pebb
Public Employees' Benefit Board

Health Engagement Model (HEM)
Health Assessment Exemption Request

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Use this form if you are enrolling for the 2025 HEM program and believe you need an exemption from completing the required health assessment.

Exemption requests must be submitted for each new plan year. A previous year exemption approval IS NOT valid for 2025. This form must be submitted to PEBB.

To participate in HEM, you must complete the following before October 31, 2024:

1. **Enroll** in the 2025 HEM program during PEBB's Open Enrollment period (October 1 through October 31, 2024).
2. **Complete** an individual health assessment at your current PEBB medical plan's website between September 1 and October 31, 2024. (Contact PEBB if you do not have a 2024 PEBB medical plan.)

If you believe you cannot complete #2 because of one of the reasons specified below, complete and submit the form to PEBB between Sept. 1 to Oct. 31, 2024. PEBB will make a determination and notify you of your exemption status.

NOTE: A late submittal of this form to PEBB may not allow sufficient time to complete your health assessment if you are denied the exemption. There is no extension of timelines for the health assessment.

- If approved, you do not need to complete your PEBB medical plan's 2025 HEM health assessment.
- If the request is denied, and you enroll for the 2025 HEM program, you are responsible for completing your health assessment with your current medical plan carrier during the required time frame to be a participant (Sept. 1 to Oct. 31, 2024).

PEBB Subscriber (State employee or university employee):

PEBB will not know your HEM status for several weeks after Open Enrollment closes October 31, 2024.

First name: _____ Last name: _____

Date of birth: _____ Phone number: _____

My 2024 PEBB Medical Plan is: _____

Reason for exemption:

I am unable to complete the 2025 HEM requirements and requesting exemption for the following reason:
(Check only one. No other reasons are allowed.)

- ◯ Serving in the military overseas
- ◯ Out of the country
- ◯ Incarcerated
- ◯ Medical condition or disability (Don't include medical or disability information on this form)
- ◯ The health assessment does not meet my gender identity needs
- ◯ Religious beliefs

Employee signature and authorization

I understand if I enroll in the PEBB Health Engagement Model (HEM), I must complete the program requirements to be a HEM participant. I understand this request, if approved, exempts me from completing the required HEM program Health Assessment. My signature below confirms my agreement and that the information provided on this form is true.

I understand that:

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

☐ I certify under penalty of the State of Oregon laws that the foregoing is true and accurate to the best of my knowledge and belief, and I understand that they are subject to penalty for false claims.

Signature:_____ Date:_____

Submit form to:

PEBB
500 Summer St NE, E89
Salem, OR 97301
503-373-1102
Fax: 503-373-1654
pebb.benefits@odhsoha.oregon.gov