pebb
Public Employees' Benefit Board

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

2027 Medical Coverage Exception Form

PEBB is offering a one-time exception from November 1 – December 31, 2026, to members who did not complete Open Enrollment so that you will have medical coverage effective January 1, 2027.

Failure to return this form to PEBB Member Services by December 31, 2026, means I will not have a medical plan for 2027.

You may use this form to:

- Enroll in an available medical plan based on your current coverage.
- Opt out of medical coverage and receive the opt-out incentive, if eligible.

Important: This form does not give you another opportunity to change or correct your elections during the Open Enrollment correction period. You cannot add dependents. Dependents that you covered in 2026 will continue to be covered in 2027 unless you experience a qualified status change.

Section 1: Enrollment reason

☐ Medical Coverage Exception. I did not complete Open Enrollment and will not have medical coverage effective January 1, 2027, unless this form is completed and submitted to PEBB no later than December 31, 2026.

Section 2: Employee information

PEBB benefit number (P#########), OR#, University ID, or Lottery ID		Gender ☐ F ☐ M ☐ Other	Date of birth (mm/dd/yyyy)
Last name	First name		Middle
Work phone number	Home phone number (optional)	Cell phone number (optional)	
☐ Check if new address			
Address			Apartment or space #
City	State	ZIP	County
Personal email (optional)		Work email	
Are you Medicare eligible?			☐ Yes ☐ No
Are you serving or did you ever serve in the military?			☐ Yes ☐ No
If "Yes," do you authorize PEBB to send your name and address to the Oregon Department of Veterans' Affairs (ODVA) for the purpose of receiving benefit information?			☐ Yes ☐ No

Section 3: Medical coverage election

☐ **Opt Out of Medical Coverage**

I am choosing not to enroll in a PEBB medical plan. I understand that I must meet PEBB's opt-out requirements to receive the monthly opt-out incentive. By checking this box and signing this form, I certify that I meet the requirements below.

1. I and all other individuals for whom I reasonably expect to claim a personal tax exemption deduction have, or will have, alternative medical coverage considered to be minimum essential coverage through an employer sponsored medical plan. You do not need to provide proof of alternative medical coverage. See information at: PEBB Opt-Out and Decline information (PDF)
   - The following coverages are not eligible to Opt-Out against: Oregon Health Plan/Medicaid, Student Health, and individual market coverage.
2. I understand my employer will not pay the monthly opt-out payment to me if my employer knows or has reason to know that I or any other member of my expected tax family does not have or will not have the alternative coverage.
3. I understand that I must renew this attestation for each plan year and applicable tax year for which I want the Opt Out to apply.

By checking the opt-out box and signing the form I verify the above statements are true.

Section 4: Medical plan selection

Select a medical plan based on:

Your current coverage:

- **Currently enrolled in a Kaiser Permanente medical plan in 2026:** You must select a Kaiser Permanente medical plan for 2027.
- **Currently enrolled in a Moda or Providence medical plan or currently opted out in 2026:** You may select a Moda Health medical plan or opt out for 2027.

Your employment status:

- Full-time employees can only enroll in full-time plans.
- Part-time employees can only enroll in the same full-time or part-time option they have as of Dec. 31, 2026. If a part-time employee enrolls in full-time plans the part-time employee will not receive the part-time subsidy.

Medical plan selection	Full-time	Part-time
Kaiser Deductible (Kaiser vision included with full-time plan.)	☐	☐
Kaiser Traditional (HMO) (Kaiser vision included with full-time plan.)	☐	☐
Moda PPO	☐	☐
Moda Coordinated Care	☐	☐

If you enroll in the Moda Coordinated Care medical plan, each covered individual must use a PCP 360 for primary care to receive “in-network” benefits. If an individual receives services from a primary care provider that is not a PCP 360 with Moda, they will pay “out-of-network” cost-sharing. A list of PCP 360 providers can be found at: Moda Health provider search.

Section 5: Employee signature and authorization

I declare that the dependents listed as covered in 2026 and I are eligible for the coverage requested under Oregon Administrative Rule (OAR) Division 15. I have read the benefit materials, and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments to be deducted from my pay.

I understand that:

- The benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan.
- A person who knowingly makes a false statement in connection with an application for any benefit may be subject to penalty for false claims including, but not limited to termination of enrollment, denial of future enrollment, civil damages, imprisonment and fines.
- If I fail to report a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.
- I must submit a mid-year change form to my payroll office within 30 days of the date when an individual I provide coverage for is no longer PEBB eligible. If my notice is late, me and my qualified beneficiaries may lose the right to elect COBRA.
- This form supersedes all forms and submissions I have previously made regarding PEBB coverage for myself, and the individuals named above.
- I understand I must return this form to PEBB Member Services no later than December 31, 2026. Failure to do so means I will not have a medical plan for 2027.

☐ I certify under penalty of Oregon State law that the information I have provided within this application is true and accurate to the best of my knowledge and belief.

Employee signature	Date (mm/dd/yyyy)

Submit this completed form no later than December 31, 2026, to PEBB Members Services:

Email: pebb.benefits@odhsoha.oregon.gov

Fax: 503-373-1654

Mail: PEBB Member Services
500 Summer Street NE, E-89
Salem, OR 97301-1063

Please keep a copy of benefit documents for your records.