PUBLIC EMPLOYEES'
PEBB
BENEFIT BOARD

SUMMARY PLAN DESCRIPTION

Contents

Appendix A: Midyear Plan (Qualified Status) Changes

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
- The Oregon University System (OUS)
- Semi-independent state agencies.

The Oregon Administrative Rules 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 and 60.

Patient Protection and Affordable Care Act (ACA) Employer Shared responsibility

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.

For most permanent employees, Oregon state government offers health coverage through PEBB. Effective January 1, 2015 many temporary employees will be entitled to coverage under ACA employer shared responsibility regulations. Many of the new regulations apply to all employees regardless of employment type, permanent or temporary.
The following **ACA** employer shared responsibility definitions apply to all OSPS employees:

1. **Initial Measurement Period** means the 12 consecutive month period starting with the first day of the employee's employment
2. **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 (including disability and workers' compensation leave), 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.

3. **New Employee** means an employee who has not been employed in state service for at least one complete Standard Measurement Period.
4. **Ongoing Employee** means an employee who has been employed in state service for a least one complete Standard Measure Period
5. **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.
6. **Standard Measurement** period for the OSPS employees means a 12 consecutive month period starting November 1 and ending October 31.
7. **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 because the employee's hours are variable or otherwise uncertain.

An ***initial measurement*** period applies:

- To all new employees to state employment, regardless if 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.
- 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 they are responsible to pay. 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 vision. Must be enrolled in a medical plan choice 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 coverage (Other medical coverage does not include 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 medical opt out option 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 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 be in a job share position; or
- Be in a 0.5 FTE for unclassified OUS employees; or
- Work or receive 80 paid regular hours per month and be in a 0.5 FTE position for the Oregon Judicial Department: or
- Fit 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 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

  Note: To enroll in dental or vision an employee must be enrolled in a medical plan choice.
- 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. (Other medical coverage does not include 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 medical opt out option 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 returns from a 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 are not able to make benefit plan changes.

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

Returning reinstated 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

immediately 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 Resource 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 agency payroll, human resources or benefits office to discuss these issues prior to taking the leave. **This applies to all active benefit eligible employee types.**

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

Eligible Retirees

Active employees and eligible dependents enrolled in PEBB immediately prior to retirement may continue in PEBB medical and dental plans when they retire if they are not eligible for Medicare and meet eligibility for retiree coverage.

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

Medical and dental options

As a PEBB retiree, you may choose from all available medical and dental 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, or medical and dental coverage; however, when you choose only dental 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. The plan change period 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 conversion coverage or 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 does 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 all 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.

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 definition of a dependent child eligible for coverage. 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, adopted child or child placed for adoption, foster child or other legally placed child**; or
- The biological child of an eligible dependent child (a grandchild) and meets one of the following criteria:
  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, both the child's parent and the child live in the household of the eligible employee, and both receive more than half of their financial support from the employee; or
  2. The child is a grandchild of and lives with the eligible employee, and the employee is legally responsible for the welfare of the grandchild. The employee must provide legal documentation of guardianship, conservatorship or other custody documents upon enrollment. An employee who (1) gains legal responsibility and continues to have responsibility for a grandchild before the child reaches age 18, and (2) has provided continuous PEBB coverage since gaining legal responsibility for the child, can continue to provide PEBB coverage to the grandchild the same as if the child were a biological son or daughter beyond the age of 18. Eligible employees may

not add a grandchild age 19 or older to their PEBB coverage unless they can provide legal documentation for responsibility of the child beyond the age of 18.

3. **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*.

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.

Required Forms and Documentation

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 is not required; however court documents for the placement or guardianship are required)
- A ward of the court
- A child under legal guardianship or other court order
- An eligible grandchild

End of coverage: Coverage ends the last day of the month of when legal responsibility ends. The exception is a child that meets eligibility through the oldest allowable age, currently 26.

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, **when all the criteria in this section are met. To enroll for vision or dental coverage the child must be approved and enrolled in PEBB medical coverage.**

When the 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 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 coverage must continue until the employee's medical plan approves the child's health status as disabled 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 that the child must be the employee's *qualifying tax dependent*.
- The child's attending physician must submit to the subscriber's health plan verification and documentation of the child's disability.
- The physician must verify to the health plan that the disability existed before the child attained age 26 and the child is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

- The health plan provides a medical review of the physician's documentation and will notify PEBB of the plan's disability determination.
- 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.

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 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.

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 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.

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, or for enrollments requiring approval of medical history first of the month in the new plan year following plan approval.
Qualified Midyear Change Event, including special enrollment events. Subscribers have 30 days from the date of the event to submit forms.	**First day of the month following agency receipt of update form** Ineligible individual coverage termination dates are subject to form received date.	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 date form received
		Long term care insurance only: First of the month following agency receipt of the enrollment form and plan 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 know your plan choices before you enroll!

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 all required forms must be received by the agency 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. The Board also may require this of COBRA, Retiree, or Self Pay subscribers.** Employees who take no action during a required open enrollment period may be automatically defaulted 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 your agency before the enrollment will 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) 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. 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, which would include 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 is 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.

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 "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 coverage and to add or increase other coverage related to the addition of a dependent, such as adding optional Dependent 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 plan change allowance – 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 beyond 30 days from the event date.

What are 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 possible midyear change events. 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 PEBB coverage and termination of the spouse or partner from PEBB coverage is not allowed until a 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

The following midyear changes are specific for changes to FSA types:

Dependent Care flexible spending account (FSA) specific midyear changes 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 specific midyear changes

- 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/2015benefits/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 the 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.

When notified by the subscriber within 60 days of the ineligible individual's event date a COBRA notice of availability will be sent.

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 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 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/2015benefits/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 from the agency. Coverage will retroactively terminate to the date specified in non-payment letter. Generally, this date is the last day of the last period for which the required premium contribution was paid. .
- If the employee has a flexible spending account (FSA) or a Commuter account at the time benefits end.
- Self-pay individuals' and retired employees' benefits 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 return to work enrollment eligibility and 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), not in a protected leave status such as FMLA, and not 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 from a leave, 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 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.

Note: 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.

Section 2: Medical Benefits

Medical Plan Options

Each of PEBB's medical plans provides a member handbook (evidence of coverage, in the case of Kaiser Permanente) and summary of benefits and coverage (SBC) .They are incorporated in this Summary Plan Description by reference and are available for download as printable documents on the plans' websites. Carefully review the plans' member handbooks, SBCs and service areas to see which one best fits your and your family's healthcare needs.

- **Prescription Drug Coverage**. All the medical plans offered by PEBB include coverage for prescription drugs.
- **Routine Vision Care**. Employees and others who enroll in medical plans offered by PEBB may enroll in coverage for routine vision care. The exception is Kaiser full-time medical plans, which include routine vision care. See the Kaiser benefit summaries for information on routine vision care in those plans. See VSP Routine Vision Care for the summary of benefits in the other plans.

Health Maintenance Organization Plans

Health maintenance organization (HMO) plans offer a high level of service and benefits with low out-of-pocket copayments. To get benefits, you must use the providers and facilities that are part of the plan. You select a primary care provider within the HMO, who guides your care. If you seek care elsewhere, the plan may not pay or may pay a reduced amount.

PEBB sponsors the **Kaiser Permanente** HMO and Kaiser Deductible plans for those who live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the plan's member handbook (evidence of coverage) for details on these plans and coverage. Contact Kaiser Member Services for the ZIP codes in the service area.

Medical-home Plans

A medical home is a clinic staffed by health care professionals who work together as a team. Led by your primary provider, this team coordinates all of your health care, including referrals to outside providers or specialists when necessary. The team gives you connected health care by staying informed about and actively participating in all aspects of your care.

PEBB offers the AllCare PEBB, Balance by Trillium, Moda Summit and Synergy, and Providence Choice medical-home model plans in addition to the Kaiser plans. In these plans, you need to establish your medical home clinic and inform the plan of your selection of medical home to ensure you have access to the full benefits of your plan, including claims paid at the medical home benefit level and not the out-of-plan level. You may select different medical homes for yourself and your dependents.

Preferred Provider Organization Plans

Preferred provider organization (PPO) plans offer services and benefits at two coverage levels — from preferred providers and from non-preferred providers. PEBB offers the PEBB Statewide PPO plan in all parts of the state. You may use any doctors you wish. If you use doctors who are preferred (in-network), you pay less. If you use providers who are not preferred (out of network), you pay more. If you use providers who do not participate in the plan, the providers may bill you for amounts greater than allowed in the plan. If you use a state-recognized patient centered primary care home (PCPCH) that is in the Statewide Plan's network, your coinsurance rate for primary care services drops from 15% to 10%.

Health Improvement and Cost Containment Programs

The Board may institute health improvement and cost containment programs in the design of health plans. The goal of these programs is to assist the employer and employees to improve employee health and contain costs for health benefits. Examples are the Health Engagement Model program and the tobacco-use surcharge.

Medical Plan Premium Rates

2015 Employee Medical Plan Monthly Premium Rates				
	Employee	**Employee & Spouse/Partner**	**Employee & Children**	**Employee & Family**
Kaiser Deductible[2]	967.26	1,296.11	1,112.36	1,325.16
Kaiser HMO[2]	1,052.01	1,409.69	1,209.83	1,441.25
Moda Summit and Synergy[1]	954.26	1,278.70	1,097.40	1,307.34
Providence Choice[1]	913.67	1,224.29	1,050.73	1,251.70
PEBB Statewide PPO[1]	1,048.79	1,405.24	1,206.02	1,436.68
Kaiser Deductible Part-Time[4]	841.14	1,127.11	967.31	1,152.34
Kaiser HMO Part-Time[4]	890.59	1,193.38	1,024.17	1,220.09
Moda Summit/Synergy Part-Time[3]	773.24	1,036.15	889.22	1,059.34
PEBB Statewide PPO Part-Time[3]	851.99	1,141.56	979.74	1,167.14
Providence Choice Part-Time[3]	740.43	992.13	851.49	1,014.35

[1] Available to PEBB eligible full-time and part-time employees in plan's service area.

[2] Available to PEBB eligible full-time and part-time employees in plan's service area. Kaiser routine vision services.

[3] Additional option available to eligible part-time employees in plan's service area.

[4] Additional option available to eligible part-time employees in plan's service area. Vision exam only.

2015 Retiree Medical Plan Monthly Premium Rates					
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family	Child(ren) Only[5]
AllCare PEBB[1]	917.40	1,229.27	1,055.02	1,256.82	467.87
Balance by Trillium[1]	922.42	1,236.00	1,060.78	1,263.68	470.42
Kaiser HMO[2]	1,058.30	1,418.11	1,217.06	1,449.87	539.70
Kaiser Deductible[2]	973.04	1,303.86	1,119.01	1,333.08	496.22
Moda Summit & Synergy[1]	959.96	1,286.35	1,103.96	1,315.15	489.58
PEBB Statewide PPO[1]	$1,055.06	$1,413.64	$1,213.23	$1,445.27	$533.01
Providence Choice[1]	919.13	1,231.60	1,057.01	1,259.18	468.75
AllCare PEBB Part-Time[3]	734.42	984.08	844.60	1,006.13	374.55
Balance by Trillium Part-Time[3]	747.51	1,001.63	859.65	1,024.07	381.21
Kaiser HMO Part-time[4]	895.91	1,200.52	1,030.29	1,227.38	456.89
Kaiser Deductible Part-Time[4]	846.17	1,133.85	973.09	1,159.23	431.52
Moda Summit & Synergy Part-Time[3]	777.86	1,042.34	894.54	1,065.67	396.71
PEBB Statewide PPO Part-Time[3]	857.09	1,148.38	985.60	1,174.11	441.22
Providence Choice Part-time[3]	744.85	998.06	856.58	1,020.41	379.86

[1] Available to PEBB eligible retirees in plan service area. No vision benefit.

[2] Available to PEBB eligible retirees in plan service area. Kaiser vision coverage

[3] Additional option available to PEBB eligible retirees in plan service area. No vision benefit.

[4] Additional option available to PEBB eligible retirees in plan service area. Kaiser vision exam, only.

[5] Child(ren) Only coverage is available only to COBRA & Retiree participants.

2015 COBRA Medical Plan Monthly Premium Rates					
	Self	Self & Spouse/Partner	Self & Children	Self & Family	Child(ren) Only[6]
AllCare PEBB[1]	$930.12	$1,246.31	$1,069.64	$1,274.25	$474.36
Balance by Trillium[1]	935.21	1,253.13	1,075.49	1,281.20	476.94
Kaiser HMO[2]	1,072.97	1,437.77	1,233.93	1,469.96	547.18
Kaiser Deductible[2]	986.53	1,321.93	1,134.52	1,351.56	503.10
Moda Summit & Synergy[1]	973.27	1,304.18	1,119.26	1,333.38	496.36
PEBB Statewide PPO[1]	1,069.68	1,433.23	1,230.05	1,465.30	540.40
Providence Choice[3]	931.87	1,248.68	1,071.66	1,276.63	475.25
AllCare PEBB Part-Time[3]	744.60	997.72	856.31	1,020.08	379.74
Balance by Trillium Part-Time[3]	757.87	1,015.51	871.57	1,038.26	386.50
Kaiser HMO Part-Time[4]	908.33	1,217.16	1,044.57	1,244.40	463.23
Kaiser Deductible Part-Time[4]	857.90	1,149.56	986.58	1,175.30	437.50
Moda Part-Time[3]	788.64	1,056.79	906.94	1,080.44	402.21
PEBB Statewide Part-time PPO[3]	868.97	1,164.30	999.26	1,190.39	447.33
Providence Choice Part-time[3]	755.18	1,011.90	868.45	1,034.56	385.13

[1] Available to PEBB eligible participants. No vision benefits.

[2] Available to PEBB eligible participants in plan service area. Kaiser routine vision services.

[3] Additional option available to PEBB eligible participants. No vision benefit.

[4] Additional option available to PEBB eligible participants in plan service area. Vision exam, only

[6] Child(ren) Only coverage is available only to COBRA & Retiree participants.

PEBB 2015 Self-pay Participants Medical Plan Premium Rates				
	Self	Self & Spouse/Partner	Self & Children	Self & Family
AllCare PEBB[1]	922.25	1,232.27	1,059.05	1,259.66
Balance by Trillium[1]	927.24	1,238.96	1,064.78	1,266.47
Kaiser HMO[2]	1,062.31	1,419.99	1,220.13	1,451.55
Kaiser Deductible[2]	977.56	1,306.41	1,122.66	1,335.46
Moda Summit & Synergy[1]	964.56	1,289.00	1,107.70	1,317.64
PEBB Statewide PPO[1]	$1,059.09	$1,415.54	$1,216.32	$1,446.98
Providence Choice[1]	923.97	1,234.59	1,061.03	1,262.00

[1] Available to PEBB eligible participants in plan service area. No vision benefits.

[2] Available to PEBB eligible participants in plan service area. Kaiser routine vision benefits.

Medical Plans Comparisons

Medical plans comparisons for 2015 medical plans are located here: http://www.oregon.gov/DAS/PEBB/2015Benefits/15FinalMedCompare.pdf. They are incorporated here by reference.

Section 3: Dental Benefits

Dental Plan Options

Eligible members are ***not required*** to enroll in a dental plan when they enroll in a medical plan. They can enroll in a dental plan if they enroll in a medical plan. Here are things to know:

- Your employee premium share will be the same percentage in both medical and dental coverage.
- There is no combined medical-dental opt-out payment, even if you have other dental coverage.
- Full-time employees may enroll only in a full-time dental plan; part-time employees may enroll in a full-time medical or part-time medical plan.
- Your dental plan carrier can be different from your medical plan carrier (Moda and Kaiser).
- You may enroll all, any or none of your eligible dependents in dental coverage.

PEBB sponsors three types of dental plan designs: a traditional plan design offered by Kaiser Permanente and one administered by Moda ODS; a preferred provider dental plan design administered by ODS; and a dental health maintenance organization plan design from Willamette Dental. To enroll in the Kaiser Permanente dental plan you must live or work (at least 50 percent of the time) in the Kaiser service area (refer to the plan's evidence of coverage).

Each of PEBB's dental plans provides a member handbook (also called certificate or evidence of coverage) and benefit summary. They are incorporated in this Summary Plan Description by reference and are available for download as printable documents on each plan's website. Carefully review the plans' member handbooks and service areas to see which one best fits your and your family's dental care needs. Links to the dental plans' customer service contacts and member handbooks are on the PEBB website: www.oregon.gov/das/pebb.

Please Note: During the annual Open Enrollment, if you enroll in an ODS (Moda) dental plan (after you were first eligible), you may have waiting periods for major services and orthodontia.

2015 Full-time Dental Plans Comparison (available to full-time and part-time employees)					
Plan	**ODS (Moda) PPO[1, 2]**		**ODS (Moda) Premier[2]**	**Willamette Dental**	**Kaiser Dental**
Provider	**In-Network**	**Out-of-Network**	**Participating**	**Willamette**	**Kaiser**
Benefits					
Annual max coverage	$1,750	$1,750	$1,750	None	$1,750
Deductible person /family	$50/$150	$50/$150	$50/$150	None	None
Diagnostic, preventive	0%	10%	0%	$5 copay	0%
Basic, maintenance	20%	30%	20%	$5 copay	20%
Crowns	50%	50%	50%	$190 copay[3]	25%
Implants	50%	50%	50%	Varies	50%
Dentures	50%	50%	50%	$190 copay[3]	50%
Orthodontia	50% to $1500[4]	50% to $1500[4]	50%[4]	$1500 copay3	50% to $1500

[1]You have higher savings in the PPO plan than in the Premier plan. PPO dentists accept contracted fees as full payment for services, so you usually pay less for each visit and are protected from balance billing. Benefits start at 80% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

[2]***Individuals who enroll for coverage in this plan during an open enrollment period after they were initially eligible may have a 12-month waiting period for basic and major services and a 24-month waiting period for orthodontia. See the plan member handbook for details.***

[3] $5 office visit copayment due at each visit.

[4] Lifetime maximum of $1500; not included in annual maximum.

2015 Part-time Dental Plans Comparison (available only to part-time employees)		
Plan	**ODS (Moda) Part Time[1]**	**Kaiser Part Time**
Provider	**Participating**	**Kaiser**
Benefits		
Annual maximum coverage	$1250	$1250
Deductible per person	$50	None
Diagnostic, preventive	0%	0%[2]
Basic, maintenance	50%	50%
Crowns	50%	50%
Implants	Not covered	Not covered
Dentures	50%	50%
Orthodontia	Not covered	Not covered

[1]***Individuals who enroll for coverage in this plan during an open enrollment period after they were initially eligible may have a 12-month waiting period for basic and major services. See the plan member handbook for details.***

[2]Not applied to annual maximum coverage.

2015 COBRA Dental Plan Monthly Premium Rates					
	Self	**Self & Spouse/Partner**	**Self & Children**	**Self & Family**	**Child(ren) Only**
ODS PPO [1]	$81.18	$108.77	$93.35	$111.23	$42.23
ODS Premier [2]	87.87	117.77	101.07	120.40	45.69
Kaiser Permanente [3]	86.77	116.26	99.79	118.88	45.12
Willamette Dental Group[4]	76.56	102.60	88.05	104.90	39.81
ODS Part-time [5]	63.24	84.74	72.72	86.64	32.89
Kaiser Permanente Part-time [6]	64.63	86.61	74.32	88.57	33.61

[1] Available to PEBB eligible participants.

[2] Available to PEBB eligible participants.

[3] Available to PEBB eligible participants in plan service area.

[4] Available to PEBB eligible participants; in plan facilities.

[5] Additional option available to PEBB eligible participants.

[6] Additional option available to PEBB eligible participants in plan service area.

2015 Retiree Dental Plan Monthly Premium Rates					
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family	Child(ren) Only
ODS PPO [1]	$80.07	$107.28	$92.07	$109.71	$41.65
ODS Premier [2]	86.67	116.16	99.69	118.76	45.07
Kaiser Permanente [3]	85.59	114.68	98.42	117.25	44.50
Willamette Dental Group[4]	75.52	101.20	86.85	103.46	39.27
ODS Part-time [5]	62.38	83.58	71.73	85.46	32.44
Kaiser Permanente Part-time [6]	63.75	85.43	73.31	87.35	33.15

[1] Available to PEBB eligible retirees.

[2] Available to PEBB eligible retirees.

[3] Available to PEBB eligible retirees in plan service area.

[4] Additional option available to eligible retirees; in plan facilities.

[5] Additional option available to eligible retirees.

[6] Additional option available to eligible retirees in plan service area.

PEBB 2015 Self-pay Participants Dental Plan Premium Rates				
	Self	Self & Spouse/Partner	Self & Children	Self & Family
ODS (Moda) PPO [1]	$79.60	$106.64	$91.52	$109.05
ODS (Moda) Premier [1]	86.15	115.47	99.09	118.05
Kaiser Permanente [2]	85.08	113.99	97.84	116.55
Willamette Dental Group[3]	75.07	100.60	86.33	102.85
ODS Part-time [4]	79.60	106.64	91.52	109.05
Kaiser Permanente Part-time [5]	86.15	115.47	99.09	118.05

[1] Available to PEBB eligible self-pay participants.

[2] Available to PEBB eligible self-pay participants in plan service area

[3] Available to PEBB eligible self-pay participants in plan facilities

[5] Additional option available to eligible self-pay participants.

[6] Additional option available to eligible self-pay participants in plan service area.

Dental Plans Comparison

The tables below allow you to compare PEBB's dental plan options on a side-by-side basis. This is a high level summary only. See plan documents for details. **NOTE**: Full-time employees may not enroll in the part-time plans.

Active Employees					
2015 Full-time Dental Plans Comparison (available to full-time and part-time employees)					
Plan	**ODS (Moda) PPO[1, 2]**		**ODS (Moda) Premier[2]**	**Willamette Dental**	**Kaiser Dental**
Provider	**In-Network**	**Out-of-Network**	**Participating**	**Willamette**	**Kaiser**
Benefits					
Annual max coverage	$1,750	$1,750	$1,750	None	$1,750
Deductible person /family	$50/$150	$50/$150	$50/$150	None	None
Diagnostic, preventive	0%	10%	0%	$5 copay	0%
Basic, maintenance	20%	30%	20%	$5 copay	20%
Crowns	50%	50%	50%	$190 copay[3]	25%
Implants	50%	50%	50%	Varies	50%
Dentures	50%	50%	50%	$190 copay[3]	50%
Orthodontia	50% to $1500[4]	50% to $1500[4]	50%[4]	$1500 copay3	50% to $1500

[1]You have higher savings in the PPO plan than in the Premier plan. PPO dentists accept contracted fees as full payment for services, so you usually pay less for each visit and are protected from balance billing. Benefits start at 80% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

[2]***Individuals who enroll for coverage in this plan during an open enrollment period after they were initially eligible may have a 12-month waiting period for basic and major services and a 24-month waiting period for orthodontia. See the plan member handbook for details.***

[3] $5 office visit copayment due at each visit.

[4] Lifetime maximum of $1500; not included in annual maximum.

Active Employees		
2015 Part-time Dental Plans Comparison (available only to part-time employees)		
Plan	**ODS (Moda) Part Time[1]**	**Kaiser Part Time**
Provider	**Participating**	**Kaiser**
Benefits		
Annual maximum coverage	$1250	$1250
Deductible per person	$50	None
Diagnostic, preventive	0%	0%[2]
Basic, maintenance	50%	50%
Crowns	50%	50%
Implants	Not covered	Not covered
Dentures	50%	50%
Orthodontia	Not covered	Not covered

[1]***Individuals who enroll for coverage in this plan during an open enrollment period after they were initially eligible may have a 12-month waiting period for basic and major services. See the plan member handbook for details.***

[2]Not applied to annual maximum coverage.

Retiree

Full-Time Dental Plans Comparison					
Plan	**ODS (Moda) PPO[1],**		**ODS (Moda) Premier**	**Willamette Dental**	**Kaiser Dental**
Provider	**In-Network**	**Out-of-Network**	**Participating**	**Willamette**	**Kaiser**
Benefits					
Annual maximum coverage	$1,750	$1,750	$1,750	None	$1,750
Deductible per person /family	$50/$150	$50/$150	$50/$150	None	None
Diagnostic, preventive	0%	10%	0%	$5 copay	0%
Basic, maintenance	20%	30%	20%	$5 copay	20%
Crowns	50%	50%	50%	$190 copay[3]	25%
Implants	50%	50%	50%	Varies	50%
Dentures	50%	50%	50%	$190 copay[3]	50%
Orthodontia	50% to $1500[4]	50% to $1500[4]	50%[4]	$1500 copay[3]	50% to $1500

[1]You have higher savings in the PPO plan than in the Premier plan. PPO dentists accept contracted fees as full payment for services, so you usually pay less for each visit and are protected from balance billing. Benefits start at 80% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

[2]You cannot enroll dependents in dental coverage during the plan change period.

[3]$5 office visit copayment due at each visit.

4Lifetime maximum of $1500; not included in annual maximum.

Retiree		
Part-Time Dental Plans Comparison		
Plan	**ODS (Moda) Part Time [1]**	**Kaiser Part Time**
Provider	**Participating**	**Kaiser**
Benefits		
Annual maximum coverage	$1250	$1250
Deductible per person	$50	None
Diagnostic, preventive	0%	0%[2]
Basic, maintenance	50%	50%
Crowns	50%	50%
Implants	Not covered	Not covered
Dentures	50%	50%
Orthodontia	Not covered	Not covered

[1]Individuals who enroll for coverage in this plan during an open enrollment period after they were initially eligible may have a 12 month waiting period for basic and major services. See the plan member handbook for details.

[2]Not applied to annual maximum coverage.

Section 4: Optional Benefits

PEBB offers eligible employees the opportunity to select optional benefits. This section summarizes the following plans.

- **Optional Employee and Spouse or Domestic Partner Life Insurance** (beyond the employer-provided $5,000 basic employee insurance) for the employee, the employee's spouse or domestic partner
- **Dependent Life Insurance for the employee's spouse or domestic partner,** and eligible children
- **Short and Long Term Disability Insurance** for the employee only. (This option is not available for seasonal or intermittent employees.)
- **Accidental Death and Dismemberment Insurance** for the employee, or the employee and eligible dependents
- **Healthcare and Dependent Care Flexible Spending Accounts (FSAs)**
- **Long Term Care Insurance** for the employee, spouse or domestic partner, dependents and certain extended family members

The employer provides no benefit amount toward the cost of optional benefits. Optional benefits are voluntary choices you purchase on your own. Monthly premium payments or contributions for these benefits are your responsibility. When optional benefits become effective, your payroll deducts the insurance premium or FSA contribution from your pay. Your pay stub or statement shows the monthly deductions.

Life Insurance

This subsection summarizes the group Optional Life Insurance plan available through PEBB. It is a summary only. For full details, see the Certificate of Insurance on the PEBB website. The controlling provisions of the plan are in the group policy issued by Standard Insurance Company. The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Life insurance, you must be one of the following:

- An active employee of the State of Oregon who is regularly scheduled to work and who meets the terms of eligibility outlined in the PEBB Administrative Rules.
- A retiree of the State of Oregon who:
  - Retired under the employer's retirement plan during the month of December 2001 and whose insurance under the group policy as an active employee terminated on or after January 1, 2002; or
  - Retired under the Employer's retirement plan on or after January 1, 2002, and was insured as an active employee under the group policy on the day before retirement.

The following dependents are eligible for coverage if they meet eligibility requirements of the PEBB Administrative rules:

- Spouse
- Domestic partner
- Your child or your spouse's or domestic partner's child

Employees and dependents who are full-time members of the armed forces of any country are not eligible for coverage.

Amounts of Life Insurance for Active Employees

Basic Life Insurance for Active Employees: $5,000. This coverage is part of core benefits for which employees pay a share of premium.

Optional Life Insurance for Active Employees and their Spouse or Domestic Partner:

- Employee: Any multiple of $20,000, up to $600,000. You pay the premiums. Newly eligible employees have a guarantee issue choice (medical history not required) of $20,000 or $40,000 if enrolled within 30 days of eligibility.
- Spouse or domestic partner: Any multiple of $20,000, up to $400,000. You pay the premiums. Newly eligible spouse or domestic partners have a guarantee issue (medical history not required) of $20,000 if enrolled within 30days of eligibility

Note: If you are covered as both an employee and a spouse or domestic partner, the combined maximum amount is $600,000.

Dependent Life Insurance for Spouse or Domestic Partner and Eligible Children of Active Employees: $5,000. You pay the premiums. The rate is $1.29 per month to cover all PEBB eligible dependents.

Evidence of Insurability

Evidence of insurability is required when you apply for:

- Any amount of coverage more than 30 days after becoming eligible for the coverage.
- More than the guarantee issue amount of $40,000 of Employee Optional Life coverage when you are first eligible to apply.
- More than the guarantee issue amount of $20,000 of Spouse or Domestic Partner Optional Life coverage when you are first eligible to apply.
- An elective increase in coverage.
- Re-application for coverage that has lapsed.
- Re-application after converting coverage to an individual policy.

Coverage during Retirement

If you are insured for life insurance under this program immediately prior to your retirement under the State of Oregon's retirement plan, you may elect to continue up to 50 percent of the total amount of your Employee Basic and Optional Life insurance in effect on the day before your retirement (in increments of $2,500 not to exceed $200,000). You must apply to the plan for coverage within 30 days after your retirement and agree to pay the cost of coverage.

At age 65 and older, the amount available to you as a retiree decreases to a percentage of the amount determined above, as follows:

Your Age	Percentage
65 – 69	65%
70 – 74	50%
75 or older	35%

Your spouse or domestic partner and any children are not eligible for coverage during your retirement.

Note: If you return to work and become eligible for coverage as an active employee, your retiree coverage will end.

Effective Date of Coverage

Basic Life Insurance for Employees: The day when your PEBB medical or dental coverage becomes effective.

Optional Life Insurance for Employee and Spouse or Domestic Partner:

- **For amounts that do not require evidence of insurability:** The first day of the calendar month following the date you enroll for the coverage.
- **For amounts subject to evidence of insurability:** The first day of the calendar month following the date The Standard approves evidence of insurability.

Dependent Life Insurance for Spouses/Domestic Partners and Children: The first day of the calendar month following the date you enroll for the coverage.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective. If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively At Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work.

Additional Benefits

Repatriation Benefit for Employees: If you die while more than 200 miles away from home, The Standard will pay an additional benefit to reimburse the cost to transport your body to a mortuary near your home, up to the lesser of $5,000 or 10 percent of the life insurance benefit payable for your death. The Standard will pay the benefit to the person who incurs the costs of transportation.

Travel Assistance Benefit: The Standard includes a travel assistance program that provides a full range of 24-hour medical, legal and travel assistance services to you and your dependents when you travel more than 100 miles from home or in a foreign country. Download the brochure www.standard.com/eforms/12092.pdf and certificate www.standard.com/eforms/12061.pdf.

Designating a Beneficiary

When you enroll for coverage, you should name a beneficiary or beneficiaries to receive death benefits. You may do this online or by completing the appropriate form. Your designation must be dated and delivered to your employer during your lifetime. If you name more than one beneficiary, they will share equally unless you specify otherwise. You may change beneficiaries at any time without the consent of the beneficiary.

If you do not name a beneficiary or your named beneficiary dies before you, The Standard will pay benefits in equal shares to the first surviving of the following: your spouse; your children; your parents; your estate. You are the beneficiary of benefits paid on the death of your spouse or domestic partner or child.

Payment of Benefits

For amounts less than $10,000, The Standard issues a check to the beneficiary. The Standard pays amounts of $10,000 or more to the beneficiary by depositing funds into Standard Secure Access — a no fee, interest-bearing draft account. The beneficiary receives a personalized checkbook and has complete control of the account. Beneficiaries can write checks as needed or for the full amount. This arrangement allows beneficiaries to earn interest on the benefit while they consider financial decisions.

Coverage during Total Disability

If you become totally disabled (as determined by The Standard) while insured as an active employee under the group policy and while under age 60, you may continue your coverage without payment of premium. You must provide The Standard with satisfactory proof of your continuing total disability, and you must remain totally disabled during a six-month waiting period. If The Standard approves your claim, The Standard will refund premiums paid during the waiting period.

So long as you remain totally disabled and eligible for coverage under this provision, you will not be required to pay premiums, and your coverage will continue through your lifetime.

Totally Disabled means you are unable, as a result of sickness or accidental injury, to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

Accelerated Benefit

If you qualify for continued benefits during total disability and you are terminally ill with a life expectancy of 12 or fewer months, you may be eligible to receive up to 75 percent of your Basic and Optional Life coverage (to a maximum of $450,000).

This benefit allows you to use the proceeds as you desire. The amount of life insurance payable upon your death is reduced by the accelerated benefit paid and an interest charge. However, The Standard will pay at least 10 percent of the original life coverage amount at that time even if interest charges on the accelerated amount would have exhausted the remaining benefits over time. If you recover from your condition after receiving this benefit, *The Standard will not ask you for a refund.*

*C*ontinuation of Insurance if Employment Ends (Portability)

If your employment ends you may be eligible to continue your Optional Life coverage. You must apply to The Standard within 60 days following the date your employment ends.

You may continue any multiple of $20,000, up to the amount of your Optional Life Insurance in effect on the date your employment ends. If you elect to continue your Optional Life, you also may elect to continue any multiple of $20,000 of your spouse or domestic partner Optional Life insurance coverage, up to the amount in effect on the date your employment ends. You may not continue coverage under this provision if you are retiring or are totally disabled, or if you convert your coverage to an individual policy.

Coverage continued under this provision will be subject to all terms of the group policy.

Note: If you die, your spouse or domestic partner may continue his or her Optional Life Insurance.

Right to Convert

If your coverage or a dependent's coverage ends or is reduced, you may be eligible to convert the terminated amounts to certain types of individual life insurance policies without providing evidence of insurability. You must apply and pay premiums within 60 days after group coverage ends or is reduced.

You may not convert coverage amounts for which you have received an accelerated benefit.

Suicide Exclusion

The suicide exclusion applies to Optional Life insurance for yourself and your spouse or domestic partner. If the death results from suicide or other intentionally self-inflicted injury while sane or insane, The Standard will not pay amounts that have not been continuously in effect for at least two years on the date of death.

When Coverage Ends

Your Basic and Optional Life coverage ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid (except if premiums are waived while you are totally disabled)
- The date you cease to meet the terms of eligibility outlined in PEBB Administrative Rules
- The date you become a full-time member of the armed forces
- The date the group policy ends.

Optional life insurance for your spouse or domestic partner and dependent life insurance ends automatically on the earliest of the following:

- The date you cease to be insured
- Five months after the date you die (no premiums are charged for this period of coverage)
- The date the last period ends for which a premium was paid for the coverage
- The last day of the month in which a dependent loses eligibility under PEBB Administrative Rules
- For a child who is disabled, 90 days after The Standard mails you a request for proof of disability and you do not provide this proof.

Claims

To make a claim, the claimant must submit to The Standard proof that a death or total disability occurred and any other information The Standard may reasonably require in support of the claim. For a claim for continued coverage during total disability, The Standard may have you examined by a specialist of The Standard's choice at reasonable intervals. For death claims, The Standard may have an autopsy performed at The Standard's expense, except where prohibited by law.

The Standard will provide the claimant a written decision on the claim within a reasonable time after The Standard receives the claim. If the claimant does not receive a decision from The Standard within 90 days, the claimant can request a review as if the claim were denied.

If The Standard denies any part of the claim, The Standard will provide the claimant a written notice of denial containing the reasons for the decision, reference to the parts of the group policy supporting the decision, a description of any additional information needed to support the claim, and information on the claimant's right to a review of the decision.

If the claimant wants The Standard to conduct a review of the denial, the claimant:

- Must request the review in writing within 60 days after receiving notice of the denial.
- May include written comments or other items to support the claim.
- May review any non-privileged information that relates to the request for review.

The Standard will review the claim promptly after receiving the request. The Standard will send the claimant a notice of the final decision within 60 days after receiving the request for review, or within 120 days if special circumstances require an extension. The notice will include the reasons for the decision and will refer to the relevant parts of the group policy that support the decision.

Monthly Premium Rates

Premium rates are determined by age band for covered individuals and by tobacco-use status. Covered individuals who have used tobacco in the 12 months prior to enrollment have higher premium rates. Current rates are shown on the following pages.

Employee Optional Life Insurance Monthly Premium Rates (Non-Tobacco)

Rate per $10,000 by Age Band												
Age band	**Thru 24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75 & up**
Rate per $10,000	$0.40	$0.48	$0.62	$0.69	$0.75	$1.18	$1.74	$3.30	$5.13	$9.95	$16.30	$16.40
Calculated Rate by Age Band												
$20,000	$0.80	$0.96	$1.24	$1.38	$1.50	$2.36	$3.48	$6.60	$10.26	$19.90	$32.60	$32.80
$40,000	$1.60	$1.92	$2.48	$2.76	$3.00	$4.72	$6.96	$13.20	$20.52	$39.80	$65.20	$65.60
$60,000	$2.40	$2.88	$3.72	$4.14	$4.50	$7.08	$10.44	$19.80	$30.78	$59.70	$97.80	$98.40
$80,000	$3.20	$3.84	$4.96	$5.52	$6.00	$9.44	$13.92	$26.40	$41.04	$79.60	$130.40	$131.20
$100,000	$4.00	$4.80	$6.20	$6.90	$7.50	$11.80	$17.40	$33.00	$51.30	$99.50	$163.00	$164.00
$120,000	$4.80	$5.76	$7.44	$8.28	$9.00	$14.16	$20.88	$39.60	$61.56	$119.40	$195.60	$196.80
$140,000	$5.60	$6.72	$8.68	$9.66	$10.50	$16.52	$24.36	$46.20	$71.82	$139.30	$228.20	$229.60
$160,000	$6.40	$7.68	$9.92	$11.04	$12.00	$18.88	$27.84	$52.80	$82.08	$159.20	$260.80	$262.40
$180,000	$7.20	$8.64	$11.16	$12.42	$13.50	$21.24	$31.32	$59.40	$92.34	$179.10	$293.40	$295.20
$200,000	$8.00	$9.60	$12.40	$13.80	$15.00	$23.60	$34.80	$66.00	$102.60	$199.00	$326.00	$328.00
$220,000	$8.80	$10.56	$13.64	$15.18	$16.50	$25.96	$38.28	$72.60	$112.86	$218.90	$358.60	$360.80
$240,000	$9.60	$11.52	$14.88	$16.56	$18.00	$28.32	$41.76	$79.20	$123.12	$238.80	$391.20	$393.60
$260,000	$10.40	$12.48	$16.12	$17.94	$19.50	$30.68	$45.24	$85.80	$133.38	$258.70	$423.80	$426.40
$280,000	$11.20	$13.44	$17.36	$19.32	$21.00	$33.04	$48.72	$92.40	$143.64	$278.60	$456.40	$459.20
$300,000	$12.00	$14.40	$18.60	$20.70	$22.50	$35.40	$52.20	$99.00	$153.90	$298.50	$489.00	$492.00
$320,000	$12.80	$15.36	$19.84	$22.08	$24.00	$37.76	$55.68	$105.60	$164.16	$318.40	$521.60	$524.80
$340,000	$13.60	$16.32	$21.08	$23.46	$25.50	$40.12	$59.16	$112.20	$174.42	$338.30	$554.20	$557.60
$360,000	$14.40	$17.28	$22.32	$24.84	$27.00	$42.48	$62.64	$118.80	$184.68	$358.20	$586.80	$590.40
$380,000	$15.20	$18.24	$23.56	$26.22	$28.50	$44.84	$66.12	$125.40	$194.94	$378.10	$619.40	$623.20
$400,000	$16.00	$19.20	$24.80	$27.60	$30.00	$47.20	$69.60	$132.00	$205.20	$398.00	$652.00	$656.00
$420,000	$16.80	$20.16	$26.04	$28.98	$31.50	$49.56	$73.08	$138.60	$215.46	$417.90	$684.60	$688.80
$440,000	$17.60	$21.12	$27.28	$30.36	$33.00	$51.92	$76.56	$145.20	$225.72	$437.80	$717.20	$721.60
$460,000	$18.40	$22.08	$28.52	$31.74	$34.50	$54.28	$80.04	$151.80	$235.98	$457.70	$749.80	$754.40
$480,000	$19.20	$23.04	$29.76	$33.12	$36.00	$56.64	$83.52	$158.40	$246.24	$477.60	$782.40	$787.20
$500,000	$20.00	$24.00	$31.00	$34.50	$37.50	$59.00	$87.00	$165.00	$256.50	$497.50	$815.00	$820.00
$520,000	$20.80	$24.96	$32.24	$35.88	$39.00	$61.36	$90.48	$171.60	$266.76	$517.40	$847.60	$852.80
$540,000	$21.60	$25.92	$33.48	$37.26	$40.50	$63.72	$93.96	$178.20	$277.02	$537.30	$880.20	$885.60
$560,000	$22.40	$26.88	$34.72	$38.64	$42.00	$66.08	$97.44	$184.80	$287.28	$557.20	$912.80	$918.40
$580,000	$23.20	$27.84	$35.96	$40.02	$43.50	$68.44	$100.92	$191.40	$297.54	$577.10	$945.40	$951.20
$600,000	$24.00	$28.80	$37.20	$41.40	$45.00	$70.80	$104.40	$198.00	$307.80	$597.00	$978.00	$.00984

Employee Optional Life Insurance Monthly Premium Rates (Tobacco)

Rate per $10,000 by Age Band												
Age band	**Thru 24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75 & up**
Rate per $10,000	$0.40	$0.48	$0.62	$0.69	$0.75	$1.18	$1.74	$3.30	$5.13	$9.95	$16.30	$16.40
Calculated Rate by Age Band												
$20,000	$1.28	$1.48	$1.92	$2.12	$2.32	$3.56	$5.24	$9.60	$14.80	$27.80	$44.00	$43.00
$40,000	$2.56	$2.96	$3.84	$4.24	$4.64	$7.12	$10.48	$19.20	$29.60	$55.60	$88.00	$86.00
$60,000	$3.84	$4.44	$5.76	$6.36	$6.96	$10.68	$15.72	$28.80	$44.40	$83.40	$132.00	$129.00
$80,000	$5.12	$5.92	$7.68	$8.48	$9.28	$14.24	$20.96	$38.40	$59.20	$111.20	$176.00	$172.00
$100,000	$6.40	$7.40	$9.60	$10.60	$11.60	$17.80	$26.20	$48.00	$74.00	$139.00	$220.00	$215.00
$120,000	$7.68	$8.88	$11.52	$12.72	$13.92	$21.36	$31.44	$57.60	$88.80	$166.80	$264.00	$258.00
$140,000	$8.96	$10.36	$13.44	$14.84	$16.24	$24.92	$36.68	$67.20	$103.60	$194.60	$308.00	$301.00
$160,000	$10.24	$11.84	$15.36	$16.96	$18.56	$28.48	$41.92	$76.80	$118.40	$222.40	$352.00	$344.00
$180,000	$11.52	$13.32	$17.28	$19.08	$20.88	$32.04	$47.16	$86.40	$133.20	$250.20	$396.00	$387.00
$200,000	$12.80	$14.80	$19.20	$21.20	$23.20	$35.60	$52.40	$96.00	$148.00	$278.00	$440.00	$430.00
$220,000	$14.08	$16.28	$21.12	$23.32	$25.52	$39.16	$57.64	$105.60	$162.80	$305.80	$484.00	$473.00
$240,000	$15.36	$17.76	$23.04	$25.44	$27.84	$42.72	$62.88	$115.20	$177.60	$333.60	$528.00	$516.00
$260,000	$16.64	$19.24	$24.96	$27.56	$30.16	$46.28	$68.12	$124.80	$192.40	$361.40	$572.00	$559.00
$280,000	$17.92	$20.72	$26.88	$29.68	$32.48	$49.84	$73.36	$134.40	$207.20	$389.20	$616.00	$602.00
$300,000	$19.20	$22.20	$28.80	$31.80	$34.80	$53.40	$78.60	$144.00	$222.00	$417.00	$660.00	$645.00
$320,000	$20.48	$23.68	$30.72	$33.92	$37.12	$56.96	$83.84	$153.60	$236.80	$444.80	$704.00	$688.00
$340,000	$21.76	$25.16	$32.64	$36.04	$39.44	$60.52	$89.08	$163.20	$251.60	$472.60	$748.00	$731.00
$360,000	$23.04	$26.64	$34.56	$38.16	$41.76	$64.08	$94.32	$172.80	$266.40	$500.40	$792.00	$774.00
$380,000	$24.32	$28.12	$36.48	$40.28	$44.08	$67.64	$99.56	$182.40	$281.20	$528.20	$836.00	$817.00
$400,000	$25.60	$29.60	$38.40	$42.40	$46.40	$71.20	$104.80	$192.00	$296.00	$556.00	$880.00	$860.00
$420,000	$26.88	$31.08	$40.32	$44.52	$48.72	$74.76	$110.04	$201.60	$310.80	$583.80	$924.00	$903.00
$440,000	$28.16	$32.56	$42.24	$46.64	$51.04	$78.32	$115.28	$211.20	$325.60	$611.60	$968.00	$946.00
$460,000	$29.44	$34.04	$44.16	$48.76	$53.36	$81.88	$120.52	$220.80	$340.40	$639.40	$1,012.00	$989.00
$480,000	$30.72	$35.52	$46.08	$50.88	$55.68	$85.44	$125.76	$230.40	$355.20	$667.20	$1,056.00	$1,032.00
$500,000	$32.00	$37.00	$48.00	$53.00	$58.00	$89.00	$131.00	$240.00	$370.00	$695.00	$1,100.00	$1,075.00
$520,000	$33.28	$38.48	$49.92	$55.12	$60.32	$92.56	$136.24	$249.60	$384.80	$722.80	$1,144.00	$1,118.00
$540,000	$34.56	$39.96	$51.84	$57.24	$62.64	$96.12	$141.48	$259.20	$399.60	$750.60	$1,188.00	$1,161.00
$560,000	$35.84	$41.44	$53.76	$59.36	$64.96	$99.68	$146.72	$268.80	$414.40	$778.40	$1,232.00	$1,204.00
$580,000	$37.12	$42.92	$55.68	$61.48	$67.28	$103.24	$151.96	$278.40	$429.20	$806.20	$1,276.00	$1,247.00
$600,000	$38.40	$44.40	$57.60	$63.60	$69.60	$106.80	$157.20	$288.00	$444.00	$834.00	$1,320.00	$1,290.00

Spouse/Domestic Partner Optional Life Insurance Monthly Premium Rates (Non-Tobacco)

Rate per $10,000 by Age Band												
Age band	**Thru 24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75 & up**
Rate per $10,000	$0.40	$0.48	$0.62	$0.69	$0.75	$1.18	$1.74	$3.30	$5.13	$9.95	$16.30	$16.40
Calculated Rate by Age Band												
$20,000	$0.80	$0.96	$1.24	$1.38	$1.50	$2.36	$3.48	$6.60	$10.26	$19.90	$32.60	$32.80
$40,000	$1.60	$1.92	$2.48	$2.76	$3.00	$4.72	$6.96	$13.20	$20.52	$39.80	$65.20	$65.60
$60,000	$2.40	$2.88	$3.72	$4.14	$4.50	$7.08	$10.4	$19.80	$30.78	$59.70	$97.80	$98.40
$80,000	$3.20	$3.84	$4.96	$5.52	$6.00	$9.44	$13.9	$26.40	$41.04	$79.60	$130.4	$131.2
$100,00	$4.00	$4.80	$6.20	$6.90	$7.50	$11.8	$17.4	$33.00	$51.30	$99.50	$163.0	$164.0
$120,00	$4.80	$5.76	$7.44	$8.28	$9.00	$14.1	$20.8	$39.60	$61.56	$119.4	$195.6	$196.8
$140,00	$5.60	$6.72	$8.68	$9.66	$10.5	$16.5	$24.3	$46.20	$71.82	$139.3	$228.2	$229.6
$160,00	$6.40	$7.68	$9.92	$11.0	$12.0	$18.8	$27.8	$52.80	$82.08	$159.2	$260.8	$262.4
$180,00	$7.20	$8.64	$11.1	$12.4	$13.5	$21.2	$31.3	$59.40	$92.34	$179.1	$293.4	$295.2
$200,00	$8.00	$9.60	$12.4	$13.8	$15.0	$23.6	$34.8	$66.00	$102.6	$199.0	$326.0	$328.0
$220,00	$8.80	$10.5	$13.6	$15.1	$16.5	$25.9	$38.2	$72.60	$112.8	$218.9	$358.6	$360.8
$240,00	$9.60	$11.5	$14.8	$16.5	$18.0	$28.3	$41.7	$79.20	$123.1	$238.8	$391.2	$393.6
$260,00	$10.4	$12.4	$16.1	$17.9	$19.5	$30.6	$45.2	$85.80	$133.3	$258.7	$423.8	$426.4
$280,00	$11.2	$13.4	$17.3	$19.3	$21.0	$33.0	$48.7	$92.40	$143.6	$278.6	$456.4	$459.2
$300,00	$12.0	$14.4	$18.6	$20.7	$22.5	$35.4	$52.2	$99.00	$153.9	$298.5	$489.0	$492.0
$320,00	$12.8	$15.3	$19.8	$22.0	$24.0	$37.7	$55.6	$105.6	$164.1	$318.4	$521.6	$524.8
$340,00	$13.6	$16.3	$21.0	$23.4	$25.5	$40.1	$59.1	$112.2	$174.4	$338.3	$554.2	$557.6
$360,00	$14.4	$17.2	$22.3	$24.8	$27.0	$42.4	$62.6	$118.8	$184.6	$358.2	$586.8	$590.4
$380,00	$15.2	$18.2	$23.5	$26.2	$28.5	$44.8	$66.1	$125.4	$194.9	$378.1	$619.4	$623.2
$400,00	$16.0	$19.2	$24.8	$27.6	$30.0	$47.2	$69.6	$132.0	$205.2	$398.0	$652.0	$656.0
$20,000	$0.80	$0.96	$1.24	$1.38	$1.50	$2.36	$3.48	$6.60	$10.26	$19.90	$32.60	$32.80
$40,000	$1.60	$1.92	$2.48	$2.76	$3.00	$4.72	$6.96	$13.20	$20.52	$39.80	$65.20	$65.60
$60,000	$2.40	$2.88	$3.72	$4.14	$4.50	$7.08	$10.4	$19.80	$30.78	$59.70	$97.80	$98.40
$80,000	$3.20	$3.84	$4.96	$5.52	$6.00	$9.44	$13.9	$26.40	$41.04	$79.60	$130.4	$131.2
$100,00	$4.00	$4.80	$6.20	$6.90	$7.50	$11.8	$17.4	$33.00	$51.30	$99.50	$163.0	$164.0
$120,00	$4.80	$5.76	$7.44	$8.28	$9.00	$14.1	$20.8	$39.60	$61.56	$119.4	$195.6	$196.8
$140,00	$5.60	$6.72	$8.68	$9.66	$10.5	$16.5	$24.3	$46.20	$71.82	$139.3	$228.2	$229.6
$160,00	$6.40	$7.68	$9.92	$11.0	$12.0	$18.8	$27.8	$52.80	$82.08	$159.2	$260.8	$262.4
$180,00	$7.20	$8.64	$11.1	$12.4	$13.5	$21.2	$31.3	$59.40	$92.34	$179.1	$293.4	$295.2
$200,00	$8.00	$9.60	$12.4	$13.8	$15.0	$23.6	$34.8	$66.00	$102.6	$199.0	$326.0	$328.0

Spouse/Domestic Partner Optional Life Insurance Monthly Premium Rates (Tobacco)

Rate per $10,000 by Age Band												
Age band	**Thru 24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75 & up**
Rate per $10,000	$0.40	$0.48	$0.62	$0.69	$0.75	$1.18	$1.74	$3.30	$5.13	$9.95	$16.30	$16.40
Calculated Rate by Age Band												
$20,00	$1.28	$1.48	$1.92	$2.12	$2.32	$3.56	$5.24	$9.60	$14.80	$27.80	$44.00	$43.00
$40,00	$2.56	$2.96	$3.84	$4.24	$4.64	$7.12	$10.48	$19.20	$29.60	$55.60	$88.00	$86.00
$60,00	$3.84	$4.44	$5.76	$6.36	$6.96	$10.6	$15.72	$28.80	$44.40	$83.40	$132.0	$129.0
$80,00	$5.12	$5.92	$7.68	$8.48	$9.28	$14.2	$20.96	$38.40	$59.20	$111.2	$176.0	$172.0
$100,0	$6.40	$7.40	$9.60	$10.6	$11.6	$17.8	$26.20	$48.00	$74.00	$139.0	$220.0	$215.0
$120,0	$7.68	$8.88	$11.5	$12.7	$13.9	$21.3	$31.44	$57.60	$88.80	$166.8	$264.0	$258.0
$140,0	$8.96	$10.3	$13.4	$14.8	$16.2	$24.9	$36.68	$67.20	$103.6	$194.6	$308.0	$301.0
$160,0	$10.2	$11.8	$15.3	$16.9	$18.5	$28.4	$41.92	$76.80	$118.4	$222.4	$352.0	$344.0
$180,0	$11.5	$13.3	$17.2	$19.0	$20.8	$32.0	$47.16	$86.40	$133.2	$250.2	$396.0	$387.0
$200,0	$12.8	$14.8	$19.2	$21.2	$23.2	$35.6	$52.40	$96.00	$148.0	$278.0	$440.0	$430.0
$220,0	$14.0	$16.2	$21.1	$23.3	$25.5	$39.1	$57.64	$105.6	$162.8	$305.8	$484.0	$473.0
$240,0	$15.3	$17.7	$23.0	$25.4	$27.8	$42.7	$62.88	$115.2	$177.6	$333.6	$528.0	$516.0
$260,0	$16.6	$19.2	$24.9	$27.5	$30.1	$46.2	$68.12	$124.8	$192.4	$361.4	$572.0	$559.0
$280,0	$17.9	$20.7	$26.8	$29.6	$32.4	$49.8	$73.36	$134.4	$207.2	$389.2	$616.0	$602.0
$300,0	$19.2	$22.2	$28.8	$31.8	$34.8	$53.4	$78.60	$144.0	$222.0	$417.0	$660.0	$645.0
$320,0	$20.4	$23.6	$30.7	$33.9	$37.1	$56.9	$83.84	$153.6	$236.8	$444.8	$704.0	$688.0
$340,0	$21.7	$25.1	$32.6	$36.0	$39.4	$60.5	$89.08	$163.2	$251.6	$472.6	$748.0	$731.0
$360,0	$23.0	$26.6	$34.5	$38.1	$41.7	$64.0	$94.32	$172.8	$266.4	$500.4	$792.0	$774.0
$380,0	$24.3	$28.1	$36.4	$40.2	$44.0	$67.6	$99.56	$182.4	$281.2	$528.2	$836.0	$817.0
$400,0	$25.6	$29.6	$38.4	$42.4	$46.4	$71.2	$104.8	$192.0	$296.0	$556.0	$880.0	$860.0
$20,00	$1.28	$1.48	$1.92	$2.12	$2.32	$3.56	$5.24	$9.60	$14.80	$27.80	$44.00	$43.00
$40,00	$2.56	$2.96	$3.84	$4.24	$4.64	$7.12	$10.48	$19.20	$29.60	$55.60	$88.00	$86.00
$60,00	$3.84	$4.44	$5.76	$6.36	$6.96	$10.6	$15.72	$28.80	$44.40	$83.40	$132.0	$129.0
$80,00	$5.12	$5.92	$7.68	$8.48	$9.28	$14.2	$20.96	$38.40	$59.20	$111.2	$176.0	$172.0
$100,0	$6.40	$7.40	$9.60	$10.6	$11.6	$17.8	$26.20	$48.00	$74.00	$139.0	$220.0	$215.0
$120,0	$7.68	$8.88	$11.5	$12.7	$13.9	$21.3	$31.44	$57.60	$88.80	$166.8	$264.0	$258.0
$140,0	$8.96	$10.3	$13.4	$14.8	$16.2	$24.9	$36.68	$67.20	$103.6	$194.6	$308.0	$301.0
$160,0	$10.2	$11.8	$15.3	$16.9	$18.5	$28.4	$41.92	$76.80	$118.4	$222.4	$352.0	$344.0
$180,0	$11.5	$13.3	$17.2	$19.0	$20.8	$32.0	$47.16	$86.40	$133.2	$250.2	$396.0	$387.0
$200,0	$12.8	$14.8	$19.2	$21.2	$23.2	$35.6	$52.40	$96.00	$148.0	$278.0	$440.0	$430.0

Retiree Life Insurance Monthly Premium Rates									
Age >	**Thru 49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85 & up**
Rate Per $10,000 >	$2.70	$4.05	$4.95	$6.75	$13.50	$22.50	$33.75	$51.30	$73.80
AMOUNT									
$10,000	$2.70	$4.05	$4.95	$6.75	$13.50	$22.50	$33.75	$51.30	$73.80
$20,000	$5.40	$8.10	$9.90	$13.50	$27.00	$45.00	$67.50	$102.60	$147.60
$30,000	$8.10	$12.15	$14.85	$20.25	$40.50	$67.50	$101.25	$153.90	$221.40
$40,000	$10.80	$16.20	$19.80	$27.00	$54.00	$90.00	$135.00	$205.20	$295.20
$50,000	$13.50	$20.25	$24.75	$33.75	$67.50	$112.50	$168.75	$256.50	$369.00
$60,000	$16.20	$24.30	$29.70	$40.50	$81.00	$135.00	$202.50	$307.80	$442.80
$70,000	$18.90	$28.35	$34.65	$47.25	$94.50	$157.50	$236.25	$359.10	$516.60
$80,000	$21.60	$32.40	$39.60	$54.00	$108.00	$180.00	$270.00	$410.40	$590.40
$90,000	$21.60	$32.40	$39.60	$54.00	$108.00	$180.00	$270.00	$410.40	$590.40
$100,000	$27.00	$40.50	$49.50	$67.50	$135.00	$225.00	$337.50	$513.00	$738.00
$110,000	$29.70	$44.55	$54.45	$74.25	$148.50	$247.50	$371.25	$564.30	$811.80
$120,000	$32.40	$48.60	$59.40	$81.00	$162.00	$270.00	$405.00	$615.60	$885.60
$130,000	$35.10	$52.65	$64.35	$87.75	$175.50	$292.50	$438.75	$666.90	$959.40
$140,000	$37.80	$56.70	$69.30	$94.50	$189.00	$315.00	$472.50	$718.20	$1,033.20
$150,000	$40.50	$60.75	$74.25	$101.25	$202.50	$337.50	$506.25	$769.50	$1,107.00
$160,000	$43.20	$64.80	$79.20	$108.00	$216.00	$360.00	$540.00	$820.80	$1,180.80
$170,000	$45.90	$68.85	$84.15	$114.75	$229.50	$382.50	$573.75	$872.10	$1,254.60
$180,000	$48.60	$72.90	$89.10	$121.50	$243.00	$405.00	$607.50	$923.40	$1,328.40
$190,000	$51.30	$76.95	$94.05	$128.25	$256.50	$427.50	$641.25	$974.70	$1,402.20
$200,000	$54.00	$81.00	$99.00	$135.00	$270.00	$450.00	$675.00	$1,026.00	$1,476.00

Short Term Disability Insurance

This subsection summarizes the group Short Term Disability Insurance plan available through PEBB. It is a summary only. For full details, see the Certificate of Insurance on the PEBB Website. The controlling provisions of the plan are in the group policy issued by Standard Insurance Company. The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Short Term Disability (STD) Insurance, you must be an active employee of the state of Oregon who is regularly scheduled to work and who meets the terms of eligibility in PEBB Administrative Rules.

You are not eligible if you are: a seasonal or intermittent employee; an employee scheduled to work fewer than 90 days; a temporary employee; a full-time member of the armed forces of any country.

Effective Date of Coverage

Your STD Insurance becomes effective:

- The first day of the calendar month following the date you enroll, if you enroll within 60 days after becoming an eligible employee
- January 1 of the following year if you enroll during the annual open enrollment period
- The first day of the calendar month following the date you enroll, if you enroll within 60 days following a qualified status change (as determined by your employer).

You pay the entire cost of coverage.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective. If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively at Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work.

Benefit Amount

The Standard pays benefits at the end of each week in which you qualify. The weekly amount is 60 percent of the first $2,769 of your predisability earnings, reduced by deductible income. The maximum weekly benefit, before reduction by deductible income, is $1,662.

Benefit Waiting Period

If The Standard approves your claim, it will pay benefits only after the benefit waiting period. The benefit waiting period is a specified number of days for which you must remain continuously disabled. This is seven days if the disability is caused by physical disease, pregnancy or mental disorder. There is no benefit waiting period if the disability is caused by accidental injury.

However, if your disability begins while you are scheduled to be away from work under the terms of your employment, your benefit waiting period is the longer of the date determined above and the period ending on the day before you were scheduled to return to work.

Maximum Benefit Period

Benefits may continue for any one period of disability up to the maximum benefit period of 13 weeks, unless the pre-existing condition limitation applies. In that case, the maximum benefit period is four weeks.

If you are eligible to receive benefits under any other disability plan, your STD benefits will end when the other disability benefits become payable. This applies even if you become eligible for the other benefits before the end of the STD maximum benefit period.

Definition of Disability

The Standard terms you disabled if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation. The Standard terms you partially disabled if you work for the state of Oregon but are unable to earn more than 50 percent of your predisability earnings. You are no longer disabled when your earnings from any occupation exceed 50 percent of your predisability earnings.

Return to Work Incentive

You may work for the state of Oregon during the benefit waiting period and while you are receiving benefits. The Standard will reduce your weekly benefit amount to the extent your earnings exceed 100 percent of your predisability earnings when added to your gross benefit.

Reasonable Accommodation Benefit

If you return to work in any occupation for any employer (except self-employment) through the employer's workplace accommodation, The Standard will reimburse the employer for the incurred expenses to an amount agreed upon in advance and in writing by The Standard and the employer.

Temporary Recovery

If you temporarily recover and then become disabled again from the same cause or causes after benefits are payable, and the recovery period does not exceed 14 days, The Standard will

- Not impose a new benefit waiting period
- Resume paying benefits as if no break in coverage had occurred
- Use the same predisability earnings to determine your benefit
- Reduce the maximum benefit period by the previous period or periods of disability.

Predisability Earnings

Predisability earnings are your weekly earnings from the state of Oregon in effect on the last full day of active work. They include:

- Salary
- Grant assistance wages
- Stipends

- Contributions you make through a salary reduction agreement with your employer to an IRC Section 401(k), 403(b) or 457 deferred compensation arrangement, or an executive nonqualified deferred compensation arrangement
- Amounts contributed to fringe benefits according to salary reduction agreements under an IRC Section 125 plan

Predisability earnings exclude: bonuses; overtime pay; your employer's contribution to a deferred compensation arrangement or pension plan; state-paid benefit amounts in excess of your premiums for medical insurance, dental insurance and the first $50,000 of group life insurance; or any other extra compensation.

If you are paid hourly, predisability earnings are determined by multiplying your hourly pay rate by the average number of hours you worked per week during the preceding 13 weeks (or during your period of employment if less than 13 weeks), but not more than 40 hours.

Deductible Income

The Standard considers the following deductible income and deducts any amounts from your benefit:

- Work earnings, as described in Return To Work Incentive
- Benefits you are eligible to receive under any other short term disability plan that, when added to your benefit under this plan, exceed 75 percent of your predisability earnings
- Amounts received by compromise, settlement or other method as a result of a claim for the above, whether disputed or undisputed.
- Sick pay or other salary continuation (including donated leave) paid to you by your Employer, but not including vacation pay

Exclusions and Limitations

You are not covered for a disability

- Caused or contributed to by an intentionally self-inflicted injury, while sane or insane
- Arising out of or in the course of any employment for wage or profit.

No benefits will be paid for any period you are

- Not under the on-going care of a physician
- Eligible to receive workers' compensation or similar benefits
- Working for any employer other than the state of Oregon or are self-employed
- Confined for any reason in a penal or correctional institution.

Pre-existing Condition: The Standard limits your maximum benefit period to four weeks if your disability is caused or contributed to by a pre-existing condition. A pre-existing condition is a mental or physical condition for which, during the 90 days immediately preceding the date you became insured, you consulted a physician, received medical treatment or services, or took prescribed drugs or medications. The Standard will not apply this limitation to a disability that begins after you have been insured under the group policy for 12 months and have been actively at work for at least one day after those 12 months.

When Benefits End

Benefits end on the earliest of

- The date you are no longer disabled
- The end of the maximum benefit period
- The date you die
- The date you begin working for any employer other than the state of Oregon, or are self-employed
- The date long term disability benefits become payable to you.

When Coverage Ends

This coverage ends automatically on the earliest of the following dates:

- End of the period for which a premium was paid for your coverage
- You cease to be eligible under PEBB Administrative Rules
- You become a full-time member of the armed forces
- The group policy ends.

Claims

To make a claim, use the information provided on this link:
http://www.oregon.gov/DAS/PEBB/docs/PDF/2008/StdClaimsFAQ.pdf

The Standard may

- Investigate your claim at any time
- Have you examined at reasonable intervals by specialists of their choice
- Deny or suspend benefits if you fail to attend an examination or cooperate with the examiner.

The Standard will send you a written decision on your claim within a reasonable time after receiving your claim. If you do not receive the decision within 90 days, you can request a review as if your claim were denied.

If The Standard denies any part of your claim, it will send you written notice of denial. The notice will give the reasons for the decision and refer to the parts of the group policy supporting the decision. It will describe any additional information needed to support your claim and information concerning your right to a review of the decision.

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

Premium Rates

Beginning Jan. 1, 2014 the premium rate is 0.0064 times your gross monthly salary.

Example:

- Your gross monthly salary is $3,234.
- $3,234 times 0.0064 equals $20.70, the premium that is deducted from your salary.

Long Term Disability Insurance

This subsection summarizes the group Long Term Disability Insurance plan available through PEBB. It is a summary only. For full details, see the Certificate of Insurance on the PEBB Website. The controlling provisions of the plan are in the group policy issued by The Standard Insurance Company. The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Long Term Disability (LTD) Insurance, you must be an active employee of the state of Oregon who is regularly scheduled to work and who meets the terms of eligibility in PEBB Administrative Rules.

You are not eligible if you are: a seasonal or intermittent employee; an employee scheduled to work fewer than 90 days; a temporary employee; a full-time member of the armed forces of any country.

Effective Date of Coverage

Your LTD Insurance becomes effective:

- The first day of the calendar month following the date you enroll, if you enroll within 60 days after becoming an eligible employee
- January 1 of the following year if you enroll during the annual open enrollment period
- The first day of the calendar month following the date you enroll, if you enroll within 60 days following a qualified status change (as determined by your employer).

You pay the entire cost of coverage.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective.

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.
You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively at Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work.

Benefit Amount

The Standard pays benefits at the end of each month in which you qualify. When you apply for coverage, you elect one of the following monthly benefits:

- An amount equal to 60 percent of the first $12,000 of your predisability earnings. The monthly maximum benefit, before reduction by deductible income, is $7,200.
- An amount equal to 66 2/3 percent of the first $12,000 of your predisability earnings. The monthly maximum benefit, before reduction by deductible income, is $8,000.

The monthly minimum benefit, after reduction by deductible income, is $50. Your monthly benefit will be no less than $50 while you qualify. Beginning May 1, 2011, members who qualify for disability benefit payments can choose to use accrued leave greater than 40 hours and receive a reduced benefit payment (minimum of $50 per week); or they can elect to receive the full benefit payment without using accrued sick leave greater than 40 hours.

If you are disabled for less than a full month, The Standard will pay you one-thirtieth (1/30) of the benefit for each day of disability.

Note: If you initially elect the 60-percent benefit and later increase to the 66 2/3-percent benefit, The Standard will apply a new pre-existing condition exclusion to the change. In this case, if you become disabled and the increased benefit is not payable because of the new pre-existing condition exclusion, The Standard will administer your claim as if you had not elected to change your benefit percentage.

Benefit Waiting Period

The benefit waiting period is the number of days for which you must remain continuously disabled and during which benefits are not payable. When you apply for coverage, you elect a benefit waiting period of either 90 or 180 days. If The Standard approves your claim, it will pay benefits after the end of the benefit waiting period.

Note: If you initially elect a 180-day benefit waiting period and later reduce your benefit waiting period to 90 days, The Standard will apply a new pre-existing condition exclusion. If you become disabled and benefits are not payable because of the new pre-existing condition exclusion, The Standard will administer your claim as if you had not elected to change your benefit waiting period.

Maximum Benefit Period

LTD benefits may continue during Disability up to the end of the maximum benefit period (shown below). This is the maximum period for which LTD benefits are payable for any one period of continuous Disability.

Your age when Disability began	Maximum Benefit Period
61 or younger	to age 65, or 3 years 6 months if longer
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Additional Benefits for the Severely Disabled

If you are eligible for the Assisted Living Benefit, the amount of your benefit (before reduction by deductible income) will be increased to 80 percent of the first $12,000 of your predisability earnings.

To be eligible for the Assisted Living Benefit you must provide proof that, while you are disabled and LTD benefits are payable, either of the following occurs:

- You become unable to safely and completely perform two or more activities of daily living* without hands-on assistance or standby assistance; or
- You require substantial supervision for your health or safety because of severe cognitive impairment.

The condition must be expected to last 90 days or more, as certified by a physician in the appropriate specialty.

The Assisted Living Benefit is not payable if the condition is caused or contributed to by:

- War or act of war, whether declared or undeclared
- Intentionally self-inflicted injury, while sane or insane;
- Mental disorder
- Being under the influence of intoxicating liquor as defined by the laws of Oregon
- Alcoholism
- Use of any drug (unless under direction of physician)
- Drug addiction
- A preexisting condition (as defined in Exclusions and Limitations)
- Committing or attempting to commit an assault or felony
- Active participation in a violent disorder or riot (except while performing official duties).

*Activities of daily living are bathing, continence, dressing, eating, toileting and transferring.

Definition of Disability

The Standard terms you disabled if, during the benefit waiting period and the next 24 months, you are unable to perform with reasonable continuity the material duties of your own occupation as a result of physical disease, injury, pregnancy or mental disorder.

Thereafter, The Standard terms you disabled if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

Return to Work Incentive

You may work for any employer while receiving LTD benefits, provided you meet the definition of Disability described above. Earnings from work are used to reduce the amount of your LTD benefit, as follows:

- During the first 12 months of working, your work earnings are used to reduce the LTD benefit to the extent that they exceed 100% of your predisability earnings when added to your gross LTD benefit.
- Thereafter, your LTD benefit is reduced by one-half of your work earnings.

Family Care Expense Adjustment

If you must pay family care expenses in order to work, your work earnings for purposes of calculating your LTD benefit will be reduced by those family care expenses, subject to the following limits:

- Your work earnings will be reduced by up to $250 of expenses per eligible family member.
- The total expenses by which work earnings will be reduced will not exceed $500 per month for all eligible family members.
- This benefit will end 24 months after it begins.

A family care expense is the amount you pay a licensed care provider for the care of an eligible family member which is necessary in order for you to work.

Eligible family members are:

- Your child or the child of your spouse or domestic partner from live birth through age 11 (or over age 11, if the child is continuously incapable of self-sustaining employment because of mental retardation or physical handicap and chiefly dependent upon you for support and maintenance).
- Your spouse, domestic partner, parent, grandparent, sibling, or other close family member residing in your home who is continuously incapable of self-sustaining employment because of mental retardation or physical handicap and chiefly dependent upon you for support and maintenance.

Rehabilitation Plan

You may apply to participate in a Rehabilitation Plan by submitting a form or letter to The Standard. If they approved your Rehabilitation Plan, The Standard may reimburse you for some or all of the following expenses you incur in connection with the plan, including: training and education expenses; family care expenses; job-related expenses; job search expenses.

Reasonable Accommodation Benefit

If you return to work in any occupation for any employer (not including self-employment) as a result of a workplace accommodation made by the employer, The Standard will reimburse the employer for the expenses incurred, up to an amount agreed upon in advance and in writing.

Temporary Recovery

If you temporarily recover and then become Disabled again from the same cause or causes, you will not be required to serve a new benefit waiting period, provided the period of recovery does not exceed the following applicable periods:

- During the benefit waiting period: a total equal to 5 days for every 30 days of the benefit waiting period
- During the maximum benefit period: 180 days for each period of recovery

Benefits will resume as if no break in coverage had occurred (the predisability earnings used to determine your LTD benefit remain the same, and the maximum benefit period, own occupation period and maximum period for benefits under the Mental Disorder limitation will be reduced by the previous period or periods of Disability).

Predisability Earnings

Predisability earnings are your monthly earnings from the State of Oregon in effect on **the last full day of active work**, and include:

- Salary
- Grant assistance wages
- Stipends
- Contributions you make through a salary reduction agreement with your employer to an IRC Section 401(k), 403(b) or 457 deferred compensation arrangement, or an executive nonqualified deferred compensation arrangement
- Amounts contributed to fringe benefits according to salary reduction agreements under an IRC Section 125 plan

Predisability earnings exclude: bonuses; overtime pay; your employer's contribution to a deferred compensation arrangement or pension plan; your state-paid benefit amounts in excess of your premiums for medical insurance, dental insurance and the first $50,000 of group life insurance; or any other extra compensation.

If you are paid hourly, predisability earnings are determined by multiplying your hourly pay rate by the average number of hours you worked per month during the preceding 3 calendar months (or during your period of employment if less than 3 months), but not more than 173 hours.

Deductible Income

The following amounts will be considered deductible income, and used to reduce the amount of your LTD benefit:

- Work earnings, as described in the Return To Work Incentive.
- Sick pay or other salary continuation (including donated leave) paid to you by your Employer, but not including vacation pay
- Amounts for which you are eligible under a workers' compensation law or similar law.
- Amounts you, your spouse, or your children under age 18 are eligible to receive because of your disability or retirement under the Federal Social Security Act or any similar plan or act.
- Amounts you are eligible to receive under any state disability income benefit law or similar law.
- Amounts you are eligible to receive because of your disability under any other group insurance coverage.
- Disability or retirement benefits you are eligible to receive under your employer's retirement plan, including PERS, STRS and any plan arranged and maintained by a union or employee association for the benefit of its members.
- For employees of the Oregon University System, benefits you are eligible to receive under an employer-sponsored individual disability policy arranged for individuals in a common group.
- Amounts received by compromise, settlement or other method as a result of a claim for the above, whether disputed or undisputed.

Survivors Benefit

If you die while receiving LTD benefits, a lump sum benefit equal to 3 times your LTD benefit (before reduction by deductible income) will be paid to the first of the following eligible survivors:

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

- Any person providing care and support for any of the above.
- A spouse is a person to whom you are legally married. A domestic partner is a person who meets the eligibility requirements outlined in the PEBB Administrative Rules.

Exclusions and Limitations

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

- An intentionally self-inflicted injury, while sane or insane.
- A Preexisting Condition. A Preexisting Condition is a mental or physical condition for which, during the 90 days immediately preceding the date you became insured, you consulted a physician, received medical treatment or services, or took prescribed drugs or medications. This exclusion will not apply to a Disability which begins after you have been insured under the group policy for 12 months and have been actively at work for at least one day after those 12 months.

Note: A new Preexisting Condition exclusion will apply to an increase in benefit percentage and/or decrease in benefit waiting period.

No LTD benefits will be paid for any period:

- You are not under the on-going care of a physician.
- You are confined for any reason in a penal or correctional institution.

Mental Disorder Limitation: Payment of LTD benefits will be limited to 24 months for each period of continuous Disability caused or contributed to by a mental disorder. However, if you are confined in a hospital* at the end of the 24 months, this limitation will not apply while you are continuously confined.

*Hospital includes only legally-operated hospitals providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Hospital does not include rest homes, nursing homes, convalescent homes, homes for the aged or facilities primarily affording custodial, educational, or rehabilitative care.

When LTD Benefits End

LTD benefits will end on the earliest of the following dates:

- The date you are no longer disabled.
- The end of the maximum benefit period.
- The date you die.
- The date benefits become payable to you under any other group long term disability insurance policy under which you become insured during a period of temporary recovery.

When Coverage Ends

Your Long Term Disability coverage ends automatically on the earliest of the following dates:

- The date the last period ends for which a premium was paid for your coverage.
- The date you cease to meet the terms of eligibility outlined in the PEBB Administrative Rules.
- The date you become a full-time member of the armed forces.
- The date the group policy terminates.

Claims

If you wish to make a claim you must, at your expense, submit to The Standard completed claims statements, your signed authorization to obtain information and any other items they may reasonably require in support of your claim.

The Standard may investigate your claim at any time. They may have you examined at reasonable intervals by specialists of their choice, and they may deny or suspend benefits if you fail to attend an examination or cooperate with the examiner.

You will receive a written decision on your claim within a reasonable time after The Standard receives your claim. If you do not receive their decision within 90 days, you can request a review as if your claim had been denied.

If The Standard denies any part of your claim, you will receive a written notice of denial containing the reasons for their decision, reference to the parts of the group policy supporting their decision, a description of any additional information needed to support your claim, and information concerning your right to a review of their decision.

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

Premium Rates

This insurance may replace a portion of your monthly income should you become disabled. You must self pay for this coverage; the state does not provide a benefit amount for this benefit.

Long-term Disability Premium Rates Beginning Jan. 1, 2014 Premium = Rate X month salary				
Option	Rate	Waiting Period	Coverage	Coverage Maximum/Minimum
1	$0.0051	90 days	60% of first $12,000 minus deductible income	$7,200 before reduction by deductible income/$50
2	$0.0018	180 days		
3	$0.0106	90 days	66 2/3% of first $12,000 minus deductible income	$8,000 before reduction by deductible income/$50
4	$0.0027	180 days		

Here is an example to illustrate your premium cost based on your choice of options:

You choose option 1 -- with a 90-day waiting period and a monthly benefit amount of 60 percent of your pre-disability earnings.

Your gross monthly salary (before any deductions)	$1,900
Times premium	X 0.0051
Premium amount you pay each month	$9.69

Accidental Death and Dismemberment Insurance

This subsection summarizes the group Optional Accidental Death and Dismemberment insurance plan available through PEBB. It is a summary only. For full details, see the Certificate of Insurance on the PEBB Website. The controlling provisions of the plan are in the group policy issued by Standard Insurance Company. The information presented in this summary and in the Certificate of Insurance in no way modifies that group policy or the insurance coverage.

Eligibility for Coverage

To be eligible for Optional Accidental Death and Dismemberment (AD&D) insurance, you must be an active employee of the State of Oregon who is regularly scheduled to work and who meets the terms of eligibility outlined in the PEBB Administrative Rules.

Dependents eligible for coverage are:

- Spouse: A person to whom you are legally married.
- Domestic Partner: A domestic partner who meets the eligibility requirements outlined in the PEBB Administrative Rules.
- Child: Your child or your spouse's or domestic partner's child who meets the eligibility requirements outlined in the PEBB Administrative Rules.

Employees and dependents who are full-time members of the armed forces of any country are not eligible for coverage.

Amounts of Optional AD&D Insurance

Optional AD&D Insurance for you:
You may apply for any multiple of $50,000 up to $500,000.

Optional AD&D Insurance for your Spouse or Domestic Partner and Children:
If you elect employee and dependent coverage, the AD&D insurance amounts for each of your dependents is equal to a percentage of your AD&D insurance amount, determined as follows:

- If on the date your spouse or domestic partner dies or suffers a loss you do not have any eligible children, your spouse's or domestic partner's AD&D insurance amount is 50 percent of your AD&D insurance amount.
- If on the date your spouse or domestic partner dies or suffers a loss and you have both a spouse or domestic partner and eligible children, your spouse' or domestic partner's AD&D insurance amount is 40 percent of your AD&D insurance amount.
- If your eligible child dies or suffers a loss, the child's AD&D insurance amount is 15 percent of your AD&D insurance amount.

Covered Losses

With Optional AD&D insurance, benefits are payable in the event of an employee's or insured dependent's death or covered loss resulting from an accident. The amount payable is a percentage of the AD&D insurance amount in effect for the person who suffers the loss on the date of the accident, as shown below:

Loss:	Percentage Payable:
Life	100%
One hand or one foot	50%
Sight in one eye, speech or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger on the same hand	25%
Quadriplegia	100%
Hemiplegia	50%
Paraplegia	50%

The loss must occur due to an accident (or accidental exposure to the natural elements), independently of all other causes, and within 365 days after the accident.

If you or your dependent disappears in an accident that could have caused loss of life and is not located within one year despite reasonable search efforts, death will be presumed.

Additional Benefits

The AD&D coverage includes the following additional benefits when an AD&D insurance benefit is payable:

- **Seat Belt Benefit**. The Seat Belt Benefit is included if you are enrolled for Optional Life insurance under group policy 606814-B. This provision provides an additional benefit in the event you die as a result of an automobile accident and you were properly wearing and using a seat belt. The amount of the Seat Belt Benefit is the least of (a) the amount of your Optional Life insurance, (b) the amount of your Optional AD&D insurance, and (c) $50,000.
- **Higher Education Benefit**. If you have employee and dependent AD&D coverage and die in a covered accident, any of your eligible children who are registered and in full-time attendance at an accredited institution of higher education may be paid an annual benefit for up to four years. The annual benefit is the lesser of 5 percent of your AD&D insurance amount or $5,000. If there is no child eligible for the benefit, $1,500 will be paid to your beneficiary.
- **Career Adjustment Benefit.** If you have employee and dependent AD&D coverage and die in a covered accident, your spouse or domestic partner will be paid an amount equal to the lesser of 5 percent of your AD&D insurance amount or $5,000. If there is no spouse or domestic partner, no benefit will be paid.
- **Occupational Assault Benefit**. The Occupational Assault Benefit pays an additional benefit if you suffer death or dismemberment as a result of an act of workplace physical violence that is punishable by law. The amount of the Occupational Assault Benefit is the lesser of 50 percent of the AD&D insurance benefit payable for the loss or $25,000.
- **Public Transportation Benefit**. The Public Transportation provision pays an additional benefit in the event of your death or a covered dependent's death resulting from an accident that occurs while riding as a fare-paying passenger on public transportation. The amount of the Public Transportation Benefit is 200 percent of the amount in effect with a maximum of $300,000.

- **Line of Duty Benefit.** The Line of Duty Benefit pays an additional benefit for public safety officers who suffer death or dismemberment in an accident while acting in the line of duty. The amount of the Line of Duty Benefit is the lesser of the AD&D insurance benefit payable for the loss or $50,000.

Effective Date of Coverage

Coverage for Employee and Dependents

Your AD&D Insurance becomes effective on the first day of the calendar month following the date you enroll, provided you apply within 60 days after becoming an eligible employee. If you wish to enroll for employee and dependent coverage, you must apply within 60 days after becoming an eligible employee with eligible dependents.

If you do not enroll within 60 days after becoming eligible, you may enroll only during the annual open enrollment period or within 60 days following a qualified status change, as determined by your employer. The effective date of coverage for which you enroll during the annual open enrollment period is the following January 1. The effective date of coverage for which you enroll following a qualified status change is the first day of the calendar month following the date you enroll.

You pay the entire cost of coverage. While employee and dependent coverage is in effect, each new dependent becomes insured automatically.

Actively at Work Requirement

You must meet the Actively at Work Requirement for any coverage or increase in coverage to become effective. If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member. Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively at Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work.

Designating a Beneficiary

When you enroll for coverage, you should name a beneficiary or beneficiaries to receive death benefits. You may do this online or by completing the appropriate form. Your designation must be dated and delivered to your employer during your lifetime. If you name more than one beneficiary, they will share equally unless you specify otherwise. You may change beneficiaries at any time without the consent of the beneficiary.

If you don’t name a beneficiary or your named beneficiary dies before you, death benefits will be paid in equal shares to the first surviving of the following: your spouse; your children; your parents; your estate.

Benefits payable for losses other than loss of life are paid to the person suffering the loss. You are the beneficiary of benefits paid due to the death of your spouse, domestic partner or child.

Payment of Benefits

For amounts less than $25,000, The Standard issues a check to the claimant. The Standard pays amounts of $25,000 or more to the claimant by depositing funds into Standard Secure Access — a no fee, interest-bearing draft account. The claimant receives a personalized checkbook and has complete control of the account. Claimants can write checks as needed or for the full amount. This arrangement allows claimants to earn interest on the benefit while they consider financial decisions.

Exclusions

AD&D insurance benefits are not payable for death or dismemberment caused or contributed to by:

- War or act of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Suicide or other intentionally self-inflicted injury while sane or insane
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot (except while performing official duties)
- Voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above
- Travel or flight in or descent from any kind of aircraft, as a pilot or crew member, except in employer owned, leased or operated aircraft while on state business

When Coverage Ends

AD&D insurance ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid for coverage.
- The date you cease to meet the terms of eligibility outlined in the PEBB Administrative Rules.
- The date you become a full-time member of the armed forces.
- The date the group policy terminates.

AD&D insurance for your spouse or domestic partner and children ends automatically on the earliest of the following:

- The date the last period ends for which a premium was paid for the coverage.
- The date your AD&D insurance ends.
- The last day of the month in which a dependent loses eligibility under the PEBB plans.
- For a child who is disabled, 90 days after we mail you a request for proof of disability, if proof is not given.

Claims

A person wishing to make a claim must, at the claimant's expense, submit to The Standard proof that a death or other loss occurred, and any other information The Standard may reasonably require in support of the claim. The Standard may have you or your dependents examined by a specialist of The Standard's choice at reasonable intervals. The Standard may have an autopsy performed at The Standard's expense, except where prohibited by law.

The claimant will receive a written decision on the claim within a reasonable time after The Standard receives the claim. If the claimant does not receive a decision from The Standard within 90 days, the claimant can request a review as if the claim had been denied.

If The Standard denies any part of the claim, the claimant will receive a written notice of denial containing the reasons for the decision, reference to the parts of the group policy supporting the decision, a description of any additional information needed to support the claim, and information concerning the claimant's right to a review of the decision.

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

Premium Rates

Accidental Death and Dismemberment Premium Rates		
Amount	Employee	Employee & Dependents
$50,000	$1.00	$1.70
$100,000	$2.00	$3.40
$150,000	$3.00	$5.10
$200,000	$4.00	$6.80
$250,000	$5.00	$8.50
$300,000	$6.00	$10.20
$350,000	$7.00	$11.90
$400,000	$8.00	$13.60
$450,000	$9.00	$15.30
$500,000	$10.00	$17.00

Flexible Spending and Commuter Accounts

PEBB offers healthcare and dependent care flexible spending accounts (FSAs) and commuter accounts (CAs) for eligible employees.

FSAs

An FSA is a tax-free account that allows you to use pre-tax dollars to pay for eligible out-of-pocket healthcare or dependent care expenses. You choose an annual amount to contribute to your account, and your payroll deducts your salary contribution before calculating your taxes. Paying for eligible expenses with these pre-tax dollars saves money.

Here are things you should know about these accounts.

- FSAs operate according to IRS regulations.
- Enrollment in an FSA terminates at the end of each plan year. To have an FSA in the following plan year you must enroll before the start of the new plan year, generally this is during the Open Enrollment period.
- When you enroll, you enroll for the entire plan year. Your enrollment is irrevocable except for limited situations. So you should plan accordingly.
- You may change your contribution amount midyear only within 30 days of a qualified midyear change event.
- You forfeit any funds that you don't use and claim for valid expenses by the end of the grace period.
- Your payroll will deduct even portions of your annual election amount each month over the course of the year. You can only have one contribution per month to your FSA account.
- Expenses for a Domestic Partner cannot be reimbursed.
- The health care FSA period of coverage is the plan year. The exception is for employees who terminate participation, in which case it means the portion of the plan year before the active participation end date. Active participation in a health care FSA ends the last day of the month that a last contribution is deducted by payroll for that month.
  a. An Oregon State Payroll System employee terminating employment will not have final contribution taken from their final paycheck.
  b. An employee of an Oregon state university employee terminating employment who meets the 80-hour work termination rule will have a contribution taken from their final paycheck.
- Reimbursement of eligible expenses may occur only for the period of coverage in which your participation was active, provided the claim is filed within the eligible plan year, including the grace period. The exception is a dependent care FSA from which you request reimbursement of expenses: 1) incurred in the month following the end of participation, 2) in the current plan year (not the grace period) and 3) made within 90 days of the participation end date.
- You cannot use your FSA funds as reimbursement for expenses you incur after you leave employment with the state. The exception is a health care FSA, which you may continue by enrolling in COBRA .

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

Healthcare flexible spending account

A healthcare flexible spending account is an allowable benefit of a Cafeteria Plan as defined in Section 125 of the Internal Revenue Code. It permits eligible employees to contribute pre-tax to an account for reimbursement of certain healthcare expenses. Deductions from your paycheck to the plan are exempt from federal and state income tax and

Social Security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns. Note that reducing your taxable income may have the effect of reducing your total Social Security benefit earning

Generally, employees with a higher income have a higher percentage tax break through the healthcare flexible spending account. Contact your tax advisor if you have questions about which is best for you.

You may elect to have up to $2,500 deducted from your pay during the year. The minimum monthly contribution amount is $20.00.

Administrator

ASIFlex administers PEBB's healthcare flexible spending account program. The customer service department is open from 5 a.m. to 5 p.m. Pacific Time Monday through Friday, and from 7 a.m. to 11 a.m. on Saturday. Contact: (800) 659-3035; TTY (866) 908-6043; fax (866) 381-9682; email asi@asiflex.com. Website http://orpebb.asiflex.com.

Mailing Address:
ASIFlex
PO Box 6044
Columbia, MO 65205-6044

Physical Address:
ASIFlex
201 W. Broadway #4C
Columbia, MO 65203

To Participate:

1. **Estimate your family's annual out-of-pocket medical expenses**. You may include expenses for anyone included on your federal tax return. Include predictable expenses only. Divide your annual out-of-pocket medical expense estimate by the number of months you expect to receive paychecks during the Plan Year.
2. **Enroll in the healthcare FSA**. Enroll online during Open Enrollment or by submitting a paper form to PEBB. If you become eligible to enroll midyear submit your forms to PEBB.
3. **Receive healthcare services.** You incur an expense when you receive the services or supplies that create the expense. You can file a claim for healthcare services only after you receive the services.
4. **File claims.** After you receive the healthcare services and know the amount of your responsibility for the bill, submit a claim (with required substantiation) for those expenses to ASIFlex. See the ASIFlex web site for additional information about eligible reimbursements.
5. **Receive reimbursements.** ASIFlex will review your claim. If ASIFlex approves the claim, it will reimburse you for the healthcare expenses within one business day of receipt of the claim.

Qualifying Healthcare Expenses include only those expenses that are defined as medical expenses in Internal Revenue Code §213 and are not reimbursed by any other insurance or another plan. As stated in §213, qualifying Medical Care Expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They exclude all insurance premiums, long-term care expenses, and cosmetic expenses.

Refer to IRS Publication 502 for further details on qualifying expenses. You may link to this publication from ASIFlex's Website. The purpose of Publication 502 is to assist people with their income tax filing. It does not address

healthcare flexible spending account plans. However, most of the items listed as deductible in Publication 502 can be claimed through your healthcare FSA. You cannot deduct on your income tax return expenses reimbursed by the healthcare flexible spending account plan. You cannot file for healthcare FSA expense reimbursements for expenses you deduct on your income tax return.

You can only claim expenses based on the date incurred or date of service (not "paid" as stated in IRS Publication 502). Contact ASIFlex at asi@asiflex.com, (800) 659-3035 if you have any questions regarding particular expenses. Below is a **partial list of qualified expenses**.

- Deductibles
- Coinsurance amounts and co-pays
- Doctor's fees
- Dental expenses
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Prescription drugs and medicines (not imported from another country) used to treat a medical condition
- Insulin
- Orthodontia (braces)
- Routine physicals
- Medical equipment
- Hearing aids, including batteries
- Transportation expenses related to illness
- Chiropractor's fees
- Over-the-counter drugs for which you have a prescription

This is a **partial list of expenses that do not quality.**

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
- Sunglasses - non-prescription
- Toiletries
- Medicines, drugs, herbs, or vitamins for general health and not used to treat a specific medical condition
- Expenses that are merely beneficial to your general health (e.g., vacations and vitamins)
- Health club dues (not prescribed for a particular condition)
- Any sort of insurance premiums
- Warranties
- Long-term care expenses
- Prescription drugs imported from another country

Debit Card

The FSA administrator, ASIFlex, offers a debit card for use in the healthcare flexible spending account program. Use of this debit card may reduce the amount of paperwork required in substantiating some claims. It will not eliminate the need to substantiate all claims. See the ASIFlex website http://orpebb.asiflex.com/debitcard/debitcard.htm.

Coverage Continuation

COBRA. To the extent required by COBRA, participants and those covered on the participants' tax return may elect to continue the coverage elected under the healthcare flexible spending account plan. This applies even if the participant's election to receive benefits expired or ended under the following circumstances (qualifying events):

- The participant dies
- The participant's employment is terminated (other than for gross misconduct) or the participant's paid work hours are reduced
- The participant divorces or becomes legally separated
- The participant's dependent child ceases to be a dependent under the terms of this plan

When the plan is notified that one of the events has occurred, the plan will provide to each eligible person the right to choose continuation coverage if, on the date of the qualifying event, the participant's remaining benefits for the current Plan Year are greater than the participant's remaining contribution payments. The right to elect to continue ends 60 days from the date the plan administrator provides notice of the right to continue coverage. It is the responsibility of the participant or a responsible family member to inform the administrator of the occurrence of an event described above.

Continuation coverage will not extend beyond the end of the current Plan Year or Grace Period. Continuation coverage may terminate earlier if the premiums are not paid within 30 days of their due dates.

Payment for expenses incurred during any period of continuation will not be made until the administrator receives the contributions for that period. An administrative charge of two percent is assessed for each premium paid for continuation coverage.

FMLA Leave: Employees approved for a Family Medical Leave Act (FMLA) may continue their FSA during the leave only if prepayment of the monthly contributions is received prior to the start of the leave. Prepayment must be made as a pre-tax salary deduction. Submit a request for prepayment to PEBB.

QRD - Qualified Reservist Distribution

Conditions. You must meet the following conditions to elect a qualified reservist distribution (QRD) from your healthcare flexible spending account (FSA):

- You have made contributions to your FSA that exceed plan-year reimbursements on the date of your QRD request.
- You are ordered or called to active military duty for a period of at least 180 days or for an indefinite period by reason of being a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- You have provided the Administrator with a copy of the order or call to active duty. An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.
- You are ordered or called to active military duty on or after the beginning of the plan year that began Jan. 1, 2009.
- You submit to the Administrator a QRD election form during the period beginning on the date of your order or call to active duty and ending on the last day of the Plan Year (or grace period) during which the order or call occurred. For example, if you are called to active duty on Sept. 13, 2009, you must request the QRD between Sept. 13, 2009, and March 31, 2010 (for the 2009 plan year only).

Amount. If you meet these conditions, you will receive a QRD equal to your plan-year contributions to your FSA as of the date of your request, minus any reimbursements you already received as of that date. Example: You elected FSA benefits of $1,000 for the plan year. During the first six months of the plan year, you make FSA contributions of

$500 and receive reimbursements of $200 for substantiated medical care expenses. If you request a QRD upon being called to active duty for an indefinite period on June 30, you would receive a distribution of $300.

Further Reimbursement and Account Status. When you request a QRD, you forfeit the right to receive reimbursements for medical care expenses incurred during the period that begins on the date of your request and ends on the last day of the plan year. Your FSA terminates as of the date you request a QRD.

Tax Treatment. Your QRD will be included in your gross income and will be reported as wages on your Form W-2 for the year in which it is paid to you.

Dependent Care flexible spending account

A dependent care flexible spending account is an allowable benefit of a Cafeteria Plan as defined in Section 125 of the Internal Revenue Code. It permits eligible employees to contribute pre-tax to an account for reimbursement of certain dependent care expenses provided to a qualifying individual by a qualified provider. Deductions from your paycheck to the plan are exempt from federal and state income tax and Social Security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns. Note that reducing your taxable income may have the effect of reducing your total Social Security benefit earnings.

You may contribute up to $5,000 per year to a dependent care flexible spending account. The minimum monthly contribution is $20.00. If you and your spouse (not Domestic Partner) both contribute to an account, your combined yearly contribution may not be more than $5,000.

A dependent care flexible spending account is an alternative to taking a tax credit allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the tax credit or the dependent care flexible spending account. The IRS will not allow you to receive two tax breaks on the same expenses.

Generally, employees with a higher income have a higher percentage tax break through the dependent care flexible spending account. Contact your tax advisor if you have questions about which is best for you.

Administrator

ASIFlex administers PEBB's dependent care flexible spending account program. The customer service department is open from 5 a.m. to 5 p.m. Pacific Time Monday through Friday, and from 7 a.m. to 11 a.m. on Saturday. Contact: (800) 659-3035; TTY (866) 908-6043; fax (866) 381-9682; email asi@asiflex.com. Website http://orpebb.asiflex.com.

Mailing Address:
ASIFlex
PO Box 6044
Columbia, MO 65205-6044

Physical Address:
ASIFlex
201 W. Broadway #4C
Columbia, MO 65203

To Participate

1. **Estimate your total dependent care expenses for the Plan Year**. Include predictable expenses only. Divide your yearly dependent care expenses estimate by the number of months you expect to receive paychecks during the Plan Year.
2. **Enroll in the dependent care flexible spending account**. Enroll online during Open Enrollment or by submitting a paper form to PEBB. If you become eligible to enroll midyear submit the form to PEBB.
3. **Receive Dependent care services.** You incur expenses when you receive the services that create the expense. You can file a claim for dependent care services only after you receive the services.
4. **File claims.** After you have received the dependent care services, submit a claim for those expenses (with required substantiation) to ASIFlex.
5. **Receive reimbursements.** ASIFlex will review your claim. If ASIFlex approves the claim, it will reimburse you for the dependent care expenses within one business day of receipt of the claim up to the amount you have on deposit in your account. If your claim exceeds your available funds, ASIFlex will record the difference and will pay as funds become available from payroll.

A qualifying individual is:

- Your dependent who is under the age of 13 who lives with you at least one half of the year
- Your spouse or an older dependent who is mentally or physically incapable of self-care who resides with you for more than one half of the year and is a qualifying child or relative under Section 152 of the IRS Code

A qualified provider can provide care in your home or outside your home. If the care is provided outside your home by a facility that cares for more than five individuals, it must be licensed by the state. The expenses may not be paid to your spouse, a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred, or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

Commuter Benefit

The Commuter benefit is an allowable benefit of a Cafeteria plan regulated by Internal Revenue Code. It permits eligible employees to contribute to a Commuter account for reimbursement of certain commuter expenses provided to a qualifying individual,. Deductions from your paycheck to the account are exempt from federal and state income tax, and Social Security tax. These deductions reduce your **taxable** income reported on your W-2 and on your income tax returns. Note that reducing your taxable income may have the effect of reducing your total Social Security benefit earnings.

The Commuter benefit has two accounts available: a Transportation account and a Parking account. PEBB-enrolled employees may contribute to one or both accounts on a pretax basis to pay for work-related commuting expenses.

ASIFlex, PEBB's third party administrator for the Flexible Spending Accounts (FSAs), is also the administrator for the Commuter Accounts.

Eligibility and Accounts

All active employees enrolled in PEBB benefits are eligible for these accounts. They are employee-only accounts; spouses/partners and dependents are not eligible for this benefit.

Two types of accounts are available: Transportation and Parking. You may enroll in one or both.

Transportation Account

This is a pretax account to pay for work-related commuting expenses for bus, ferry, rail, monorail, streetcar, train, subway or vanpooling expenses. The 2015 maximum monthly contribution/reimbursement is $130. The account reimburses for the following qualified expenses:

- **Transit Pass Expenses:** These are expenses incurred for a pass, token, fare card, voucher, or similar item for transportation using Mass Transit Facilities. These include public or commercial facilities. Commercial facilities are those provided by any person in the business of transporting persons for compensation or hire if such transportation is provided in a vehicle with a seating capacity of at least six adults (excluding the driver).
- **Commuter Highway Vehicle (Vanpool) expenses**. The transportation must be in connection with travel between your residence and place of employment. A commuter highway vehicle is any highway vehicle with a seating capacity of at least six adults (not including the drive). At least 80% of the mileage must be for purposes of transporting employees in connection with travel between their residences and their places of employment. The number of employees transported for such purposes must be, on average, at least half of the adult seating capacity of the vehicle.

Parking Account

(If you park in a state parking lot, DO NOT enroll in this account for your monthly state parking lot fee. Your agency deducts state lot fees pre-tax each month from your paycheck.)

This is a pretax account to pay for certain parking expenses incurred to work. The expenses are those for parking at the following:

- At or near the business premise of the employer
- A location from which to commute to work by mass transit facilities or commuter highway vehicle (carpool)

The 2015 maximum monthly contribution/ reimbursement for a parking account is $250. This maximum contribution amount allowed includes any monthly payroll deduction for State of Oregon parking lot usage. State parking lot fees are deducted pretax from the employee's monthly pay. The Commuter Parking account is not used to pay the monthly state-parking fee. However, both amounts added together cannot exceed the monthly allowable maximum.

Monthly Contribution

The minimum monthly contribution is $20 for each account. The monthly maximum limits are set each year by the Internal Revenue Service (IRS) and are subject to change. The 2015 maximum monthly contribution is $130 for a Transportation account and $250 for a Parking account.

To estimate what you should contribute each month, review your expenses for commuting to and from work in the previous year. Make note of what you spend on a regular monthly basis.

Account Changes

You can enroll, change, or cancel your Commuter accounts at any time. You must submit a Commuter account enrollment/change form to your agency by the 10th of the month for changes to be effective in the following month's pay. Forms received beyond the 10th **may not** process until the next month.

No fund transfers are allowed. You may not transfer funds from one account to another to cover unanticipated expenses, even if you have a leftover balance in one account. For example, if you have excess money in your Transportation account, you cannot use that money to pay for your parking expenses.

Reimbursement

To be reimbursed for commuter expenses incurred or paid, submit a completed claim form along with appropriate supporting documentation. See the ASIFlex website for forms and instructions: http://orpebb.asiflex.

- You can submit claims for reimbursement to ASIFlex via toll-free fax or mail.
- You cannot be reimbursed for more than the cash balance in your account.
- You may make changes and adjust future contributions to avoid having an excess balance.
- Expenses must be "incurred or paid" before being reimbursed. Reimbursement cannot be made before the date an expense has been incurred or paid.

ASIFlex Card (debit card): You can order an ASIFlex Card (debit card) for use with Transportation accounts. In some cases, transportation expenses may require documentation; ASIFlex will notify you when this is required. If you do not provide the documentation timely, the card will be temporarily inactivated.

- If you are currently using an ASIFlex card in your health care FSA, ASIFlex will add the transportation account to your existing benefit debit card. If you don't have a health care FSA, or do not have a health FSA card, you can order a transportation account card by completing and submitting an order form. There is no cost to you for the card. You will receive two cards. Additional or replacement cards are $5 per set, billed to your account.
- Excess account balances will be carried over to the following month. However, you can only spend the amount to the monthly IRS limits – $250 for parking and $130 for transit.

End of plan year

Commuter accounts are a month-to-month benefit; there is no plan year. Commuter Accounts will not terminate as long as they are "active" and do not require re-enrollment each year. You may terminate your account by submitting a form to your agency.

If six months lapse without making a contribution or submitting a reimbursement claim, any funds in your account will be forfeited.

Terminating Employment

- **If you are separating service you will have access to your funds for a limited time (six months) for reimbursement of valid claims that you incurred while you were an active employee.**

- **The Internal Revenue Code does not permit any funds remaining in your account to be refunded. If you terminate employment any unclaimed funds cannot be refunded to you**, ***unless you file a claim for expenses incurred before you terminated employment*.**

IMPORTANT: YOU FORFEIT YOUR ACCOUNT FUNDS IF SIX MONTHS LAPSE WITHOUT A CONTRIBUTION BEING MADE OR A REIMBURSEMENT CLAIM PROCESSED.

When does my participation in the Commuter Benefit Program end?

- You are no longer employed by the state of Oregon;
- You elect to stop contributing (expenses may be submitted for six months from the date on which they occurred);
- The Commuter Benefit Program is federally terminated

- Your account forfeits because six months lapse without a contribution or a reimbursement claim processed

Examples of expenses that are NOT eligible for reimbursement:

- Tolls
- Traffic tickets
- Fuel
- Mileage or other costs you incur in operating a vehicle
- Taxis
- Payments to a fellow participant in a carpool or to a friend who drives you to work
- Parking at or near your personal residence
- Parking at your spouse's place of work
- Parking at a mall or similar location where you stop on your drive to or from your place of work
- Costs that have been or will be paid by your employer, such as for a business trip

Long Term Care Insurance

Caution: If you must complete an Application for Long Term Care Insurance which includes evidence of insurability, the issuance of a long term care insurance certificate will be based on your response to the questions in your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, UNUM may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact UNUM at this address: UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

Notice to buyer: This plan may not cover all of the costs associated with long term care which you may incur during the period of coverage. You are advised to review carefully all coverage limitations.

1. Outline of Coverage

This outline of coverage provides a brief description of the important features of the plan. You should compare this outline of coverage to outlines of coverage for other plans available to you.

This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and UNUM. Therefore, if you purchase this coverage, or any other coverage, it is important that you read your certificate carefully.

2. This Policy is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

3. Terms under which the certificate may be returned and premium refunded

- You have a 30 day right to examine the certificate. If, after examining the certificate, you are not satisfied for any reason, you may withdraw your enrollment in the plan by returning your certificate within 30 days of its delivery to you. The certificate, together with a written request for withdrawal must be sent to the Plan Administrator if the applicant is an employee, employee's spouse or employee's domestic partner. All other applicants should send the certificate and written request to UNUM. Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.
- Premiums for additional, increased or terminated insurance may cause a pro-rata adjustment on the next premium due date.

4. This is not Medicare supplement coverage

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from UNUM. You may obtain a copy of the Guide by calling 1-800-227-4165. UNUM Life Insurance Company of America is not representing Medicare, the federal government or any state government.

5. Long term care coverage

Plans of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This plan provides coverage in the form of a fixed dollar indemnity monthly benefit if you become Disabled. Coverage is subject to policy limitations, benefit maximums and elimination periods.

6. Benefits provided by the policy

You are eligible for a monthly benefit after:

- You become Disabled;
- You are receiving services in a Long Term Care Facility or Assisted Living Facility/Adult Foster Home; or Professional Home Care Services if your plan includes a Professional Home Care Services benefit; or Total Home Care if your plan includes a Total Home Care benefit;
- You have satisfied your Elimination Period; and
- A Physician has certified that you are unable to perform, without Substantial Assistance from another individual, two or more ADLs for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you and others from threats to health or safety due to Severe Cognitive Impairment. You will be required to submit a Physician certification every 12 months.

A monthly benefit will become payable once all of these requirements are met.

The treatment and services you receive for your Disability must be provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner.

If you have an existing loss of ADLs or Severe Cognitive Impairment on your effective date of coverage, that loss or impairment will only be eligible for coverage if you recover from that loss or impairment. We must receive acceptable proof of your ADL or cognitive recovery, such as a physician's statement or an assessment.

The amount of your monthly benefit will be based on the coverage options you chose and the place of residence used for long term care. If your coverage includes Professional Home Care Services, the benefit payment will be based on the number of days you receive these services.

Adult Day Care means a community-based program offering health, social and related support services to impaired adults. Adult Day Care can be provided by a Home Health Care Provider or an Adult Day Care Facility.

Adult Day Care Facility means a facility that operates under applicable state licensing laws and any other laws that apply, or meets the following tests:

- operates a minimum of 5 days a week;
- remains open for at least 6 hours a day;
- is not an overnight facility;
- maintains a written record of care on each patient;
- includes a plan of care and record of services provided;
- has a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
- has established procedures for obtaining appropriate aid in the event of a medical emergency; and
- provides a range of physical and social support services to adults.

Assisted Living Facility means:

- An institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage in providing ongoing care and services to a minimum of 6 residents in one location and operates under state licensing laws and any other laws that apply.
- any other institution that meets all of the following tests:
    - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a disability;
    - has an employee on duty at all times who is awake, trained and ready to provide care;
    - provides 3 meals a day, including special dietary requirements;
    - operates under applicable state licensing laws and any other laws that apply;
    - has formal arrangements for the services of a doctor or nurse to furnish medical care in the event of an emergency;
    - is authorized to administer medication to patients on the order of a doctor; and is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers; or

- a similar facility approved by UNUM.
- for these purposes, an institution that meets the requirements is a Residential Care Facility or Assisted Living Facility.

Adult Foster Home means:

- a family home or facility that is licensed by the appropriate licensing agency and is primarily engaged in providing (1) room and board to 5 or fewer adults who are not related to the provider by blood or marriage; and (2) services that assist the resident in daily activities, such as bathing, dressing, eating, medication management or money management; or
- any other resident home that meets all of the following tests:

    - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a disability;
    - has an employee on duty at all times who is awake, trained and ready to provide care;
    - 3 meals a day, including special dietary requirements; -operates under applicable state licensing laws and any other laws that apply;
    - has formal arrangements for the services of a doctor or nurse to furnish medical care in the event of an emergency;
    - is authorized to administer medication to patients on the order of a doctor;
    - and is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers; or
    - a similar institution approved by UNUM.

Disability and Disabled means you are unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living or you require Substantial Supervision by another individual to protect you from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are: Bathing, Dressing, Toileting, Transferring, Continence and Eating.

The Elimination Period is the number of consecutive days during which you must continue to be eligible for a monthly benefit before a benefit becomes payable.

Lifetime Maximum is the maximum that UNUM will pay you for all long term care benefits. You have your own Lifetime Maximum.

Professional Home Care Services Benefit:
We will pay you 1/30th of the Monthly Professional Home Care Services Benefit Amount for each day you receive Professional Home Care Services if:

- you are disabled; and
- you choose to receive care anywhere other than in a Long Term Care Facility, or Assisted Living Facility.

This care can be provided at any type of facility, such as an Adult Day Care Facility, or your home by/through a licensed Home Health Care Provider.

Respite Care: If you are eligible for a home care monthly benefit but benefits have not yet become payable, payments will be made to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your home care monthly benefit for each day that you receive respite care.

Respite care means formal care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities.

Severe Cognitive Impairment means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in short or long term memory, orientation to people, places or time; and deductive or abstract reasoning.

Substantial Assistance means stand-by assistance by another person without which you would not be able to safely and completely perform the ADL.

Substantial Supervision means the presence of another individual for the purpose of protecting you from harming yourself or others.

Optional Benefits Available

Total Home Care Benefit
We will pay you the Monthly Total Home Care Benefit Amount if you are disabled and you choose to receive care anywhere other than in a Long Term Care Facility or Assisted Living Facility.

This care can be provided at any type of facility, such as an Adult Day Care Facility or your home. Care can be provided to you by:

- a formal caregiver, such as a licensed Home Health Care Provider, a registered nurse, a licensed practical nurse, or
- an informal caregiver, such as a friend or relative.

Inflation Protection Provision - 5% Simple Inflation with No Cap
Your Monthly Benefit Amount will increase each year on January 1st by 5% of the original Monthly Benefit. Increases will be automatic and will occur regardless of your health and whether or not you are Disabled. Your premium will not increase due to automatic increases in your Monthly Benefit Amount.

The benefit paid is subject to the Lifetime Maximum Benefit Amount. Benefits are not paid during the Elimination Period.

Refer to the graphic Comparison Chart of all types of Inflation

7. Limitations and exclusions
UNUM will not make long term care payments to you for:

- a Disability caused by war (whether declared or not) or any act of war,
- a Disability caused by attempted suicide (while sane or insane) or self-destruction,
- a Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law,
- Disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- a Disability caused by alcoholism or alcohol abuse,
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments), or
- a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital (this exclusion does not apply to those periods covered under the Bed Reservation Benefit), or
- a Disability caused by psychological or psychiatric or mental conditions, regardless of cause, which include:

    - depression,
    - generalized anxiety disorders,
    - personality disorders,
    - schizophrenia,
    - manic depressive disorders, or
    - adjustment disorders and other conditions that are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar methods of treatment.

However, UNUM will make payments to you for conditions that are not psychological, psychiatric or mental in nature, including Alzheimer's disease or similar forms of irreversible dementia.

Pre-existing Conditions Exclusion

If you do not have to complete an Application for Long Term Care Insurance, which includes evidence of insurability, a pre-existing conditions exclusion may apply to you.

Pre-Existing Condition means any condition that exists for which you received medical treatment, consultation, care or services, including diagnostic measures for the condition, or took drugs or medicines that were prescribed for the condition, during the six month period right before your coverage began.

UNUM will not make any payments to you for a Disability that is caused by, contributed to by, or results from a pre-existing condition, and begins during the first six months after your coverage begins.

This plan may not cover all the expenses associated with your long term care needs.

8. Relationship of cost of care and benefits

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

- **Cost.** The premium rate paid for your coverage over the duration of your initial coverage or for any increases is based on your insurance age.
- **Election to increase coverage.** You can apply at any time to increase coverage by filling out a new Benefit Election Form and a Long Term Care/Evidence of Insurability Application.

Inflation Protection Comparison

The following chart is an example comparison of monthly benefits with Simple Inflation Protection Option.

	Without Inflation Protection	**With 5% Simple Inflation Protection**
Policy Year	**Monthly Benefit**	**Monthly Benefit**
1	$ 2,000	$ 2,100
2	$ 2,000	$ 2,200
3	$ 2,000	$ 2,300
4	$ 2,000	$ 2,400
5	$ 2,000	$ 2,500
6	$ 2,000	$ 2,600
7	$ 2,000	$ 2,700
8	$ 2,000	$ 2,800
9	$ 2,000	$ 2,900
10	$ 2,000	$ 3,000
11	$ 2,000	$ 3,100
12	$ 2,000	$ 3,200
13	$ 2,000	$ 3,300
14	$ 2,000	$ 3,400
15	$ 2,000	$ 3,500
16	$ 2,000	$ 3,600
17	$ 2,000	$ 3,700
18	$ 2,000	$ 3,800
19	$ 2,000	$ 3,900
20	$ 2,000	$ 4,000

9. Terms under which the group coverage through the plan may be continued in force or discontinued

- **Renewability.** The policy is guaranteed renewable. This means you have the right, subject to the terms of the policy, to continue this coverage as long as you pay your premiums on time. UNUM cannot change any of the terms of the policy on its own except that, in the future, it may increase the premium you pay.
- **When coverage will end.** Your coverage will end on the earliest of these dates;
  - the date the Policy ends,
  - the date you are no longer an Active Employee with the Policyholder,
  - the date you no longer work for the Policyholder, or
  - the end of the period for which premiums were last paid to UNUM for your coverage,
  - the date your total benefit payments equal your Lifetime Maximum Amount, or
  - the date you die.

If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to UNUM.

- **Converted coverage.** If your group long term care coverage ends, for reasons other than your choice to have premium payments stopped for your coverage, you may elect converted coverage. This means that the same coverage you had under this plan can continue on a direct billed basis. If you are already direct billed, your coverage will automatically transfer to converted coverage. Election for converted coverage must be made within 60 days of the date the group coverage would otherwise end. Any premium that applies must be paid directly to UNUM by you for any converted coverage to be continued.
- **Premium waiver**. When benefits become payable, there will be no more cost for your coverage as long as you continue to be eligible for a monthly benefit. If your plan includes Professional Home Care Services and you do not receive these services for a period of 30 consecutive days, premium payments will again become due. Premiums are **not waived** while you are receiving a payment for Respite Care.
- **Right to Change Premiums**. The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies under this type of insurance.

10. Alzheimer's disease and other organic brain disorders

The policy provides coverage for Severe Cognitive Impairment. Severe Cognitive Impairment is not related to the inability to perform ADLs. Rather, Severe Cognitive Impairment means that you have lost the ability to reason and suffer a decrease in awareness, intuition and memory. Examples of conditions which may cause Severe Cognitive Impairment are: Alzheimer's disease, multi-infarct dementia, brain injury, brain tumors, and other such structural alterations of the brain.

11. Premium

Premiums are based on the plan design selected and the insurance age of each enrolled person. UNUM may change the premium rates when the terms of the policy are changed.

12. Additional features

- Medical underwriting may be required
- Eligibility and Participation

You are eligible for the plan if you are an Active or Retired employee of the Policyholder, spouses, domestic partners and your family members.

PLAN HIGHLIGHTS/SCHEDULE OF BENEFITS

Your Long Term Care (LTC) insurance plan is described below.

Elimination Period: Your plan's Elimination Period of 90 consecutive days is the amount of time you must wait before benefits become payable. This time period must be satisfied only once during the life of your plan.

Newly Hired Employees – Will have 60 days from date of hire to sign up for Guarantee Issue coverage. Coverage is effective the first of the month following the date your Benefit Election Form is received by the agency. **Guarantee Issue** – As an Employee you are eligible for benefit amounts on a guarantee Issue basis of up to and including $4,000 and a facility Benefit Duration of 3 or 6 years. Completion of the Benefit Election Form is required for enrollment. This does not require completion of the Long Term Care Insurance Application (medical questionnaire) if you are applying during your initial eligibility period.

Medical Underwriting Effective Date: The effective date for those applicants passing medical underwriting is the first of the month following the approval into the plan.

Medical Underwriting means that you must answer all questions on a medical questionnaire. In some cases, an interview may also be necessary.

Delayed Effective Date – If you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence, your coverage will not begin on your otherwise expected effective date.

Medical Underwriting for Employees and Family: (Completion of the Benefit Election Form is required for enrollment) As an **Employee** you are eligible for benefit amounts on a Guarantee Issue basis of up to and including $4,000 and a Facility Benefit Duration of 3 or 6 years. This does not require completion of the Long Term Care Insurance Application (medical questionnaire) if you apply during your initial eligibility period. The Long Term Care Insurance Application (medical questionnaire) is required if enrolling after your initial eligibility period or if you choose to buy $5,000, $6,000 or the Unlimited Duration coverage. **Spouses, Domestic Partners, Retirees** and all **Family Members** must complete the Long Term Care Insurance Application (medical questionnaire) and must be approved for coverage in order to enroll in the Long Term Care plan. **All** Medical Questionnaires must accompany a signed Authorization to request Medical Information Form #6720-03 located in the enrollment kit.

Benefit Duration	**3 Years**	**6 Years**	**Unlimited Duration**
Facility Benefit Amount Per $1,000 Increments	$1,000 to $6,000	$1,000 to $6,000	$1,000 to $6,000
Adult Foster Care/Assisted Living Facility	60%	60%	60%
Lifetime Maximum Per $1,000 Increments	$36,000	$72,000	Unlimited
Professional Home Care	50%	50%	50%
Total Home Care -Option	50%	50%	50%
Inflation Protection * -Option	Simple Uncapped	Simple Uncapped	Simple Uncapped

* If you selected an inflation option, and you terminate that inflation option at a future date, you can purchase the inflated coverage amount at your original age.

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount UNUM will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration. For Example: If you choose $3,000 Facility Monthly Benefit Amount & 3 Year Duration, your Lifetime Maximum is calculated as follows,$3,000 per Month X 12 Months X 3 Years = $108,000 Lifetime Maximum

Insurance Age: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the plan effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage on or after the plan effective date, insurance age is your age on the date you sign the enrollment form.

Questions: Please call, 1-800-227-4165 with questions regarding your Long Term Care Insurance.

Rates: Please see rates beginning June 2015 on the following pages.

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation	**Simple**
Facility Benefit Duration	**3 Years**	Protection	**Uncapped**
Home Benefit Lifetime Maximum	**50%**		
Elimination Period	**$36,000**		
Home Care Level	**90 Days**		
	Professional		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____	X	_____	÷ $1,000 =	_____
Rate for Plan Chosen		Facility Monthly Benefit Amount		Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
18-30	2.60	3.90	4.30	6.30
31	2.60	3.90	4.50	6.50
32	2.60	3.90	4.50	6.60
33	2.70	4.00	4.70	6.90
34	2.70	4.10	4.80	7.10
35	2.90	4.30	5.00	7.40
36	2.90	4.40	5.20	7.60
37	3.00	4.60	5.40	7.90
38	3.20	4.80	5.80	8.40
39	3.30	5.00	6.00	8.70
40	3.40	5.10	6.20	9.00
41	3.60	5.30	6.50	9.40
42	3.70	5.50	6.70	9.70
43	4.00	5.90	7.20	10.20
44	4.10	6.20	7.50	10.70
45	4.40	6.40	7.90	11.30
46	4.50	6.70	8.10	11.70
47	4.80	7.20	8.50	12.30
48	5.00	7.60	9.00	13.00
49	5.20	8.00	9.30	13.50
50	5.50	8.30	9.80	14.20
51	6.00	9.00	10.40	15.10
52	6.20	9.50	10.80	15.90
53	6.70	10.20	11.50	16.80
54	7.00	10.70	11.90	17.60
55	7.50	11.40	12.70	18.50
56	7.90	12.10	13.30	19.40
57	8.50	13.00	14.30	20.80
58	9.10	13.90	15.00	21.80
59	9.90	14.90	16.10	23.30

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**3 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$36,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
60	10.70	16.00	17.30	24.80
61	11.60	17.30	18.60	26.50
62	12.90	19.00	20.40	28.80
63	14.00	20.50	22.00	31.00
64	15.40	22.30	23.90	33.30
65	17.60	25.00	27.10	37.00
66	19.50	27.20	29.60	40.00
67	21.80	29.90	32.60	43.30
68	24.00	32.50	35.40	46.70
69	26.60	35.50	38.80	50.40
70	29.50	38.80	42.40	54.40
71	32.80	42.50	46.50	59.20
72	36.40	46.60	51.40	64.50
73	40.30	51.10	56.00	69.90
74	44.60	56.00	61.60	75.90
75	53.80	66.80	73.40	89.60
76	59.10	72.70	79.50	96.40
77	64.90	79.10	86.70	104.10
78	71.10	86.00	93.60	111.60
79	78.20	93.70	102.00	120.70
80	85.90	101.90	110.40	129.70
81	94.60	111.30	120.80	140.70
82	105.00	122.60	131.80	152.60
83	116.00	134.80	144.70	166.60
84	127.80	147.60	156.90	179.90

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
18-30	3.30	5.20	5.70	8.50
31	3.40	5.30	5.70	8.60
32	3.50	5.40	6.00	9.00
33	3.60	5.50	6.30	9.40
34	3.70	5.60	6.50	9.60
35	3.80	5.80	6.70	10.10
36	3.90	6.00	6.90	10.30
37	4.10	6.20	7.40	10.80
38	4.30	6.50	7.70	11.20
39	4.40	6.70	7.90	11.60
40	4.60	7.00	8.30	12.20
41	4.70	7.20	8.60	12.60
42	5.10	7.70	9.10	13.40
43	5.30	8.00	9.50	13.80
44	5.50	8.30	10.00	14.60
45	5.80	8.70	10.50	15.20
46	6.20	9.30	10.90	15.90
47	6.40	9.70	11.40	16.70
48	6.80	10.30	11.90	17.50
49	7.00	10.90	12.50	18.50
50	7.40	11.50	13.00	19.40
51	7.80	12.10	13.60	20.40
52	8.20	12.90	14.40	21.50
53	8.80	13.80	15.10	22.80
54	9.20	14.50	15.80	23.80
55	9.90	15.50	16.70	25.00
56	10.50	16.50	17.60	26.50
57	11.30	17.70	18.80	28.10
58	12.10	19.00	19.80	29.70
59	12.90	20.40	21.10	31.60

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
60	13.80	21.80	22.30	33.50
61	15.30	23.80	24.40	36.40
62	16.60	25.90	26.30	39.10
63	18.20	28.10	28.60	42.30
64	20.10	30.70	31.10	45.60
65	22.70	34.30	34.90	50.50
66	25.20	37.50	38.30	54.90
67	28.00	41.10	41.90	59.30
68	30.90	44.80	45.50	63.90
69	34.20	48.90	49.60	68.80
70	37.80	53.50	54.20	74.50
71	42.10	58.80	59.50	81.20
72	46.50	64.30	65.50	88.20
73	51.40	70.40	71.30	95.70
74	56.90	77.10	78.40	104.00
75	68.40	92.10	92.90	122.60
76	75.10	100.20	100.70	131.80
77	82.40	109.10	109.60	142.40
78	90.40	118.80	118.70	153.40
79	99.10	129.30	129.10	165.60
80	108.70	140.70	139.50	177.90
81	119.40	153.50	152.10	192.60
82	132.20	169.00	165.80	209.10
83	145.80	185.60	181.40	227.90
84	160.40	203.20	196.50	246.20

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**		
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
18-30	4.60	7.40	7.80	12.10
31	4.60	7.40	7.90	12.30
32	4.80	7.60	8.20	12.80
33	4.90	7.80	8.40	13.10
34	5.00	7.90	8.70	13.40
35	5.10	8.20	9.10	14.10
36	5.30	8.40	9.30	14.40
37	5.50	8.80	9.90	15.20
38	5.70	9.00	10.20	15.60
39	5.90	9.40	10.50	16.10
40	6.20	9.70	11.10	16.90
41	6.40	10.20	11.60	17.70
42	6.70	10.60	12.10	18.40
43	7.10	11.10	12.60	19.10
44	7.30	11.60	13.20	20.00
45	7.70	12.10	13.80	21.00
46	8.20	12.80	14.40	21.90
47	8.50	13.50	14.90	22.90
48	9.00	14.30	15.80	24.30
49	9.30	15.10	16.40	25.40
50	9.90	16.10	17.10	26.80
51	10.40	17.00	18.00	28.20
52	10.90	18.00	18.80	29.70
53	11.60	19.20	19.90	31.50
54	12.20	20.40	20.70	33.00
55	12.80	21.50	21.50	34.30
56	13.70	23.00	22.90	36.50
57	14.60	24.60	24.20	38.70
58	15.60	26.40	25.50	40.90
59	16.70	28.30	27.10	43.60

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Simple Uncapped**
Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**		
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
Home Care Level	**Professional**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium: _____ X _____ ÷ $1,000 = _____

Rate for Plan Chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Simple Inflation Option	Plan 4 Base Plan With Total Home Care Simple Inflation Option
60	17.90	30.40	28.70	46.20
61	19.60	33.10	31.10	50.00
62	21.40	36.10	33.70	54.10
63	23.30	39.30	36.30	58.30
64	25.40	42.70	39.20	62.60
65	28.80	47.70	44.00	69.50
66	31.90	52.20	48.20	75.60
67	35.40	57.00	52.60	81.40
68	39.10	62.30	57.30	88.10
69	43.10	67.90	62.40	94.80
70	47.70	74.20	68.00	102.50
71	52.80	81.20	74.70	111.70
72	58.40	88.80	81.90	120.80
73	64.30	96.90	89.10	130.90
74	70.80	105.70	97.40	141.30
75	85.00	125.80	115.20	166.20
76	93.50	136.90	125.00	178.90
77	102.50	149.00	136.10	193.30
78	112.10	161.90	146.70	207.50
79	122.60	175.70	159.30	223.60
80	134.10	190.80	171.70	239.60
81	147.20	207.60	187.10	259.00
82	162.60	227.70	203.60	280.40
83	178.80	249.20	222.10	304.50
84	195.90	271.60	239.70	327.50

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:

- 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 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.

Beginning in 2011, 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 with 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. 19, 2014. Name of Entity/Sender: PEBB. Contact: Benefits Manager
Address:1225 Ferry St SE, Ste B, 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.flmedicaidtplrecovery.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 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
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

Your Continuation Coverage Rights under COBRA

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health benefits offered under the Plan and not to any other benefits offered under the Plan.

The Plan provides no greater COBRA rights than what COBRA requires — nothing in this notice is intended to expand your rights beyond COBRA requirements.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify BenefitHelp Solutions of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies.

The disability extension is available only if you notify BenefitHelp Solutions in writing of the Social Security Administration's determination of disability within the 18-month period of continuation of coverage.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed, or if the notice is not provided to BenefitHelp Solutions within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify BenefitHelp Solutions of that fact within 30 days after the Social Security Administration's determination. In providing this notice, you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures."

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second

qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

If your employer maintains separate plans for each health benefit component of the Plan, you may elect COBRA coverage for any one or more of the Plan components under which you were covered on the day before the qualifying event. For example, if you had the option to choose medical and/or dental and/or vision coverage, you will have the option to continue any one of the plans that you were covered under on the day before the qualifying event. However, if your employer has one health plan that covers medical, dental and vision, you must elect or decline continuation coverage for the plan as a whole.

If the health plan you are enrolled in at the time of your qualifying event is regional specific (such as a managed care plan), and you move outside the service area, and the employer has a health plan available in the area you have moved to, you may elect coverage under the other health plan. This also applies if you move after electing COBRA coverage. It is your responsibility to inform the employer of your move.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. Medicare becomes the primary payer for an age-based or disability-based Medicare beneficiary who also has COBRA coverage. If Medicare entitlement is based on ESRD, then Medicare is the secondary payer for the first 30 months of the Medicare entitlement. Carriers may assume enrollment in Medicare and estimate claims as if Medicare is the primary payer. If you haven't enrolled in Medicare Part B and are eligible, contact the Centers for Medicare and Medicaid Services (CMS) to discuss your options. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving

continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period defined in the law or subsequent extensions. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a no forfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Electing COBRA under the Health FSA component

If you are currently participating in a Health FSA, and there is a positive balance of funds in your Health FSA on the termination date, you, your covered spouse and qualified beneficiaries covered under the Health FSA component are entitled to continue coverage in the Health FSA plan. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). **The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year**. All qualified beneficiaries who were covered under the Health FSA component of the Plan will be covered together for Health FSA COBRA coverage.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you make your first payment for continuation coverage in full later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact BHS to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. As a courtesy, BHS will send monthly notices of payments due for these coverage periods if you elect to pay your premium via check. (If you do not receive a bill, it is still your responsibility to pay your COBRA premiums on time).

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Send your first payment and all periodic payments for continuation coverage to:

BenefitHelp Solutions, Inc.
P.O. Box 67240, Portland, Oregon 97268-1240
Phone: 800-556-3137 or 503-765-3581 Fax: 503-765-3453
Web: www.benefithelpsolutions.com

Important Information

Continuation of Coverage for Spouses Age 55 of Older: Under Oregon law (ORS 743.600-743.602), if you are a spouse who is age 55 or older and your eligibility for group health plan coverage has ended due to legal separation, termination of marriage or the member's death, you may be entitled to continue your plan coverage (including coverage for dependent children) until one of the following events occur:

- the date you become covered under any other group health plan, regardless if the other plan has an exclusion or limitation period;
- the date you become eligible for federal Medicare coverage, regardless if you enroll in Medicare;
- the last day of the month that premiums were paid to us in the event of non-payment of premiums;
- the date the Plan terminates or the date the employer terminates participation under this Plan;
- a Dependent child may remain on the plan with you until he/she no longer meets the plan's definition of a dependent child.

Oregon continued coverage is available only if you (spouse age 55 or older) notify the Plan Administrator in writing of the legal separation, termination of marriage or your spouse's death within:

- thirty days of the date of the member's death;
- sixty days of the date of legal separation; or
- sixty days of the date of entry of the divorce decree.

You have 60 days from the date BHS sent this COBRA Enrollment Notice to you to exercise your Oregon continuation coverage rights.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. If you have any questions concerning the information in this notice, your rights to coverage contact:

BenefitHelp Solutions, Inc.
P.O. Box 67240, Portland, Oregon 97268-1240
Phone: 800-556-3137 or 503-765-3581
Fax: 503-765-3453
Web: www.benefithelpsolutions.com

Keep Your Plan Informed of Address and Plan Eligibility Changes

In order to protect your and your family's rights, you should keep BenefitHelp Solutions informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to BenefitHelp Solutions.

If you become eligible for coverage under another group health plan or Medicare, you must notify BenefitHelp Solutions of such eligibility in writing, even if you do not elect such other coverage. Failure to notify BenefitHelp Solutions of eligibility for such other coverage may subject you to a federal penalty equal to 110% of the premium assistance provided to you after the date you became eligible for such other coverage.

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.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.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.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.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.

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).

[1]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.

1

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, 2014. PEBB is required to abide by the terms of this notice until it is changed. We reserve the right to change 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.