

Section 5: Required Notices

Plan Administration

Administrator Responsibilities

The plan administrator administers the plan in accordance with its terms for the exclusive benefit of participants and their covered spouses, domestic partners and dependents.

The plan administrator has authority to interpret or construe ambiguous, unclear or implied terms in the plan, make any findings of fact or law needed in the administration of the plan, determine eligibility of employees to participate in the plan and to receive benefits, and control and manage the operation and administration of the plan. This includes the authority to do the following:

- Establish the method of accounting and to maintain accounts under the plan;
- Prescribe any forms to administer the plan;
- Make and enforce rules (Oregon Administrative Rule Chapter 101) and regulations needed to implement and administer the plan;
- Appoint individuals to assist in the administration of the plan;
- Furnish administrative reports to the participating employer;
- Provide information required by law to employees, governmental agencies, or other persons entitled to benefits under the plan;
- Receive, review, and keep on file reports of benefits;
- Receive information from the participating employer and from participants for the efficient administration of the plan;
- Require participants to complete and file needed applications, forms, pertinent information and documents, including receipts, and the participant's current mailing address;
- Take needed actions to satisfy IRS Code requirements;
- Review claims or claims denials under the plan;
- Sign checks or other instruments incidental to the operation of the plan;
- Make needed amendments to the plan to carry out the intent of the employer legal requirements;
- Terminate the plan unless it is required to continue under either an applicable memorandum of understanding, resolution of PEBB, or both.

Any decision the plan administrator makes in the exercise of its authority is conclusive and binding.

Delegation of Authority

The plan administrator has the discretion to delegate others to act on behalf of the plan administrator including the authority to make any benefits determination, or to sign checks or other instruments incidental to the operation of the plan.

Information Required for Plan Administration

Participants and other persons entitled to benefits must furnish the administrator with information for the purpose of administering the plan.

Reliance

The administrator is entitled to rely on information furnished by a participant, participating employers, and any applicable provider or contract administrator.

Facility of Payment

When a person entitled to any benefits under the plan is legally disabled or unable to manage his financial affairs, the administrator may

- Direct payment of benefits to the person's legal representative or immediate relative or;
- Direct the application of the benefits for the benefit of the person as the administrator considers advisable. Any payment made will be a full and complete discharge of any liability for such payment under the plan.

Payment

Payment of any claim for benefits will be made to the participant unless he or she has previously authorized payment to a person rendering services, treatment, or supplies. If the participant dies before all benefits have been paid to the participant, the remaining benefits, if any, will be paid to the participant's estate or to any person or corporation that has been approved by the administrator to be entitled to payment. Such payment will fully discharge the plan's obligations with respect to that claim for benefits. If a participant is a minor, or not competent to give a valid receipt for payment of any benefit due to him under the plan and if no request for payment has been received from a duly appointed guardian or other legally appointed representative of that person, payment may be made directly to the individual or institution that has assumed the custody or the principal support of that person.

Subrogation

If any payment for benefits under the plan is paid, the plan will, to the extent of such payment, be subrogated to all the rights of recovery of the participant arising out of any claim or cause of action that may occur because of the negligence or willful misconduct of a third party. Each participant or his legal guardian agrees to reimburse the plan for amounts paid for such claims, out of any monies recovered from the third party, including but not limited to, any third-parties and the participant's own insurance company as the result of judgment, settlement or otherwise. In addition, each participant agrees to assist a Provider, the Contract administrator, or the plan administrator in enforcing these rights.

Right of Recovery

Whenever payments for a claim for benefits have been made in excess of the maximum limit for that claim under the plan, the plan will have the right to recover such amounts to the extent of the excess from whoever received the excess payment or the participant.

Government-provided Benefits

The plan does not provide benefits in lieu of, and does not affect any requirement for coverage by, any benefits provided under any federal, state or local government including, without limitation, any workers' compensation insurance or benefit.

Effect of Mistake

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

Insurance Contracts

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

Miscellaneous

Filing of Information

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

Addresses

Each participant must file the participant's contact address and any change of contact address with the administrator. The administrator will use the participant's last contact address.

Mistake of Fact

The administrator will correct any mistake of fact or misstatement of fact when it becomes known and when equitable and practical.

Employee Authorization of Payroll Deductions

The administrator may distribute and collect information or conduct transactions by means of electronic media, including electronic mail systems, Internet, or voice response system. By using electronic media, an employee consents to deductions from compensation in accordance with elections made through the systems and recording of telephone calls on the voice response system.

No Guarantee of Tax Consequences

Neither the plan administrator, the employer, nor any participating employer makes any warranty or other representation as to whether any payment received under the plan will be treated as excludable from the employee's gross income for federal, state, or local income tax purposes. It is the obligation of each Employee to determine whether each payment under the plan is excludable from the Employee's gross income for such purposes.

Quality of Health Services

The selection by the employer of the coverage that may be financed through the plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any health, dental, or vision care service provider, nor does the employer or any participating employer assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances.

Governing Law

The plan will be construed and enforced in accordance with the internal laws of the State of Oregon.

Conflicting Provisions of Component Plan

In the event of a direct conflict between the provisions of a component plan or the Summary Plan Description and the provisions of the plan, the provisions of the plan will prevail. Where terms and provisions specifically applicable to an individual component plan are not addressed in the plan document, such terms and provisions as set forth in the component plan document will govern.

Qualified Medical Child Support Order

The plan administrator will comply with the terms of a QMCSO.

Benefit Fraud or Abuse

Rights of the Medical Plans

Your medical plan has the right to investigate fraudulent or abusive use of your plan benefits. Your plan will notify you of an investigation. If the plan identifies what may be fraud or abuse by a member, it may cancel the member's coverage. If the plan identifies what may be fraud or abuse by one of your dependents, the carrier may remove the individual from coverage.

You will receive notification prior to cancellation or removal from coverage. You have the right to appeal the plan's action through the plan's appeal process. In some cases removal from a plan may be a qualified midyear plan change, contact your payroll or benefits office for more information.

Rights of PEBB

When you enroll in any PEBB benefits, you declare that you:

- Are eligible for the coverage requested on the enrollment form or in your online benefit record, as are the individuals you list for coverage
- Understand the benefit elections you make are in effect for as long as you continue to meet PEBB's eligibility requirements or until you elect to change them subject to the provisions of PEBB's plan
- Have read the benefit materials and understand the limitations and qualifications of the PEBB benefits program.
- Authorize premium payments to be deducted from your pay

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

Appeals

Benefit Plan Appeal Procedure

You must appeal benefit plan decisions directly to the plan. Follow the appeal rights and procedures in the plan's member handbook (sometimes called certificate or evidence of coverage). If you ask PEBB to review the plan's determination, PEBB will verify only that the plan's determination was within the scope of the current plan contract or request that the plan provide you more explanation of its determination. If it appears that the plan's determination is outside the scope of the contract, PEBB will ask the plan to review your appeal again.

Public Employees' Benefit Board Appeal

Eligible employees may submit appeal requests to PEBB concerning PEBB policy, eligibility, or plan enrollments. PEBB staff, the Operations Subcommittee, and the Board use relevant state and federal regulations, policy, PEBB's documented Internal Revenue Code (IRC) 125 Cafeteria plan, and Oregon Administrative Rules to provide appeal decisions.

PEBB does not accept appeals related to contracted plans or plan administrators, such as but not limited to medical, dental, life, disability, COBRA, and long term care, services, decisions, or claims.

If PEBB rescinds plan coverage due to an individual's ineligibility for coverage, the ineligible individual may appeal the rescission decision to PEBB using this rule. Until the appeal process for the rescission is exhausted, the individual's premium and claim payments will continue as if the rescission had not occurred. Upon final appeal determination, if the rescission is upheld the employee will be responsible to pay all claims and premium payments paid by the plan or PEBB during the period of ineligibility. Eligible employees, or individuals notified of coverage rescission, have four levels of PEBB appeal.

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

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

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

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

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

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

- An employee or individual requesting a Level Three review must submit the request in writing to the Plan Design Manager within 30 days of the Level Two determination letter date.
- The Subcommittee appeal determination requires a majority vote of the members. If an agreement cannot be reached, the appeal may be referred to the full Board. Decisions by the full Board require a majority vote. The appeals Subcommittee may render a decision to the employee or individual and also refer the issue to the full Board for a benefit policy review.
- The Operations Subcommittee may recommend a review and determination of the appeal by the Board without providing a decision to the employee or individual. The employee or individual will receive notice of the recommendation.
- When the Subcommittee completes a review, or in the case of a full Board review, the employee or individual will receive a written explanation and determination within 30 days after the next regularly scheduled meeting.

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

Federally Required Notices

Important Notice from PEBB about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Public Employees' Benefit Board (PEBB) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PEBB has determined that the prescription drug coverage offered by PEBB is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? Your current PEBB group coverage pays for other health care expenses, in addition to prescription drugs. If you decide to join a Medicare drug plan, your current PEBB group coverage will not be affected. However, if you decide to join a Medicare drug plan and drop your current PEBB group coverage, be aware that you and your dependents will lose health care and prescription drug coverage through PEBB and may not be able to get this coverage back prior to open enrollment or a change-in-status event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with PEBB and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or Your Current Prescription Drug Coverage: Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PEBB changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325 0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: Aug. 1, 2016. Name of Entity/Sender: PEBB. Contact: Benefits Manager
Address: 500 Summer St NE, Salem, OR 97301; Phone number: 503-373-1102.

Notice of Women’s Health and Cancer Rights Act

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator at 503-373-1102 for more information.

Special Enrollment Rights

Under the special enrollment provisions of HIPAA, you will be eligible, in certain situations, to enroll in a PEBB medical plan during the year, even if you previously declined coverage. This right extends to you and all eligible family members.

You will be eligible to enroll yourself (and eligible dependents) if, during the year you or your dependents have lost coverage under another plan because:

- Coverage ended due to termination of employment, divorce, death, or a reduction in hours that affected benefits eligibility;
- Employer contributions to the plan stopped;
- The plan was terminated;
- COBRA coverage ended; or
- The lifetime maximum for medical benefits was exceeded under the existing medical coverage option.

If you gain a new dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll that dependent, as well as yourself and any other eligible dependents, in the plan — again, even if you previously declined medical coverage. Coverage will be retroactive to the date of the birth or adoption for children enrolled during the year under these provisions.

You will also be eligible to enroll yourself and any eligible dependents if either of two events occurs: (1) You or your dependent loses Medicaid or Children’s Health Insurance Program (CHIP) coverage because of a loss of eligibility. (2) You or your dependent qualifies for state assistance in paying employer group medical plan premiums.

Regardless of other enrollment deadlines, you will have 60 days from the date of the Medicaid/CHIP event to request enrollment in the employer medical plan.

Please note that special enrollment rights allow you to either enroll in current medical coverage; or enroll in any medical plan benefit option for which you and your dependents are eligible.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP) If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-3272.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility – To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392
MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

COBRA Continuation Coverage Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or aren't required to pay*] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- [add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period*]

permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

PEBB Administrator
1225 Ferry St SE
Salem, Oregon 97301-3802
Phone: 503.373.1102

Please Note: Although BenefitHelp Solutions, Inc. has contracted with PEBB to provide various COBRA administrative services; BenefitHelp Solutions, Inc. is not the Plan Administrator. The Plan Administrator, PEBB, is the sponsor of the Plan.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by PEBB and how you can get access to this information.

The Public Employees' Benefit Board (PEBB) and the PEBB sponsored benefit plans respect the privacy of personal information about all eligible employees and retirees (PEBB members), including eligible family members (together, PEBB Participants), and will maintain confidentiality in a responsible and professional manner.

PEBB sponsors various benefit plans for the benefit of PEBB Members. Some of these benefit plans fall under the definition of "Health Plans" under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. The regulations address the privacy requirements related to the use of protected health information when PEBB is acting as a Plan Sponsor in relation to a Health Plan. PEBB is providing PEBB Members with this notice explaining how it uses, discloses and protects your medical or health information as a Plan Sponsor.

A separate Notice of Privacy Practices will be provided to you by your Health Plans.

For purposes of this notice, your Protected Health Information ("PHI") is information that identifies PEBB Participants and relates to a past, present or future physical or mental health condition; the provision of health care to you; or the past, present, or future payment for health care furnished to the PEBB Participant. PEBB is required by law to maintain the privacy of PHI and to provide PEBB Members with this notice of its legal duties and privacy practices with respect to PHI.

This notice does not apply to PEBB in its capacity of administering benefits that are not for health care benefits, such as life insurance, short term or long term disability insurance, long term care insurance, or accidental death & dismemberment insurance.

How information is collected and protected

As the Plan Sponsor, PEBB must collect a certain amount of PHI to provide customer service, offer new benefits, plans, products or services, administer its plans, and to fulfill legal and regulatory requirements. PEBB also collects information provided when the PEBB Member enrolls or makes changes to benefits. Examples include:

- PHI on enrollment forms and related forms, such as name, address, date of birth, gender, marital status.
- PHI about your relationship to benefit plans, including plans selected and enrollment and disenrollment information, and appeals about eligibility and contract coverage issues.
- Information from employer about eligibility dates.
- PHI from visits to PEBB's Websites, such as that provided through online forms, and online information-collecting devices known as "cookies." Cookies enable the site to remember who visits so navigating the site is

easier. They also permit you to access your secured information and conduct secured transactions. PEBB does not record personal or sensitive information in cookies.

This information is stored in the electronic benefit system, called “pebb dot benefits.” Your information is provided to the Health Plans you select for benefit coverage. The Health Plans collect and use this information to administer benefits and to pay claims for services PEBB Participants receive. PEBB ensures the security of your information through physical, technical and procedural safeguards. PEBB restricts the access to and use of confidential information by employees and has established internal policies and procedures to protect member confidential information from unauthorized disclosure.

How information is used or shared by PEBB

As the Plan Sponsor, PEBB transmits enrollment information to the Health Plans selected by the PEBB Member. Information is transmitted electronically through the pebb dot benefits system. Health Plans may disclose to PEBB information on whether an individual is participating in the plan, or is enrolled or has been disenrolled from the plan. In accordance with the HIPAA privacy regulations, PEBB provides for adequate separation between the Plan Sponsor and the Health Plans with regard to the use and disclosure of PHI. For that purpose, access to PHI for use as a Plan Sponsor is limited to the following employees or classes of employees of PEBB or designated individuals:

- Director of Operations or designees,
- Internal Auditors, including representatives of the Oregon Secretary of State when performing Health Plan audits, or
- The Department of Justice.

Access to PHI by the employees designated above is limited to the administrative functions that the employees perform for PEBB with regard to the member’s plan.

Plan administration functions that may involve PHI being provided to PEBB include the appeals under PEBB rules, where the individual asks PEBB to review a denial of insurance coverage or a PEBB Member asks PEBB to decide if the Health Plan acted in accordance with PEBB’s contract. Otherwise, PEBB is not involved in individual or member appeals.

PEBB will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit administered by PEBB.

The Health Plans may disclose summary health information to PEBB, if PEBB requests summary information for the purpose of (a) obtaining, terminating, or amending the agreements for providing coverage; or (b) modifying, terminating or amending the agreements. PEBB does not have access to your PHI held by a Health Plan. If you contact PEBB and provide PHI to PEBB, PEBB will refer that information to the Plan.

Your authorization is required for uses and disclosures of PHI other than those allowed or required by law. If you provide authorization for the use and disclosure of your information and later change your mind, you may revoke the authorization.

Review and access to information

PEBB Participants have the right to access PHI held by PEBB, receive a list of disclosures PEBB has made of PHI, request restriction on use or disclosure of PHI, or correction of incorrect information. You may submit a complaint if you believe PEBB has improperly used or disclosed your PHI or if you have concerns regarding PEBB’s privacy policies.

- PEBB Members may access, inspect and obtain a copy of their records through the electronic benefit system, pebb dot benefits.
- PEBB Participants may ask to review any information you believe may be on file at PEBB by submitting a written request with your signature to the PEBB Plan Design Manager. PEBB will respond to the request within

30 days. PEBB will either schedule an appointment for review of records on-site in the PEBB office, or will provide a photocopy of the requested record. PEBB may ask for reimbursement of copies made at your request.

- PEBB Participants may ask that PEBB restrict the use and disclosure of your individual information in the course of PEBB activities on your behalf; and to amend incorrect information held by PEBB.
- PEBB Members may correct information in their PEBB file by accessing their record in the electronic benefit system, pebb dot benefits during Open Enrollment, by submitting a Qualified Status Change (QSC) to your agency or to PEBB, or by filing an appeal. Any other request to correct information or to request a restriction should be made in writing to the PEBB Plan Design Manager. PEBB will consider the request, although PEBB is not required to agree to the request.
- You may request an accounting of disclosures of your personal information in writing to the PEBB Plan Design Manager. PEBB will provide a list of disclosures within 30 days of receipt of your request; however the list does not have to include PHI disclosures made to individuals about their own PHI or prior to the HIPAA compliance date.
- PEBB Participants have a right to receive a paper copy of this notice upon request at any time. Log on to <http://oregon.gov/das/pebb/privacy.shtml> to access this notice.

Notice about Request for Social Security Numbers

The Affordable Care Act (ACA) requires providers of employer-sponsored health plans to provide Social Security numbers of individuals covered in the plan to the IRS for tax-reporting purposes.

PEBB self-insures two of its medical plans – PEBB Statewide and Providence Choice; PEBB is considered the health plan provider for these plans. When an employee enrolls in either of these plans, we have access to the employee’s SSN through the employer. When the member covers dependents (including spouse/partner) in either of these plans, we must ask the employee for the dependents’ Social Security numbers (SSN).

Our fully insured plans through AllCare, Kaiser, and Moda request this information from employees enrolled in their plans.

There is no penalty for the employee, PEBB or the plan if the employee does not provide the information.

The IRS uses the SSNs to crosscheck that members had employer-sponsored health care coverage during the plan year and didn’t get a health care tax subsidy.

The IRS has posted helpful information about this request: <http://tinyurl.com/HealthSSNqa> and <http://tinyurl.com/HealthMayAsk>.

If you have any questions about this notice, contact the PEBB Plan Design Manager.

PEBB Plan Design Manager
1225 Ferry St SE
Salem, Oregon 97301-3802
Phone: 503.373.1102

If you believe PEBB has inappropriately disclosed your confidential information, you may file a written complaint with the PEBB Administrator.

PEBB Administrator
1225 Ferry St SE
Salem, Oregon 97301-3802
Phone: 503.373.1102

You may appeal to the full Board if the issue is not resolved at the Administrator level.

You have the right to file a complaint regarding how PEBB uses confidential information with the Privacy Officer of the State of Oregon, Department of Administrative Services (DAS).

DAS Privacy Officer
155 Cottage St. NE
Salem 97301-3972
Phone: 503.945.7296

You may also file a written complaint with the U.S. Department of Health and Human Services; Office of Civil Rights if you believe PEBB has violated your rights. PEBB will not take any action against you for filing a complaint.

Office for Civil Rights, Medical Privacy Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Phone: 866-627-7748 TTY 866-788-4989
Email: OCRComplaint@hhs.gov

Changes to Our Notice

This notice is effective on January 1, 2016. PEBB is required to abide by the terms of this notice until it is changed. We reserve the right the terms of this notice and to make the new notice effective for all PHI we maintain. Once revised, we will notify you that a change has been made through and post the notice on our website at <http://oregon.gov/das/pebb>.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the health insurance marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I save money on my health insurance premiums in the marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your

employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage v- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your agency human resources or benefits office.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit <http://HealthCare.gov> for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. Employer-sponsored health plans through PEBB meet the minimum value standard.