SECTION 1: ELIGIBILITY, ENROLLMENT AND DATES OF COVERAGE

Who is Eligible

Eligible Employees

An eligible employee means an employee of a PEBB participating organization, and state officials in an exempt, unclassified, classified, or management position, who are expected to work at least 90 days and work at least half time or in a position classified as job share. The term active eligible employee can apply to a permanent employee appointed to a benefit eligible position or a temporary or impermanent worker who becomes benefit eligible due to work expectations or becomes benefit eligible following an initial measurement period.

Employers of eligible employees are:

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

Oregon Administrative Rules (OARs) determine application of eligibility for PEBB benefits. The rules are available from the Secretary of State's website at http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_101/101_tofc.html. Refer to Chapter 11, Divisions 10, 15, 20, 30, 50 60, and 70.

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

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

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

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

- Standard Measurement period for the OSPS employees means a 12 consecutive month period starting November 1 and ending October 31.
- Variable Hour Employee means a New Employee if, based on the facts and circumstances at the New Employee's start date, the agency cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week. during the initial measurement period.

An initial measurement period applies to all new employees to state employment, regardless if their appointment is to a permanent position or temporary position.

During the initial measurement period and until meeting the requirements of a stability period, benefit eligible employees must be in regular paid status a minimum of 80 hours each month to earn benefits for the following month.

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

Stability period:

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

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

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

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

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

Current full-time permanent employees (as classified by the Human Resources system)who are not in a current "stability period" must work or be in paid regular status at least half time during the preceding month to be eligible for benefits the next month. Half time means employed and:

- Work or receive 80 paid regular hours per month; or
- 0.5 FTE for OUS employees;
- 80 paid regular hours per month and in a documented 0.5 FTE position for the Oregon Judicial Department; or
- As defined by collective bargaining agreements.

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

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

Benefit Options for Full-time Employees

- **Core Benefits** – Core benefits are
    - All available full time medical plans, and dental plans according to where you live or work (at least 50 percent of the time) and a vision plan. You must be enrolled in a choice of medical plan (which includes Opt Out) to enroll in dental or vision coverage.
    - Basic employee life insurance coverage of $5,000
- Employees choosing core benefits can also enroll in all available optional benefit plans, for which they pay the premiums.
- **Opt out** – **Opting out is a choice of medical plans.** Employees may opt out of PEBB medical coverage if they have other employer group coverage (which does not include for example, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance). All employees who opt out will receive a monthly taxable opt-out amount determined by the Board. Part time employees receive a prorated amount according to hours worked compared with full-time hours in the month. All employees who opt out must pay a share of the premium for employee basic life coverage. Employees who choose to opt out of PEBB medical coverage can enroll in vision and dental coverage. The employee cost of basic life premiums, and enrolled dental or vision coverage is deducted pretax. Employees who opt out may enroll in optional benefit plans, for which they pay the full premium amount. Opt Out money is not paid during a leave without pay.
- **Decline** – Employees may decline core benefits. If they decline core benefits, they choose not to participate in the PEBB program. They will not receive a portion of the employer's premium share and they cannot enroll in any of the optional benefit plans.

Eligible Permanent Position Part-time Employees

(Includes Limited Duration and Job Share positions)

- Permanent position part-time employees (as classified by the Human Resources system) who are <u>not</u> in a current "stability period" must work or be in paid regular status at least half time during the preceding month to be eligible for benefits the next month. Half time means the individual is employed and:
- Works or receives 80 paid regular hours per month or is in a job share position; or
- Is 0.5 FTE for unclassified OUS employees; or
- Works or receives 80 paid regular hours per month and is in a 0.5 FTE position for the Oregon Judicial Department: or
- Fits the definition in an applicable collective bargaining agreement.

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

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

The monthly employer share of premium for core benefits for most eligible part-time employees is pro-rated based on hours worked in the month when compared with the month's available full

time hours less the employee's premium share. Employees should check with their payroll for the amount of premium they are responsible to pay. PEBB is not a source for that information.

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

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

Benefit Options for Part-time Employees

- **Core Benefits** -
    - All full time medical and dental plans available according to where you live or work (at least 50 percent of the time).
    - All "medical and dental plans labeled "part time" plans, according to where you live or work (at least 50 percent of the time).
    - Vision coverage
    - You must be enrolled in a choice of medical plan (which includes Opt Out) to enroll in dental or vision coverage
- Basic employee life insurance coverage of $5,000
- Employees who enroll in core benefits can also enroll in all available optional benefit plans, for which they pay the premiums.
- **Opt out** – **Opting out is a choice of medical plans.** Employees may opt out of PEBB medical coverage if they have other coverage (which does not include for example, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance). All employees who opt out will receive a monthly taxable opt-out amount determined by the Board and prorated for part-time employees according to hours worked when compared with full-time hours in the month. All employees who opt out must pay a share of the premium for employee basic life coverage. Employees who choose to opt out of PEBB medical coverage can enroll in vision and dental coverage. The employee cost of basic life premium, and enrolled dental or vision coverage is deducted pretax. Employees who opt out may enroll in optional benefit plans, for which they pay the full premium amount. Opt out money is not paid during a leave without pay.

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

New Permanent Seasonal Employees

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

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

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

Seasonal employees expected to work fewer than 90 days are not eligible for PEBB benefits. If the agency extends the length of the seasonal position to 90 days or longer, the employee is eligible for retroactive enrollment in benefits effective 30 days from the date of hire.

Benefit Options for Seasonal Employees

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

Returning Permanent Seasonal Employees

Previously benefit-eligible employees returning to work:

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

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

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

Previously ineligible seasonal employee returning to work:

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

Temporary, Impermanent or Variable Hour Employees

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

When benefit eligible:

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

Eligibility when on extended leave

The type of leave employees take – family medical leave, active duty military leave, job-related-injury leave, etc. – and whether it is a paid or unpaid leave may affect eligibility and benefits.

Contact your agency payroll, human resources or benefits office to discuss these issues prior to taking the leave. **This applies to all active benefit eligible employees.**

Active Employees and Medicare Eligibility

An active employee, or a spouse or domestic partner of an active employee, who gains Medicare eligibility remains eligible for active employee PEBB medical plan coverage. PEBB medical plans will generally continue to pay claims as primary and Medicare will pay claims as secondary coverage. Medicare provides a booklet entitled "Who Pays First." Employee's and family members may find this publication helpful. The booklet can be found at this link:
http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf

You may also find this information regarding Medicare helpful:
http://www.oregon.gov/DCBS/insurance/shiba/shiba_65/Pages/medicarestartsat65.aspx

Eligible Retirees

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

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

Medical and dental options

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

Eligibility

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

- Eligible to receive a retirement benefit through a state of Oregon retirement system, and
- Enrolled in a PEBB medical or dental plan, and
- Non-Medicare eligible.

You may also cover your

- Non-Medicare eligible spouse or domestic partner who is covered on your plans at the time of retirement, and
- Dependent children who are covered on your plans at the time of retirement, if they are still eligible according to PEBB rules.

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

How to enroll as a PEBB Retiree

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

When to enroll as a PEBB Retiree

PEBB coverage must be continuous. **You must enroll for medical and dental benefits within 60 days of when your active PEBB coverage ends.** Contact your employing agency for the date your active PEBB coverage will end. The enrollment deadline is 60 days from that date. If you enroll and pay premiums during this 60-day window, coverage is retroactive to the date your PEBB employee coverage ended.

Exceptions:

- If you have coverage under a spouse's or partner's active PEBB plan, you may enroll in the PEBB retiree plan later if you lose the current coverage.
- If you choose COBRA continuation coverage, you can transfer to the retiree group during or at the end of the COBRA period.

Changing Plans

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

- The Plan Change Period allows you the opportunity to change plans**; it does not allow you to add coverage you did not already have**. For example, if you chose not to enroll in medical coverage when you retired, you may not enroll for medical coverage during subsequent Plan Change Periods.
- **You may not add dependents during this period**. You may add dependents only within 30 days of and consistent with a qualified midyear change event.

Effective dates

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

If you relocate outside a plan's service area: If you leave a plan's service area, you may enroll in a new plan. You must do so within 30 days.

If a dependent loses other coverage: If a domestic partner or family member not currently enrolled on your retiree plan loses other employer group coverage, you may enroll the spouse or domestic partner or dependent child for coverage in your plan, if they meet the PEBB eligibility. You must do so within 30 days of the loss of coverage.

Coverage Duration: Coverage continues as long as:

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

Continuing life and long term care insurance after retirement

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability if you enroll in a conversion coverage or the PEBB retiree life insurance portability

coverage **within 30 days from the date of your retirement.** Please contact The Standard Insurance Company for more information about this option.

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

Continuation of other optional benefits

You cannot continue PEBB dependent life, spouse or domestic partner life, disability, or accidental death and dismemberment insurance.

Continuing Coverage after PEBB

PERS. Contact the PERS Health Insurance Program for information on PERS health insurance.

COBRA. The federal COBRA law allows you to continue the same coverage in the PEBB plan you had as an employee. You must self-pay your premium. However, there are some important differences to keep in mind.

- COBRA usually allows continuation of your participation in the active-employee group for only 18 months. If you have a qualified Social Security disability or become qualified within the first 60 days of COBRA coverage, you may be eligible for an additional 11 months of COBRA coverage, for a total of 29 months.
- COBRA coverage for you ends if you:
    - Become eligible for Medicare in the 18-month period (except those with end-stage renal disease)
    - Become covered by another group medical plan that does not exclude or limit coverage for pre-existing conditions
    - Fail to make a timely premium payment.
- In the event of your death, COBRA coverage may continue for dependents up to 36 months from the time you began to pay your own premium. Other provisions may apply for COBRA coverage. Contact BHS for more information.

If you choose COBRA coverage, you may enroll as a PEBB retiree at any time during your COBRA coverage.

Conversion to an Individual Plan. Your plan may offer you available private coverage options if your PEBB group coverage ends. Contact your plan's customer service for more information.

Coverage in the Marketplace. When other health care coverage ends, citizens are eligible to enroll in marketplace coverage. Oregon citizens do this through https://www.healthcare.gov. The website provides all necessary information.

Medicare Coverage. Medicare covers:

- People 65 years of age and older
- Certain people younger than 65 with disabilities.

For information about individual plans to supplement Medicare coverage, contact the Senior Health Insurance Benefits Assistance program at (800) 722-4134.

Retirees Returning to Active Employee Status

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

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

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

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

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

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

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

COBRA Participants

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

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

See Section 5 for more information regarding your COBRA rights and qualifying events.

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

Other Self-pay Participants

The following individuals may participate in PEBB.

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

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

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

Individuals Eligible for Coverage

Employees may enroll the following individuals for coverage:

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

Qualifying Dependent Children

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

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

- Son, daughter, stepson, stepdaughter, or adopted child and the child will not have attained age 27 as of December 31 of the plan year. The exception is a child who meets all the requirements of a child with a disability as stated under *Disabled Dependent Children*. Marital status, tax dependency, or residency does not effect this eligibility; or

- A biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a grandchild by affidavit) and meets all the following criteria; or

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

- A child by Affidavit (Child by Affidavit of Dependency) which includes but not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child and meets all the following criteria:

    1. The child lives in the household of the eligible employee and is the eligible employee's IRS dependent.

2. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first. An eligible employee may not add a child by affidavit age 18 or older to PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18. When are Special Forms and Documentation Required for Children?

An employee must complete and submit the correct PEBB enrollment forms, notarized affidavit, and any required legal documents to provide coverage to the following children:

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

Note: Employees must pay an imputed value tax for the coverage of a domestic partner's eligible children when they are not the employee's tax dependents.

End of coverage Coverage for a child ends last day of the plan year (12/31) in which the child is 26. In some cases, such as for foster children or wards of the court, coverage can end the last day of the month of legal responsibility or 18 whichever comes first.

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

Disabled Dependent Children

There is no age limit for medical plan coverage for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. **All the criteria in this section must be met in order for the child to remain eligible. To enroll a disabled child over the age of 26 in PEBB vision or dental plans the child must be approved and enrolled in PEBB medical coverage first.**

When an employee requests to enroll a disabled child over the age of 26:

- The employee must submit to PEBB an appeal and enrollment form to enroll a disabled child age 26 or older. The employee must also provide evidence to PEBB that the child has had continuous health plan coverage, group or individual, prior to attaining age 26 and the coverage remains in effect.
- The other medical coverage must continue until the employee's PEBB medical plan approves the child's health status as disabled and other eligibility is met, and the PEBB plan is effective.
- If the child has not had continuous coverage, the child is not eligible for PEBB coverage.
- The employee must state to PEBB that the child is the employee's or spouse's *qualifying tax dependent*.

- The child's attending physician must submit to the employee's health plan verification and documentation of the child's disability.
- The physician must verify to the health plan that:

  1. the disability existed before the child attained age 26 and

  2 the child is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.
- Note: The child must be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.
- The health plan provides a medical review of the physician's documentation and will notify PEBB of the plan's disability determination.

PEBB will notify the subscriber of the child's final PEBB coverage determination and effective date if approved.

When a disabled child is receiving coverage beyond the age of 26, the employee's health plan can review the health status at any time to determine if the child continues to meet the criteria for coverage.

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

Termination of Coverage When a Child Ages Out of PEBB Coverage

PEBB terminates all health plan coverage at midnight on December 31 for children who reached age 26 during the current calendar plan year. PEBB will not terminate coverage for a dependent child age 26 or older when the medical plan determines the child meets all the criteria for a disabled child.

Examples of Eligible and Ineligible Dependents	**Eligible**	**Ineligible**
A 15-year-old biological grandchild of an eligible employee lives in the employee's household, and the employee has legal custody.	**X**	
A 25-year-old child is married and lives in Colorado. (Note: check your health plan's service area for benefits available.)	**X**	
An 18-year-old child has health coverage through another parent or the child's own employment.	**X**	
An eligible employee has a son-in-law or daughter in-law of any age.		**X**
An eligible employee's, spouse's, or domestic partner's eligible dependent child has a biological child (grandchild) who lives with the eligible employee, the child's parent is not married and does not have a domestic partner, and the employee provides more than half the support for both the grandchild and the parent.	**X**	
An eligible employee's biological grandchild of any age and does not live with the employee.		**X**
A newborn is placed for adoption with the employee.	**X**	
An employee has a child who is 27 years old and is not disabled.		**X**
An employee's 23-year-old child does not live with the employee and does not attend school.	**X**	
The eligible employee's mother or father of any age or level of dependency.		**X**
An eligible employee has an eligible dependent who has a three-year-old stepchild, and the employee wants to cover the stepchild.		**X**
An eligible employee's eight-year-old sister lives with the employee, and the employee has legal guardianship of the sister.	**X**	
An eligible employee's eight-year-old sister lives with the employee, and the employee does not have a legal obligation to provide for the child's welfare.		**X**

Domestic partners and their dependents

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

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

The member and the domestic partner are eligible if they have

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

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

Affidavit of Domestic Partnership Process

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

Children of Domestic Partners

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

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

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

Tax Considerations

Before enrolling a domestic partner or a partner's children for coverage, employees should know there may be important tax considerations. Payroll will add an imputed value to the eligible employee's taxable wages for the fair market value of the insurance premium for coverage of the domestic partner and domestic partner's children, unless the employee notifies payroll that the domestic partner qualifies as a tax dependent under IRS rules.

Following is information provided by the Oregon Department of Justice Attorney General's Office regarding this topic.

Domestic Partner and Domestic Partner Children as Dependents for Pre-Tax Health Benefit Purposes

Domestic Partners Eligible for Health Coverage

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

Tax Consequences of Domestic Partner Coverage

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

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

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

You should also note that state tax treatment of domestic partner health coverage will differ. See OAR 150-316.007-(B) Policy -- Application of Various Provisions of Tax Law to Domestic Partners, or call the Oregon Department of Revenue at 503-378-4988 or toll-free from an Oregon prefix at 1-800-356-4222 for more information about state tax treatment.

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

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

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

IRS Publication 501 contains information on how to determine a dependent. In general, the following conditions must be met (in addition to meeting PEBB domestic partner eligibility requirements) for your same-sex or opposite-sex domestic partner to qualify as your tax dependent for pre-tax health coverage purposes under federal tax law.

- You and your domestic partner have the same principal place of abode for the entire calendar year;
- Your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law);
- During the calendar year you provide more than half of your domestic partner's total support
- Your domestic partner is not your (or anyone else's) qualifying child under Code 152 c; and
- Your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

Your domestic partner could be your federal tax dependent for health coverage purposes even if you do not claim an exemption for him or her on your Form 1040. If your tax year is a year other than the calendar year, use the other year instead. Your employer will also consider your opposite-sex domestic partner to be your federal tax dependent for health coverage purposes if he or she meets the above requirements for the first portion of the year, then you marry, and he or she remains your legal spouse for the remainder of the year.

To determine whether you provide more than half of your domestic partner's total support, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including Social Security, welfare payments, the support you provide, and the support your domestic partner provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and the like. If you believe you might provide more than half of your domestic partner's support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you complete the Certification described below.

When is a Domestic Partner's Child Considered a Dependent for Pre-Tax Health Coverage?

Determining whether a domestic partner's child is a dependent is more complicated than determining if a domestic partner is a dependent. Seeking the advice of a tax professional is recommended before certifying that a domestic partner's child(ren) is/are dependent(s). This is because in addition to PEBB's requirements for dependent children, generally all of the following must be met for your domestic partner's children to qualify as your tax dependent(s) for pretax health coverage under federal tax law:

- The child is your domestic partner's child, adopted child, child placed for adoption, or eligible foster child
- The child is a member of your household who shares your principal place of abode. (Note that the child is not a member of your household if your relationship with the child violates local law.)
- You provide over half the child's support for the calendar year.
- **The child is NOT a Qualifying child of any other taxpayer***

- The child is a U.S, citizen, national or resident of the U.S. or a resident of Canada, or Mexico; or is an adopted child and you are a U.S. citizen or national.

***Note**: Under IRS Notice 2008-5, a domestic partner's child is not a qualifying child of the domestic partner if the domestic partner (or any other person with respect to whom the child potentially would be a qualifying child, such as child's other parent) is not required to file a federal income tax return and either does not file such a return, or does so solely to obtain a refund of withheld income taxes.

Filing a Certification of Dependent Domestic Partner Status

If your domestic partner qualifies as your tax dependent for health coverage purposes, you can avoid having the value of your domestic partner's health coverage treated as taxable income. To avoid taxation, you must complete and return the Certification of Dependent Domestic Partner Status, indicating that your domestic partner qualifies as your federal tax dependent for health coverage purposes. Because the determination of whether a person is a tax dependent for health coverage purposes turns on facts solely within your knowledge, your employer cannot make this determination for you. You should make this determination in consultation with your tax professional. **You will be asked to complete a Certification each year at open enrollment. For any year in which your employer does not receive a Certification from you, your employer will assume that your domestic partner does not qualify as your federal tax dependent for health coverage purposes for that year.**

This information is only a summary of the tax provisions governing the tax status of a domestic partner (or the domestic partner's children) for health plan purposes, and is not intended nor should it be relied upon as legal or tax advice. Due to the complexity of these tax rules and the potential impact of any imputed income you may incur, you should seek advice from a competent tax professional before certifying as to the tax status of the person being enrolled.

Removing a Domestic Partner and Domestic Partner's Children from Coverage

On dissolution of a domestic partnership, you must remove the domestic partner and partner's children from coverage within 30 days of the date of dissolution. If you terminate a Domestic Partnership by Affidavit, you must complete and submit a Termination of Domestic Partnership form and any other necessary midyear change forms (PEBB forms page).

Enrollment Periods and Effective Dates

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

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

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

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

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

Enrolling

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

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

- **Newly hired or newly eligible employees** may enroll online or by submitting required forms and any necessary documentation to their agency within 30 days of their eligibility or hire date. Enrollment elections for Opt Out, Dependent Child by Affidavit, Grandchild by Affidavit, and Domestic Partner by Affidavit require submission of enrollment forms and other legal documentation to the agency. Employees can enroll electronically for these elections; however, the agency must receive all required forms within 10 business days to complete the enrollment. Employees submitting printed enrollment forms and documentation to the agency must ensure that the submissions are complete or the agency will not process the enrollment.

- **Open Enrollment Period: The Board may require all eligible employees to actively enroll for core benefits during Open Enrollment for the following plan year. This is called a Mandatory Open Enrollment. The Board also may require this of COBRA, Retiree, or Self-pay subscribers.** Employees who take no enrollment action during a mandatory open enrollment period may default in some programs and plans. **An enrollment action means to enroll, add to, save, or change benefit plan enrollment elections or to enroll, add to, save, or change coverage for an individual.**

    - The agency must provide an opportunity for open enrollment elections to an employe**e** who becomes newly eligible or hired after the open enrollment period but before the start of the new plan year. The employee must submit required enrollment forms and documentation to the agency before the start of the new plan year.
    - During the open enrollment period, the eligible employee is accountable for enrolling and providing coverage to only those individuals who will meet PEBB eligibility criteria for coverage the **first day in the new plan year**. Certain enrollment elections require the submission of documentation to the employing agency before the enrollment will go into effect or the individuals enrollment will not go into effect.
    - Employees are not to use the open enrollment period to remove individuals who have lost eligibility or will lose eligibility. Employees should remove individuals from their coverage and benefit record by submitting a midyear change form to the agency or to PEBB.
    - During open enrollment employees can terminate coverage for an individual electronically or by using a form if they know the individual will be ineligible for coverage the first day of the plan year or if the employee no longer wants to provide coverage to the individual even though the individual will continue to meet eligibility. **The individual's coverage will not end until the last day of the last month of the current plan year.**

- Before the start of the new plan year the agency must provide an opportunity for open enrollment elections to eligible employees away from work because of an employer-approved leave status and the employee's core benefits are continuing. Examples include but are not limited to FMLA, CBIW, and Active Military Duty.
- **Some Self-pay participants** (e.g., COBRA, Retiree) must enroll by completing the enrollment forms identified by enrollment group type on the PEBB forms site. Self-pay participants send the forms to BenefitHelp Solutions (BHS), the third-party administrator.

Failure to Enroll

Newly benefit eligible employees who do not enroll for benefits within the 30 days of becoming eligible may not participate in the benefit program for that plan year. However, if you fail to enroll because of circumstances beyond your control, you may appeal to PEBB. If PEBB approves the appeal, you may enroll **only** for core benefit coverage for the plan year, this includes coverage for eligible family members.

Correcting Enrollment Errors

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

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

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

Certain Open Enrollment errors may be correctable. Your agency can correct these errors from the close of Open Enrollment up to 30 days from when you receive your first pay statement of the new plan year. Some corrections can only be prospective; others can be retroactive. Once a medical or dental plan becomes effective a correction to change to a different plan can be prospective only.

PEBB must review all employee requests for a midyear change when received beyond 30 days from the original date of eligibility or the date that qualifies for a midyear plan change event. Requests received more than 30 days from either of these dates must demonstrate facts and circumstances that clearly establish that an employee error occurred or there were circumstances beyond the employees control.

Midyear Plan Changes

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

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

The IRS requires that PEBB comply with federal regulations for midyear plan changes. Midyear plan change events must meet the IRS "general consistency rule." **Under the general consistency**

rule, an election change satisfies the consistency requirement for changes in status "if the election change is *on account of and corresponds with* a change in status that affects eligibility for coverage under an employer's plan." Some qualified midyear events do not apply to all the benefits offered under the plan. Here are two examples.

- **Example 1. You adopt a child.** This is a QSC event that allows you to add the child to your current core coverages and to add or increase other coverage related to the addition of a dependent, such as adding optional Dependent Life, or increasing your optional life insurance. However, this event would not allow you to change to a different medical or dental plan than what your current enrollment is. The one exception to the medical plan– change is a request to change from one type of medical plan to another, for example a PPO to an HMO plan or a HMO to a POS, but never a PPO to PPO, or POS to POS etc.….
- **Example 2. You move from an eligible classified full-time position to an eligible classified part-time position (a true position job classification change, not just a decrease in hours worked.** This change is also a QSC and will allow you to enroll in either the part-time or the full-time plans. You may change core benefit plans and add or delete coverage, however changes to some optional coverage may not be allowed.

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

Qualifying Midyear Change Events

Midyear change events that affect eligibility for insurance benefits fall into three broad categories. The following provides only an outline of the broad categories.. Each event is detailed in federal regulation and criteria for the event must be met. See the appendix chart, or contact your agency or PEBB for assistance if needed.

1. Qualified status changes (QSCs), such as changes in:
   - Legal marital status – marriage, divorce or death of a spouse. A separation, whether legal or not, is not a change in marital status for purposes of terminating spouse or partner PEBB coverage. Termination of an ex-spouse or partner cannot occur as a midyear change until the divorce or a domestic partner dissolution is final.
   - Number of dependents changes, such as birth, death, or placement for adoption and adoption of a child,
   - You or a family member's employment status affects eligibility changes, such as the start or end of employment, or a change from part-time to full-time job status
   - Eligibility of a dependent, for example a dependent losing eligibility or gains eligibility
   - Your place of residence or that of a family member, when the change entails a move that results in a loss of plan eligibility
   - Your domestic partnership status changes

2. Changes in cost or coverage, such as a significant or automatic:
   - Increase in premium cost that you pay
   - Reduction or a change in your spouse's. domestic partner's, or dependent's group health insurance plan benefits provided by an employer
   - A reduction or a loss of plan coverage (spouse, domestic partner's or dependent's)

3. Changes by law or court order, such as National Medical Support Notice, Medicare, or HIPAA

:

Allowable changes specific to Flexible Spending Accounts:

Dependent Care FSA

- You marry and gain children as dependents
- Your spouse dies, or you divorce or have a legal separation or annulment, and this affects the need for dependent care
- Your biological child is born, you adopt a child, or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your employment status changes
- Your spouse's employment status changes
- You experience a change in cost or coverage of dependent care.

Health Care FSA

- You marry
- Your spouse dies, you divorce or your marriage is annulled
- Your biological child is born; you adopt a child or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your or your spouse's employment changes, and the change affects your health care flexible spending account eligibility

Appendix A (http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf) details QSCs and consistent benefit changes that may be made.

Individuals No Longer Eligible for Coverage

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

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

(a) **When an employee experiences a qualifying midyear change that permits the employee to remove an eligible individual from coverage, agencies will terminate the coverage prospectively** if submitted within 30 days of the event date .(Prospective = the last day of the month following receipt of the appropriate forms). Submission of the forms beyond 30 days requires an appeal to PEBB and will result in termination of the coverage retroactive to the last day of the month of the event date.

> **Example:** Bill currently provides PEBB coverage for his 22-year-old son, Mark. On May 5 ,Mark starts a new job that provides him with health care coverage. Bill can continue Mark's PEBB coverage or based on the qualified midyear event of "Gain of Coverage Eligibility under Another Employer's Plans," Bill can terminate Marks, coverage. Bill decides to terminate coverage for Mark and submits a midyear change form to his agency on June 1 (within 30 days of the event date). The agency will terminate Mark's PEBB coverage effective June 30.

(b) Employees must request termination of coverage for an individual receiving PEBB coverage under their enrollments when the individual becomes ***ineligible for the coverage***. Examples of individuals who no longer meet eligibility and require termination from coverage include but are not limited to an ex- spouse, an ex-domestic partner, a child by affidavit no longer eligible due to age limitation within the responsibility of a legal document, and a disabled child who no longer meets criteria.

Agencies will terminate an ineligible individual's coverage prospectively when notified within 30 days of the ineligible event date (i.e., divorce date). The coverage ends the last day of the month following receipt of the appropriate forms from the employee. The exception to prospective termination is termination of coverage for an ex-spouse or an ex -domestic partner, and their children who are not biological children or adopted children of the employee when notification is beyond 30 days from the event. In this case, PEBB coverage terminates retroactively to the last day of the month in which eligibility is lost. This is not considered a rescission. PEBB, not the agency, processes retroactive terminations.

> **Example 1:** Ann's divorce is final on June 6. On June 22, she submits the correct change form to her agency to remove her ex-spouse from coverage. The agency can process Ann's former spouse's termination from PEBB coverage effective June 30.
>
> **Example 2:** Mary's divorce is final on May 15. On July 1, Mary submits the correct change forms to her agency to remove her ex-spouse from coverage. The notification to the agency isn't within the allowable 30 days of the event date. The ex-spouse coverage must terminate retroactively. The agency will send Mary's forms to PEBB to process, and coverage will terminate May 31.

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

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

An employee's failure to report a family member's or domestic partner's loss of eligibility during the 12-month period before the start of each annual open enrollment period can result in civil or criminal charges against the employee for fraud or the intent to misrepresent the material facts of enrollment. To the extent allowed by law, PEBB may rescind coverage back to the last day of the month of the plan year when eligibility was lost. Rescission of coverage can occur to an employee, or an individual for whom the employee provides coverage. The following actions will occur during a rescission of coverage action taken by PEBB:

- PEBB or agency will provide at least 30 calendar days' advance notice of the rescission date to the ineligible individual. Coverage will rescind to the last day of the month and plan year in which the individual lost eligibility.
- PEBB or agency will include a notice of appeal rights with the rescission notice to the individual losing coverage.
- The agency may request premium refunds from PEBB or the Plan.
- An agency may determine that an employee must repay to the agency the state-funded premiums paid for coverage during the ineligible period.
- As contractually agreed to, a plan may determine that an employee must repay insurance claims paid by a plan for the ineligible individual during the ineligible period.
- An employee's agency can take disciplinary action against the employee for the employee's failure to remove an ineligible individual from coverage.
- The employee may have imputed value added to taxable income for premiums not refunded by the plans or repaid by the employee to the agency.

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

(a) The employee may choose, as a midyear plan change, an alternative PEBB plan to replace the terminated plan. If no alternative PEBB plan is available in the employee's service area, there is no coverage.

(b) The plan may retain all premiums paid and has the right to recover from the employee the benefits paid because of such wrongful activity that are in excess of the premiums.

(c) The plan may deny future enrollments of the individual.

HIPAA Special Enrollment Rights

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

If you previously declined enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a PEBB plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops

contributing toward the other coverage). Your coverage will be effective from the first day of the month of the other coverage loss.

Tag along rule applies. If you add a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents that were eligible but never enrolled previously. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact PEBB at (503) 373-1102, or email inquiries.pebb@state.or.us.

Appendix A (http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf) details QSCs and consistent benefit changes that may be made.

Ending Participation in PEBB

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

Returning to Work

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

Generally:

- An active eligible employee who is returning from a leave without pay (LWOP), but who has not been in a protected leave status such as FMLA, OFLA etc., and isn't in a current benefit eligible stability period must work at least half-time in the month of return to be eligible for benefits in the following month. The exception is an eligible employee in job share positions.

- An active eligible employee not in a current stability period returning from a reduction in hours below eligibility criteria must work at least half-time in the month of return to be eligible for benefits in the following month. The exception is an eligible employee in job share positions.
- A previous permanent, benefit eligible employee returning to a permanent benefit eligible position in paid regular status within 12 months of a core benefit coverage termination date following a layoff or termination of employment, is not required to work at least half time in the month they return to be eligible for benefits the following month. The agency will reinstate the previous plan enrollments, if available, effective the first of the month following the employee's return to work. The employee has 30 days to change reinstated benefit elections. Reinstatement excludes Flexible Spending Accounts, Long Term Care insurance, and Commuter accounts. NOTE: A stability period ends when there is a break in employment longer than 13 weeks. The employee's initial measurement period will start over.
- Flexible Spending Accounts, Long Term Care insurance, and Commuter accounts are never reinstated. The employee has 30 days from the date of rehire, or return to work, to change benefit elections. Long Term Care insurance can be reinstated as a payroll deduction if the employee continued the plan through portability. An exception occurs if the individual continued participation in a healthcare FSA while on COBRA or prepaid or made arrangements with the agency to pay the FSA prior to taking a FMLA leave. In this case, PEBB will reinstate the FSA.
- A previously benefit eligible employee returning to paid regular status in a benefit eligible position after a termination of core benefits of 12 months or longer must enroll as a newly eligible employee.

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

- Standard Measurement period for the OSPS employees means a 12 consecutive month period starting November 1 and ending October 31.
- Variable Hour Employee means a New Employee if, based on the facts and circumstances at the New Employee's start date, the agency cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week. during the initial measurement period.

An initial measurement period applies to all new employees to state employment, regardless if their appointment is to a permanent position or temporary position.

During the initial measurement period and until meeting the requirements of a stability period, benefit eligible employees must be in regular paid status a minimum of 80 hours each month to earn benefits for the following month.

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

Stability period:

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

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

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

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

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

Current full-time permanent employees (as classified by the Human Resources system)who are not in a current "stability period" must work or be in paid regular status at least half time during the preceding month to be eligible for benefits the next month. Half time means employed and:

- Work or receive 80 paid regular hours per month; or
- 0.5 FTE for OUS employees;
- 80 paid regular hours per month and in a documented 0.5 FTE position for the Oregon Judicial Department; or
- As defined by collective bargaining agreements.

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

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

Benefit Options for Full-time Employees

- **Core Benefits** – Core benefits are
    - All available full time medical plans, and dental plans according to where you live or work (at least 50 percent of the time) and a vision plan. You must be enrolled in a choice of medical plan (which includes Opt Out) to enroll in dental or vision coverage.
    - Basic employee life insurance coverage of $5,000
- Employees choosing core benefits can also enroll in all available optional benefit plans, for which they pay the premiums.
- **Opt out** – **Opting out is a choice of medical plans.** Employees may opt out of PEBB medical coverage if they have other employer group coverage (which does not include for example, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance). All employees who opt out will receive a monthly taxable opt-out amount determined by the Board. Part time employees receive a prorated amount according to hours worked compared with full-time hours in the month. All employees who opt out must pay a share of the premium for employee basic life coverage. Employees who choose to opt out of PEBB medical coverage can enroll in vision and dental coverage. The employee cost of basic life premiums, and enrolled dental or vision coverage is deducted pretax. Employees who opt out may enroll in optional benefit plans, for which they pay the full premium amount. Opt Out money is not paid during a leave without pay.
- **Decline** – Employees may decline core benefits. If they decline core benefits, they choose not to participate in the PEBB program. They will not receive a portion of the employer's premium share and they cannot enroll in any of the optional benefit plans.

Eligible Permanent Position Part-time Employees

(Includes Limited Duration and Job Share positions)

- Permanent position part-time employees (as classified by the Human Resources system) who are <u>not</u> in a current "stability period" must work or be in paid regular status at least half time during the preceding month to be eligible for benefits the next month. Half time means the individual is employed and:
- Works or receives 80 paid regular hours per month or is in a job share position; or
- Is 0.5 FTE for unclassified OUS employees; or
- Works or receives 80 paid regular hours per month and is in a 0.5 FTE position for the Oregon Judicial Department: or
- Fits the definition in an applicable collective bargaining agreement.

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

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

The monthly employer share of premium for core benefits for most eligible part-time employees is pro-rated based on hours worked in the month when compared with the month's available full

time hours less the employee's premium share. Employees should check with their payroll for the amount of premium they are responsible to pay. PEBB is not a source for that information.

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

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

Benefit Options for Part-time Employees

- **Core Benefits** -
    - All full time medical and dental plans available according to where you live or work (at least 50 percent of the time).
    - All "medical and dental plans labeled "part time" plans, according to where you live or work (at least 50 percent of the time).
    - Vision coverage
    - You must be enrolled in a choice of medical plan (which includes Opt Out) to enroll in dental or vision coverage
- Basic employee life insurance coverage of $5,000
- Employees who enroll in core benefits can also enroll in all available optional benefit plans, for which they pay the premiums.
- **Opt out** – **Opting out is a choice of medical plans.** Employees may opt out of PEBB medical coverage if they have other coverage (which does not include for example, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance). All employees who opt out will receive a monthly taxable opt-out amount determined by the Board and prorated for part-time employees according to hours worked when compared with full-time hours in the month. All employees who opt out must pay a share of the premium for employee basic life coverage. Employees who choose to opt out of PEBB medical coverage can enroll in vision and dental coverage. The employee cost of basic life premium, and enrolled dental or vision coverage is deducted pretax. Employees who opt out may enroll in optional benefit plans, for which they pay the full premium amount. Opt out money is not paid during a leave without pay.

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

New Permanent Seasonal Employees

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

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

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

Seasonal employees expected to work fewer than 90 days are not eligible for PEBB benefits. If the agency extends the length of the seasonal position to 90 days or longer, the employee is eligible for retroactive enrollment in benefits effective 30 days from the date of hire.

Benefit Options for Seasonal Employees

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

Returning Permanent Seasonal Employees

Previously benefit-eligible employees returning to work:

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

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

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

Previously ineligible seasonal employee returning to work:

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

Temporary, Impermanent or Variable Hour Employees

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

When benefit eligible:

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

Eligibility when on extended leave

The type of leave employees take – family medical leave, active duty military leave, job-related-injury leave, etc. – and whether it is a paid or unpaid leave may affect eligibility and benefits.

Contact your agency payroll, human resources or benefits office to discuss these issues prior to taking the leave. **This applies to all active benefit eligible employees.**

Active Employees and Medicare Eligibility

An active employee, or a spouse or domestic partner of an active employee, who gains Medicare eligibility remains eligible for active employee PEBB medical plan coverage. PEBB medical plans will generally continue to pay claims as primary and Medicare will pay claims as secondary coverage. Medicare provides a booklet entitled "Who Pays First." Employee's and family members may find this publication helpful. The booklet can be found at this link:
http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf

You may also find this information regarding Medicare helpful:
http://www.oregon.gov/DCBS/insurance/shiba/shiba_65/Pages/medicarestartsat65.aspx

Eligible Retirees

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

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

Medical and dental options

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

Eligibility

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

- Eligible to receive a retirement benefit through a state of Oregon retirement system, and
- Enrolled in a PEBB medical or dental plan, and
- Non-Medicare eligible.

You may also cover your

- Non-Medicare eligible spouse or domestic partner who is covered on your plans at the time of retirement, and
- Dependent children who are covered on your plans at the time of retirement, if they are still eligible according to PEBB rules.

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

How to enroll as a PEBB Retiree

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

When to enroll as a PEBB Retiree

PEBB coverage must be continuous. **You must enroll for medical and dental benefits within 60 days of when your active PEBB coverage ends.** Contact your employing agency for the date your active PEBB coverage will end. The enrollment deadline is 60 days from that date. If you enroll and pay premiums during this 60-day window, coverage is retroactive to the date your PEBB employee coverage ended.

Exceptions:

- If you have coverage under a spouse's or partner's active PEBB plan, you may enroll in the PEBB retiree plan later if you lose the current coverage.
- If you choose COBRA continuation coverage, you can transfer to the retiree group during or at the end of the COBRA period.

Changing Plans

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

- The Plan Change Period allows you the opportunity to change plans**; it does not allow you to add coverage you did not already have**. For example, if you chose not to enroll in medical coverage when you retired, you may not enroll for medical coverage during subsequent Plan Change Periods.
- **You may not add dependents during this period**. You may add dependents only within 30 days of and consistent with a qualified midyear change event.

Effective dates

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

If you relocate outside a plan's service area: If you leave a plan's service area, you may enroll in a new plan. You must do so within 30 days.

If a dependent loses other coverage: If a domestic partner or family member not currently enrolled on your retiree plan loses other employer group coverage, you may enroll the spouse or domestic partner or dependent child for coverage in your plan, if they meet the PEBB eligibility. You must do so within 30 days of the loss of coverage.

Coverage Duration: Coverage continues as long as:

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

Continuing life and long term care insurance after retirement

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability if you enroll in a conversion coverage or the PEBB retiree life insurance portability

coverage **within 30 days from the date of your retirement.** Please contact The Standard Insurance Company for more information about this option.

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

Continuation of other optional benefits

You cannot continue PEBB dependent life, spouse or domestic partner life, disability, or accidental death and dismemberment insurance.

Continuing Coverage after PEBB

PERS. Contact the PERS Health Insurance Program for information on PERS health insurance.

COBRA. The federal COBRA law allows you to continue the same coverage in the PEBB plan you had as an employee. You must self-pay your premium. However, there are some important differences to keep in mind.

- COBRA usually allows continuation of your participation in the active-employee group for only 18 months. If you have a qualified Social Security disability or become qualified within the first 60 days of COBRA coverage, you may be eligible for an additional 11 months of COBRA coverage, for a total of 29 months.
- COBRA coverage for you ends if you:
    - Become eligible for Medicare in the 18-month period (except those with end-stage renal disease)
    - Become covered by another group medical plan that does not exclude or limit coverage for pre-existing conditions
    - Fail to make a timely premium payment.
- In the event of your death, COBRA coverage may continue for dependents up to 36 months from the time you began to pay your own premium. Other provisions may apply for COBRA coverage. Contact BHS for more information.

If you choose COBRA coverage, you may enroll as a PEBB retiree at any time during your COBRA coverage.

Conversion to an Individual Plan. Your plan may offer you available private coverage options if your PEBB group coverage ends. Contact your plan's customer service for more information.

Coverage in the Marketplace. When other health care coverage ends, citizens are eligible to enroll in marketplace coverage. Oregon citizens do this through https://www.healthcare.gov. The website provides all necessary information.

Medicare Coverage. Medicare covers:

- People 65 years of age and older
- Certain people younger than 65 with disabilities.

For information about individual plans to supplement Medicare coverage, contact the Senior Health Insurance Benefits Assistance program at (800) 722-4134.

Retirees Returning to Active Employee Status

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

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

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

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

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

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

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

COBRA Participants

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

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

See Section 5 for more information regarding your COBRA rights and qualifying events.

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

Other Self-pay Participants

The following individuals may participate in PEBB.

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

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

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

Individuals Eligible for Coverage

Employees may enroll the following individuals for coverage:

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

Qualifying Dependent Children

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

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

- Son, daughter, stepson, stepdaughter, or adopted child and the child will not have attained age 27 as of December 31 of the plan year. The exception is a child who meets all the requirements of a child with a disability as stated under *Disabled Dependent Children*. Marital status, tax dependency, or residency does not effect this eligibility; or

- A biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a grandchild by affidavit) and meets all the following criteria; or

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

- A child by Affidavit (Child by Affidavit of Dependency) which includes but not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child and meets all the following criteria:

    1. The child lives in the household of the eligible employee and is the eligible employee's IRS dependent.

2. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first. An eligible employee may not add a child by affidavit age 18 or older to PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18. When are Special Forms and Documentation Required for Children?

An employee must complete and submit the correct PEBB enrollment forms, notarized affidavit, and any required legal documents to provide coverage to the following children:

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

Note: Employees must pay an imputed value tax for the coverage of a domestic partner's eligible children when they are not the employee's tax dependents.

End of coverage Coverage for a child ends last day of the plan year (12/31) in which the child is 26. In some cases, such as for foster children or wards of the court, coverage can end the last day of the month of legal responsibility or 18 whichever comes first.

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

Disabled Dependent Children

There is no age limit for medical plan coverage for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. **All the criteria in this section must be met in order for the child to remain eligible. To enroll a disabled child over the age of 26 in PEBB vision or dental plans the child must be approved and enrolled in PEBB medical coverage first.**

When an employee requests to enroll a disabled child over the age of 26:

- The employee must submit to PEBB an appeal and enrollment form to enroll a disabled child age 26 or older. The employee must also provide evidence to PEBB that the child has had continuous health plan coverage, group or individual, prior to attaining age 26 and the coverage remains in effect.
- The other medical coverage must continue until the employee's PEBB medical plan approves the child's health status as disabled and other eligibility is met, and the PEBB plan is effective.
- If the child has not had continuous coverage, the child is not eligible for PEBB coverage.
- The employee must state to PEBB that the child is the employee's or spouse's *qualifying tax dependent*.

- The child's attending physician must submit to the employee's health plan verification and documentation of the child's disability.
- The physician must verify to the health plan that:

  1. the disability existed before the child attained age 26 and

  2 the child is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.
- Note: The child must be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.
- The health plan provides a medical review of the physician's documentation and will notify PEBB of the plan's disability determination.

PEBB will notify the subscriber of the child's final PEBB coverage determination and effective date if approved.

When a disabled child is receiving coverage beyond the age of 26, the employee's health plan can review the health status at any time to determine if the child continues to meet the criteria for coverage.

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

Termination of Coverage When a Child Ages Out of PEBB Coverage

PEBB terminates all health plan coverage at midnight on December 31 for children who reached age 26 during the current calendar plan year. PEBB will not terminate coverage for a dependent child age 26 or older when the medical plan determines the child meets all the criteria for a disabled child.

Examples of Eligible and Ineligible Dependents	**Eligible**	**Ineligible**
A 15-year-old biological grandchild of an eligible employee lives in the employee's household, and the employee has legal custody.	**X**	
A 25-year-old child is married and lives in Colorado. (Note: check your health plan's service area for benefits available.)	**X**	
An 18-year-old child has health coverage through another parent or the child's own employment.	**X**	
An eligible employee has a son-in-law or daughter in-law of any age.		**X**
An eligible employee's, spouse's, or domestic partner's eligible dependent child has a biological child (grandchild) who lives with the eligible employee, the child's parent is not married and does not have a domestic partner, and the employee provides more than half the support for both the grandchild and the parent.	**X**	
An eligible employee's biological grandchild of any age and does not live with the employee.		**X**
A newborn is placed for adoption with the employee.	**X**	
An employee has a child who is 27 years old and is not disabled.		**X**
An employee's 23-year-old child does not live with the employee and does not attend school.	**X**	
The eligible employee's mother or father of any age or level of dependency.		**X**
An eligible employee has an eligible dependent who has a three-year-old stepchild, and the employee wants to cover the stepchild.		**X**
An eligible employee's eight-year-old sister lives with the employee, and the employee has legal guardianship of the sister.	**X**	
An eligible employee's eight-year-old sister lives with the employee, and the employee does not have a legal obligation to provide for the child's welfare.		**X**

Domestic partners and their dependents

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

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

The member and the domestic partner are eligible if they have

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

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

Affidavit of Domestic Partnership Process

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

Children of Domestic Partners

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

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

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

Tax Considerations

Before enrolling a domestic partner or a partner's children for coverage, employees should know there may be important tax considerations. Payroll will add an imputed value to the eligible employee's taxable wages for the fair market value of the insurance premium for coverage of the domestic partner and domestic partner's children, unless the employee notifies payroll that the domestic partner qualifies as a tax dependent under IRS rules.

Following is information provided by the Oregon Department of Justice Attorney General's Office regarding this topic.

Domestic Partner and Domestic Partner Children as Dependents for Pre-Tax Health Benefit Purposes

Domestic Partners Eligible for Health Coverage

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

Tax Consequences of Domestic Partner Coverage

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

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

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

You should also note that state tax treatment of domestic partner health coverage will differ. See OAR 150-316.007-(B) Policy -- Application of Various Provisions of Tax Law to Domestic Partners, or call the Oregon Department of Revenue at 503-378-4988 or toll-free from an Oregon prefix at 1-800-356-4222 for more information about state tax treatment.

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

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

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

IRS Publication 501 contains information on how to determine a dependent. In general, the following conditions must be met (in addition to meeting PEBB domestic partner eligibility requirements) for your same-sex or opposite-sex domestic partner to qualify as your tax dependent for pre-tax health coverage purposes under federal tax law.

- You and your domestic partner have the same principal place of abode for the entire calendar year;
- Your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law);
- During the calendar year you provide more than half of your domestic partner's total support
- Your domestic partner is not your (or anyone else's) qualifying child under Code 152 c; and
- Your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

Your domestic partner could be your federal tax dependent for health coverage purposes even if you do not claim an exemption for him or her on your Form 1040. If your tax year is a year other than the calendar year, use the other year instead. Your employer will also consider your opposite-sex domestic partner to be your federal tax dependent for health coverage purposes if he or she meets the above requirements for the first portion of the year, then you marry, and he or she remains your legal spouse for the remainder of the year.

To determine whether you provide more than half of your domestic partner's total support, you must compare the amount of support you provide with the amount of support your domestic partner receives from all sources, including Social Security, welfare payments, the support you provide, and the support your domestic partner provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and the like. If you believe you might provide more than half of your domestic partner's support, you should use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you complete the Certification described below.

When is a Domestic Partner's Child Considered a Dependent for Pre-Tax Health Coverage?

Determining whether a domestic partner's child is a dependent is more complicated than determining if a domestic partner is a dependent. Seeking the advice of a tax professional is recommended before certifying that a domestic partner's child(ren) is/are dependent(s). This is because in addition to PEBB's requirements for dependent children, generally all of the following must be met for your domestic partner's children to qualify as your tax dependent(s) for pretax health coverage under federal tax law:

- The child is your domestic partner's child, adopted child, child placed for adoption, or eligible foster child
- The child is a member of your household who shares your principal place of abode. (Note that the child is not a member of your household if your relationship with the child violates local law.)
- You provide over half the child's support for the calendar year.
- **The child is NOT a Qualifying child of any other taxpayer***

- The child is a U.S, citizen, national or resident of the U.S. or a resident of Canada, or Mexico; or is an adopted child and you are a U.S. citizen or national.

***Note**: Under IRS Notice 2008-5, a domestic partner's child is not a qualifying child of the domestic partner if the domestic partner (or any other person with respect to whom the child potentially would be a qualifying child, such as child's other parent) is not required to file a federal income tax return and either does not file such a return, or does so solely to obtain a refund of withheld income taxes.

Filing a Certification of Dependent Domestic Partner Status

If your domestic partner qualifies as your tax dependent for health coverage purposes, you can avoid having the value of your domestic partner's health coverage treated as taxable income. To avoid taxation, you must complete and return the Certification of Dependent Domestic Partner Status, indicating that your domestic partner qualifies as your federal tax dependent for health coverage purposes. Because the determination of whether a person is a tax dependent for health coverage purposes turns on facts solely within your knowledge, your employer cannot make this determination for you. You should make this determination in consultation with your tax professional. **You will be asked to complete a Certification each year at open enrollment. For any year in which your employer does not receive a Certification from you, your employer will assume that your domestic partner does not qualify as your federal tax dependent for health coverage purposes for that year.**

This information is only a summary of the tax provisions governing the tax status of a domestic partner (or the domestic partner's children) for health plan purposes, and is not intended nor should it be relied upon as legal or tax advice. Due to the complexity of these tax rules and the potential impact of any imputed income you may incur, you should seek advice from a competent tax professional before certifying as to the tax status of the person being enrolled.

Removing a Domestic Partner and Domestic Partner's Children from Coverage

On dissolution of a domestic partnership, you must remove the domestic partner and partner's children from coverage within 30 days of the date of dissolution. If you terminate a Domestic Partnership by Affidavit, you must complete and submit a Termination of Domestic Partnership form and any other necessary midyear change forms (PEBB forms page).

Enrollment Periods and Effective Dates

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

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

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

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

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

Enrolling

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

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

- **Newly hired or newly eligible employees** may enroll online or by submitting required forms and any necessary documentation to their agency within 30 days of their eligibility or hire date. Enrollment elections for Opt Out, Dependent Child by Affidavit, Grandchild by Affidavit, and Domestic Partner by Affidavit require submission of enrollment forms and other legal documentation to the agency. Employees can enroll electronically for these elections; however, the agency must receive all required forms within 10 business days to complete the enrollment. Employees submitting printed enrollment forms and documentation to the agency must ensure that the submissions are complete or the agency will not process the enrollment.

- **Open Enrollment Period: The Board may require all eligible employees to actively enroll for core benefits during Open Enrollment for the following plan year. This is called a Mandatory Open Enrollment. The Board also may require this of COBRA, Retiree, or Self-pay subscribers.** Employees who take no enrollment action during a mandatory open enrollment period may default in some programs and plans. **An enrollment action means to enroll, add to, save, or change benefit plan enrollment elections or to enroll, add to, save, or change coverage for an individual.**

    - The agency must provide an opportunity for open enrollment elections to an employe**e** who becomes newly eligible or hired after the open enrollment period but before the start of the new plan year. The employee must submit required enrollment forms and documentation to the agency before the start of the new plan year.
    - During the open enrollment period, the eligible employee is accountable for enrolling and providing coverage to only those individuals who will meet PEBB eligibility criteria for coverage the **first day in the new plan year**. Certain enrollment elections require the submission of documentation to the employing agency before the enrollment will go into effect or the individuals enrollment will not go into effect.
    - Employees are not to use the open enrollment period to remove individuals who have lost eligibility or will lose eligibility. Employees should remove individuals from their coverage and benefit record by submitting a midyear change form to the agency or to PEBB.
    - During open enrollment employees can terminate coverage for an individual electronically or by using a form if they know the individual will be ineligible for coverage the first day of the plan year or if the employee no longer wants to provide coverage to the individual even though the individual will continue to meet eligibility. **The individual's coverage will not end until the last day of the last month of the current plan year.**

- Before the start of the new plan year the agency must provide an opportunity for open enrollment elections to eligible employees away from work because of an employer-approved leave status and the employee's core benefits are continuing. Examples include but are not limited to FMLA, CBIW, and Active Military Duty.
- **Some Self-pay participants** (e.g., COBRA, Retiree) must enroll by completing the enrollment forms identified by enrollment group type on the PEBB forms site. Self-pay participants send the forms to BenefitHelp Solutions (BHS), the third-party administrator.

Failure to Enroll

Newly benefit eligible employees who do not enroll for benefits within the 30 days of becoming eligible may not participate in the benefit program for that plan year. However, if you fail to enroll because of circumstances beyond your control, you may appeal to PEBB. If PEBB approves the appeal, you may enroll **only** for core benefit coverage for the plan year, this includes coverage for eligible family members.

Correcting Enrollment Errors

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

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

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

Certain Open Enrollment errors may be correctable. Your agency can correct these errors from the close of Open Enrollment up to 30 days from when you receive your first pay statement of the new plan year. Some corrections can only be prospective; others can be retroactive. Once a medical or dental plan becomes effective a correction to change to a different plan can be prospective only.

PEBB must review all employee requests for a midyear change when received beyond 30 days from the original date of eligibility or the date that qualifies for a midyear plan change event. Requests received more than 30 days from either of these dates must demonstrate facts and circumstances that clearly establish that an employee error occurred or there were circumstances beyond the employees control.

Midyear Plan Changes

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

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

The IRS requires that PEBB comply with federal regulations for midyear plan changes. Midyear plan change events must meet the IRS "general consistency rule." **Under the general consistency**

rule, an election change satisfies the consistency requirement for changes in status "if the election change is *on account of and corresponds with* a change in status that affects eligibility for coverage under an employer's plan." Some qualified midyear events do not apply to all the benefits offered under the plan. Here are two examples.

- **Example 1. You adopt a child.** This is a QSC event that allows you to add the child to your current core coverages and to add or increase other coverage related to the addition of a dependent, such as adding optional Dependent Life, or increasing your optional life insurance. However, this event would not allow you to change to a different medical or dental plan than what your current enrollment is. The one exception to the medical plan– change is a request to change from one type of medical plan to another, for example a PPO to an HMO plan or a HMO to a POS, but never a PPO to PPO, or POS to POS etc.….
- **Example 2. You move from an eligible classified full-time position to an eligible classified part-time position (a true position job classification change, not just a decrease in hours worked.** This change is also a QSC and will allow you to enroll in either the part-time or the full-time plans. You may change core benefit plans and add or delete coverage, however changes to some optional coverage may not be allowed.

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

Qualifying Midyear Change Events

Midyear change events that affect eligibility for insurance benefits fall into three broad categories. The following provides only an outline of the broad categories.. Each event is detailed in federal regulation and criteria for the event must be met. See the appendix chart, or contact your agency or PEBB for assistance if needed.

1. Qualified status changes (QSCs), such as changes in:
   - Legal marital status – marriage, divorce or death of a spouse. A separation, whether legal or not, is not a change in marital status for purposes of terminating spouse or partner PEBB coverage. Termination of an ex-spouse or partner cannot occur as a midyear change until the divorce or a domestic partner dissolution is final.
   - Number of dependents changes, such as birth, death, or placement for adoption and adoption of a child,
   - You or a family member's employment status affects eligibility changes, such as the start or end of employment, or a change from part-time to full-time job status
   - Eligibility of a dependent, for example a dependent losing eligibility or gains eligibility
   - Your place of residence or that of a family member, when the change entails a move that results in a loss of plan eligibility
   - Your domestic partnership status changes

2. Changes in cost or coverage, such as a significant or automatic:
   - Increase in premium cost that you pay
   - Reduction or a change in your spouse's. domestic partner's, or dependent's group health insurance plan benefits provided by an employer
   - A reduction or a loss of plan coverage (spouse, domestic partner's or dependent's)

3. Changes by law or court order, such as National Medical Support Notice, Medicare, or HIPAA

:

Allowable changes specific to Flexible Spending Accounts:

Dependent Care FSA

- You marry and gain children as dependents
- Your spouse dies, or you divorce or have a legal separation or annulment, and this affects the need for dependent care
- Your biological child is born, you adopt a child, or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your employment status changes
- Your spouse's employment status changes
- You experience a change in cost or coverage of dependent care.

Health Care FSA

- You marry
- Your spouse dies, you divorce or your marriage is annulled
- Your biological child is born; you adopt a child or a child is placed with you for adoption
- A dependent child dies
- A child becomes eligible as a dependent for coverage under your benefits
- A child is no longer eligible as a dependent for coverage under your benefits
- Your or your spouse's employment changes, and the change affects your health care flexible spending account eligibility

Appendix A (http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf) details QSCs and consistent benefit changes that may be made.

Individuals No Longer Eligible for Coverage

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

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

(a) **When an employee experiences a qualifying midyear change that permits the employee to remove an eligible individual from coverage, agencies will terminate the coverage prospectively** if submitted within 30 days of the event date .(Prospective = the last day of the month following receipt of the appropriate forms). Submission of the forms beyond 30 days requires an appeal to PEBB and will result in termination of the coverage retroactive to the last day of the month of the event date.

> **Example:** Bill currently provides PEBB coverage for his 22-year-old son, Mark. On May 5 ,Mark starts a new job that provides him with health care coverage. Bill can continue Mark's PEBB coverage or based on the qualified midyear event of "Gain of Coverage Eligibility under Another Employer's Plans," Bill can terminate Marks, coverage. Bill decides to terminate coverage for Mark and submits a midyear change form to his agency on June 1 (within 30 days of the event date). The agency will terminate Mark's PEBB coverage effective June 30.

(b) Employees must request termination of coverage for an individual receiving PEBB coverage under their enrollments when the individual becomes ***ineligible for the coverage***. Examples of individuals who no longer meet eligibility and require termination from coverage include but are not limited to an ex- spouse, an ex-domestic partner, a child by affidavit no longer eligible due to age limitation within the responsibility of a legal document, and a disabled child who no longer meets criteria.

Agencies will terminate an ineligible individual's coverage prospectively when notified within 30 days of the ineligible event date (i.e., divorce date). The coverage ends the last day of the month following receipt of the appropriate forms from the employee. The exception to prospective termination is termination of coverage for an ex-spouse or an ex -domestic partner, and their children who are not biological children or adopted children of the employee when notification is beyond 30 days from the event. In this case, PEBB coverage terminates retroactively to the last day of the month in which eligibility is lost. This is not considered a rescission. PEBB, not the agency, processes retroactive terminations.

> **Example 1:** Ann's divorce is final on June 6. On June 22, she submits the correct change form to her agency to remove her ex-spouse from coverage. The agency can process Ann's former spouse's termination from PEBB coverage effective June 30.
>
> **Example 2:** Mary's divorce is final on May 15. On July 1, Mary submits the correct change forms to her agency to remove her ex-spouse from coverage. The notification to the agency isn't within the allowable 30 days of the event date. The ex-spouse coverage must terminate retroactively. The agency will send Mary's forms to PEBB to process, and coverage will terminate May 31.

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

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

An employee's failure to report a family member's or domestic partner's loss of eligibility during the 12-month period before the start of each annual open enrollment period can result in civil or criminal charges against the employee for fraud or the intent to misrepresent the material facts of enrollment. To the extent allowed by law, PEBB may rescind coverage back to the last day of the month of the plan year when eligibility was lost. Rescission of coverage can occur to an employee, or an individual for whom the employee provides coverage. The following actions will occur during a rescission of coverage action taken by PEBB:

- PEBB or agency will provide at least 30 calendar days' advance notice of the rescission date to the ineligible individual. Coverage will rescind to the last day of the month and plan year in which the individual lost eligibility.
- PEBB or agency will include a notice of appeal rights with the rescission notice to the individual losing coverage.
- The agency may request premium refunds from PEBB or the Plan.
- An agency may determine that an employee must repay to the agency the state-funded premiums paid for coverage during the ineligible period.
- As contractually agreed to, a plan may determine that an employee must repay insurance claims paid by a plan for the ineligible individual during the ineligible period.
- An employee's agency can take disciplinary action against the employee for the employee's failure to remove an ineligible individual from coverage.
- The employee may have imputed value added to taxable income for premiums not refunded by the plans or repaid by the employee to the agency.

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

(a) The employee may choose, as a midyear plan change, an alternative PEBB plan to replace the terminated plan. If no alternative PEBB plan is available in the employee's service area, there is no coverage.

(b) The plan may retain all premiums paid and has the right to recover from the employee the benefits paid because of such wrongful activity that are in excess of the premiums.

(c) The plan may deny future enrollments of the individual.

HIPAA Special Enrollment Rights

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

If you previously declined enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a PEBB plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops

contributing toward the other coverage). Your coverage will be effective from the first day of the month of the other coverage loss.

Tag along rule applies. If you add a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents that were eligible but never enrolled previously. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact PEBB at (503) 373-1102, or email inquiries.pebb@state.or.us.

Appendix A (http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf) details QSCs and consistent benefit changes that may be made.

Ending Participation in PEBB

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

Returning to Work

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

Generally:

- An active eligible employee who is returning from a leave without pay (LWOP), but who has not been in a protected leave status such as FMLA, OFLA etc., and isn't in a current benefit eligible stability period must work at least half-time in the month of return to be eligible for benefits in the following month. The exception is an eligible employee in job share positions.

- An active eligible employee not in a current stability period returning from a reduction in hours below eligibility criteria must work at least half-time in the month of return to be eligible for benefits in the following month. The exception is an eligible employee in job share positions.
- A previous permanent, benefit eligible employee returning to a permanent benefit eligible position in paid regular status within 12 months of a core benefit coverage termination date following a layoff or termination of employment, is not required to work at least half time in the month they return to be eligible for benefits the following month. The agency will reinstate the previous plan enrollments, if available, effective the first of the month following the employee's return to work. The employee has 30 days to change reinstated benefit elections. Reinstatement excludes Flexible Spending Accounts, Long Term Care insurance, and Commuter accounts. NOTE: A stability period ends when there is a break in employment longer than 13 weeks. The employee's initial measurement period will start over.
- Flexible Spending Accounts, Long Term Care insurance, and Commuter accounts are never reinstated. The employee has 30 days from the date of rehire, or return to work, to change benefit elections. Long Term Care insurance can be reinstated as a payroll deduction if the employee continued the plan through portability. An exception occurs if the individual continued participation in a healthcare FSA while on COBRA or prepaid or made arrangements with the agency to pay the FSA prior to taking a FMLA leave. In this case, PEBB will reinstate the FSA.
- A previously benefit eligible employee returning to paid regular status in a benefit eligible position after a termination of core benefits of 12 months or longer must enroll as a newly eligible employee.

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