

PUBLIC EMPLOYEES'
PEBB
BENEFIT BOARD

**SUMMARY PLAN
DESCRIPTION**

Table of Contents

SECTION 1: ELIGIBILITY, ENROLLMENT AND DATES OF COVERAGE.....	4
Who is Eligible.....	4
Eligible Employees	4
Eligible Retirees.....	7
COBRA Participants.....	10
Other Self-pay Participants	11
Individuals Eligible for Coverage.....	12
Qualifying Dependent Children.....	12
Domestic partners and their dependents	15
Enrollment Periods and Effective Dates	19
How to Enroll.....	20
Midyear Plan Changes.....	21
Individuals No Longer Eligible for Coverage.....	24
HIPAA Special Enrollment Rights	25
SECTION 2: MEDICAL BENEFITS.....	27
Medical Plan Options.....	27
Kaiser Permanente HMO Benefit Summary.....	27
Kaiser Permanente HMO Part-time Benefit Summary.....	27
Providence Choice Benefit Summary	28
Providence Choice Part-time Benefit Summary	28
PEBB Statewide Plan Benefit Summary	28
PEBB Statewide Plan Part-time Benefit Summary	28
VSP Benefit Summary in Providence Choice and PEBB Statewide Plans (except part-time) ..	28
Premium Rates	29
Medical Plans Comparison, Including Prescription Coverage.....	30
SECTION 3: DENTAL BENEFITS	34
Dental Plan Options	34
Kaiser Permanente Dental Plan Benefit Summary	34
Kaiser Permanente Dental Part-time Plan Benefit Summary	34
ODS Preferred Plan Benefit Summary	34
ODS Traditional Plan Benefit Summary	34
ODS Traditional Plan Part-time Benefit Summary	35
Willamette Dental Benefit Summary.....	35
Premium Rates	35
Dental Plans Comparison.....	37

State of Oregon
Public Employees' Benefit Board Summary Plan Description

SECTION 4: OPTIONAL BENEFITS.....	38
Life Insurance.....	38
Premium Rates.....	45
Short Term Disability Insurance.....	48
Premium Rates.....	52
Long Term Disability Insurance.....	53
Premium Rates.....	61
Accidental Death and Dismemberment Insurance.....	62
Premium Rates.....	67
Flexible Spending Accounts.....	68
Healthcare flexible spending account.....	69
QRD - Qualified Reservist Distribution.....	72
Dependent Care flexible spending account.....	74
Long Term Care Insurance.....	76
Premium Rates.....	86
SECTION 5: REQUIRED NOTICES.....	88
Plan Administration.....	88
Miscellaneous.....	90
Benefit Fraud or Abuse.....	91
Appeals.....	92
Notice of Women's Health and Cancer Rights.....	94
Your Prescription Drug Coverage and Medicare.....	94
Special Enrollment Rights.....	96
Medicaid and the Children's Health Insurance Program (CHIP).....	97
Your Continuation Coverage Rights under COBRA.....	99
Notice of Privacy Practices.....	105

Appendix A: Midyear Plan (Qualified Status) Changes

Appendix B: Health Improvement and Cost Containment Programs

Chronology of Updates

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 meet the following criteria:

- Are expected to work at least 90 days; and
- Work at least half time or in a position classified as job share.

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.

Eligible Full-time Employees

(Including Limited Duration Employees)

The current monthly benefit amount from the employer fully covers the premium amount for the core benefits of medical, dental, and basic life insurance coverage for full-time employees. The amount covers these premiums on all enrollment tiers: employee only, employee and spouse or domestic partner; employee and children; and family.

Current full-time employees (position classification) 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.

New 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 medical plans (which include vision coverage except those labeled “Part Time”) and dental plans according to where you live or work (at least 50 percent of the time).

State of Oregon

Public Employees' Benefit Board Summary Plan Description

- Basic employee life insurance coverage of \$5,000 paid by the employer.

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 medical coverage or the combination of medical and dental coverage if they have other employer-sponsored group coverage for each as defined by PEBB. Employees cannot opt out of dental coverage alone. Other group coverage does not include Medicare, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance. All members who opt out will receive a monthly opt-out amount determined by the Board and prorated for part-time employees according to hours worked compared with full-time hours available for the month. Members who opt out of medical coverage, only, must enroll in and pay premium for PEBB dental coverage. All employees who opt out must pay the premium for the employee basic life coverage. The cost of dental and basic life premiums will be deducted from the monthly opt-out amount pretax. The balance will be added to the employee's monthly pay as taxable income. Employees who opt out may enroll in optional benefit plans, for which they pay the premiums.
- **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 monthly benefit amount and they cannot enroll in any of the optional benefit plans.

Eligible Part-time Employees

(Including Limited Duration and Job Share)

The current monthly benefit amount for eligible part-time employees is pro-rated based on hours worked in the month compared with the month's available full time hours.

To be eligible for benefits, part-time employees must:

- Work or receive 80 paid regular hours per month or be in a job share position;
- Be a 0.5 FTE for unclassified OUS employees;
- 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 by collective bargaining agreements.

New 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.

Part-time employees receive a pro-rated monthly benefit amount from the employer for the core benefits of medical, dental and basic life insurance coverage. For most part-time employees, the pro-rated amount is based on the number of hours worked in the previous month. For job-share employees, the amount is fixed by their share of the position.

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

Benefit Options for Part-time Employees

- **Core Benefits** - Core benefits are

State of Oregon

Public Employees' Benefit Board Summary Plan Description

- Medical plans and dental plans available to full-time employees according to where you live or work (at least 50 percent of the time). These medical plans include vision coverage.
- Medical and dental plans labeled “Part time” plans according to where you live or work (at least 50 percent of the time). These medical plans do not include vision coverage.
- Basic employee life insurance coverage of \$5,000 paid by the employer.

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 medical coverage or the combination of medical and dental coverage if they have other employer-sponsored group coverage for each as defined by PEBB. Employees cannot opt out of dental coverage alone. Other group coverage does not include Medicare, Medicaid, Veterans Administration Health Benefits, or Student Health Insurance. All members who opt out will receive a monthly opt-out amount determined by the Board and prorated for part-time employees according to hours worked compared with full-time hours available for the month. Members who opt out of medical coverage, only, must enroll in and pay premium for PEBB dental coverage. All employees who opt out must pay the premium for the employee basic life coverage. The cost of dental and basic life premiums will be deducted from the monthly opt-out amount pretax. The balance will be added to the employee’s monthly pay as taxable income. Employees who opt out may enroll in optional benefit plans, for which they pay the premiums.
- **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 monthly benefit amount and they cannot enroll in any of the optional benefit plans.

New 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.

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

Returning Seasonal Employees

Previously benefit eligible employee 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

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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. An employee returning within 30 days without a break in coverage will have their previous coverage reinstated but is 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, 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.

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 their eligibility and their benefits. Contact your agency payroll, human resources or benefits office to discuss these issues prior to taking the leave. **This applies to all active eligible employee types.**

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; 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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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 Enrollment Form, Eligible Retiree and Dependents.

When to enroll as a PEBB Retiree

PEBB coverage must be continuous. **You must enroll 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 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 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 status change.

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.

Coverage Duration

Coverage continues as long as:

- You are not eligible for Medicare (except those with end-stage renal disease)
- You pay premiums timely
- PEBB continues to offer retiree coverage.

Continuing life and long term care insurance after retirement

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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 60 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 Provident](#) 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.

Optional healthcare insurance for retirees

PERS. Contact the [PERS Health Insurance Program](#) for more information.

COBRA. The federal COBRA law allows you to continue the same coverage 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.

Portability Coverage or Oregon Medical Insurance Program. The Kaiser HMO medical plan offers portability. Portability means that you may purchase an individual medical plan offered by the company on a guaranteed issue basis within 63 days after leaving the PEBB group. To be eligible you must:

- Have 180 days of continuous employer group medical coverage
- Be an Oregon resident
- Not be eligible for Medicare
- Not be currently enrolled in another medical plan.

In the case of your death your dependents may continue coverage if they continue to meet the eligibility requirements. For portability information and rates, call the plan directly.

The PEBB Statewide Plan and Providence Choice medical plan are self-insured medical plans. If you leave a self-insured plan, you may be able to access coverage through the Oregon Medical

State of Oregon

Public Employees' Benefit Board Summary Plan Description

Insurance Program (OMIP). To apply for coverage through OMIP, you must first exhaust your COBRA coverage. Contact [OMIP](#) for more 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 benefit-eligible position are eligible for PEBB benefits. Retirees returning to work as active employees (not temporary employees) must work the equivalent of at least half time during the month to be eligible for benefits for the following month. Active job-share employees are not required to work half time.

For retirees returning within 12 months of their loss of coverage date, benefits are reinstated. You will not need to work half time the month you return to work to be eligible for benefits the following month. However, you must work at least half time each month after that to qualify for benefits the following month. Reinstatement means to reactivate all previous medical, dental, life and disability insurance policies, if available, on a guaranteed basis. You will have 30 days from the date you return to work to change your 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 re-enroll for all benefits.

Full-time employees are not eligible for part-time plans. Part-time employees receive a pro-rated benefit amount (based on the hours worked) and may choose from all the medical and dental plans.

Retirees returning to work and enrolled with Benefit Help Solutions (BHS), the third-party administrator, may suspend self-pay coverage while in active employee status by notifying BHS. To restart your self-pay coverage, you must notify BHS when you are no longer an active employee who meets the half time work requirement. Remember, your coverage must be continuous to remain eligible to participate in PEBB plans.

Non-Medicare-eligible retirees may decline active employee benefits. Medicare-enrolled retirees cannot select the opt-out option of PEBB medical coverage against their Medicare coverage.

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. In general, individuals receive the opportunity to elect only the healthcare coverage they were receiving immediately before

State of Oregon

Public Employees' Benefit Board Summary Plan Description

the event. 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

These self-pay participants may enroll only in the PEBB medical and dental plans that are available to full-time state employees. The part-time and retiree plans are not an option. Blind Business Enterprise agents may enroll in a medical plan, only. All other self-pay participants may enroll in medical and dental plans. They must enroll in a medical plan to enroll in a dental plan. Self-pay participants 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 an eligible dependent child 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 over half of their financial support from the employee; or
 2. The child 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. An eligible employee 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. 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 enrollment forms and appropriate PEBB notarized affidavit with any required legal documents to provide coverage to the following children:

- A foster child
- A child placed for adoption
- 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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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 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.

The employee must submit to PEBB any appeal and enrollment forms to enroll a disabled child age 26 or older, or to indicate the child disabled in the PEBB benefit record when the child is already receiving coverage. The child's attending physician must submit documentation of the child's disability to the employee's health plan. The health plan provides a medical review of the physician's medical documentation and provides PEBB a disability determination based on the review.

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

- The child must be the employee's qualifying tax dependent.
- The physician must verify to the health plan that the disability existed before the child attained age 26.
- The child must be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
- 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.

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

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 when the employee is rehired later into a PEBB benefit eligible position. In this situation, to enroll the child again as disabled all PEBB criteria for disabled child must be met.

Termination of Dependent Coverage

PEBB terminates all health plan coverage at midnight on December 31 for dependent children who reach age 26 during the calendar year. PEBB will not terminate coverage for a dependent child age 26 or older when the medical plan determines the child is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

State of Oregon
Public Employees' Benefit Board Summary Plan Description
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.)	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 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. Federal laws may require differences in administration of benefits. For example, Medicare will pay as primary coverage for a domestic partner who becomes eligible for Medicare while covered under an employee's coverage.

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

- 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

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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***

State of Oregon

Public Employees' Benefit Board Summary Plan Description

- 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. You may also terminate coverage for a domestic partner and partner's children within 30 days of and consistent with a qualified midyear change event.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 this Cafeteria plan status, PEBB must follow Code 125 federal regulations, which mandate that participant elections are irrevocable for the plan year and provide only limited circumstances in which the elections may change (e.g., qualified midyear plan changes or correction).

Current Employees		
Enrollment Period	Core Benefits Effective	Optional Benefits Effective
Open Enrollment (Generally held each October)	First of the new plan year following online enrollment (or agency receipt of enrollment form) and timely agency receipt of any required documentation	First of the new plan year or first of the month in the new plan year following online enrollment (or agency receipt of enrollment form) and plan approval of medical history
Because of qualified midyear change event, including special enrollment events	First of the month following agency receipt of update form (no earlier than the event date) Ineligible individual coverage termination dates dependent on type of ineligibility.	First of the month following agency receipt of midyear change form and plan approval of medical history if medical history is required. Termination: dependent on type of ineligibility.
		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	First of the month following online enrollment (or agency receipt of enrollment form) along with agency receipt of any required documentation after initial hire date	First of the month following online enrollment (or agency receipt of enrollment form) 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	First of the month following online enrollment (or agency receipt of enrollment form) along with agency receipt of any required documentation after date of eligibility	First of the month following online enrollment (or agency receipt of enrollment form) and plan approval of medical history if medical history is required

State of Oregon
Public Employees' Benefit Board Summary Plan Description

How to Enroll

Eligible employees may enroll online during Open Enrollment.

- Certain enrollment elections require the submission of documentation to your agency before the enrollment will go into effect. Check your election requirements. 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. The eligible employee is accountable during open enrollment for ensuring that only those individuals who meet PEBB eligibility are enrolled in the new plan year.
 - Employees can terminate an individual currently receiving coverage, electronically or by using a form, if they know the individual will be ineligible for coverage the first day of the plan year or the employee no longer wants to provide coverage to the individual even though the individual will continue to meet eligibility. When terminated by an employee as part of the open enrollment period the individual's coverage ends the last day of the last month of the current plan year. PEBB can audit an employee's benefit record and investigate the reason why an individual will no longer receive coverage in the new plan year. When necessary PEBB can correct the coverage termination date of a terminated individual and take the appropriate termination of coverage action.
 - Employees are not to use the open enrollment period to remove individuals who have lost eligibility or will lose eligibility. Employees must remove individuals who lose eligibility from their coverage and benefit record by submitting the correct midyear change forms to the agency or to PEBB
- The agency must provide an opportunity for open enrollment elections to an eligible employee who becomes newly eligible or hired after the open enrollment period but before the start of the new plan year. These employees must submit required Open Enrollment forms and documentation to the agency before the start of the new plan year.
 - The agency must provide an opportunity for open enrollment elections before the start of the new plan year to eligible employees away from work because they are on employer-approved leave status where the employer continues the employee's core benefits, examples include but are not limited to FMLA, CBIW, and Active Military Duty.
 - Employees who take no action when the open enrollment period requires an action will default to PEBB-selected plans for the employee only; thereby losing coverage for all currently covered dependents at the start of the new plan year.
 - Employee plan elections are irrevocable for the plan year.

Newly hired or newly eligible employees may enroll online or by submitting required forms and documentation to their agency within 30 days of their eligibility or hire date.

- Enrollment elections by these employees for Opt Out, Dependent Child by Affidavit, Grandchild by Affidavit, and Domestic Partner by Affidavit require submission of enrollment forms and documentation to the agency; employees cannot enroll for these elections electronically. The agency will not process elections that do not include all required forms and documentation.
- Employee plan elections are irrevocable for the plan year.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

Self-pay participants must enroll by completing the enrollment forms identified for each group. These forms are available online or from BenefitHelp Solutions (BHS), the third-party administrator.

Failure to Enroll

Newly 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 medical and dental coverage, including coverage for eligible dependents. You will also receive employee basic life insurance coverage.

Correcting Enrollment Errors

Employees may make errors in the process of enrolling for benefits when they provide information or make selections on forms or through the online system.

An employee's failure to take an enrollment action during a period of required 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 to some elections back to the original effective date.

If you make an Open Enrollment error, your agency can correct the error up to 30 days from when you receive your first paycheck of the new plan year. The correction will be retroactive to the first day of the new plan year. The exception to retroactive correction is correcting errors for core benefits (medical, dental, employee basic life). Once coverage is effective for these benefits, it can terminate only prospectively.

PEBB must review all employee requests to correct enrollment errors received after 30 days of the original date of eligibility or the date that qualifies for a midyear plan change. Requests received more than 60 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, there are several other change events allowed. The IRS requires that PEBB comply with federal regulations for midyear plan changes. Midyear plan change events must meet the IRS "consistency rule," which means the event must affect eligibility, and the requested plan change must be consistent with the way eligibility has been affected. This means the requested benefit change must link to the event.

Here are two examples.

- **Example 1. You adopt a child.** This is a QSC event that allows you to add the dependent child to your current medical and dental insurance coverage and to add or increase other coverage related to the adoption, such as adding optional Dependent Life insurance. There is no other fact

State of Oregon

Public Employees' Benefit Board Summary Plan Description

around this single event that would allow you to change to a different medical or dental plan than what you currently have. The one exception to this is a request to change from a PPO to an HMO plan or vice versa.

- **Example 2. You move from an eligible classified full-time position to an eligible classified part-time position (a true position classification change, not just a decrease in hours).** This change is also a QSC and makes you eligible to enroll in the part-time or the full-time plans. It also changes the monthly benefit amount from the employer. You may change benefit plans and add or delete coverage.

To make a change based on a midyear plan change event your agency must receive the appropriate form within 30 days of the date of the event. Midyear change [forms are available online](#). PEGB must receive all midyear plan change requests beyond 30 days from the event date.

Examples of Midyear Change Events

Midyear change events that affect eligibility for insurance benefits

These changes fall into three broad categories.

1. Qualified status changes, such as changes in
 - Legal marital status – marriage, divorce or death of a spouse
 - Number of dependents, such as birth, death or adoption of a child
 - Your or a family member's employment status, such as the start or end of employment, or a change from part-time to full-time job status
 - Eligibility of a dependent, such as a dependent losing eligibility because of age
 - Your residence or that of a family member
 - Your domestic partnership
2. Changes in cost or coverage, such as
 - An increase in premium cost that you pay
 - Reduction in your spouse's or domestic partner's group health insurance plan benefits provided by an employer
 - A reduction or a loss of plan coverage
3. Changes by law or court order, such as National Medical Support Notice, Medicare, or HIPAA

Midyear changes that affect eligibility for dependent care flexible spending accounts

- 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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

Midyear changes that affect eligibility for health care flexible spending accounts

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

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

Individuals No Longer Eligible for Coverage

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

(a) When an employee experiences a qualifying midyear change that permits the employee to remove an individual from coverage, but does not require the employee to terminate the coverage due to a loss of eligibility agencies must terminate the coverage prospectively. Coverage ends prospectively, the last day of the month following receipt of the appropriate forms. Submission of the forms beyond 30 days will result in a denial of the termination and the employee must wait until open enrollment to end the coverage.

Example: Bill currently provides PEBB coverage for his 22-year-old son, Mark. On May 5th 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 coverage effective June 30.

(b) An employee must request termination of coverage for an individual receiving PEBB coverage under their enrollments that 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, ex-domestic partner, a child by affidavit no longer eligible due to age limitation within the legal responsibility document, and a disabled child who no longer meets criteria. Agencies will terminate an ineligible individual's coverage prospectively, 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, ex-domestic partner, and their children who are not biological children or adopted children of the employee, in which case PEBB coverage must terminate retroactively to the last day of the month that the eligibility is lost. PEBB must process and complete all 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 June 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 is in the month following the date of divorce however it is 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, coverage will terminate June 30.

An ineligible individual will receive a COBRA availability notice when the coverage terminates within 60 days from eligibility loss.

Late Requests for Terminations: PEBB must receive all employee requests for termination of coverage of ineligible individuals beyond the allowable 30 days. PEBB will follow either (a) or (b) above in determining the correct termination date for the ineligible individual.

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

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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 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 their taxable income for premiums not refunded by the plans or repaid by the employee to the agency.

Example: Ann's divorce is final on June 6, 2010. Ann submits her update form to her agency a year later on June 1, 2011, after she certified during the October 2010 open enrollment period that all individuals receiving coverage in the new plan year were eligible for coverage. The agency sends Ann's update forms to PEBB. PEBB sends a notice to Ann's ex-spouse at the last known address informing the individual that on July 1, 2011 PEBB will rescind the individual's coverage to June 30, 2010 (the month that eligibility was lost). PEBB includes a notice of appeal rights. The ex-spouse will receive a COBRA unavailability notice due to the employee's late notice of loss of eligibility. Ann's agency can receive premium refunds for the most recent months of allowable premium according to this rule.

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, you must submit the update and enrollment forms to your 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, so 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 date of other coverage loss.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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

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

Ending Participation in PEBB

- Employees no longer participate in a PEBB plan when the PEBB plan ends or the employee or a covered individual is no longer eligible to participate.
- When an active employee is no longer eligible, and the employee has 80 or more paid regular hours in that month, benefits will end the last day of the following month.
- When an active employee is no longer eligible, is not on an employer-approved leave with core benefit continuation such as FMLA, Active Military Duty or CBIW, and has less than 80 paid regular hours in the month, benefits will end the last day of that month.
- If the employee has a flexible spending account (FSA) at the time benefits end, the account will end as described in the FSA member handbook.
- Self-pay individuals or retired employees' benefits terminate the last day of the last period of which the required premium contribution is paid.
- Optional plan coverage ends according to the optional plan's policy or certificate directives.

Becoming Eligible after Ending Participation

- An eligible employee 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.
- An active eligible employee who is returning from 1) leave without pay where the employer did not continue core benefits, or 2) is returning from a reduction in hours below benefit eligibility criteria, must work at least half-time in the month of return to be eligible for coverage in core benefits and optional plans the following month. The exception is eligible employees in job share positions.
- An eligible employee returning to paid regular status within 12 months of the 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 and Long Term Care.
- Flexible Spending Accounts and Long Term Care benefits are not reinstated. The exception is if the individual continued participation in a healthcare FSA while on COBRA. In this case, PEBB will reinstate the FSA. The employee has 30 days from the date of rehire to change benefit elections. Long Term Care will be reinstated as a payroll deduction if the employee continued the plan through portability.
- When an employee is rehired more than 12 months after ending participation and is benefit eligible, the employee must enroll as a newly eligible 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 benefit summary. They are incorporated in this Summary Plan Description by reference and are available for download as printable documents on PEBB's Web site. Carefully review the plans' member handbooks and service areas to see which one best fits your and your family's healthcare needs. View Covered Service Areas by Plan www.oregon.gov/DAS/PEBB/2011Benefits/ServArea.shtml

- **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 the plans offered by PEBB receive coverage for routine vision care except in the *part-time* versions of the plans, which do not have coverage for routine vision services. The exception is part-time HMO plan, which covers a routine vision exam with a \$30 copay. See the HMO plan 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 plan 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 this plan and coverage, long with a list of the ZIP codes in the service area.

Kaiser Permanente HMO Benefit Summary

This document is on the Web at http://my.kp.org/nw/pebb/benefits_nw_traditionalHMOPlan.html. It is incorporated here by reference. The summary includes routine vision services.

Kaiser Permanente HMO Part-time Benefit Summary

This document is on the Web at http://my.kp.org/nw/pebb/benefits_nw_traditionalHMOPlan.html. It is incorporated here by reference. The summary includes routine vision services.

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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

PEBB offers the Providence Choice medical-home model plan. You need to establish your medical home clinic 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.

Providence Choice Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBChoicePlanFT2012.pdf. It is incorporated here by reference. See the VSP benefit summary for routine vision services in this plan.

Providence Choice Part-time Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBChoicePlanPT2012.pdf. It is incorporated here by reference. This plan does not cover routine vision services.

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 as preferred or non-preferred, the providers may bill you for amounts greater than allowed in the plan.

PEBB Statewide Plan Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBStatewidePlanFT2012.pdf. It is incorporated here by reference. See the VSP benefit summary for routine vision services in this plan.

PEBB Statewide Plan Part-time Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBStatewidePlanPT2012.pdf. It is incorporated here by reference. This plan does not cover routine vision services.

Vision Service Plan

VSP provides vision coverage in the Providence Choice and PEBB Statewide plans. The part-time versions of these plans have no vision coverage. The VSP benefit summary is on the Web at www.oregon.gov/DAS/PEBB/2012Benefits/Docs/VSPBrochure.pdf. It is incorporated here by reference.

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 improve employee health and contain costs for health benefits. See Appendix B.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Premium Rates

The state, as the employer, provides a monthly benefit amount for eligible employees. Payroll applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the employer's contribution. That is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

Table 1. 2012 Employee Medical Plan Monthly Premium Rates				
	Employees	Employee & Spouse/Partner	Employee & Children	Employee & Family
PEBB Statewide PPO¹	\$990.52	\$1,327.15	\$1,139.02	\$1,356.87
Providence Choice²	870.22	1,166.06	1,000.76	1,192.18
Kaiser HMO³	983.01	1,317.23	1,130.49	1,346.73
Kaiser Deductible³	903.83	1,211.11	1,039.40	1,238.24
PEBB Statewide Part-time PPO⁴	793.10	1,062.66	912.03	1,086.46
Providence Choice Part-time⁵	693.57	929.36	797.61	950.17
Kaiser HMO Part-time⁶	832.18	1,115.10	957.00	1,140.06
Kaiser Deductible Part-Time⁶	785.96	1,053.18	903.87	1,076.76

¹ Available to PEBB eligible full-time and part-time employees. VSP routine vision services.

² Available to PEBB eligible full-time and part-time employees in plan service area. VSP routine vision services.

³ Available to PEBB eligible full-time and part-time employees in plan service area. Kaiser routine vision services.

⁴ Additional option available to eligible part-time employees. No vision benefit.

⁵ Additional option available to eligible part-time employees in plan service area. No vision benefit.

⁶ Additional option available to eligible part-time employees in plan service area. Vision exam only.

2012 Retiree Medical Plan Monthly Premium Rates				
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family
PEBB Statewide PPO¹	\$983.37	\$1,317.58	\$1,130.80	\$1,347.08
Providence Choice²	863.80	1,157.46	993.37	1,183.38
Kaiser³	975.97	1,307.80	1,122.39	1,337.09
Kaiser Deductible³	897.35	1,202.44	1,031.96	1,229.37
PEBB Statewide Part-Time PPO⁴	787.38	1,054.99	905.45	1,078.62
Providence Choice Part-Time⁵	688.57	922.65	791.85	943.31
Kaiser Part-Time⁶	826.22	1,107.12	950.15	1,131.90
Kaiser Deductible Part-Time⁶	780.34	1,045.64	897.40	1,069.05

¹ Available to PEBB eligible retirees. VSP routine vision services.

² Available to PEBB eligible retirees in plan service area. VSP routine vision services.

³ Available to PEBB eligible retirees in plan service area. Kaiser routine vision services.

⁴ Additional option available to eligible retirees. No vision benefit.

⁵ Additional option available to eligible retirees in plan service area. No vision benefit.

⁶ Additional option available to eligible retirees in plan service area. Vision exam only.

2012 Retiree Optional Vision Plan Monthly Premium Rates					
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family	Child(ren) Only⁷
VSP Optional Part-time	\$12.90	\$25.80	\$25.80	\$30.31	\$12.90

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2012 COBRA Medical Plan Monthly Premium Rates				
	Self	Self & Spouse/Partner	Self & Children	Self & Family
PEBB Statewide PPO¹	\$996.88	\$1,335.67	\$1,146.33	\$1,365.57
Providence Choice²	875.66	1,173.34	1,007.01	1,199.63
Kaiser³	989.50	1,325.93	1,137.95	1,355.62
Kaiser Deductible³	909.79	1,219.10	1,046.26	1,246.41
PEBB Statewide Part-Time PPO⁴	798.18	1,069.47	917.87	1,093.43
Providence Choice Part-Time⁵	698.02	935.31	802.72	956.26
Kaiser Part-Time⁶	837.67	1,122.47	963.32	1,147.59
Kaiser Deductible Part-Time⁶	791.15	1,060.14	909.83	1,083.87

¹ Available to PEBB eligible individuals. VSP routine vision services.

² Available to PEBB eligible individuals in plan service area. VSP routine vision services.

³ Available to PEBB eligible individuals in plan service area. Kaiser routine vision services.

⁴ Additional option available to PEBB eligible individuals. No vision benefit.

⁵ Additional option available to PEBB eligible individuals; in plan service area. No vision benefit.

⁶ Additional option available to PEBB eligible individuals; in plan service area. Vision exam only.

Medical Plans Comparison, Including Prescription and Vision Coverage

The tables on the following pages allow you to compare PEBB's health care plans on a side-by-side basis. **NOTE:** Full-time employees may not enroll in the part-time plans.

State of Oregon
Public Employees' Benefit Board Summary Plan Description
2012 Full-time Medical Plan

This information gives a high-level summary only. See plan documents for details.

Benefits apply without regard to HEM participation ¹	PEBB Statewide Plan		Providence Choice		Kaiser HMO	Kaiser Deductible Plan
Service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Provider Status	In Network	Out of Network	In Network	Out of Network	Kaiser Permanente	Kaiser Permanente
Deductible²	\$250/individual \$750/family 4 primary care visits not subject	\$500/individual \$1500/family 4 primary care visits not subject	\$250/individual \$750/family 4 primary care visits not subject	\$500/individual \$1500/family 4 primary care visits not subject	\$0	\$250/individual \$750/family office visits and some services not subject
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum³	\$1500/individual \$4500/family	\$2500/individual \$7500/family	\$1500/individual \$4500/family	\$2500/individual \$7500/family	\$600/individual \$1200/family	\$1500/individual \$4500/family
Spouse/Domestic Partner Surcharge⁴	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month
Tobacco Surcharge⁵	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner
Primary Care	15%	30%	\$5	30%	\$5	\$5
Chronic Care Office Visit	0%	30% subject to deductible	\$0	30% subject to deductible	\$5	\$5
Specialty Care	15%	30%	\$5	30%	\$5	\$5
Mental Health	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity/Childbirth Provider Services	15%	30%	\$0	30%	\$0/prenatal, \$50/day; up to \$250 maximum/admission	\$0/prenatal; \$50/day; up to \$250 maximum per admission. Prenatal not subject to deductible; deductible does apply to maternity/childbirth
Preventive	\$0	30%	\$0	30%	\$0	\$0
Lab & X-ray	15%	30%	\$0	30%	\$0	\$15
MRI, CT, PET, SPECT	15% + \$100	30% + \$100	\$100	30% + \$100	\$100	\$100
Sleep Study	15% + \$100	30% + \$100	\$100	30% + \$100	\$100	\$100
Inpatient Hospital	15%	30%	\$50/day; up to \$250 maximum per admission	30%	\$50/day; up to \$250 maximum per admission	\$50/day; up to \$250 maximum after deductible
Emergency Department	15% + \$100	15% + \$100	\$100	\$100	\$75	\$75, after deductible has been met
Durable Med Equipment	15%	30%	15%	30%	\$0	15%
Insulin/Diabetic Supplies	\$0	\$0	\$0	\$0	\$0	\$0
Prescription Drugs⁶	\$50 deductible (not applied to Value) \$0 Value \$10 generic \$30 preferred brand \$100 specialty 2.5X for 90-day No tier exceptions	Paid as if filled in network; Member pays difference between network & billed amt + coinsurance 2.5X for 90-day	\$50 deductible (not applied to Value) \$0 Value \$10 generic \$30 preferred brand \$100 specialty 2.5X for 90-day No tier exceptions	Paid as if filled in network; Member pays difference between network & billed amt + coinsurance 2.5X for 90-day	\$1 generic/\$15 brand \$1 generic 31-90 day maintenance mail order \$15 brand 31-90 day maintenance mail order	\$5 generic / \$25 brand \$50/50% whichever is greater for exception-approved non-formulary drugs \$5 generic 31-90 day maintenance mail order \$25 brand 31-90 day maintenance mail order
Vision	\$10 exam copay	VSP reimburses exam to \$50 office	\$10 exam copay	VSP reimburses exam to \$50	\$5 exam copay	\$5 exam copay

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits apply without regard to HEM participation ¹	PEBB Statewide Plan		Providence Choice		Kaiser HMO	Kaiser Deductible Plan
	\$25 frame copay \$150 retail frame allowance Single and lined bifocal and trifocal lenses covered in full Progressive lenses available at a 35-40% discount. Or \$200 allowance for contacts and contacts fitting/evaluation	copay \$70 frame allowance \$50-\$125 single and lined bi or trifocal lenses allowance Progressive lenses available at a 35-40% discount Contact lenses covered in full to \$105 if elective, \$210 if necessary	\$25 frame copay \$150 retail frame allowance Single and lined bifocal and trifocal lenses covered in full Progressive lenses available at a 35-40% discount. Or \$200 allowance for contacts and contacts fitting/evaluation	\$70 frame allowance \$50-\$125 single and lined bi or trifocal lenses allowance Progressive lenses available at a 35-40% discount Contact lenses covered in full to \$105 if elective, \$210 if necessary	\$200 hardware allowance max/24 months	\$200 hardware allowance max/24 months
Chiropractic, Acupuncture, Naturopathic Services	30% coinsurance, applies to in-network deductible 60 visits/yr max		\$10 copay, applies to in-network deductible, limited to the lesser of \$1000 or 60 visits/yr		\$10 up to \$1000/yr	\$10 up to \$1000/yr
Additional-cost Tier (does not apply to cancer related services)						
Hip replacement Knee replacement Knee arthroscopy Shoulder arthroscopy Bariatric Surgery Spine pain procedures Sinus surgery Knee/Hip resurfacing Hip arthroplasty	15% + \$500	30% + \$500	\$500	30% + \$500	Copay same as other conditions	Copay same as other conditions
Upper endoscopy	15% + \$100	30% + \$100	\$100	30% + \$100 copay	Copay same as other conditions	Copay same as other conditions
Excluded Services⁷						
<p>¹ Benefits and HEM: The benefits shown here apply in or out of the Health Engagement Model (HEM) program. Employees (and spouses or domestic partners) who participate in HEM will have \$20 (or \$35) per month less deducted from their pay. NOTE: A PEBB-eligible employee <u>must</u> participate in the HEM program to allow a spouse or domestic partner to participate. A spouse or domestic partner of a PEBB-eligible employee may not participate in the HEM program as an individual if the employee does not.</p> <p>² Deductibles: In the Statewide and Providence Choice plans, the deductible does not apply to the first 4 visits to a primary care provider, preventive services, or the out-of-pocket maximum; however, the coinsurance applies even if the deductible does not. The deductible applies to all specialty visits and all lab and x-ray services. Once 3 members of family have met their individual deductible, all in-network services for all members of the family will be paid as if their individual in-network deductible has been met. Deductible amounts accumulate separately in these plans when using in-network and out-of-network providers. The Kaiser Health Maintenance Organization (HMO) plan has no deductible. In the Kaiser Deductible plan, office visits and some other services do not apply to the deductible. See the plan's evidence of coverage or call Kaiser Member Services. In this plan, once 3 members of family have met their individual deductible, all in-network services for all members of the family will be paid as if their individual in-network deductible has been met.</p> <p>³ Annual Out-of-Pocket (OOP) Maximums: In the Statewide and Providence choice plans, once 3 members of a family have met their individual \$1500 in-network OOP, all in-network services for all members of the family will be paid as if their individual in-network OOP has been met; once 3 members of a family have met their individual \$2500 out-of-network OOP, all out-of-network services for all members of the family will be paid as if their individual out-of-network OOP has been met. In the Kaiser HMO, once 2 members of a family have met their individual \$600 OOP, all in-plan services for all members of the family will be paid as if their individual in-network OOP has been met. In the Kaiser Deductible Plan, once 3 members of a family have met their individual \$1500 in-network OOP, all in-plan services for all members of the family will be paid as if their individual in-network OOP has been met.</p> <p>⁴ Spouse or Domestic Partner Coverage Surcharge: A \$50 monthly surcharge is applied if an employee's spouse or domestic partner has access to other non-Oregon-state-agency employer-based group health insurance and chooses not to enroll.</p> <p>⁵ Tobacco Surcharge: A \$25 monthly surcharge is applied to employees and covered spouses or domestic partners who use tobacco as stated when they enroll.</p> <p>⁶ Prescription Drugs: See the plans' formularies, which list drugs covered in the plan and how they are covered.</p> <p>⁷ Excluded Services: PEBB Statewide and Providence Choice (full- and part-time) plan members will pay 100% of the cost for excluded services. Beginning 2012, these include surgery for warts, varicose vein surgery (including radio frequency ablation), varicose vein stripping, TMJ surgery, surgery for ganglions of the wrist, surgery for Morton's neuroma, hammertoe surgery, bunionectomy surgery and breast reduction surgery. Surgery for certain varicose vein conditions may be considered for prior authorization. Kaiser HMO and Kaiser Deductible (full- and part-time) plan members will pay a copay, as for treatment of other conditions.</p>						

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2012 Part-time Medical Plan. See footnotes on page 32.

This information gives a high-level summary only. See plan documents for details. See footnotes on page 32.

Benefits apply without regard to HEM participation ¹	Part-Time PEBB Statewide Plan		Part-Time Providence Choice		Part-Time Kaiser HMO	Part-Time Kaiser Deductible Plan
Service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Provider Status	In Network (Medical home)	Out of Network	In Network	Out of Network	Kaiser Permanente	Kaiser Permanente
Deductible ²	\$500/individual, \$1500/ family' 4 primary care visits not subject	\$1000/individual, \$3000/family; 4 primary care visits not subject	\$500/individual, \$1500/ family; 4 primary care visits not subject	\$1000/individual, \$3000/family; 4 primary care visits not subject	\$0	\$250/individual, \$750/Family; office visits & some services not subject
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum ³	\$2500/individual, \$7500/family	\$4500/individual, \$13500/family	\$2500 individual, \$7500/family	\$4500/individual, \$13500/family	\$1500/individual, \$3000/family	\$1500/individual, \$4500/family
Spouse/Partner Surcharge ⁴	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month
Tobacco Surcharge ⁵	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner
Primary Care	20%	50%	\$30	50%	\$30	\$30
Chronic Care Office Visit	\$0	50% subject to deductible	\$0	50% subject to deductible	\$30	\$30
Specialty Care	20%	50%	\$30	50%	\$30	\$30
Mental Health	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity/Childbirth Provider Services	20%	50%	\$0	50%	\$0/prenatal; up to \$500 maximum per admission	\$0/prenatal (not subject); \$500/admit. deductible doesn't apply
Preventive	0%	50%	\$0	50%	\$0	\$0
Lab & X-ray	20%	50%	20%	50%	\$10	\$20
MRI, CT, PET, SPECT	20% + \$100	50% + \$100	20% + \$100	50% + \$100	\$100	\$100
Sleep Study	20% + \$100	50% + \$100	20% + \$100	50% + \$100	\$100	\$100
Inpatient Hospital	20%	50%	\$500/admission	50%	\$500 per admission	\$500/admit after deductible
Emergency Department	20% + \$100	20% + \$100	\$100	\$100	\$100	\$100, after deductible
Durable Med Equipment	20%	50%	20%	50%	50%	50%
Insulin/Diabetic Supplies	\$0	\$0	\$0	\$0	Both Plans: 20% (insulin covered as prescription drug)	
Prescription Drugs ⁶	\$50 deductible (not applied to Value drugs); \$0 Value; \$20 generic/\$40 preferred brand; \$100 specialty 2.5X for 90-day; No tier exceptions	PD as if filled in network; Member pays difference between network & billed amt + coinsurance; 2.5X for 90-day	\$50 deductible (not applied to Value drugs); \$0 Value; \$20 generic/\$40 preferred brand; \$100 specialty 2.5X for 90-day; No tier exceptions	PD as if filled in network; Member pays difference between network & billed amt + coinsurance; 2.5X for 90-day	\$10 generic; \$25 brand; \$20 generic and \$50 brand 31-90 day maintenance mail order	\$10 generic; \$25 brand \$20 generic and \$50 brand 31-90 day maintenance mail order
Vision	The VSP full time vision plan is available to retirees enrolled in these plans as a separate policy. Vision not covered for all other enrollees			These plans have a \$30 exam copay; hardware not covered		
Chiropractic, Acupuncture, Naturopathic	50% coinsurance, applies to in-network deductible 60 visits/yr max		50% copayment, applies to in-network deductible, limited to the lesser of \$1000 or 60 visits/yr		not covered	not covered
Additional-cost Tier (does not apply to cancer related services) Applies to Hip and Knee replacement, Knee and shoulder arthroscopy. Bariatric Surgery. Spine pain procedures Sinus surgery, Knee/Hip resurfacing, Hip arthroplasty						
	20% + \$500	50% + \$500	\$500	50% + \$500	Copay same as other conditions	Copay same as other conditions
Upper endoscopy	20% + \$100	50% + \$100	\$100 copay	50% + \$100 copay	Copay same as other conditions	Copay same as other conditions
Excluded Services⁷						

Section 3: Dental Benefits

Dental Plan Options

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 PEBB's Website. Carefully review the plans' member handbooks and service areas to see which one best fits your and your family's healthcare needs.

PEBB sponsors three types of dental plan designs: a traditional plan design offered by Kaiser Permanente and one administered by ODS; a preferred provider dental plan design administered by ODS; and a dental health maintenance organization plan design from Willamette Dental.

You may enroll different eligible dependents in your dental plan than are enrolled in your medical plan. 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). Following are links to the Benefit Summaries for the dental plans.

Kaiser Permanente Dental Plan Benefit Summary

This document is on the Web at: http://my.kp.org/nw/pebb/pdfs/pebb_ft_den_2011.pdf. It is incorporated here by reference.

Kaiser Permanente Dental Part-time Plan Benefit Summary

This document is on the Web at: http://my.kp.org/nw/pebb/pdfs/pebb_pt_den_2011.pdf. It is incorporated here by reference.

ODS Preferred Plan Benefit Summary

This document is on the Web at: www.odscompanies.com/pdfs/pebb/summaries/preferred.pdf. The summary of orthodontic benefits is on the Web at: www.odscompanies.com/pdfs/pebb/summaries/ortho.pdf. They are incorporated here by reference.

Note: Late enrollees have a 12 month waiting period for Basic and Major services and a 24 month waiting period for Orthodontic services.

ODS Traditional Plan Benefit Summary

This document is on the Web at: <http://www.odscompanies.com/pdfs/pebb/summaries/traditional.pdf>. The summary of orthodontia benefits is on the Web at: www.odscompanies.com/pdfs/pebb/summaries/ortho.pdf. They are incorporated here by reference.

Note: Late enrollees have a 12 month waiting period for Basic and Major services.

ODS Traditional Plan Part-time Benefit Summary

This document is on the Web at http://www.odscompanies.com/pdfs/pebb/summaries/part_time.pdf. The summary of orthodontia benefits is on the Web at: www.odscompanies.com/pdfs/pebb/summaries/ortho.pdf. They are incorporated here by reference.

Note: Late enrollees have a 12 month waiting period for Basic and Major services.

Willamette Dental Benefit Summary

This document is on the Web at:

https://www.willametedental.com/literature_112853/OR_PEBB_Enrollment_Booklet_2012. It is incorporated here by reference.

Premium Rates

The state, as the employer, provides a monthly benefit amount for employees. Payroll applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the benefit amount, which is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

2012 Employee Dental Plan Monthly Premium Rates				
	Employee	Employee & Spouse/Partner	Employee & Children	Employee & Family
ODS Preferred ¹	\$75.08	\$100.60	\$86.33	\$102.86
ODS Traditional ²	81.27	108.91	93.47	111.35
Kaiser Permanente ³	75.61	101.31	86.96	103.58
Willamette Dental Group	75.08	100.61	86.34	102.86
ODS Part-time⁵	58.48	78.36	67.26	80.13
Kaiser Permanente Part-time⁶	56.35	75.50	64.80	77.21
¹ Available to PEBB eligible full-time and part-time employees.				
² Available to PEBB eligible full-time and part-time employees.				
³ Available to PEBB eligible full-time and part-time employees in plan service area.				
⁵ Additional option available to eligible part-time employees in plan service area.				
⁶ Additional option available to eligible part-time employees; in plan facilities.				

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2012 Retiree Dental Plan Monthly Premium Rates					
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family	Child(ren) Only ⁷
ODS Preferred ¹	\$75.53	\$101.20	\$86.85	\$103.47	\$39.29
ODS Traditional ²	81.76	109.56	94.03	112.02	42.50
Kaiser Permanente ³	76.06	101.92	87.48	104.20	39.56
Willamette Dental Group ⁴	75.53	101.21	86.86	103.47	39.28
ODS Part-time ⁵	58.83	78.83	67.66	80.61	30.59
Kaiser Permanente Part-time ⁶	56.69	75.95	65.19	77.67	29.48

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.
⁷ Child(ren) Only coverage is available only to COBRA & Retiree participants.

2012 COBRA Dental Plan Monthly Premium Rates					
	Self	Self & Spouse/Partner	Self & Children	Self & Family	Child(ren) Only ⁷
ODS Preferred ¹	\$76.57	\$102.60	\$88.05	\$104.91	\$39.83
ODS Traditional ²	82.89	111.08	95.33	113.57	43.09
Kaiser Permanente ³	77.12	103.33	88.69	105.65	40.11
Willamette Dental Group ⁴	76.57	102.62	88.06	104.91	39.82
ODS Part-time ⁵	59.65	79.92	68.60	81.73	31.02
Kaiser Permanente Part-time ⁶	57.48	77.00	66.09	78.75	29.89

¹ Available to eligible individuals.
² Available to eligible individuals.
³ Available to eligible individuals in plan service area.
⁴ Available to eligible individuals; in plan facilities.
⁵ Additional option available to eligible individuals.
⁶ Additional option available to eligible individuals in plan service area.
⁷ Child(ren) Only coverage is available only to COBRA & Retiree participants.

2011 Self-pay Participant Dental Plan Monthly Premium Rates				
	Self	Self & Spouse/Partner	Self & Children	Self & Family
ODS Preferred ¹	\$75.08	\$100.60	\$86.33	\$102.86
ODS Traditional ²	81.27	108.91	93.47	111.35
Kaiser Permanente ³	75.61	101.31	86.96	103.58
Willamette Dental Group ⁴	75.08	100.61	86.34	102.86

¹ Available to eligible individuals.
² Available to eligible individuals.
³ Available to eligible individuals in plan service area.
⁴ Available to eligible individuals; in plan facilities.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Dental Plans Comparison

The table below allows you to compare PEBB's dental plan options on a side-by-side basis. **NOTE:** Full-time employees may not enroll in the part-time plans.

This information gives a high-level summary only. See plan documents for details.

2012 Dental Plans Summary Comparison							
Benefits	ODS Preferred		ODS Traditional	Willamette	Kaiser	Kaiser Part-Time	ODS Part-Time
Provider Status	In-Network	Out-of-Network	Participating	Willamette	Kaiser	Kaiser	Provider Status
Plan Max Coverage: Per person/year	\$1,750	\$1,750	\$1,750	No Max	\$1,750	\$1,250	Plan Max Coverage: Per person/year
Annual Deductible: Individual/family	\$50/ \$150	\$50/ \$150	\$50/ \$150	None	None	None	Annual Deductible: Individual/family
Diagnostic, preventive	0%						
Basic, maintenance	20%	30%	20%	0%	20%	50%	Basic, maintenance
Crowns	50%	50%	50%	\$190	25%	50%	Crowns
Implants	50%	50%	50%	Varies	50%	Not covered	Implants
Dentures	50%	50%	50%	\$190	50%	50%	Dentures
Orthodontia	50%	50%	50%	\$1500 total out-of-pocket	50%	Not covered	Orthodontia

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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. Your employer pays the premiums for this coverage.

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 60 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 60 days 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 dependents.

Evidence of Insurability

Evidence of insurability is required when you apply for:

- Any amount of coverage more than 60 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

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 for coverage within 60 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:

<u>Your Age</u>	<u>Percentage</u>
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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

MEDEX Travel Assist 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

Continuation of Insurance if Employment Ends (Portability)

If your employment ends you may be eligible to continue your Optional Life coverage. You must apply 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

- 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Premium Rates

Employee Optional Life Insurance Monthly Premium Rates											
Age >	Thru 24	25- 29	30- 34	35- 39	40- 44	45- 49	50- 54	55-59	60-64	65-69	70& up
Rate Per \$10,000 >	\$0.44	\$0.52	\$0.67	\$0.74	\$0.81	\$1.26	\$1.85	\$3.48	\$5.40	\$10.36	\$16.80
AMOUNT											
\$20,000	0.89	1.04	1.33	1.48	1.63	2.52	3.7	6.96	10.8	20.72	33.6
\$40,000	1.78	2.07	2.66	2.96	3.26	5.03	7.4	13.91	21.61	41.44	67.19
\$60,000	2.66	3.11	4	4.44	4.88	7.55	11.1	20.87	32.41	62.16	100.79
\$80,000	3.55	4.14	5.33	5.92	6.51	10.06	14.8	27.82	43.22	82.88	134.38
\$100,000	4.44	5.18	6.66	7.4	8.14	12.58	18.5	34.78	54.02	103.6	167.98
\$120,000	5.33	6.22	7.99	8.88	9.77	15.1	22.2	41.74	64.82	124.32	201.58
\$140,000	6.22	7.25	9.32	10.36	11.4	17.61	25.9	48.69	75.63	145.04	235.17
\$160,000	7.1	8.29	10.66	11.84	13.02	20.13	29.6	55.65	86.43	165.76	268.77
\$180,000	7.99	9.32	11.99	13.32	14.65	22.64	33.3	62.6	97.24	186.48	302.36
\$200,000	8.88	10.36	13.32	14.8	16.28	25.16	37	69.56	108.04	207.2	335.96
\$220,000	9.77	11.4	14.65	16.28	17.91	27.68	40.7	76.52	118.84	227.92	369.56
\$240,000	10.66	12.43	15.98	17.76	19.54	30.19	44.4	83.47	129.65	248.64	403.15
\$260,000	11.54	13.47	17.32	19.24	21.16	32.71	48.1	90.43	140.45	269.36	436.75
\$280,000	12.43	14.5	18.65	20.72	22.79	35.22	51.8	97.38	151.26	290.08	470.34
\$300,000	13.32	15.54	19.98	22.2	24.42	37.74	55.5	104.34	162.06	310.8	503.94
\$320,000	14.21	16.58	21.31	23.68	26.05	40.26	59.2	111.3	172.86	331.52	537.54
\$340,000	15.1	17.61	22.64	25.16	27.68	42.77	62.9	118.25	183.67	352.24	571.13
\$360,000	15.98	18.65	23.98	26.64	29.3	45.29	66.6	125.21	194.47	372.96	604.73
\$380,000	16.87	19.68	25.31	28.12	30.93	47.8	70.3	132.16	205.28	393.68	638.32
\$400,000	17.76	20.72	26.64	29.6	32.56	50.32	74	139.12	216.08	414.4	671.92
\$420,000	18.65	21.76	27.97	31.08	34.19	52.84	77.7	146.08	226.88	435.12	705.52
\$440,000	19.54	22.79	29.3	32.56	35.82	55.35	81.4	153.03	237.69	455.84	739.11
\$460,000	20.42	23.83	30.64	34.04	37.44	57.87	85.1	159.99	248.49	476.56	772.71
\$480,000	21.31	24.86	31.97	35.52	39.07	60.38	88.8	166.94	259.3	497.28	806.3
\$500,000	22.2	25.9	33.3	37	40.7	62.9	92.5	173.9	270.1	518	839.9
\$520,000	23.09	26.94	34.63	38.48	42.33	65.42	96.2	180.86	280.9	538.72	873.5
\$540,000	23.98	27.97	35.96	39.96	43.96	67.93	99.9	187.81	291.71	559.44	907.09
\$560,000	24.86	29.01	37.3	41.44	45.58	70.45	103.6	194.77	302.51	580.16	940.69
\$580,000	25.75	30.04	38.63	42.92	47.21	72.96	107.3	201.72	313.32	600.88	974.28
\$600,000	26.64	31.08	39.96	44.4	48.84	75.48	111	208.68	324.12	621.6	1007.88

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Spouse or Domestic Partner Optional Life Insurance											
Monthly Premium Rates											
Age >	Thru 24	25- 29	30- 34	35- 39	40- 44	45- 49	50- 54	55-59	60-64	65-69	70& up
Rate Per \$10,000 >	\$0.44	\$0.52	\$0.67	\$0.74	\$0.81	\$1.26	\$1.85	\$3.48	\$5.40	\$10.36	\$16.80
AMOUNT											
\$20,000	0.89	1.04	1.33	1.48	1.63	2.52	3.7	6.96	10.8	20.72	33.6
\$40,000	1.78	2.07	2.66	2.96	3.26	5.03	7.4	13.91	21.61	41.44	67.19
\$60,000	2.66	3.11	4	4.44	4.88	7.55	11.1	20.87	32.41	62.16	100.79
\$80,000	3.55	4.14	5.33	5.92	6.51	10.06	14.8	27.82	43.22	82.88	134.38
\$100,000	4.44	5.18	6.66	7.4	8.14	12.58	18.5	34.78	54.02	103.6	167.98
\$120,000	5.33	6.22	7.99	8.88	9.77	15.1	22.2	41.74	64.82	124.32	201.58
\$140,000	6.22	7.25	9.32	10.36	11.4	17.61	25.9	48.69	75.63	145.04	235.17
\$160,000	7.1	8.29	10.66	11.84	13.02	20.13	29.6	55.65	86.43	165.76	268.77
\$180,000	7.99	9.32	11.99	13.32	14.65	22.64	33.3	62.6	97.24	186.48	302.36
\$200,000	8.88	10.36	13.32	14.8	16.28	25.16	37	69.56	108.04	207.2	335.96
\$220,000	9.77	11.4	14.65	16.28	17.91	27.68	40.7	76.52	118.84	227.92	369.56
\$240,000	10.66	12.43	15.98	17.76	19.54	30.19	44.4	83.47	129.65	248.64	403.15
\$260,000	11.54	13.47	17.32	19.24	21.16	32.71	48.1	90.43	140.45	269.36	436.75
\$280,000	12.43	14.5	18.65	20.72	22.79	35.22	51.8	97.38	151.26	290.08	470.34
\$300,000	13.32	15.54	19.98	22.2	24.42	37.74	55.5	104.34	162.06	310.8	503.94
\$320,000	14.21	16.58	21.31	23.68	26.05	40.26	59.2	111.3	172.86	331.52	537.54
\$340,000	15.1	17.61	22.64	25.16	27.68	42.77	62.9	118.25	183.67	352.24	571.13
\$360,000	15.98	18.65	23.98	26.64	29.3	45.29	66.6	125.21	194.47	372.96	604.73
\$380,000	16.87	19.68	25.31	28.12	30.93	47.8	70.3	132.16	205.28	393.68	638.32
\$400,000	17.76	20.72	26.64	29.6	32.56	50.32	74	139.12	216.08	414.4	671.92

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

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 \$25 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 week, you will be paid one-seventh of the benefit for each day of disability.

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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

The premium rate is 0.0054 times your gross monthly salary.

Example:

- Your gross monthly salary is \$3,234.
- \$3,234 times 0.0054 equals \$17.46, 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

<u>Your age when Disability began</u>	<u>Maximum Benefit Period</u>
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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

- 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 Summary Premium = Rate X month salary				
Option	Rate	Waiting Period	Coverage	Coverage Maximum/Minimum
1	\$0.0046	90 days	60% of first \$12,000 minus deductible income	\$7,200 before reduction by deductible income/\$50
2	\$0.0018	180 days		
3	\$0.0099	90 days	66 2/3% of first \$12,000 minus deductible income	\$8,000 before reduction by deductible income/\$50
4	\$0.0025	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 0.0046
Premium amount you pay each month	\$8.74

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

- 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 Accounts

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

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.
- When you enroll, you enroll for the entire plan year, 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 deadline.
- 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 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 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 Oregon University (OUS) 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 incurred in the month following the end of participation and the request is in the current plan year (not the grace period) and 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 that you continue by enrolling in COBRA .

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

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 earnings.

You may elect to have up to \$5,000 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 expense when you receive the services 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 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

State of Oregon
Public Employees' Benefit Board Summary Plan Description

- Over-the-counter drugs for which you have a prescription

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

- 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
- Breast pumps

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

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

Protected leave. Persons on protected leave may maintain their healthcare FSA. Protected leave includes leave through Continuation of Group Medical and Dental Insurance Coverage for Injured Workers (CBIW), Active Military Duty, and the Family Medical Leave Act (FMLA). Participants may make payment to their healthcare FSA as follows:

- Paid leave. Through pre-tax salary reduction
- Unpaid leave: Pre-tax out of pre-leave compensation – Submit prepay requests to PEBB on the appropriate form.

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 2009 plan year.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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, 2009, 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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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.

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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:

State of Oregon

Public Employees' Benefit Board Summary Plan Description

- 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, Contenance 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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,

State of Oregon
Public Employees' Benefit Board Summary Plan Description

- 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

	<u>Without Inflation Protection</u>	<u>With 5% Simple Inflation Protection</u>
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

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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,

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Premium Rates

Rates for \$1,000 Monthly Facility Benefit												
You may choose from \$1,000 - \$6,000 in Facility monthly Benefit. Your monthly Premium will equal the monthly rate for the plan you choose times the facility monthly benefit amount per thousand.												
	Plan 1 Coverage			Plan 2 Coverage			Plan 3 Coverage			Plan 4 Coverage		
	Long Term Care Facility			Long Term Care Facility			Long Term Care Facility			Long Term Care Facility		
	Professional Home Care			Professional Home Care			Professional Home Care			Professional Home Care		
				Total Home Care			Simple Inflation Uncapped			Total Home Care		
										Simple Inflation Uncapped		
	Benefit Duration			Benefit Duration			Benefit Duration			Benefit Duration		
AGE	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited
18-30	\$2.20	\$2.90	\$4	\$3.40	\$4.50	\$6.40	\$3.70	\$4.90	\$6.80	\$5.50	\$7.40	\$10.50
31	2.20	3	4	3.40	4.60	6.50	3.80	5	6.90	5.60	7.60	10.70
32	2.20	3	4.20	3.40	4.70	6.60	3.80	5.20	7.20	5.70	7.80	11.10
33	2.30	3.10	4.20	3.50	4.80	6.70	4	5.50	7.30	6	8.10	11.40
34	2.40	3.20	4.30	3.60	4.90	6.90	4.20	5.60	7.60	6.20	8.40	11.70
35	2.50	3.30	4.50	3.70	5.10	7.10	4.30	5.90	7.90	6.40	8.70	12.20
36	2.50	3.40	4.60	3.80	5.20	7.30	4.50	6.10	8.10	6.60	9	12.50
37	2.60	3.60	4.80	3.90	5.40	7.60	4.70	6.40	8.60	6.90	9.40	13.10
38	2.80	3.70	4.90	4.10	5.60	7.80	5	6.70	8.80	7.20	9.80	13.60
39	2.90	3.80	5.20	4.30	5.80	8.20	5.20	6.90	9.20	7.50	10.10	14.10
40	3	4	5.40	4.50	6.10	8.50	5.40	7.20	9.60	7.80	10.50	14.70
41	3.10	4.10	5.60	4.70	6.30	8.90	5.70	7.50	10.10	8.20	11	15.30
42	3.30	4.40	5.80	4.90	6.60	9.20	5.90	7.90	10.50	8.50	11.60	16
43	3.40	4.60	6.10	5.10	6.90	9.60	6.20	8.20	11	8.90	12	16.60
44	3.60	4.80	6.40	5.30	7.20	10.10	6.50	8.70	11.50	9.30	12.70	17.40
45	3.80	5.10	6.70	5.60	7.60	10.60	6.90	9.10	12.10	9.80	13.20	18.30
46	3.90	5.30	7.10	5.90	8	11.20	7.10	9.50	12.50	10.20	13.80	19
47	4.10	5.60	7.40	6.20	8.50	11.80	7.40	9.90	13	10.60	14.50	20
48	4.40	5.90	7.80	6.60	9	12.50	7.80	10.40	13.70	11.30	15.30	21.10
49	4.60	6.10	8.10	6.90	9.40	13.10	8.10	10.80	14.30	11.80	16	22.10
50	4.80	6.40	8.60	7.30	10	14	8.50	11.30	14.90	12.40	16.90	23.30
51	5.10	6.80	9	7.80	10.50	14.80	9	11.90	15.70	13.10	17.70	24.60
52	5.40	7.20	9.50	8.30	11.20	15.70	9.50	12.50	16.40	13.80	18.70	25.80
53	5.80	7.60	10.10	8.80	11.90	16.70	10	13.10	17.20	14.60	19.70	27.40
54	6.10	8.10	10.60	9.30	12.70	17.70	10.40	13.70	18	15.20	20.70	28.70
55	6.50	8.60	11.10	9.90	13.50	18.70	11	14.50	18.70	16.10	21.70	29.80
56	6.90	9.10	11.90	10.50	14.40	20	11.60	15.30	19.90	16.90	23	31.80

State of Oregon
Public Employees' Benefit Board Summary Plan Description

AGE	Plan 1 Coverage			Plan 2 Coverage			Plan 3 Coverage			Plan 4 Coverage		
	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited	3 YR	6 YR	Unlimited
57	7.40	9.80	12.70	11.30	15.40	21.40	12.40	16.30	21	18	24.40	33.70
58	7.90	10.50	13.60	12.10	16.50	23	13.10	17.20	22.20	18.90	25.80	35.60
59	8.60	11.20	14.60	13	17.70	24.60	14	18.40	23.50	20.30	27.50	37.90
60	9.30	12.10	15.60	13.90	18.90	26.40	15	19.40	25	21.60	29.10	40.20
61	10.10	13.20	17	15	20.70	28.80	16.20	21.10	27.10	23.10	31.60	43.50
62	11.10	14.50	18.60	16.40	22.50	31.30	17.70	22.90	29.20	25	34.10	46.90
63	12.20	15.90	20.30	17.80	24.50	34.10	19.10	24.90	31.60	26.90	36.80	50.70
64	13.40	17.40	22.10	19.40	26.70	37.10	20.80	27	34.10	29	39.60	54.40
65	15.30	19.80	25	21.70	29.80	41.50	23.50	30.30	38.20	32.20	43.90	60.40
66	16.90	21.90	27.80	23.60	32.60	45.40	25.80	33.30	41.90	34.80	47.70	65.70
67	18.90	24.30	30.70	25.90	35.70	49.50	28.30	36.40	45.70	37.60	51.50	70.80
68	20.90	26.90	34	28.20	38.90	54.10	30.80	39.60	49.80	40.60	55.70	76.60
69	23.20	29.70	37.50	30.90	42.50	59	33.70	43.10	54.30	43.80	59.90	82.40
70	25.70	32.90	41.40	33.70	46.50	64.50	36.80	47.20	59.20	47.30	64.80	89.10
71	28.50	36.50	46	37	51	70.70	40.50	51.80	64.90	51.50	70.60	97.10
72	31.60	40.50	50.80	40.50	55.90	77.20	44.60	57	71.20	56	76.80	105
73	35.10	44.70	55.90	44.50	61.30	84.30	48.80	62.10	77.50	60.80	83.30	113.80
74	38.80	49.50	61.60	48.70	67.10	91.90	53.60	68.20	84.60	66	90.40	122.80
75	46.80	59.50	74	58.10	80.10	109.40	63.80	80.80	100.20	77.90	106.60	144.50
76	51.40	65.30	81.20	63.20	87.20	119.10	69.10	87.60	108.70	83.80	114.70	155.60
77	56.40	71.70	89.10	68.70	94.90	129.50	75.30	95.40	118.20	90.50	123.90	168
78	61.90	78.60	97.40	74.80	103.30	140.70	81.50	103.10	127.50	97.20	133.30	180.30
79	68	86.10	106.60	81.40	112.40	152.80	88.70	112.20	138.60	104.90	144	194.50
80	74.70	94.50	116.70	88.60	122.30	165.90	96	121.20	149.40	112.80	154.60	208.50
81	82.3	103.80	128	96.80	133.50	180.50	105.10	132.20	162.70	122.30	167.50	225.20
82	91.30	115	141.40	106.60	146.90	1980	114.70	144.20	177	132.70	181.90	243.80
83	100.90	126.80	155.50	117.20	161.30	216.70	125.80	157.80	193.10	144.90	198.20	264.70
84	111.20	139.40	170.30	128.40	176.70	236.10	136.40	170.90	208.40	156.50	214.10	284.70

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 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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 coverages 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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

- 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 Operations 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 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, the employee or individual will receive a written explanation and determination within 30 days after the next regularly scheduled meeting.

Level Four: An eligible employee dissatisfied with a determination by Operations Subcommittee or a rescission individual may request a review and determination of the appeal by the Board. The Board may review appeals submitted directly by the Operations Subcommittee.

- An employee or individual requesting a Level Four review must submit the request in writing to the Plan Design Manager within 30 days of the Operations Subcommittee determination letter date.
- When the board completes a review, the employee or individual will receive a written explanation and determination within 30 days after the next regularly scheduled meeting. Should the decision require longer than 30 days the Board will send notice to the employee.

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

Federally Required Notices

Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under PEBB-sponsored medical plans no longer applies as of Jan. 1, 2011. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice or until the end of open enrollment to request enrollment. For more information contact PEBB at 503-373-1102.

Opportunity to Enroll with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in PEBB-sponsored medical plans. Individuals may request enrollment for such children for 30 days from Oct. 1, 2010, or until the end of open enrollment. Enrollment will be effective Jan. 1, 2011. For more information contact PEBB at 503-373-1102.

Notice of Women's Health and Cancer Rights

If you or your insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, coverage will be provided for: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and treatment of physical complications of all stages of mastectomy, including lymph edemas. Reconstruction benefits are subject to the same provisions as any other benefit provided under the PEBB plans.

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.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

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?

You 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 nineteen 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 their 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 them at 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).

State of Oregon
Public Employees' Benefit Board Summary Plan Description

**Date: Sept. 9, 2010. Name of Entity/Sender: PEBB. Contact: Benefits Office, Ste B.
Address:1225 Ferry St SE, Salem, OR 97301. Phone Number: 503-373-1102.**

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 occur: (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.

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the states listed on the following page, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility. To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can 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, Ext. 61

State of Oregon
Public Employees' Benefit Board Summary Plan Description

ALABAMA – Medicaid	MAINE – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557
ALASKA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120
ARIZONA – CHIP	MINNESOTA – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739
ARKANSAS – CHIP	MISSOURI – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944
CALIFORNIA – Medicaid	MONTANA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
COLORADO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: www.CHPplus.org CHIP Phone: 303-866-3243	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
FLORIDA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
GEORGIA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
IDAHO – Medicaid and CHIP	NEW JERSEY – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
INDIANA – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html (Click on Insure New Mexico); CHIP Phone: 1-888-997-2583
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW YORK – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

State of Oregon
Public Employees' Benefit Board Summary Plan Description

KENTUCKY – Medicaid	NORTH CAROLINA – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.nc.gov Phone: 919-855-4100
LOUISIANA – Medicaid	
Website: http://www.la.hipp.dhh.louisiana.gov Phone: 1-888-342-6207	

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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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?

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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?

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Web: www.benefithelpsolutions.com

Important Information

Continuation of Coverage for Spouses Age 55 or 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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

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.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

- 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).

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

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

Office for Civil Rights, Medical Privacy Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Phone: 866-627-7748 TTY 866-788-4989

Email: OCRComplaint@hhs.gov

Changes to Our Notice

This notice is effective on January 1, 2008. 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 the PEBB member newsletter and post the notice on our website at <http://oregon.gov/das/pebb>.