

## **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 \$5,000 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 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 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. 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.

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## 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 Administrative Rules.
- 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 Administrative rules:

- 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:** \$5,000. 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 premiums. Newly eligible employees have a guarantee issue choice (medical history not required) of \$20,000 up to \$100,000 if enrolled within 30 days of eligibility.
- Spouse or domestic partner: Any multiple of \$20,000, up to \$400,000. You pay the premiums. Newly eligible spouse or domestic partners have a guarantee 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 premiums. The rate is the same, regardless of the number of eligible dependents.

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## 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 guarantee issue amount of \$100,000 for Employee Optional Life coverage when you are first eligible to apply.
- More than the guarantee 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 designated timeline established by PEBB for 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.

**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 in order 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.

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**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 beneficiary, they will share equally unless you specify otherwise. You may change beneficiaries at any time 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

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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.

### **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 Administrative Rules
- 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:

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- 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 Administrative Rules
- 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 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**

See current rates [here](#).

## **Short Term Disability 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:

- 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).

You pay the entire cost of coverage.

## **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.

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### **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.

### **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 terms 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 your own occupation. The Standard terms 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.

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## 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
- 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

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## 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 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 Administrative Rules
- 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.

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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.

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 non-privileged 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.

## **Premium Rates**

See premium rates [here](#).

## ***Long Term Disability 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:

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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)

You pay the entire cost of coverage.

### **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.

Beginning May 1, 2011, members who qualify for disability benefit payments can choose to use accrued leave greater than 40 hours and receive a reduced benefit payment (minimum of \$50 per week); or they can elect to receive the full benefit payment without using accrued sick leave greater than 40 hours.

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.

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**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.

### **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 terms 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 terms 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.

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## 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 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) as a result 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.

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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.

### **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 Administrative Rules
- Your spouse or Domestic Partner's children under age 24 who meet the terms of eligibility outlined in the PEBB Administrative Rules
- 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 Administrative Rules

### **Exclusions and Limitations**

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

- An intentionally self-inflicted injury, while sane or insane

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- 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

### **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.

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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 would like The Standard to conduct a review of the denial of all or part of your claim, you must request the review in writing within 60 days after you receive the notice of the denial. When you request a review, you may send written comments or other items to support your claim. You also may review any non-privileged information that relates to your request for review. The Standard will review your claim promptly after receiving your request. They will send you a notice of their final decision within 60 days after receiving your request, or within 120 days if special circumstances require an extension. In the notice, they will state the reasons for their decision and refer you to the relevant parts of the group policy that support their decision.

## **Premium Rates**

See rates [here](#).

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 Insurance***

This subsection summarizes the group Optional Accidental Death and Dismemberment 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.

## **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 Administrative Rules.

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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 Administrative Rules
- Child: Your child or your spouse's or domestic partner's child who meets the eligibility requirements outlined in the PEBB Administrative Rules

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.

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.

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## **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.

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

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## **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
- 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 Administrative Rules
- The date you become a full-time member of the armed forces
- The date the group policy terminates

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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 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.

## Premium Rates

See rates [here](#).

## ***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
- Enrollment in an FSA terminates at the end of each plan year. To have an FSA in the following plan year, you must 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
  - 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 state 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

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- 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

PEBB contracts with ASIFlex to administer the FSA program under PEBB administrative rules and in keeping with IRS code.

### ***Healthcare Flexible Spending Account***

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 PEBB current annual maximum for the calendar year deducted from your pay during the year. The minimum monthly contribution amount is \$20.00.

### **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](mailto:asi@asiflex.com). Website <http://asiflex.com/orpebb/>

<b>Mailing Address:</b> ASIFlex PO Box 6044 Columbia, MO 65205-6044	<b>Physical Address:</b> 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 are not age 27 in the calendar year. 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. See the ASIFlex web site for additional information about eligible reimbursements.

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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.

### **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

### **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 coverage will not extend beyond the end of the current Plan Year or Grace Period. Continuation 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.

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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.

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.

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, 2018, you must request the QRD between September 13, 2018, and March 31, 2019 (for the 2018 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***

A Dependent Care 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 dependent care expenses provided to a qualifying individual by a qualified provider.

### **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. The minimum monthly contribution is \$20.00. If you and your spouse (not Domestic Partner) both contribute to an account, your **combined** yearly contribution may not be more than \$5,000.

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](mailto:asi@asiflex.com)

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<b>Mailing Address:</b> ASIFlex PO Box 6044 Columbia, MO 65205-6044	<b>Physical Address:</b> 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 Service code.

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:

- Commuter accounts operate according to IRS regulations
- Enrollment in a commuter account does not require annual enrollment during open enrollment

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- When you enroll, your enrollment will not term 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 January 15<sup>th</sup> of the new 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 state university employee 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 administrative rules 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, DO NOT enroll in this account. Your agency deducts the fees for vouchers pre-tax each month from your paycheck.)**

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The PEBB maximum monthly contribution/reimbursement information may be different than the allowable recommendation by the IRS. Please contact PEBB for the current monthly maximum at 503-373-1102. The minimum monthly contribution is \$20. 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 PEBB maximum monthly contribution/reimbursement information may be different than the allowable recommendation by the IRS. Please contact PEBB for the current monthly maximum at 503-373-1102. 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.

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.

### **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.

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## 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 January 15 of the following plan year, submission after that date will result in a 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.

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.

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- The Internal Revenue Code 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** <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 the agency. **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.

**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.

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**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.

### **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.

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### **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 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.

**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;

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- 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 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:
  - 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;
  - 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;

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- 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, Continence 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.

## 7. 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 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.

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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.**

## **8. 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.
- **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.

## **9. 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.

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- **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.

## 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.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB) under plan documents or <http://unuminfo.com/pebb/index.aspx>.

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

## **Section 6: Plan Administration**

### ***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.

## **Effect of Mistake**

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

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## **Insurance Contracts**

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

## **Miscellaneous**

### **Filing of Information**

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

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 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

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.oregon.gov/OHA/PEBB](http://www.oregon.gov/OHA/PEBB) - 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

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

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

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

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

- The employee or individual must submit the request to the Plan Design Manager in writing and provide any new supporting documentation that would support the request. The manager may request additional information from the employee or the employer. Requested information from the employee or individual must be received within 10 business days or the appeal is closed.

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- The Plan Design Manager will review the request and determine whether to provide a determination to the employee or move the request directly to Level Three. The Plan Design Manager may request that the Administrator or the Administrator's designee assist in the appeal review and determination.
- When the Plan Design Manager completes a review, the employee or rescission individual will receive a written explanation and determination within 30 days of PEBB receiving all the necessary appeal documentation. When the Plan Design Manager sends the appeal to Level Three without providing a determination, the employee will receive notice.

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

- An employee or individual requesting a Level Three review must submit the request in writing to the Plan Design Manager within 30 days of the Level Two determination letter date.
- The 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 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.

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