

Appendix A: Midyear Plan (Qualified Status) Changes

SECTION 1: ELIGIBILITY, ENROLLMENT AND DATES OF COVERAGE

Who is Eligible

Eligible Employees

An eligible employee means an employee of a PEBB participating organization, and state officials in an exempt, unclassified, classified, or management position, who are expected to work at least 90 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 from the Secretary of State's website at www.oregon.gov/oha/PEBB link to administrative rules. Refer to Chapter 11, 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 provides 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 during the preceding month to be eligible for benefits the next month. Half time means employed and:

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- Work or receive 80 paid regular hours per month; or
- 0.5 FTE for OUS 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 \$5,000.
- Employees choosing core benefits can 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 example, Medicaid, Veterans Administration Health Benefits, or Student 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 can 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 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 OUS employees, or;

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- 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.

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 the amount of premium 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 -**
 - 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 \$5,000
- Employees who enroll in core benefits can 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 example, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance). All employees who opt out will receive a monthly taxable opt-out amount determined by the Board and 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.

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- **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 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.

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

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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 take – 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, or a 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 at this link: <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>

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 and dental 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 or dental plans when you enroll as PEBB retiree. You and your eligible dependents (as long as you and your dependents are not Medicare eligible) may choose medical only, dental

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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) or dental 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

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

When to enroll as a PEBB Retiree

PEBB coverage must be continuous. **You must enroll for medical and dental 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 partners active PEBB plan, you may enroll in the PEBB retiree plan later if you lose the current coverage.
- If you choose COBRA continuation coverage, you can transfer to the retiree group during or at the end of the COBRA period.

Changing Plans

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

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

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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 (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.

Retirees Returning to Active Employee Status

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

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.

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Retirees who return beyond 12 months from their retirement date must enroll for any benefits as newly eligible employees. 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 1-800-556-3137;

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

Other Self-pay Participants

The following individuals may participate in PEBB:

- Blind Business Enterprise agents
- State-certified foster parents
- Oregon Liquor Control Commission agents
- Oregon State University and University of Oregon post doctorates and J1 Visa recipients
- Nurses who teach or work less than half-time 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 1-800-556-3137;

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

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.oregon.gov/oha/pebb 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 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 and the child will not have attained age 27 in the plan year. 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;
 1. The child's parent will not be older than age 26 in the plan year, 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.
 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.
- A child by Affidavit (Child by Affidavit of Dependency) which includes but 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.

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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.

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

End of coverage: Beginning January 1, 2019 coverage for a child ends the last day of the month in which the child is 26. In some cases, such as for foster children or wards of the court, coverage can 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 in order 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.
- If the child has not had continuous coverage, the child is not eligible for PEBB coverage.
- The employee must verify to PEBB that the child is the employee's or spouse's **qualifying tax dependent**.
- The child's attending physician must submit to the employee's health plan verification and documentation of the child's disability.

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- 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.

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 can 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 can be enrolled again if all PEBB criteria for disabled child are met.

Termination of Coverage When a Child Ages Out of PEBB Coverage

Beginning January 1, 2019 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.

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Domestic partners and their dependents

You may cover a domestic partner and dependents who meet certain requirements.

Adding a domestic partner who is not a tax dependent will increase your tax withholding, and you will take home less pay.

PEBB provides benefits to domestic partners that are comparable to those offered to married spouses, where legally possible. You may enroll your domestic partner in all benefit coverage available to a spouse either within 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

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either within 30 days of meeting the qualifications or during the open enrollment period.

- If the employee does not have a registered certificate of domestic partnership, the employee must submit the completed, notarized 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 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 catch-up on withholding will reduce your take-home pay and such reduction could be for some periods. The catch up on withholding to your agency payroll must be completed before the end of the current tax year.

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

PEBB has implemented a Dependent Eligibility 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

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as ineligible will be 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.

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 to your choices after the 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 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 are not to 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 the agency or to PEBB.

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- During open enrollment employees can terminate coverage for an individual electronically or by using a form if they know the individual will be ineligible for 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), the third-party administrator.

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. Check rules on late enrollment.

Correcting Enrollment Errors

Employees may make benefit enrollment errors when they provide information, make selections on paper forms, or through the online 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 or dental plan becomes effective a correction to change to a different plan can 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.

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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.oregon.gov/oha/PEBB 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.

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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 was never met. Rescission of coverage can occur to an employee, or an individual for whom the employee provides coverage.

Examples of fraud thought not limited to this list would be 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.
- 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.

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- An employee's agency can 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 alongs will have a prospective date.

To request special enrollment or obtain more information, contact PEBB at (503) 373-1102, or email inquiries.pebb@dhsosha.state.or.us

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

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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 non-payment 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:** Exception is Flexible Spending Accounts, Commuter Accounts and UNUM. Check with your payroll/HR benefit office on enrollment for these accounts.

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.

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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 can 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 or 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.