

**PEBB Amended Rules  
Effective 10/1/2009**

**101-015-0015 - Child by Affidavit [Repealed 10-1-09]**

## **PEBB Amended Rules**

**Effective 10/01/2009**

### **101-010-0005 - Definitions**

Unless the context indicates otherwise, as used in OAR chapter 101, divisions 1 through 60, the following definitions will apply:

- (1) "Actively at work" for medical and dental insurance coverage means an active eligible employee at work, in paid regular status and scheduled for work during the month of requested insurance coverage, or using accrued leave on the effective date of coverage. Reference optional insurance policies or certificates for plan specific "actively at work" criteria.
- (2) "Active Participation" in reference to a Flexible Spending Account (FSA) means an eligible employee currently enrolled and who contributes each month to the account.
- (3) "Affidavit of Dependency" means a notarized document that attests a dependent child meets the criteria in section OAR (101-015-0011).
- (4) "Affidavit of Domestic Partnership" means a notarized document that attests the eligible employee and one other individual meet the criteria in OAR 101-015-0025(2).
- (5) "Benefit amount" means the amount of money paid by a PEBB participating organization on behalf of active eligible employees for the purchase of benefit plans.
- (6) "CBIW" means Continuation of Benefits for Injured Workers.
- (7) "Certificate of Registered Domestic Partnership" means the certificate issued by an Oregon county clerk to two individuals of the same sex after they file a Declaration of Domestic Partnership with the county clerk.
- (8) "COBRA" means the federal Consolidated Omnibus Reconciliation Act.
- (9) "Dependent Care Flexible Spending Account (FSA)" means the dependent care assistance program.

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(10) "Dependent child" is defined by OAR 101-015-0011

(11) "Domestic partner" means an eligible employee's partner in a registered domestic partnership under Chapter 99 Oregon Laws 2007 or unmarried partner of the same or opposite sex that meets the requirements as outlined in OAR 101-015-0025(2).

(12) "Eligible employee" means and includes:

(a) "Active eligible employee" means an employee of a PEBB participating organization, including state officials, in exempt, unclassified, classified and management service positions who are expected to work at least 90 days; and who work at least half-time or are in a position classified as job share.

(b) "Retired eligible employee" means a previously active eligible employee, who meets retiree eligibility as defined in OAR 101-050-0005. A retired eligible employee is eligible only for those benefit plans established in division 50 of this chapter.

(c) "Other eligible employees" means individuals of self-pay groups as established by ORS 243.140 and 243.200. This group is eligible only for medical or dental benefits as approved by PEBB.

(13) "Family member" means a spouse or dependent child.

(14) "FMLA" means the federal Family Medical Leave Act.

(15) "FTE" means full time equivalent job position.

(16) "Half-time" means an eligible employee who works less than full time but at least:

(a) Eighty paid regular hours per month; or

(b) Eighty paid regular hours per month or .5 FTE for OUS employees; or

(c) Eighty paid regular hours per month and is in a .5 FTE position for the Oregon Judicial Department; or

(d) As defined by collective bargaining.

(17) "Health Flexible Spending Account (FSA)" means the health flexible spending arrangement.

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(18) "Imputed value" means a dollar amount established yearly for an insurance premium at fair market value. The IRS views the imputed value as taxable income. The imputed value dollar amount is added to the eligible employee's taxable wages.

(19) "Ineligible individual" means an individual who does not meet the definition of an eligible employee, spouse, domestic partner, or dependent child.

(20) "Job share" means two eligible employees sharing one full time equivalent position. Each eligible employee's percentage of the total position determines the benefit amount the employee receives. The monthly benefit percentage amount remains the same regardless of individual hours worked per month. Job share employees may not donate their portion of the benefit amount to the job share co-worker.

**Example 1:** John and Jill share one full time equivalent position. When they were hired into the position in July, John's percentage of the total position was 40 percent; Jill's percentage was 60 percent. John worked 70 percent of the available hours in September. John's benefit amount percentage for September remains at 40 percent. Jill's benefit amount percentage remains at 60 percent.

(21) "OFLA" means the Oregon Family Leave Act.

(22) "OSPS" means the Oregon State Payroll System.

(23) "OUS" means the Oregon University System.

(24) "Open enrollment period" means an annual period chosen by PEBB when both active and other eligible employees and COBRA participants can make benefit plan changes or elections for the next plan year.

(25) "Optional insurances" means, but is not limited to:

(a) Dependent life insurance;

(b) Employee, spouse, or domestic partner life insurance;

(c) Accidental Death & Dismemberment (AD&D) insurance;

(d) Short Term Disability insurance;

(e) Long Term Disability insurance;

(f) Flexible Spending Accounts (Health and Dependent Care); and

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(g) Long Term Care insurance

(26) "Paid regular" means in current payroll status, and receiving payment for work time including vacation, sick, holiday or personal leave and compensatory time.

(27) "Pebb.benefits" means the electronic benefit management system sponsored by PEBB. The system allows electronic enrollment and termination of the eligible individual's benefit plans, personal information updates, and the transmittal of data to plans, payroll centers, and third party administrators.

(28) "PEBB participating organization" means a state agency, board, commission, university, or other entity that receives approval to participate in PEBB benefit plans.

(29) "Plan change period" means a period chosen by PEBB when retirees can make limited benefit plan changes.

(30) "Plan year" means a period of twelve consecutive months.

(31) "Qualified status change" (QSC) means a change in family or work status that allows limited mid-year changes to benefit plans consistent with the individual event.

(32) "Reinstate" means to reactivate previous benefits and enrollments, if available, to an eligible employee returning to eligible status within a specific time frame. Reinstated enrollment does not include FSA or Long Term Care.

(33) "Spouse" means a person of the opposite sex who is a husband or wife. A relationship recognized as a marriage in another state between two opposite sex partners will be recognized in Oregon even though such a relationship would not be a marriage if the same facts had been relied upon to create a marriage in Oregon. The definition of spouse does not include a former spouse and a former spouse does not qualify as a dependent.

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**Dependent Child**

1) In defining dependent child eligibility, PEBB uses the Internal Revenue Code (IRC) 152 as revised by the Working Families Tax Relief Act of 2004. A dependent child must meet the following PEBB eligibility requirements:

(a) The child is an eligible employee's, spouse's, or domestic partner's:

(A) Biological, adopted, or a placed for adoption child; or

(B) Child by Affidavit. A Child by Affidavit includes, but is not limited to, a foster child, a ward of the court, a child under legal guardianship, or the child of a dependent. The child must meet PEBB eligibility requirements. The eligible employee must complete and return to the agency a notarized PEBB Affidavit of Dependency form within five business days of the child's electronic enrollment date or the date the agency receives the enrollment forms. PEBB terminates the child's coverage retroactive to the effective date if the notarized affidavit is not received within the specified time.

(b) The dependent child is not married, does not have a domestic partner, is not in the military and is a member of the eligible employee's household.

(c) Regarding age, the dependent child is:

(A) Under the age of 19 at the end of the calendar plan year.

(B) Between the ages of 19 and up to age 24 during the plan year, and is a full time student who has not attained the age of 24.

(i) Student means an individual who during each of five calendar months during the calendar year is a full-time student at an education organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried on.

(ii) To be full-time, the student must be enrolled for the number of hours or courses the school considers full-time attendance. The term school includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, or schools offering courses only through the internet. People who work "co-op" jobs in private industry as part of a school's regular course of classroom and practical training are full-time students.

(iii) Beginning in 2010, seriously ill or injured full time student dependents covered under an eligible employee's plan immediately before the first day of a medically necessary leave of absence, or change in enrollment such as full-time to part-time, may

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continue coverage for up to one year while on a medically necessary leave of absence. "Medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any other change in enrollment at the institution that starts while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of PEBB eligibility. A physician of the dependent must provide a written certification to PEBB stating that the child is suffering from a serious illness or injury and that the leave of absence (or change in enrollment) is medically necessary. The extension of coverage continues until the earlier of one year after the first day of the leave or the date that coverage would otherwise terminate, (e.g., due to an age limitation).

(C) Between the ages of 19 and up to age 24, lives in the eligible employee's household over six months of the calendar year, and the eligible employee provides over half the child's yearly support.

(d) 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.

(A) The attending physician must submit documentation of the disability to the eligible employee's PEBB medical insurance plan for eligibility approval. Once approved, the medical plan may review the dependent's health status at any time to determine the child's continued PEBB eligibility.

(B) When the dependent child is 24 years of age or older, the disability must have existed before attaining age 24. The child must have had continuous medical insurance coverage, group or individual, prior to attaining age 24 and the insurance must continue until the PEBB insurance effective date.

(C) If the child terminates from PEBB insurance coverage after age 24, the child is ineligible for future enrollment as a dependent child under PEBB coverage.

(e) The child must be a U.S. citizen, national or resident of the U.S. or a resident of Canada or Mexico. When an adopted child or child placed for adoption fails this requirement, they can still be the employees' dependent child if the child has the employee's home as his principal home and is a member of the employees' household, and the employee is a citizen or national of the U.S. Foreign students are not eligible for PEBB coverage.

(f) The child must not qualify as any other person's dependent child, except that a child of divorced or separated parents meeting conditions under IRC 152(e) can be treated as dependent of both parents for the purpose of health insurance coverage.

(2) Eligible employees who want to provide insurance coverage to dependent children that will be between the ages of 19 and up to age 24 must certify during the open enrollment period the dependent's continued eligibility for the following plan year. Dependents not certified during open enrollment will lose coverage the last day of the

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current plan year. The yearly dependent certification excludes children approved by the insurance plan as incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

(3) PEBB terminates all insurance coverage for dependent children the last day of the month in which the child reaches age 24. PEBB will not terminate coverage for children age 24 or older when approved by the insurance plan as incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

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**101-020-0040 - Late Enrollment**

(1) Late enrollment occurs when an eligible employee fails to enroll themselves, eligible family members, domestic partner, or a domestic partner's child in benefit plans within the required time period. Excluding section (4) of this rule, PEBB must review all late enrollment requests.

(2) An enrolled employee requesting late enrollment for a family member, domestic partner, or domestic partner's dependent child must provide supporting documentation that shows an inability to enroll the individual when first eligible because of circumstances beyond the employee's control.

(3) A newly eligible employee approved for late enrollment receives only employee basic life insurance coverage and may only elect medical and dental coverage for themselves, spouse, domestic partner, or dependent children. If late enrollment is approved, benefit coverage is effective the first of the month following receipt of the completed enrollment forms.

(4) Following receipt of the completed forms, agencies are responsible for approving the late enrollment of the employee's biological newborn dependent child during the first twelve months of life. The enrollment is always retroactive to the first of the month following the date of birth.

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**101-020-0045**

**Returning to Work**

(1) Refer to the following rules for an employee returning to active or paid regular status from the following qualified protected leave status:

(a) Continuation of Benefits for Injured Workers (CBIW). See OAR 101-030-0010.

(b) Federal Family Medical Leave Act (FMLA). See OAR 101-030-0015.

(c) Oregon Family Leave Act (OFLA). See OAR 101-030-0020.

(d) Active Military Duty Leave (USERRA). See OAR 101-030-0022.

(2) An eligible employee returning from an unprotected leave without pay or a reduction in hours must work at least half-time in the month of return to be eligible for medical, dental, and optional insurance coverages for the following month. The exception is eligible employees in job share positions.

(3) An eligible 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.

**Example:** Gary begins leave without pay on May 20. Gary has enough hours for benefits to continue through June; therefore, his scheduled benefit end date is June 30. Gary returns to work on May 25 (within 30 days with no break in benefit coverage). Gary receives insurance for June because he worked enough hours in May to pay for his June benefits. Gary's benefits are reinstated June 1 because he returned to work within 30 days. Gary must work at least half time in June for his benefits to continue in July. Gary is not eligible to make benefit changes.

(4) An eligible employee returning to paid regular status within 12 months of the insurance coverage end date following 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 previous enrollments will be reinstated, if available, the first of the month following their return to work. This excludes Flexible Spending Accounts and Long Term Care. The employee may make midyear plan changes within 60 days of the date they return to work.

(5) An eligible employee returning to active or paid regular status after 12 months from the insurance coverage end date must enroll as a newly eligible employee.

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**101-020-0065**

**Health Flexible Spending Arrangement**

(1) An eligible employee may enroll in a pretax Health Flexible Spending Arrangement (Health FSA). The employee must enroll each year during open enrollment to participate in a Health FSA in the new plan year. The Board determines the annual maximum contribution amounts.

(2) PEBB requires a minimum monthly contribution amount to participate. An employee may make only one contribution in each month. An employee may not change their monthly contribution unless they experience a qualified mid-year plan change event.

(3) An eligible employee approved for FMLA, CBIW, or active Military Duty Leave can request to prepay their Health FSA contribution if prepayment:

(a) Totals the required contribution amount for the leave period;

(b) Is for the current plan year;

(c) Is completed by the last paycheck prior to the start of the leave and;

(d) Is requested and submitted on the appropriate form to PEBB.

(4) An eligible employee may request a qualified reservist distribution from a Health FSA account when ordered or called to active military duty for a period of at least 180 days or for an indefinite period. The eligible employee must be 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.

(a) The following conditions must be met by the eligible employee in order to elect the qualified reservist distribution:

(A) The order or call to active military duty is on or after the plan year date of January 1, 2009.

(B) Contributions to the Health FSA account for the plan year as of the date of the request for a distribution exceed the reimbursements received from the Health FSA Account for the plan year as of that date.

(C) The agency receives a copy of the order or call to active duty along with the distribution request form. 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.

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(D) During the period beginning with the date of the order or call to active duty and ending on the last eligible day of the plan year during which the order or call occurred, the employee submits a qualified reservist distribution election form to the agency.

**Example:** An eligible employee is called to active duty on September 13, 2009 and wants a Health FSA qualified reservist distribution. The employee must request the qualified reservist distribution between September 13, 2009 and March 31, 2010.

(b) The distribution amount paid to the eligible employee is equal to the contributions to the Health FSA Account for the plan year as of the date of the distribution request, minus any reimbursements received by the employee for the plan year as of that date. A qualified reservist distribution is included in an eligible employee's gross income and reported as wages for the year it is paid.

**Example:** An eligible employee elects Health FSA benefits of \$1,000 for the 2009 plan year, and during the first six months of the plan year, makes Health FSA contributions of \$500 and receives Health FSA reimbursements of \$200 for substantiated medical care expenses. The employee is called to active duty for an indefinite period and on June 30 requests a reservist distribution from the agency. The employee will receive a distribution of \$300, and the agency must add that amount to the employees' taxable wages for the 2009 tax year.

(c) An employee forfeits the right to receive reimbursements for medical care expenses incurred during the period that begins on the date of the distribution request and ending on the last day the Plan Year. The Health FSA Account is closed as of the date of request for a reservist distribution.

(5) 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 ends the last day of the month that a contribution is received for that month.

(6) Reimbursement of eligible expenses may occur only for the period of coverage in which participation was active, provided the claim is filed within the eligible plan year. OUS and academic OSPS employees that contribute during the plan year based on 9 or 10-month contributions are considered actively participating during the months of no contribution, as scheduled at the time of enrollment.

(7) Final contribution at termination of employment or leave without prepayment.

(a) An OSPS employee will not have a contribution taken from their final paycheck.

**Example:** Ann's last day of work is September 16. Her final check will not have a contribution taken. Ann's participation ends September 30 and her period of coverage is through September 30.

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(b) An OUS employee who meets the 80-hour work rule will have a contribution taken from their final paycheck, in accordance with OAR 101-020-0002.

**Example 1:** Ann's last day of work is June 6. She has less than 80 hours of work for the month. Ann's final check will not have a contribution taken. Ann's participation ends May 31 and her period of coverage is through May 31.

**Example 2:** Ann's last day of work is June 20. She has more than 80 hours of work for the month. Ann's final check will have a contribution taken. Ann's participation ends June 30, and her period of coverage is through June 30.

(8) The Health FSA is subject to the "Use It or Lose It" rule. Any funds remaining in the account beyond March 31 following the plan year forfeit to PEBB.

(9) An eligible employee ending employment or on leave of absence may continue to participate in the Health FSA up to the end of the current plan year through COBRA if:

(a) There is a positive balance in the eligible employee's account; and

(b) The eligible employee self-pays contributions to the account post-tax.

(10) An eligible employee who separates from the employer and later returns to work within 12 months of the separation is not reinstated in the Health FSA. They may enroll within 60 days of their eligibility date.

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**101-020-0060**

**Dependent Care Flexible Spending Account**

(1) An eligible employee may enroll in a pretax Dependent Care Flexible Spending Account (Dependent Care FSA). The employee must enroll each year during open enrollment to participate in a Dependent Care FSA in the new plan year. The employee may enroll for Dependent Care when:

(a) Their expenses qualify for reimbursement for:

(A) The care and well-being of a dependent child under the age of 13; or

(B) The care of a disabled dependent who is incapable of self-care and who spends at least eight hours per day in the employee's home; and

(b) The employee is:

(A) Single, or

(B) Married, and the expenses are necessary for both the eligible employee and the spouse to work, or

(C) Married, and the spouse is either disabled, actively seeking employment, or a full time student for some part of each of five months during the year.

(2) An eligible employee may not allocate more than \$5,000 to any pretax Dependent Care FSA per plan year or more than \$2,500 per plan year if married and filing a separate income tax return.

(3) PEBB requires a minimum monthly contribution amount to participate. An employee may make only one contribution in each month. An employee may not change their monthly contribution unless they experience a qualified mid-year plan change event.

(4) The Dependent Care FSA period of coverage is the plan year. The exception is for employees who terminate participation, in which case it means the portion of the plan year before the active participation end date. Active participation ends the last day of the month that a contribution is received for that month.

(5) Reimbursement of eligible expenses may occur only for the period of coverage in which the participation was active, provided the claim is filed within the eligible plan year. The exception is eligible expenses incurred in the month following participation or cessation of eligibility, if the month is in the current plan year (not the grace period) and the eligible employee files a claim within 90 days after the date participation ends.

(6) Final contribution at termination of employment or leave.

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(a) An OSPS employee will not have a contribution taken from their final paycheck.

**Example:** Ann's last day of work is September 16. Her final check will not have a contribution taken. Ann's participation ends September 30 and her period of coverage could be through October 31.

(b) An OUS employee who meets the 80-hour work rule will have a contribution taken from their final paycheck, in accordance with OAR 101-020-0002.

**Example 1:** Ann's last day of work is June 6. She has less than 80 hours of work for the month. Ann's final check will not have a contribution taken. Ann's participation ends May 31 and her period of coverage could be through June 30.

**Example 2:** Ann's last day of work is June 20. She has more than 80 hours of work for the month. Ann's final check will have a contribution taken. Ann's participation ends June 30, and her period of coverage could be through July 31.

(7) The Dependent Care FSA is subject to the "Use It or Lose It" rule. Any funds remaining in the account beyond March 31, of the following plan year forfeit to PEBB

(8) An eligible employee who separates from the employer and later returns to work within 12 months of the separation is not reinstated in the Dependent Care FSA. They may enroll within 60 days of their eligibility date.

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**101-030-0022**

**Continuation of Insurance Coverage for Employees on Active Military Leave (USERRA)**

(1) The state will continue to pay the benefit amount for medical, dental, and employee basic life insurance coverage in effect at the time an eligible employee begins active military duty. This benefit coverage will continue for the duration of the active military leave, up to 24 consecutive months. The agency may end this coverage before or during the 24 months active duty only if the member submits a signed written request to end the coverages.

(2) An eligible employee may continue the following optional plans during active military duty up to 12 months by self paying premiums or contributions to the agency:

(a) Optional Life Insurances

(b) Accidental Death and Dismemberment Insurance

(c) Health Flexible Spending Account (FSA).

(3) An eligible employee on active military leave during open enrollment may make open enrollment benefit elections. The employee must file a power of attorney with the agency to allow another individual to make plan elections in the employee's absence. Enrollment in a Health FSA must occur during open enrollment in order to participate in the new plan year.

(4) An eligible employee who returns to work within 24 months will have available previous optional plan enrollments reinstated retroactive to the first day of the month the employee returns. A returning employee is not required to work at least half-time in the month they return to be eligible for benefits the following month.

(a) The employee must self-pay premiums for optional insurance plan reinstatements for the month in which they return.

(b) An employee returning to work will not be reinstated in Long Term Care or any FSA, unless they continued contributions to their Health FSA while on military leave.

(c) The employee may make midyear plan changes within 60 days of the date they return to work.

(5) A COBRA qualifying event occurs when an eligible employee:

(a) Is no longer in active duty status or paid regular status, and does not return to work following the allowed decompression time;

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- (b) Remains in active duty status after 24 months of active duty; or
- (c) Terminates employment

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**101-020-0025**

**Removing an Ineligible Individual from Benefit Plans**

(1) An ineligible individual must be removed from insurance coverage within 60 days of the loss of eligibility. The eligible employee is responsible for removing ineligible individuals from their insurance coverage by submitting completed enrollment update forms to the agency. Insurance coverage ends the last day of the month that eligibility is lost.

(2) PEBB must review all requests to remove an ineligible individual submitted after 60 days of the loss of eligibility. A COBRA unavailability letter will be sent to ineligible individuals removed due to late notification by the eligible employee.

(3) An eligible employee may be responsible to repay claims paid by benefit plans for an ineligible individual during any period of ineligibility.

(3) PEBB will remove individuals identified as ineligible from insurance coverage retroactive to the end of the month that eligibility is lost, whether or not requested by the employee within the 60 day period.

**Example 1:** Cindy's divorce was finalized September 14. The spouse lost PEBB eligibility September 30 due to the divorce. Cindy did not submit update forms, instead she removed her spouse during Open Enrollment in October. This resulted in continued coverage for the former spouse to January 1 of the new plan year. The error was identified, PEBB removed Cindy's former spouse from coverage effective September 30 and a COBRA unavailability letter was sent to the former spouse. Cindy may be responsible for claims paid for her former spouse after September 30.

**Example 2:** John's dependent child, who is not disabled, reaches age 24, PEBB automatically removes the child from coverage the last day of the month in which the child turned 24.

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**101-020-0037**

**Correcting Enrollment and Processing Errors**

(1) Employee enrollment errors occur when an eligible employee provides incorrect information or fails to make correct selections when making benefit plan elections. An employee's failure to take enrollment action is not considered an employee error. The eligible employee is responsible for identifying enrollment errors.

(a) PEBB authorizes the agency to correct employee enrollment errors when reported by the employee within 60 days of the original eligibility date or midyear plan change date. Corrections are retroactive to the first of the month following the date the original paper form or electronic equivalent was first received by the agency.

(A) PEBB must review all employee requests to correct enrollment errors received after 60 days of the original eligibility date or the midyear plan change date. If the correction is approved, the effective date is the first of the month following the receipt of the employee's correction request.

(B) Enrollment error correction requests considered beyond 90 days of the eligibility date or the midyear plan change date must demonstrate facts and circumstances that clearly establish an employee error occurred.

**Example:** As a new employee Anne enrolled in the Dependent Care Flexible Spending Account. Anne does not have any eligible dependents. Six months later Anne realizes the error after her first Health FSA claim is rejected. Anne may request an enrollment correction from PEBB.

(b) PEBB authorizes the agency to correct employee open enrollment errors. The agency must receive employee correction requests after the open enrollment end date but no later than 30 days from receipt of the first paycheck of the new plan year. PEBB must review all employee correction requests received beyond 30 days from receipt of the first paycheck of the new plan year. Open Enrollment employee error corrections are effective the first day of the new plan year.

(2) Administrative processing errors occur when benefit plan elections are processed incorrectly in the payroll and benefit system by the agency, PEBB, or third party administrative staff, or when a newly eligible employee does not receive correct enrollment information or materials within 30 days of the eligibility date.

(a) PEBB authorizes the agency to correct processing errors identified within 60 days of the eligibility date or the midyear plan change date. Corrections are retroactive to the first of the month following the date the paper form or electronic equivalent was first received by the agency. The agency must reconcile all premium discrepancies as described by contract with the insurer.

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(b) PEBB must review all processing error correction requests identified after 60 days of the eligibility date or the midyear plan change date. If approved, corrections are retroactive to the first of the month following the date the paper form or electronic equivalent was first received by the agency. The agency must reconcile all premium discrepancies as described by contract with the insurer.

(c) PEBB authorizes the agency to correct open enrollment processing errors. The agency must receive requests for correction after the open enrollment end date but no later than 30 days from receipt of the first paycheck of the new plan year. PEBB must review all open enrollment correction requests received beyond the 30 days from receipt of the first paycheck of the new plan year. All processing error corrections are effective the first day of the new plan year.

(d) When a newly eligible employee fails to receive enrollment information within 30 days of the eligibility date or receives incorrect information, benefit plan elections will be effective retroactive to the first of the month following the eligibility date.

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**Opting Out of Medical Insurance Coverage**

(1) An eligible employee covered by another employer-sponsored group medical plan may opt out of PEBB-sponsored medical insurance coverage. Opting out is a medical insurance plan election and applies only to the medical insurance benefit. The eligible employee may receive a portion of the benefit amount as cash in lieu of medical insurance coverage as determined by PEBB.

(2) The eligible employee must provide proof of current coverage under another employer-sponsored group medical insurance plan. The employee must provide to the agency documentation of current group medical coverage within five business days of the electronic enrollment or the date the agency receives enrollment forms. Examples of documentation, include but is not limited to, plan identification cards or an employer letter of coverage. If documentation is not received, the employee's medical opt out terminates retroactive to the effective date. PEBB will enroll only the employee in the PEBB state wide medical plan and continue all other employee insurance selections.

(3) Mandatory enrollment in other plans such as dental insurance may be required of eligible employees electing to opt out.

(4) An eligible employee enrolled in Medicare, Medicaid, Veterans' Administration Benefit Programs, TRICARE or Student Health Insurance may not opt out in lieu of enrollment in a PEBB medical insurance plan.

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**101-020-0005**

**Newly Hired and Newly Eligible Employee**

(1) A newly hired or newly eligible employee has 60 days from the date of hire or date of eligibility to enroll in PEBB-sponsored benefit plans.

(a) The newly hired eligible employee may enroll in benefit plans for the following month regardless of the number of hours worked in the month.

(b) The eligible employee must be actively at work on the effective date of the insurance coverage.

(c) Benefit plan elections are irrevocable for the plan year except as specified in OAR 101-020-0050.

(d) A newly eligible employee enrolling in PEBB-sponsored benefit plans and terminating employment before the effective date of insurance coverage is not eligible to receive benefits.

**Example 1:** Sarah was hired and enrolled in benefit plans on June 25. She quit on July 2. Sarah is eligible for insurance coverage effective July 1 through July 31, because she was in paid regular status on July 1.

**Example 2:** Ron was hired and enrolled in benefit plans on June 25. He quit on June 30. Ron is not eligible for insurance coverage, because he was not in paid regular status on July 1.

(2) An employee that becomes eligible for benefits during or after the open enrollment period but before the start of the new plan year, must receive the opportunity for open enrollment changes.

**PEBB Amended Rules**

**Effective 10/01/2009**

**101-001-0020 – Social Security Numbers [Repealed 10-1-09]**