

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.