

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/rules/OARS_100/OAR_101/101_tofc.html. Refer to Chapter 101, 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).

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- 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

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- 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

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reactivate all previous enrollments in medical, dental, and life plans, if available, on a guaranteed basis when the employee returns from a leave or a termination of employment within 12 months of the coverage end date. Employees have 30 days from the date of their return to change reinstated benefits. 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.

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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.

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Continuing life and long term care insurance after retirement

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability if you enroll in conversion coverage or PEBB retiree life insurance portability coverage within 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.

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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 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

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receive the opportunity to elect only the healthcare coverage they were receiving immediately before 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.

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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.

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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.

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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.

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- 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

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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***

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- 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.

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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

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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.

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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

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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.

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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

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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.

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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 e-mail 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.