:
<http://unuminfo.com/pebb/index.aspx>

Plan Highlights/Schedule of Benefits

Your Long Term Care (LTC) insurance plan is described below.

Elimination Period: Your plan's Elimination Period of 90 consecutive days is the amount of time you must wait before benefits become payable. This time period must be satisfied only once during the life of your plan.

Newly Hired Employees – Will have 60 days from date of hire to sign up for Guarantee Issue coverage. Coverage is effective the first of the month following the date your Benefit Election Form is received by PEBB. **Guarantee Issue** – As an Employee you are eligible for benefit amounts on a guarantee Issue basis of up to and including \$4,000 and a facility Benefit Duration of 3 or 6 years. Completion of the Benefit Election Form is required for enrollment. This does not require completion of the Long Term Care Insurance Application (medical questionnaire) if you are applying during your initial eligibility period.

Medical Underwriting Effective Date: The effective date for those applicants passing medical underwriting is the first of the month following the approval into the plan.

Medical Underwriting means that you must answer all questions on a medical questionnaire. In some cases, an interview may also be necessary.

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Delayed Effective Date – If you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence, your coverage will not begin on your otherwise expected effective date.

Medical Underwriting for Employees and Family: (Completion of the Benefit Election Form is required for enrollment) As an **Employee** you are eligible for benefit amounts on a Guarantee Issue basis of up to and including \$4,000 and a Facility Benefit Duration of 3 or 6 years. This does not require completion of the Long-Term Care Insurance Application (medical questionnaire) if you apply during your initial eligibility period. The Long-Term Care Insurance Application (medical questionnaire) is required if enrolling after your initial eligibility period or if you choose to buy \$5,000, \$6,000 or the Unlimited Duration coverage.

Spouses, Domestic Partners, Retirees and all Family Members must complete the Long-Term Care Insurance Application (medical questionnaire) and must be approved for coverage in order to enroll in the Long-Term Care plan. **All** Medical Questionnaires must accompany a signed Authorization to request Medical Information Form #6720-03 located in the enrollment kit.

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount UNUM will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration. Example: If you choose \$3,000 Facility Monthly Benefit Amount & 3 Year Duration, your Lifetime Maximum is calculated as follows, \$3,000 per Month X 12 Months X 3 Years = \$108,000 Lifetime Maximum.

Insurance Age: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the plan effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage on or after the plan effective date, insurance age is your age on the date you sign the enrollment form.

Caution: If you must complete an Application for Long Term Care Insurance which includes evidence of insurability, the issuance of a long-term care insurance certificate will be based on your response to the questions in your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, UNUM may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact UNUM at this address: UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

Notice to buyer: This plan may not cover all of the costs associated with long term care which you may incur during the period of coverage. You are advised to review carefully all coverage limitations.

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1. Outline of Coverage

This outline of coverage provides a brief description of the important features of the plan. You should compare this outline of coverage to outlines of coverage for other plans available to you.

This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and UNUM. Therefore, if you purchase this coverage, or any other coverage, it is important that you read your certificate carefully.

2. This Policy is intended to be a qualified Long-Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

3. Terms under which the certificate may be returned and premium refunded

- You have a right to examine the certificate for a period of 30 days. If, after examining the certificate, you are not satisfied for any reason, you may withdraw your enrollment in the plan by returning your certificate within 30 days of its delivery to you. The certificate, together with a written request for withdrawal for an employee, an employee's spouse, or domestic partner must be sent to the employee's payroll/benefit office. All other applicants should send the certificate and written request to UNUM. Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.
- Premiums for additional, increased or terminated insurance may cause a pro-rata adjustment on the next premium due date.

4. This is not Medicare supplement coverage

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from UNUM. You may obtain a copy of the Guide by calling 1-800-227-4165. UNUM Life Insurance Company of America is not representing Medicare, the federal government or any state government.

5. Long term care coverage

Plans of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care

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services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This plan provides coverage in the form of a fixed dollar indemnity monthly benefit if you become Disabled.

Coverage is subject to policy limitations, benefit maximums and elimination periods.

6. Benefits provided by the policy

You are eligible for a monthly benefit after:

- You become Disabled;
- You are receiving services in a Long-Term Care Facility or Assisted Living Facility/Adult Foster Home; or Professional Home Care Services if your plan includes a Professional Home Care Services benefit; or Total Home Care if your plan includes a Total Home Care benefit;
- You have satisfied your Elimination Period, and;
- A Physician has certified that you are unable to perform, without Substantial Assistance from another individual, two or more ADLs for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you and others from threats to health or safety due to Severe Cognitive Impairment. You will be required to submit a Physician certification every 12 months.

A monthly benefit will become payable once all of these requirements are met.

The treatment and services you receive for your Disability must be provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner.

If you have an existing loss of ADLs or Severe Cognitive Impairment on your effective date of coverage, that loss or impairment will only be eligible for coverage if you recover from that loss or impairment. We must receive acceptable proof of your ADL or cognitive recovery, such as a physician's statement or an assessment.

The amount of your monthly benefit will be based on the coverage options you chose, and the place of residence used for long term care. If your coverage includes Professional Home Care Services, the benefit payment will be based on the number of days you receive these services.

Adult Day Care means:

A community-based program offering health, social and related support services to impaired adults. Adult Day Care can be provided by a Home Health Care Provider or an Adult Day Care Facility.

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Adult Day Care Facility means a facility that operates under applicable state licensing laws and any other laws that apply, or meets the following tests:

- operates a minimum of 5 days a week;
- remains open for at least 6 hours a day;
- is not an overnight facility;
- maintains a written record of care on each patient;
- includes a plan of care and record of services provided;
- has a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
- has established procedures for obtaining appropriate aid in the event of a medical emergency, and;
- provides a range of physical and social support services to adults.

Assisted Living Facility means:

- An institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage in providing ongoing care and services to a minimum of 6 residents in one location and operates under state licensing laws and any other laws that apply.
- Any other institution that meets all of the following tests:
 - Provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a disability;
 - has an employee on duty at all times who is awake, trained and ready to provide care;
 - Provides 3 meals a day, including special dietary requirements;
 - operates under applicable state licensing laws and any other laws that apply;
 - has formal arrangements for the services of a doctor or nurse to furnish medical care in the event of an emergency;
 - is authorized to administer medication to patients on the order of a doctor; and is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers, or;
 - a similar facility approved by UNUM.

For these purposes, an institution that meets the requirements is a Residential Care Facility or Assisted Living Facility.

Adult Foster Home means:

- a family home or facility that is licensed by the appropriate licensing agency and is primarily engaged in providing (1) room and board to 5 or fewer adults who are not

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related to the provider by blood or marriage; and (2) services that assist the resident in daily activities, such as bathing, dressing, eating, medication management or money management, or;

- any other resident home that meets all of the following tests:
 - has formal arrangements for the services of a doctor or nurse to furnish medical care in the event of an emergency;
 - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a disability;
 - has an employee on duty at all times who is awake, trained and ready to provide care;
 - provides 3 meals a day, including special dietary requirements;
 - operates under applicable state licensing law and any other laws that apply;
 - is authorized to administer medication to patients on the order of a doctor;
 - and is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers, or;
 - a similar institution approved by UNUM.

Disability and Disabled means you are unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living or you require Substantial Supervision by another individual to protect you from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living (ADL) are: Bathing, Dressing, Toileting, Transferring, Contenance and Eating.

The Elimination Period is the number of consecutive days during which you must continue to be eligible for a monthly benefit before a benefit becomes payable.

Lifetime Maximum is the maximum that UNUM will pay you for all long-term care benefits. You have your own Lifetime Maximum.

1. Limitations and exclusions

UNUM will not make long term care payments to you for:

- a Disability caused by war (whether declared or not) or any act of war;
- a Disability caused by attempted suicide (while sane or insane) or self-destruction;
- a Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law;
- Disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- a Disability caused by alcoholism or alcohol abuse;
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. (“Controlled substance” is defined in

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Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments);

- a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation Benefit), or;
- a Disability caused by psychological or psychiatric or mental conditions, regardless of cause, which include:
 - depression,
 - generalized anxiety disorders,
 - personality disorders,
 - schizophrenia,
 - manic depressive disorders, or,
 - adjustment disorders and other conditions that are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar methods of treatment.

However, UNUM will make payments to you for conditions that are not psychological, psychiatric or mental in nature, including Alzheimer's disease or similar forms of irreversible dementia.

Pre-existing Conditions Exclusion

If you do not have to complete an Application for Long Term Care Insurance, which includes evidence of insurability, a pre-existing conditions exclusion may apply to you.

Pre-Existing Condition means any condition that exists for which you received medical treatment, consultation, care or services, including diagnostic measures for the condition, or took drugs or medicines that were prescribed for the condition, during the six-month period right before your coverage began.

UNUM will not make any payments to you for a Disability that is caused by, contributed to by, or results from a pre-existing condition, and begins during the first six months after your coverage begins.

This plan may not cover all the expenses associated with your long-term care needs.

2. Relationship of cost of care and benefits

Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

- **Cost.** The premium rate paid for your coverage over the duration of your initial coverage or for any increases is based on your insurance age.

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- **Election to increase coverage.** You can apply at any time to increase coverage by filling out a new Benefit Election Form and a Long-Term Care/Evidence of Insurability Application.

3. **Terms under which the group coverage through the plan may be continued in force or discontinued**

Renewability. The policy is guaranteed renewable. This means you have the right, subject to the terms of the policy, to continue this coverage as long as you pay your premiums on time. UNUM cannot change any of the terms of the policy on its own except that, in the future, it may increase the premium you pay

When coverage will end. Your coverage will end on the earliest of these dates:

- the date the Policy ends,
- the date you are no longer an Active Employee with the Policyholder,
- the date you no longer work for the Policyholder,
- the end of the period for which premiums were last paid to UNUM for your coverage,
- the date your total benefit payments equal your Lifetime Maximum Amount, or,
- the date you die.

If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to UNUM.

Converted coverage. If your group long term care coverage ends, for reasons other than your choice to have premium payments stopped for your coverage, you may elect converted coverage. This means that the same coverage you had under this plan can continue on a direct billed basis. If you are already direct billed, your coverage will automatically transfer to converted coverage. Election for converted coverage must be made within 60 days of the date the group coverage would otherwise end. Any premium that applies must be paid directly to UNUM by you for any converted coverage to be continued.

Premium waiver. When benefits become payable, there will be no more cost for your coverage as long as you continue to be eligible for a monthly benefit. If your plan includes Professional Home Care Services and you do not receive these services for a period of 30 consecutive days, premium payments will again become due. Premiums are **not waived** while you are receiving a payment for Respite Care.

Right to Change Premiums. The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors.

Any such change will be made on a class basis according to UNUM's underwriting risk studies under this type of insurance.

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10. Premium

Premiums are based on the plan design selected and the insurance age of each enrolled person. UNUM may change the premium rates when the terms of the policy are changed.

11. Additional features

- Medical underwriting may be required
- Eligibility and Participation

You are eligible for the plan if you are an Active or Retired employee of the Policyholder, spouses, domestic partners and your family members.

12. For a definition of and additional information for:

Professional Home Care Services,
Respite Care, Severe Cognitive Impairment, Substantial Assistance, Substantial Supervision, Alzheimer's disease and other organic brain disorders see the certificate at www.pebbinfo.com under plan documents or <http://unuminfo.com/pebb/index.aspx>.

Questions and rate information: 1-800-227-4165;
<http://unuminfo.com/pebb/index.aspx>

SECTION 6: PLAN ADMINISTRATION

Administrator Responsibilities

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

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

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

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

Delegation of Authority

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

Information Required for Plan Administration

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

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Reliance

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

Facility of Payment

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

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

Payment

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

Subrogation

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

Right of Recovery

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

Government-provided Benefits

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

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Effect of Mistake

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

Insurance Contracts

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

Miscellaneous

Filing of Information

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

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

Mistake of Fact

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

Employee Authorization of Payroll Deductions

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

No Guarantee of Tax Consequences

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

Quality of Health Services

The selection by the employer of the coverage that may be financed through the plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any health, dental, or vision care service provider, nor does the employer or any participating employer assume or accept any responsibility with respect to the

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denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances.

Governing Law

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

Conflicting Provisions of Component Plan

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

Qualified Medical Child Support Order (QMCSO)

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

Benefit Fraud or Abuse

Rights of the Medical Plans

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

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

Rights of PEBB

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

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

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

An employee's failure to notify PEBB or their agency/university benefit office of a family member's or domestic partner's loss of eligibility may result in civil or criminal charges against the employee for fraud or the intent to misrepresent the material facts of enrollment.

PEBB may rescind coverage back to the last day of the month in which eligibility was lost or retroactively to the effective date of coverage if eligibility criteria was never met. Rescission of coverage can occur to an employee, or an individual for whom the employee provides coverage.

Appeals

See *Administrative Rules for PEBB appeal rights* at www.pebinfo.com - Oregon Administrative Rules.

Benefit Plan Appeal Procedure

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

Public Employees' Benefit Board Appeal

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

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

If PEBB rescinds plan coverage due to an individual's ineligibility for coverage, the ineligible individual may appeal the rescission decision to PEBB using this rule. Until the appeal process for the rescission is exhausted, the individual's premium and claim payments will continue as if the rescission had not occurred. Upon final appeal determination, if the rescission is upheld the employee will be responsible to pay all claims and premium payments paid by the plan or PEBB

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during the period of ineligibility. Eligible employees, or individuals notified of coverage rescission, have four levels of PEBB appeal.

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

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

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

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

Level Three: An eligible employee or a plan rescission individual receiving both a first and second level denial may request that the Board's Appeals Subcommittee review the appeal. The Subcommittee may review appeals submitted directly by the Benefit Manager.

- An employee or individual requesting a Level Three review must submit the request in writing to the Benefit Manager within 30 days of the Level Two determination letter date.
- The Subcommittee appeal determination requires a majority vote of the members. If an agreement cannot be reached, the appeal may be referred to the full Board. Decisions by the full Board require a majority vote. The Appeals Subcommittee may render a decision to

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the employee or individual and also refer the issue to the full Board for a benefit policy review.

- The Appeals Subcommittee may recommend a review and determination of the appeal by the Board without providing a decision to the employee or individual. The employee or individual will receive notice of the recommendation.
- When the Subcommittee completes a review, or in the case of a full Board review, the employee or individual will receive a written explanation and determination within 30 days after the next regularly scheduled meeting.

SECTION 7 – 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 October 15 through December 7. 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

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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 October to join. For More Information about this Notice or your Current Prescription Drug Coverage: Contact the person listed below for further information. **NOTE:** This notice is reviewed and updated every year. You can review this notice each year. You will receive an updated notice 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 7-877-486-2048.

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 them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty). **Date:** December 27, 2023 for the 2024 PEBB plan year.

Name of Entity/Sender: PEBB, Benefits Manager, 500 Summer St. NE, E89, Salem OR 97301; 503-373-1102.

Notice of Women's Health and Cancer Rights Act

If you are an PEBB medical plan member, we would like to take this opportunity to remind you that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. This coverage is provided in consultation with your attending physician and will be subject to the same terms and conditions, including the annual deductible, coinsurance and/or copayment provisions otherwise applicable under your plan. Your benefit handbook or insurance policy contains more information about these mastectomy-related benefits. If you have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact your insurance carrier's customer service or 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 due to 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. Changes in plan enrollments and tag along individuals are prospective, the first of the month following date of birth or adoption.

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 Children's Health Insurance Program (CHIP)

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 other than Oregon, 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).

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either: U.S. Department of Labor, Employee Benefits Security Administration www.dol.gov/ebsa or U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

Thank you for your recent enrollment in the group health plan under the Public Employee's Benefit Board (PEBB). The Plan has four group health components— Medical, Dental, Vision, and Health FSA—and you may be enrolled in one or more of these components. This notice has important information about your right to continue your health care coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. There may also be other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or 1-800-318-2596. You can coverage through the Health Insurance Marketplace **that costs less than** COBRA continuation coverage. Please read the information carefully before making a decision.

This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under PEBB (the Medical, Dental, Vision and Health FSA components) and not to any other benefits offered under the PEBB Plans.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you, your spouse, and dependent children when coverage under the Plan would otherwise end. This notice does not fully describe COBRA coverage or other rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the PEBB Summary Plan Description at www.pebbinfo.com contact PEBB at 503-373-1102 the plan administrator. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

You May Have Other Options Available to You When You Lose Group Health Coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may

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also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Who Is Entitled to Elect COBRA?

If you're an employee, you'll be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. The PEBB participating organization must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment
- Death of the employee;
- The employee is retiring;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both and the employee is terming employer coverage.

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify your payroll/HR benefit office within 30 days of the event. You must submit a midyear

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change form available at www.pebinfo.com under the link to forms. If the form is not received within 30 days of the event you and your qualified dependents may lose the right to elect COBRA.

Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified may lose their right to elect COBRA.

How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive up to a maximum of 36 months of coverage under the Plan's Medical, Dental and Vision components. These "36-month" qualifying events include the death of the employee, the covered employee's divorce or a dependent child's losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical, Dental and Vision components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical, Dental and Vision components generally can last for only up to a total of 18 months.

COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the paragraph below entitled "Health FSA Component."

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons. Please check with the Third Party Administrator BenefitHelp Solutions (BHS) at 800-556-3137 or 503-765-3581.

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There are also ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances.)

Disability extension of COBRA coverage

If a qualified beneficiary is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to get up to an additional 11 months of COBRA coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify BenefitHelp Solutions in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan, as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours, in order to be entitled to a disability extension. In providing this notice, you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to BHS during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA coverage if the employee or former employee dies or gets divorced or if the dependent child stops being eligible under the Plan as a dependent child.

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This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify BHS in writing of the second qualifying event within 60 days after the date of the second qualifying event. In providing this notice you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to BHS during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Health FSA Component

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. The use-or-lose rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact BHS for more information.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during COBRA coverage period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage, is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan Administrator during the covered employee's period of employment is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

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Are There Other Coverage Options Besides COBRA Coverage?

Yes. In lieu of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.HealthCare.gov or by calling 1-800-318-2596. You can also visit www.OregonHealthCare.gov or call 1-855-268-3767 to find a local insurance agent to help you find the right plan for you or your family.

If You Have Questions

Questions concerning your plan, or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let your payroll/HR benefit office or the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send.

Plan Contact Information

PEBB Administrator
500 Summer St. NE, E89
Salem, OR 97301
Phone: 503-373-1102
Fax: 503-373-1654

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

Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries may lose the right to any extension of COBRA coverage.

Notices Must Be Written: Any notice that you provide must be in writing and may be mailed or faxed. Oral notice, including notice by telephone, is not acceptable.

When to Send Notices: If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If faxed, your notice must be received no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "How long will COBRA coverage last", "Disability", and "Second Qualifying Event".)

Where to Send Notices:

BenefitHelp Solutions, Inc.

P.O. Box 40548, Portland, Oregon 97240-0548

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

Fax: 503-765-3453

Web: <https://www.benefithelpsolutions.com/members/group-members/pebb>

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan, PEBB; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices: The covered employee or former employee who is or was covered under the Plan, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Notice of Privacy Practices

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

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

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

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

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

How information is collected and protected:

As the Plan Sponsor, PEBB must collect a certain amount of PHI to provide customer service, offer new benefits, plans, products or services, administer its plans, and to fulfill legal and regulatory requirements.

PEBB also collects information provided when the PEBB Member enrolls or makes changes to benefits.

Examples include:

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

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

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

How information is used or shared by PEBB:

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

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

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

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

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

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

The Health Plans may disclose summary health information to PEBB, if PEBB requests summary information for the purpose of (a) obtaining, terminating, or amending the agreements for providing coverage; or (b) modifying, terminating or amending the agreements. PEBB does not have access

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to your PHI held by a Health Plan. If you contact PEBB and provide PHI to PEBB, PEBB will refer that information to the Plan.

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

Review and access to information:

PEBB Participants have the right to access PHI held by PEBB, receive a list of disclosures PEBB has made of PHI, request restriction on use or disclosure of PHI, or correction of incorrect information. You may submit a complaint if you believe PEBB has improperly used or disclosed your PHI or if you have concerns regarding PEBB's privacy policies.

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

Notice about Requests for Social Security Numbers:

The Affordable Care Act (ACA) requires providers of employer-sponsored health plans to provide Social Security numbers (SSNs) of individuals covered in the plan to the IRS for tax-reporting purposes.

PEBB self-insures two of its medical plans – Providence Statewide and Providence Choice; PEBB is considered the health plan provider for these plans. When an employee enrolls in either of these plans, we have access to the employee's SSN through the employer. When the member covers dependents (including spouse/partner) in either of these plans, we must ask the employee for the dependents' Social Security numbers (SSN).

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Our fully insured plans through Kaiser Permanente, and Moda Health request this information from employees enrolled in their plans.

There is no penalty for the employee, PEBB or the plan if the employee does not provide the information. The IRS uses the SSNs to crosscheck that members had employer-sponsored health care coverage during the plan year and didn't get a health care tax subsidy.

If you have any questions about this notice, contact the PEBB Benefit Manager:

PEBB Benefit Manager
500 Summer St NE, E89
Salem, Oregon 97301
Phone: 503.373.1102

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

PEBB Administrator
500 Summer ST NE, E89
Salem, Oregon 97301
Phone: 503.373.1102

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

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

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

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

Changes to Our Notice:

This notice is effective on January 1, 2020. PEBB is required to abide by the terms of this notice until it is changed. We reserve the right to change the terms of this notice and to make the new notice effective for all PHI we maintain. Once revised, we will notify you that a change has been made to this notice, and post the updated notice on our website at www.pebbinfo.com.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General information:

When key parts of the health care law took effect in 2014, they created a new way to buy health insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the health insurance marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I save money on my health insurance premiums in the marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% for 2018 and 9.86% for 2019 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your agency human resources or benefits office.

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit <http://HealthCare.gov> for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. Employer sponsored health plans through PEBB meet the minimum value standard.