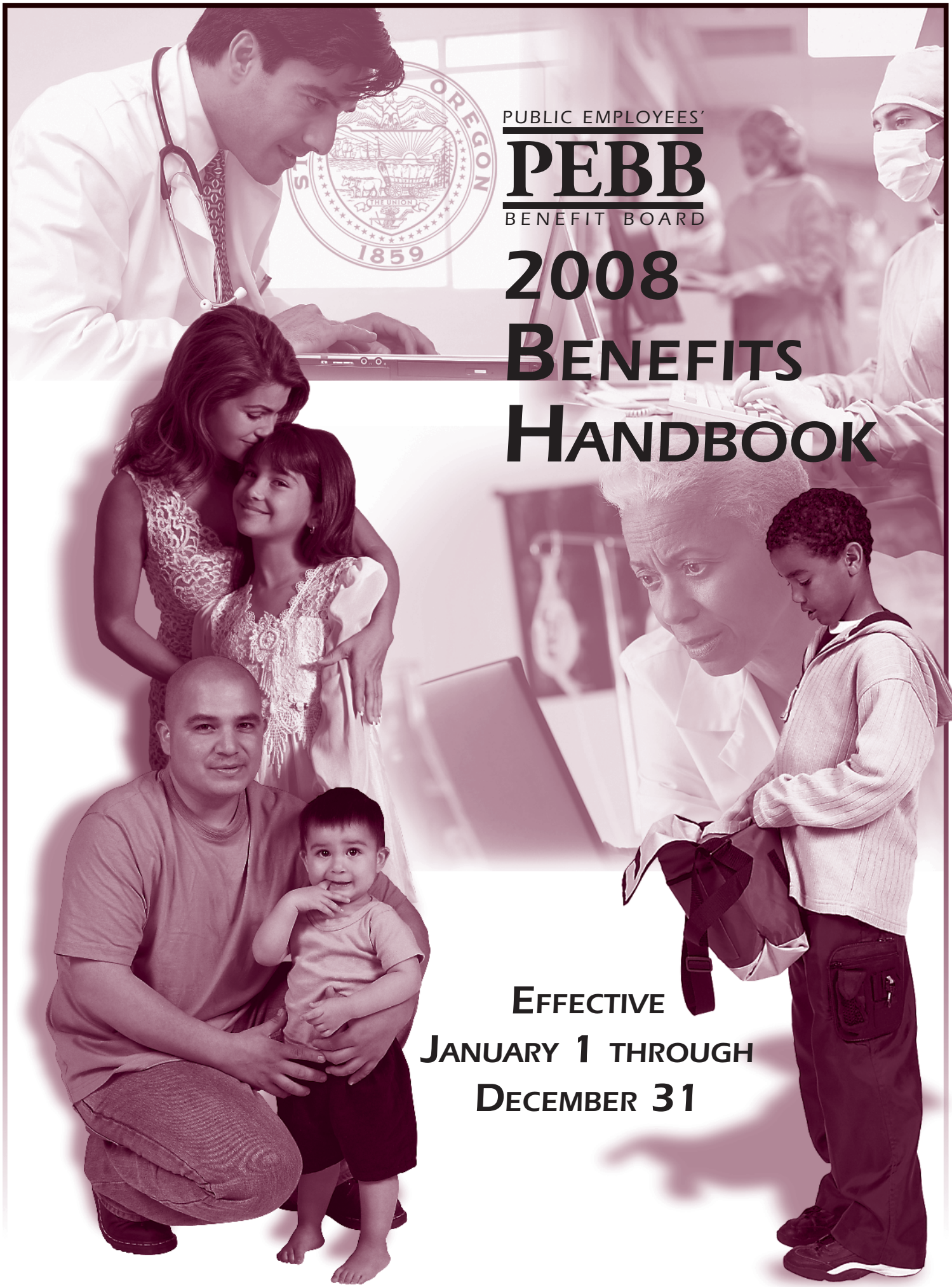


PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

2008 BENEFITS HANDBOOK

EFFECTIVE JANUARY 1 THROUGH DECEMBER 31

PEBB is committed to your health and wellness

Your Benefit Board is committed to your and your family's health, well-being and personal growth in the communities where you live and work. PEBB strategies focus on preventive care, healthy living, high-quality care, employee satisfaction and consumer education. Here are some of the wellness programs PEBB offers for its members:

- Preventive health services through the health plans
- Case management and disease management programs through the health plans for members with chronic illness
- Annual worksite health screenings and flu shot clinics
- Free & Clear, a proven, comprehensive tobacco cessation program
- Cascade Centers' employee assistance program (EAP)
- Discounts to some gyms and fitness centers through the health plans
- Health risk assessments through the health plans
- Information and tips through the PEBB newsletter
- Access to books, CDs, videos and other materials through the Wellness Collection at the State Library

Check out these Wellness Resources to find out more about what PEBB offers to support your health and wellness.

Wellness Resources

Free & Clear Tobacco Cessation Program
www.freeclear.com/pebb/
(800) 292-2336
TTY: (877) 777-6534

Cascade Centers EAP
www.cascadecenters.com/pebb.htm
Portland (503) 639-3009
Salem (503) 588-0777
Toll Free (800) 433-2320

PEBB Wellness Web site
http://oregon.gov/das/pebb/wellness

Healthy Worksites Initiative
www.oregon.gov/dhs/ph/worksites/index

PEBB newsletters
http://oregon.gov/das/PEBB/publications.shtml

Wellness Collection at the State Library
http://catalog.willamette.edu/search-S2/X
Keyword: wellness

E-mail for more information about PEBB wellness programs: pebb.wellness@das.state.or.us

Message from the Board

What do you expect from the healthcare system? Quality, safety, affordability and support to be healthy? It's what your Benefit Board expects, too.

The Board has been moving the system to meet those goals since 2006. That was a watershed year, when the Board invited the state's healthcare delivery system to join its Vision of healthcare for PEBB members. In this Vision, all PEBB members have healthcare that is

- Based on the best scientific guidelines about choices of medicines and treatments
- Patient-centered through medical homes, where teams of providers focus on the best outcomes for individual patients
- Designed to support them in making healthy choices
- As safe as possible from potential harms
- Coordinated through sharing of information among all providers
- Open and transparent in terms of costs, outcomes and quality
- Affordable to employees and the state.

PEBB chose medical plans that demonstrate they are willing to bring down barriers to achieving this Vision. Working with PEBB, the plans are

- Ensuring that the care they provide follows the best scientific guidelines
- Organizing themselves to focus more on outcomes rather than just provision of healthcare services
- Putting systems in place to measure the quality of care members receive and track their health outcomes
- Helping members learn their health risks and how to reduce them
- Participating in efforts to report on costs, outcomes and quality
- Working to show value for the cost.

Beginning in 2008, the medical plans will pilot new programs that have demonstrated increased value through better outcomes. For example, plans may waive prescription costs and provide more support for diabetic members who must take certain medications. Other pilot programs will help members and their primary care doctors make decisions on treatment of chronic conditions based on the latest evidence.

For 2008, PEBB also chose dental plans that follow science-based guidelines and that show value for the cost. For example, the plans will now cover dental implants and cover preventive care based on health indicators.

Your Benefit Board is committed to ensuring you get value for your healthcare dollars through high quality, affordable care. We hope you share this Vision for PEBB.

About Your 2008 Benefits Handbook

This handbook provides all the information you need to review or enroll in 2008 benefits as a PEBB member.

In it, you will find answers to important benefit questions. Please pay special attention to the changes listed on page iv and to Sections 1 and 3.

The Resource Directory on page 86 lists contacts for all the plans, as does the PEBB Web site. If you have questions about a specific plan, go to the plan's Web site or call the plan's customer service line and tell them you are a PEBB member.

If you need more information about your benefits, call PEBB at (503) 373-1102 in Salem or (800) 788-0520 statewide. Or e-mail inquiries.pebb@state.or.us.

Employees can find all of the information in this book online at the PEBB Web site: http://.oregon.gov/das/pebb. If you do not have Internet access, you can get a printed copy of this handbook from your agency.

NOTE: Throughout this handbook, the term agency means a state agency payroll or personnel office, or university benefits office.

This document presents a summary only. Any error or omission is unintentional. Any discrepancy between this handbook and the plan documents or rule or law will be satisfied in favor of the documents, rule or law.

Table of Contents

PEBB Changes for 2008

Eligibility

- Members who wish to cover dependents age 19 and up to 24 must certify the dependents' eligibility for coverage.
- Seasonal and intermittent employees are no longer eligible to enroll in short term or long term disability insurance.

Medical Plans

- Each of the PPO plans offers new pilot programs to improve care for members with chronic conditions.
- Monthly premium rates for the medical plans change for 2008. See pages 25-26.
- Hearing aids are covered at $4,000, with a 10 percent member coinsurance. The benefit is available once every four years.
- The materials (glasses and contacts) allowance for the routine vision care benefit increases to $200.

Dental Plans

- Kaiser Permanente offers a Traditional Dental Plan Design. Members pay a percentage coinsurance rather than set co-payment for services that require a payment.
- Kaiser Permanente offers a new Part-time and Retiree Traditional Dental Plan design, like the ODS Part-time and Retiree Traditional Plan.
- Routine dental cleaning is covered once per year. You may qualify for more if your dentist determines they are indicated and you meet plan-specific criteria.
- X-rays are covered on an age-based schedule.
- Replacement crowns and similar attachments are covered every seven years.
- Dental implants are covered at a member coinsurance rate of 50 percent in the Kaiser and ODS plans and 75 percent in the Willamette Dental plan.
- Member coinsurance for crowns decreases from 50 percent to 25 percent in the Kaiser and ODS plans.
- The maximum annual benefit in the Kaiser and ODS plans increases from $1,500 to $1,750 per person.
- The maximum annual benefit in the Part-time and Retiree Plans increases from $1,000 to $1,250 per person.
- The lifetime orthodontia benefit in the Kaiser and ODS plans increases from $1,000 to $1,500 per person.

Optional Benefits

- Standard offers enhanced long term and short term disability benefits, with no premium increase, for eligible employees.
- Optional life insurance premium rates decrease.

Flexible Spending Accounts

ASIFlex, the new third-party administrator for flexible spending accounts, offers debit cards for healthcare accounts, and enhanced online support for claims processing.

New Travel Benefit

In 2008, a free travel benefit is available for all eligible employees enrolled in the employee basic life insurance. Called MEDEX Travel Assist, this program may help you and your dependents if you get sick while traveling more than 100 miles from home. Find more information about this program on the PEBB Web site.

SECTION 1: GENERAL INFORMATION

Eligible Members

This section will help you identify:

- What type of PEBB member you are
- Your benefit options
- Basic enrollment information
- General effective dates
- Dependent eligibility
- Domestic partner eligibility

Who is eligible to participate in PEBB ?

1. **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:
   - Is expected to work at least 90 days
   - Works at least half time or is 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.

2. **Retirees:** Active employees enrolled in PEBB immediately prior to retirement can continue in PEBB medical and dental plans when they retire if they are not Medicare eligible. They may also have other insurance options. The retiree must self pay the premiums.
3. **COBRA Participants:** Former PEBB members who have continued their coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) are eligible. COBRA participants must self-pay the premiums.
4. **Other Self-pay Participants:** The following individuals may participate in PEBB. They also self-pay the premiums:
   - 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.

If I'm a PEBB member, who can I cover?

You may enroll the following individuals for coverage in your plans:

- Spouse
- Dependent children
- Domestic partner
- Domestic partner's children.

Who is a dependent child?

Following is a summary of PEBB's definition of dependent child. If you are in doubt if a person in your family qualifies as a dependent child, contact your agency or PEBB. Retiree, COBRA and other self-pay participants, contact PEBB's third-party administrator, BenefitHelp Solutions. See the contact information on page 86.

A dependent child must be either:

- A biological or adopted child, or a child placed for adoption with the employee or the employee's spouse or domestic partner; or
- A legal ward by court decree; a dependent by Affidavit of Dependency; or under the legal guardianship of the employee, or the employee's spouse or domestic partner.

Continued on page 2.

The child:

- May not be married or have a domestic partner
- May not qualify as a dependent under IRS rules for anyone other than the eligible member
- May be treated as a dependent for the purpose of obtaining healthcare coverage by both parents who are divorced or legally separated.

A dependent child must also meet one of the following criteria. The child:

- Is under the age of 19 at the end of the calendar year; or
- Is age 19 up to 24 and meets the IRS definition of a dependent child attending school full time (this excludes foreign students); or
- Is age 19 up to 24 and the eligible member provides or expects to provide more than half the child's support for the year, and the child lives in the eligible member's home for at least six months of the year; or
- Is age 19 up to 24 and is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability; or
- Is age 24 or older and is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability that existed before the child attained age 24. The child must have had continuous individual or group medical coverage prior to attaining age 24 and remain covered until the PEBB effective coverage date.

Can I cover my domestic partner and my domestic partner's children?

Yes. However, before this coverage can happen you and your domestic partner must meet certain requirements. Adding a domestic partner will increase your tax withholding, and you will take home less pay. See pages 12-13.

What happens if I go on extended leave?

The type of leave you take – family medical leave, active duty military leave, job-related-injury leave, etc. – and whether it's a paid or unpaid leave may affect your eligibility and how you pay for and receive benefits. Contact your payroll, human resources or benefits office or PEBB to discuss these issues prior to taking the leave.

How do I participate as an eligible employee?

You participate in the PEBB benefit program when you are eligible and you enroll for basic benefits. Basic benefits include medical and dental coverage for at least you alone (or the opt out option below). If you participate in the PEBB program, you are automatically enrolled for the required basic life insurance coverage. You may also enroll in any of the optional benefits offered.

What if I don't want to participate in PEBB?

You may choose to **decline coverage.**

If you decline coverage, you waive all rights to the monthly benefit amount and enrollment in any of the available PEBB benefit plans. This includes all optional benefits. If you decline coverage, you do not receive any cash in lieu of benefits as taxable income. You may decline all benefits within 60 days of your date of hire or eligibility, consistent with a qualified status change or during Open Enrollment. For more information about declining coverage, contact your agency.

Can I opt out?

If you are covered by another employer group medical plan (as defined by PEBB) you may **opt out of medical insurance** (see Glossary for PEBB's definition of group medical plan). If you opt out of medical insurance you must enroll in a PEBB dental plan and basic life insurance. You may also choose to enroll in any of the available optional benefits within 60 days of your date of hire or eligibility, consistent with a qualified status change or during Open Enrollment.

Individual medical plan coverage does not qualify an individual to opt out.

See page 26 to calculate your opt-out amount.

Full-time Eligible Employees

(Including Limited Duration Employees)

The current employer benefit amount fully covers the premium amount for medical, dental and basic life insurance plans for full-time employees.

Current full-time employees must work at least half time during the preceding month to be eligible for benefits the next month. Half time means employed in a 0.5 FTE position and working 80 paid regular hours per month, or 0.5 FTE for OUS employees, 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.

Enroll online at:
https://pebb.benefits.oregon.gov/members

Benefit Options

- All available medical and dental plans (except for part-time and retiree plans), according to where you employee live or work
- Basic $5,000 life insurance
- All available optional benefits.

These employees may opt out of medical coverage (if they have other group coverage as defined by PEBB). They may also decline all benefits.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefits.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	***Generally***, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified change event Benefit elections must be made within 60 days of the event.	***Generally***, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

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 compared with full time.

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

- In a 0.5 FTE position with a minimum of 80 paid regular hours per month
- In a job share position,
- 0.5 FTE for an OUS employer, or
- As defined 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.

Each month, part-time employees receive a pro-rated benefit amount from the employer for medical, dental and basic life insurance plans. 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 FTE.

Enroll online at:
https://pebb.benefits.oregon.gov/members

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 and retiree, or full-time medical and dental plans. Coverage is effective at the beginning of each month.

Benefit Options:

- All available medical and dental plans, according to where the employee lives and/or works
- Basic $5,000 life insurance
- All optional benefits.

These employees may opt out of medical coverage (if they have other group medical coverage as defined by PEBB). They may also decline all benefits.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefits.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	***Generally***, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified change event Benefit elections must be made within 60 days of the event.	***Generally***, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

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, the employee is eligible for benefits retroactive to 60 days from the date of hire.

Benefit Options

- **Full-time seasonal employees:** All available medical and dental plans (except for part-time and retiree plans), according to where you live or work
- **Part-time seasonal employees:** All available medical and dental plans, according to where the employee lives and/or works
- Basic $5,000 life insurance
- All optional benefits except short term and long term disability insurance.

These employees may opt out of medical coverage (if they have other group medical coverage as defined by PEBB). They may also decline all benefits.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefits.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	***Generally***, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified change event Benefit elections must be made within 60 days of the event.	***Generally***, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

Returning Seasonal Employees

(Returning within 12 Months)

Seasonal employees returning within 12 months without prior benefit eligibility are eligible for PEBB benefits if they are expected to work at least half time and have accumulated 60 calendar days of employment. The 60 calendar days do not need to be consecutive within the past 12 months.

Seasonal employees returning within 12 months who had PEBB benefits before starting leave will have benefits reinstated the first of the month following their return-to-work date.

Benefit Options

- **Full-time seasonal employees:** All available medical and dental plans (except for part-time and retiree plans), according to where the employee lives or works
- **Part-time seasonal employees:** All available medical and dental plans, according to where the employee lives or works
- Basic $5,000 life insurance
- All optional benefits except short term and long term disability insurance.

These employees may opt out of medical coverage if they have other group medical coverage as defined by PEBB. They may also decline all benefits.

Most benefits are reinstated for returning seasonal employees. Reinstate means to reactivate prior medical, dental, and life enrollments within 12 months when the employee returns from a leave or a termination of employment.

Flexible spending accounts and the long term care plan are not reinstated. Returning seasonal employees must re-enroll if they want these plans.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefits.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	***Generally***, the first of the month following the hire date or receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified change event Benefit elections must be made within 60 days of the event.	***Generally***, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

Non-Medicare-eligible Retirees

If you are thinking of retiring before you are eligible for Medicare you have several insurance options to consider. Keep in mind that if you enroll in PEBB benefits, you must self pay the premiums; the state does not provide a benefit amount.

What are my retiree medical and dental options?

Your options include:

- All PEBB medical and dental plans
- A health plan offered by the Public Employees Retirement System (PERS)
- COBRA
- A group coverage portability plan or a plan through the Oregon Medical Insurance Pool (OMIP).

If you are a state retiree eligible for Medicare, you are no longer eligible for PEBB plans (except for those with end-stage renal disease). Your options include:

- A PERS Medicare supplement plan
- An individual Medicare supplemental plan.

For more information on these options, contact the PERS health insurance programs.

Who is a PEBB-eligible retiree?

To be eligible you must meet **both** of the following requirements:

- Be eligible to receive retirement benefits under PERS rules, and
- Be enrolled in a PEBB medical and/or dental plan.

The following individuals are eligible for retiree coverage:

- Eligible employees who will be eligible retirees
- Spouses or domestic partners, and
- Dependent children covered on the active employees' plans at the time of retirement.

What PEBB retiree plans are available?

As a PEBB retiree you may choose from all available medical and dental plans, including full-time and part-time and retiree plans, available in your service area.

You may change medical or dental plans when you enroll in a PEBB retiree plan. You and your 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.

How do I enroll for medical and/or dental coverage?

BenefitHelp Solutions (BHS) is PEBB's third-party administrator for retiree plans. Complete and submit to BHS the Medical and Dental Enrollment Form for Non-Medicare Eligible Retiree and Non-Medicare Eligible Dependent. A form is included in this book. For more information contact BHS or PEBB.

How long can I continue coverage?

As long as:

- You are not eligible for Medicare (except those with end-stage renal disease)
- Premium payments are current
- PEBB continues to offer retiree coverage.

In the event of your death, your enrolled dependents may continue coverage as long as they continue to meet the eligibility requirements.

When do I 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 group 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 active 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.

After I enroll, can I change my choices?

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 60 days of and consistent with a qualified status change (see page 17).

PEBB coverage must be continuous.

What are the effective dates for retirees?

PEBB retiree coverage must be effective immediately following the transition from PEBB employee coverage or COBRA coverage.

What are the enrollment time frames if I move out of the plan's service area?

When a retiree leaves a plan's service area, the retiree may enroll in a new plan. You must do so within 60 days. If you fail to enroll within 60 days, you may apply to PEBB late enrollment.

What are the enrollment time frames if my dependent loses other coverage?

If an eligible dependent not enrolled on your retiree plan later loses other employer group coverage, you may enroll the dependent for coverage in the retiree plan. You must do so within 60 days. If you fail to submit the correct forms within 60 days of this qualified change, you may apply for late enrollment. PEBB must review and approve the enrollment.

Can I continue life and long term care insurance after I retire?

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability if you enroll in conversion or PEBB retiree life insurance 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. Please contact UNUM Provident for more information about this option.

Can I continue other optional benefits?

No. You cannot continue dependent life, disability, or accidental death and dismemberment insurance.

What other healthcare insurance options may I have as a retiree?

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.

1. COBRA usually allows continuation of your participation in the active-employee group for only 18 months. If you retire because of disability, you may be eligible for an additional 11 months of COBRA coverage, for a total of 29 months.
2. COBRA coverage 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.
3. 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 in the PEBB Retiree Plans at any time during your COBRA coverage.

Portability Coverage or Oregon Medical Insurance Program. The PEBB Regence and Kaiser medical plans are "portable." Portability means that you may purchase an individual medical plan offered by your insurance 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
- Currently not be 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 individual plans directly.

Samaritan and Providence medical plans 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 younger people with disabilities.

When you become eligible for Medicare (except for end-stage renal disease), you are no longer eligible to participate in PEBB plans. When you become eligible for Medicare but your spouse or partner and dependents are not, these family members may continue PEBB coverage if they were enrolled in your coverage when you became Medicare eligible.

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 PEBB benefit-eligible position are eligible for employee benefits. You must work the equivalent of at least half time during the month to be eligible for benefits for the following month. Job-share employees are not required to work half time.

For retirees returning within 12 months of their retirement date, benefits are reinstated. Reinstatement means to reactivate all previous medical, dental, life and disability insurance policies, if available, on a guaranteed basis.

Retirees who return beyond 12 months from their retirement date must re-enroll for 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 enrolled in a PEBB retiree plan may suspend PEBB retiree coverage while in active employee status by notifying BenefitHelp Solutions (BHS), the third-party administrator. You must notify BHS when you are no longer an active employee meeting the half-time work criterion. 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 must enroll in the PEBB active employee plans because of the Medicare secondary payor rules.

NOTE: Special conditions apply to Standard Life insurance coverage if converted or ported. Contact Standard and your payroll office to ensure your life insurance information is correct.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefit.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	***Generally***, the first of the month following the hire date or the receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified change event Benefit elections must be made within 60 days of the event.	***Generally***, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

COBRA Participants

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employer-sponsored group health plans to give participants the opportunity to temporarily continue their benefits in certain situations when coverage would normally end.

COBRA gives employees along with their spouses, domestic partners, dependents and domestic partner's dependents a chance to continue coverage under an employer's group health plan. Participants must experience a "triggering event" for COBRA to apply. In general, individuals receive the opportunity to elect only the healthcare coverage they were receiving immediately before the event. You must self pay the premiums for this benefit coverage; the state does not provide a benefit amount.

For more information regarding your COBRA rights and qualifying events, see page 77.

BenefitHelp Solutions (BHS) administers the COBRA program for PEBB. For more information, contact BHS.

Other Self-pay Participants

Other 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. Self-pay participants may also enroll their spouse or domestic partner and eligible dependents. 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, complete and submit the application form included in this book. If you need more information, contact BHS or PEBB.

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.

Enrollment Period	Effective Dates
During Open Enrollment Change, add or remove benefit.	First of the new plan year (usually January 1).
New hire or newly eligible Benefit elections must be made within 60 days from date of hire or when employee becomes eligible.	***Generally***, the first of the month following the hire date or the receipt of enrollment forms or electronic enrollment, whichever is later. Optional insurance dates may vary.
Midyear qualified change event Benefit elections must be made within 60 days of the event.	***Generally***, the first of the month following the date the agency receives required update forms and after the event date, whichever is later.

Domestic Partners and Their Dependents

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. A domestic partner's children are also eligible for enrollment.

The member and the domestic partner must sign and submit 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 and have not had a spouse or another domestic partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;
- Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
- Have jointly shared the same regular and permanent residence for at least six months; 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.

An Affidavit of Domestic Partnership must be completed to enroll a domestic partner's children in benefit plans, whether or not the enrollment includes the domestic partner.

An Affidavit of Domestic Partnership must be completed, notarized, and submitted to the agency, in paper form, within five business days of the electronic enrollment date or the date the enrollment or update forms were received. If not, coverage will be terminated for the domestic partner and the domestic partner's dependent children back to the effective date.

If requested, the member and domestic partner would 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.

Before enrolling a domestic partner and a partner's children, employees should know there are important tax considerations. An imputed value for the fair market value of the domestic partner and domestic partner's children's insurance premium will be added to the eligible employee's taxable wages.

You may remove a domestic partner and partner's children from coverage:

- Within two weeks of receiving the first pay statement reflecting the tax implications following initial enrollment
- Within 60 days of termination of the partnership
- Within 60 days of and consistent with a qualified change event
- During Open Enrollment.

If you terminate your partnership, you must complete and submit a Termination of Domestic Partnership form and any other necessary update forms.

Did you know? A marriage recognized as a legal common-law marriage in another state is also recognized as a legal marriage in Oregon.

Domestic Partner Frequently Asked Questions

Will adding a domestic partner to coverage affect my take-home pay?

Yes. Before enrolling a domestic partner and a partner's children, there are important tax and pay considerations you should know.

What are the special considerations?

PEBB allows you to add a domestic partner (and/or the partner's children) to your benefit coverage. But if you do, you'll see a change in your pay. Payroll will withhold more taxes, so you will have less pay to take home.

Why will my pay be less?

The IRS doesn't view a domestic partner and children the same as a legal spouse and dependent children. The IRS sees domestic partner coverage as a value added to your taxable income. This is called an imputed value on which you must pay taxes.

What is imputed value?

Imputed value is an estimate of the premium cost you would pay if you bought the coverage on the open market. It is not the same as the premium cost in your PEBB handbook. Each year, PEBB reviews the market cost for each of the plans and estimates an imputed value for each plan and coverage tier.

How does imputed value affect my pay?

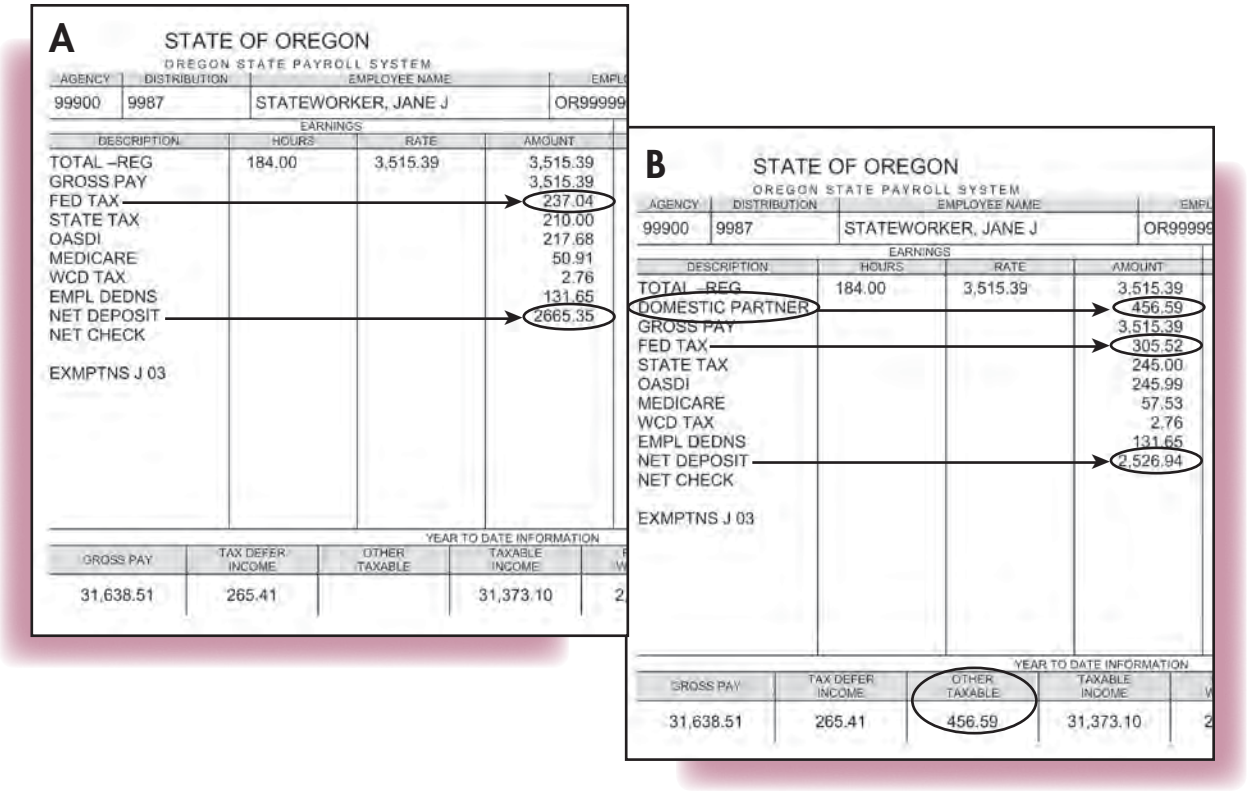
When you enroll a domestic partner or a domestic partner's children in PEBB coverage, your payroll **adds** the estimated imputed value dollar amount to your taxable wages, and then calculates and withholds the taxes. Because the new taxable total is larger than your wages alone, more taxes are withheld. So, you take home less money.

Example 1

Jane J. Stateworker enrolled for medical and dental coverage on the employee-only tier (see Paycheck Stub A). Payroll calculates her taxes based on her taxable wages of $3,515.39. After payroll deductions and withholding taxes, she takes home $ 2,665.35.

When Jane adds her domestic partner to her PEBB employee only-tier, the result is an imputed value of $456.59 (see Paycheck Stub B). You can see the $456.59 imputed value added to Jane's taxable wages of $3,515.39; now payroll calculates Jane's taxes based on the total of $3,971.98. Jane's new take home pay after payroll deductions and taxes is $2526.94. This is a net pay difference of $138.41.

The imputed value will increase with the addition of a domestic partner's children and, again, the result is less take-home pay. It's important to note that, even though the imputed value shows as a dollar amount on Jane's pay stub, she does not receive any additional dollars, and she doesn't pay the imputed value as a premium.



A

STATE OF OREGON
OREGON STATE PAYROLL SYSTEM

AGENCY	DISTRIBUTION	EMPLOYEE NAME	EMPL
99900	9987	STATEWORKER, JANE J	OR99999

EARNINGS

DESCRIPTION	HOURS	RATE	AMOUNT
TOTAL –REG	184.00	3,515.39	3,515.39
GROSS PAY			3,515.39
FED TAX			237.04
STATE TAX			210.00
OASDI			217.68
MEDICARE			50.91
WCD TAX			2.76
EMPL DEDNS			131.65
NET DEPOSIT			2665.35
NET CHECK			

EXMPTNS J 03

YEAR TO DATE INFORMATION

GROSS PAY	TAX DEFER INCOME	OTHER TAXABLE	TAXABLE INCOME	
31,638.51	265.41		31,373.10	2

B

STATE OF OREGON
OREGON STATE PAYROLL SYSTEM

AGENCY	DISTRIBUTION	EMPLOYEE NAME	EMPL
99900	9987	STATEWORKER, JANE J	OR99999

EARNINGS

DESCRIPTION	HOURS	RATE	AMOUNT
TOTAL –REG	184.00	3,515.39	3,515.39
DOMESTIC PARTNER			456.59
GROSS PAY			3,515.39
FED TAX			305.52
STATE TAX			245.00
OASDI			245.99
MEDICARE			57.53
WCD TAX			2.76
EMPL DEDNS			131.65
NET DEPOSIT			2,526.94
NET CHECK			

EXMPTNS J 03

YEAR TO DATE INFORMATION

GROSS PAY	TAX DEFER INCOME	OTHER TAXABLE	TAXABLE INCOME	
31,638.51	265.41	456.59	31,373.10	2

Health Fact

It is important to eat a variety of fruits and vegetables every day.

Important Membership Information

This section will help you understand:

- PEBB contract provisions
- How to enroll
- Midyear plan changes
- Qualified status changes
- How to appeal

What are PEBB's contract rights?

PEBB reserves the right to specify contract terms and to amend and terminate PEBB-sponsored health plans as authorized under Oregon rule and statute. The contracts may be amended from time to time or terminated in their entirety at any time by PEBB.

What happens if my provider drops out of the plan?

PEBB does not guarantee that particular providers will continue to be available to participants throughout the term of the PEBB contract. The plans and insurance companies and other vendors that contract with PEBB are not employed or supervised by PEBB. They are independent businesses. Physicians, hospitals, laboratories and other healthcare providers under the contract are not selected nor supervised by PEBB. If your provider drops out, you will need to find another provider participating in your plan or pay the uncovered costs of your current provider.

What should I expect when I enroll in a new healthcare plan?

When you first enroll in a medical or dental plan, you can expect to receive documents from the plan within a month. The documents will include a member handbook or a certificate of coverage (for Kaiser Permanente plans). You will also receive a member ID card (except for VSP).

What if I have a pre-existing condition?

PEBB's 2008 medical and dental plans impose no pre-existing condition limitations. Medical plans may impose a waiting period or limitation for specified services, such as transplants. Dental plans may impose waiting periods for some services based on when dependents are enrolled. Life and disability plans may have pre-existing condition limitations.

How do the medical plans handle benefit fraud or abuse?

Your medical plan has the right to investigate fraudulent or abusive use of your plan benefits. Your plan will notify you of an investigation. If the plan identifies what may be fraud or abuse by a member, it may cancel the member's coverage. If the plan identifies what may be fraud or abuse by one of your dependents, the carrier may remove the individual from coverage.

You will receive notification prior to cancellation or removal from coverage. You have the right to appeal the plan's action through the plan's appeal process. Removal from a plan is not a qualified midyear plan change, so the member or dependent may not enroll in a different plan until Open Enrollment.

What if this handbook differs from plan documents?

This handbook is a summary only. Any discrepancy between this handbook and plan documents or rule or law is unintentional. In case of discrepancy, the plan document, rule or law will prevail.

How to Enroll or Change Benefits

How do I enroll?

- **Eligible employees** may enroll online during Open Enrollment.
- **Newly hired eligible employees** may enroll online within 60 days of their hire date.
- **Self-pay participants** must enroll by completing the medical and dental enrollment form identified for each group. These forms are available at the end of this handbook and online. They are also available from BenefitHelp Solutions, the third-party administrator.
- **Newly eligible seasonal employees** must enroll by completing the employee enrollment forms. These forms are available from your agency and online.

How do I make midyear changes?

Complete the update form for the plans you wish to change. The Medical and Dental Update Form Midyear Change Request is included in this booklet. You can find this and all other update forms online.

Follow these steps to enroll online at https://pebb.benefits.oregon.gov/members.

1. Register. Provide the requested personal information to validate your identity, and create your user name and password.
2. Establish your security questions and answers.
3. Verify your personal information. You may change your personal information at any time.
4. Enroll in a medical and dental plan (or opt out of medical).
5. Enroll in optional life, disability and long term care insurance plans, and flexible spending accounts.
6. Designate your beneficiaries. You may do this at any time.
7. Review and save your selections, print and log out.

If you do not have access to a computer with Internet access, contact your agency or PEBB to obtain paper forms. The forms are online at: http://ww.oregon.gov/das/pebb.

When enrolling online: If you choose to enroll in optional plans, you must do so at the same time you enroll in basic plans. If, after you have saved your selections, you want to change them, you can do so during Open Enrollment. As a new hire you can do so only through your agency.

How to make Midyear Plan Changes

To make changes to your PEBB benefits plan during the year, you must experience a qualified status change (QSC).

What is a QSC?

A QSC is an event that changes your work or family circumstances. The IRS requires that PEBB comply with federal regulations for midyear benefit changes. Midyear plan changes must meet the IRS "consistency rule," which means the QSC must affect eligibility, and the requested change must be consistent with the way eligibility has been affected.

The requested benefit change must link to the QSC. Here are two examples.

Example 1

You adopt a child. This QSC allows you to add the dependent child to your current medical and dental insurance coverage. There is no other fact around this single event that would allow you to change to a new medical or dental plan. You can adopt the child and add him or her to your current coverage.

Example 2

You move from an eligible full-time position to an eligible part-time position. This QSC makes you eligible to enroll in the part-time plans or the full-time plans and also changes the employer's benefit amount. You can change benefit plans and add or delete coverage.

What is the time frame for making benefit changes because of a QSC?

Your agency must receive the completed appropriate forms within 60 days of the QSC. Changes beyond 60 days of the QSC event require PEBB review and approval.

What must I do to make a benefit change?

To make changes to your **medical or dental coverage**, complete the Medical and Dental Update form, and submit it to your agency. The agency must receive the form within 60 days of date of the QSC.

To make changes to your **life or disability coverage**, complete the Life and Disability Update form, and submit it to your agency. The agency must receive the form within 60 days of the QSC.

To make changes to your **flexible spending account**, complete the Flexible Spending Account Update form, and submit it to your agency. The agency must receive the form within 60 days of the QSC.

If you have questions or need more information regarding QSCs, contact your agency.

Qualified status changes may affect your choices.

What is the effective date of a change made because of a QSC?

If you are adding a dependent or making a benefit change because of a QSC, coverage changes are effective the first of the month following the date the agency or PEBB receives the required forms, or the date of the QSC, whichever is later. Submitting an update form before the QSC will not change the effective date.

If you are removing a dependent from coverage because of a QSC, the coverage will end the last day of the month eligibility is lost.

What are the special QSCs for dependents?

Biological newborns receive plan coverage from the moment of birth through the 31st day of life. However, you must submit the update form to your agency within 60 days of birth to continue the coverage. When forms are submitted within the 60-day period, the agency will approve coverage continuously and retroactively, so claims incurred during that time will be paid.

Dependent children age 19 and up to 24 may remain under your coverage only if, during the year following each birthday, you certify that you expect them to meet one of the following criteria:

- Meets the IRS definition of a dependent child attending school full time (this excludes foreign students)

- The eligible member provides or expects to provide more than half the child's support for the year, and the child lives in the member's home for at least six months of the year
- Is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability.

It is your responsibility to notify the agency or PEBB when any dependent, domestic partner or partner's child no longer qualifies for coverage. Not providing notification may cause you to have to repay claims expenses incurred when the individual no longer qualified for coverage.

Examples of Midyear Changes

Midyear changes that affect eligibility for insurance benefits

These changes fall into three broad categories.

1. Changes in status. For example, changes in

- Legal marital status, such as marriage or divorce
- Number of dependents, such as birth 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
- 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. Cost or coverage changes. For example:

- An increase in out-of-pocket premium cost
- Reduction in your spouse's or domestic partner's group insurance plan benefits.

3. Other laws or court orders. For example: National Medical Support Notice, Medicare, or HIPAA.

QSCs 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.

QSCs that affect eligibility for healthcare flexible spending accounts

- You marry
- Your spouse dies, or you divorce or have an annulment
- 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 that effects your health care eligibility.

Appeals

What types of issues can I appeal to PEBB?

PEBB accepts only eligibility and enrollment appeals. This includes enrollment errors or omissions, or missed enrollment timelines.

You must appeal plan decisions directly to the plan. Follow the appeal rights and procedures in the plan's member handbook. If you ask PEBB to review the plan's determination, PEBB will verify only that the plan's determination was within the scope of the contract or request that the carrier provide you more explanation of its determination. If it appears that the plan's determination is outside the scope of the contract, PEBB will ask the plan to review your appeal again.

What is the PEBB Appeal Process?

Step 1. If you believe you received an incorrect or unfair denial based on eligibility or enrollment, you may request a review by a PEBB Benefits Analyst.

- Submit a completed Appeal Form (available from your agency, the PEBB Web site or PEBB) to PEBB. Include any supporting documentation.
- A PEBB Benefits Analyst will review your appeal and notify you of a decision within 45 days of receiving your request. You will receive notice if your issue will require more than 45 days.

Step 2. If you believe the decision from the Benefits Analyst is incorrect or unfair, you may request a review by the PEBB Benefits Manager.

- You must submit this request in writing within 45 days of the date of the determination letter. Include any additional supporting documentation.
- The PEBB Benefits Manager may review your case or forward your request to the PEBB Administrator or designee for review and a determination.

In either situation,

- You will receive a written determination and explanation within 30 days of the Benefits Manager receiving your case review request.

Step 3. If you believe a determination made by the Benefits Manager is incorrect or unfair, you may request a review by the PEBB Administrator or designee.

- You must submit this request in writing within 30 days of the date of the determination letter. Include any additional supporting documentation.
- The Administrator or designee may review your case or forward your request to the PEBB Operations Subcommittee for review and a determination.

In either situation,

- You will receive a written determination within 30 days of the Administrator or designee receiving your review request, or within 30 days after the next regularly scheduled meeting of the Operations Subcommittee.

Step 4. If you believe a determination made by the Administrator or designee is incorrect or unfair, you may request a review by the PEBB Operations Subcommittee.

- You must submit this request in writing within 30 days of the date of the determination letter. Include any additional supporting documentation.
- The Operations Subcommittee may review your case or, with approval of the Chair, may forward your request to the full Board for review and a decision.

In either situation,

- You will receive a written determination within 30 days after the next regularly scheduled meeting of the Subcommittee or the Board.

Step 5. If you believe a determination made by the PEBB Operations Subcommittee is incorrect or unfair, you may request a review by the Board.

- You must submit this request in writing within 30 days of the date of the determination letter. Include any additional supporting documentation.
- You will receive a written determination within 30 days after the next regularly scheduled meeting of the Board.

Step 6. You may appeal the Board's decision under the Oregon Administrative Procedures Act, ORS Chapter 183. You will receive notice of the status of the request for reconsideration within 15 days of receipt of the request by the reviewing entity.

Health Fact

In addition to eating healthy and regular exercise, getting plenty of sleep is essential to maintaining a healthy body and mind.

SECTION 2: BENEFIT AMOUNT AND HEALTH PLAN RATES

2008 Monthly Benefit Amount Notice

This section presents:

- The monthly benefit amount
- Calculations and examples for part-time employees
- Monthly premium rates for medical and dental plans

This notice is for represented employees with a tentative agreement as of Aug. 1, 2007, unrepresented employees of state agencies, and legislative employees who are in continuing positions.

University System and Judicial Department employees, see your university or department benefits notice. Represented employees without a tentative agreement, and legislative session or personal staff employees, contact your agency for information about your monthly benefit amount.

Your employer's monthly benefit amount is established either through the collective bargaining process, by the Department of Administrative Services, or by your agency. Each year PEBB provides information about the monthly benefit amount; however PEBB has no role in determining the amount.

Full-time Employees

For the 2008 plan year, the monthly benefit amount fully covers medical, dental and basic life insurance premiums for eligible full-time employees and their eligible dependents.

Part-time Employees

For the 2008 plan year, part-time employees who work half time or more will receive a prorated monthly benefit amount based on the number of hours they work during the month. For example, if the number of hours you work is equivalent to 75 percent of full time, you will receive approximately 75 percent of the full-time monthly benefit amount for your coverage tier. If your monthly hours vary, so will the monthly benefit amount.

If you enroll in a Part-time Medical Plan for 2008, you will receive a flat subsidy amount for the coverage tier you select for that plan. This will be added to your Prorated Monthly Benefit Amount.

Part-time employees: To assist you in estimating the amount your agency will pay towards your monthly premium cost, complete the calculations on the next page. See the example calculations on pages 23 and 24.

If you work fewer than 80 paid regular hours or you are in a position that is less than 0.5 FTE, you are not eligible to enroll for benefits and you will receive no monthly benefit amount, unless your collective bargaining agreement states otherwise or you are in a job-share position.

Calculations for Part-time Employees

1.a Prorated monthly benefit amount based on hours worked compared with full-time

Select the coverage tier that applies to you. Multiply the Full-time Monthly Benefit Amount for the coverage tier you selected by the percentage of hours you work compared with full time. The result is an estimate of your Prorated Monthly Benefit Amount.

Coverage Tier	Full-time Monthly Benefit Amount	% Hours Worked	Prorated Monthly Benefit Amount
Employee only	$854.14	X _____%	= $_____
Employee & spouse/domestic partner	$1,150.12	X _____%	= $_____
Employee & children	$983.59	X _____%	= $_____
Employee & family	$1,174.79	X _____%	= $_____

1. b Subsidy amount if you enroll in a Part-time and Retiree medical plan

Next to your coverage tier, enter your Prorated Monthly Benefit Amount from the calculation above. Add the Subsidy for part-time plans for your coverage tier. The result is an estimate of your subsidized benefit amount if you enroll in a part-time plan.

Coverage Tier	Prorated Monthly Benefit Amount	Subsidy for Part-time Plan	Subsidized Monthly Benefit Amount
Employee only	$_____	+ $199.26	= $_____
Employee & spouse/domestic partner	$_____	+ $254.31	= $_____
Employee & children	$_____	+ $226.73	= $_____
Employee & family	$_____	+ $258.10	= $_____

2. Premium payment calculation

Use this calculation to help you estimate the amount of your monthly premium cost (if any) for basic benefits (medical, dental, basic life). **In no case will the amount paid by your agency exceed the cost of premiums for medical, dental and basic life coverage.** See pages ?? for examples.

1.	Enter the monthly benefit amount you calculated in 1.a or 1.b above.		$
2.	Enter $1.10 for mandatory basic life insurance.	$	
3.	Enter your monthly medical premium cost.	$	
4.	Enter your monthly dental premium cost. (You must have at least employee-only dental coverage. You may also cover dependents.)	$	
5.	Enter the sum of 2 through 4. This is your monthly premium cost.		$
6.	Subtract line 5 from line 1. This is the **estimated** monthly payroll deduction for your medical, dental and basic life coverage.		$

Example Calculations for Part-time Employees Enrolling in Part-time & Retiree Plans

Calculations show **estimated** monthly premium costs for part-time employees in the Part-time and Retiree plans.

2008 Part-time & Retiree Kaiser Permanente HMO with Part-time & Retiree ODS Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	676.03	905.52	777.28	925.76
Medical Rate	621.61	832.96	714.85	851.60	621.61	832.96	714.85	851.60
Dental Rate	53.32	71.46	61.33	73.06	53.32	71.46	61.33	73.06
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	676.03	905.52	777.28	925.76	676.03	905.52	777.28	925.76
Contribution - Total Rate	-49.20	-76.15	-58.75	-80.17	0*	0*	0*	0*
Employee Balance	-49.20	-76.15	-58.75	-80.17	0*	0*	0*	0*

2008 Part-time & Retiree Providence Choice PPO with Part-time & Retiree ODS Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	646.77	866.31	743.64	885.69
Medical Rate	592.35	793.75	681.21	811.53	592.35	793.75	681.21	811.53
Dental Rate	53.32	71.46	61.33	73.06	53.32	71.46	61.33	73.06
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	646.77	866.31	743.64	885.69	646.77	866.31	743.64	885.69
Contribution -Total Rate	-20.44	-36.94	-25.11	-40.10	0*	0*	0*	0*
Employee Balance	-20.44	-36.94	-25.11	-40.10	0*	0*	0*	0*

2008 Part-time & Retiree Regence BCBSO PPO with Part-time & Retiree ODS Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	689.66	923.70	792.92	944.38
Medical Rate	635.24	851.14	730.49	870.22	635.24	851.14	730.49	870.22
Dental Rate	53.32	71.46	61.33	73.06	53.32	71.46	61.33	73.06
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	689.66	923.70	792.92	944.38	689.66	923.70	792.92	944.38
Contribution -Total Rate	-63.33	-94.33	-74.39	-98.79	0*	0*	0*	0*
Employee Balance	-63.33	-94.33	-74.39	-98.79	0*	0*	0*	0*

2008 Part-time & Retiree Samaritan Select PPO with Part-time & Retiree ODS Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	676.03	905.52	777.28	925.76
Medical Rate	621.61	832.96	714.85	851.60	621.61	832.96	714.85	851.60
Dental Rate	53.32	71.46	61.33	73.06	53.32	71.46	61.33	73.06
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	676.03	905.52	777.28	925.76	676.03	905.52	777.28	925.76
Contribution - Total Rate	-49.20	-76.15	-58.75	-80.17	0*	0*	0*	0*
Employee Balance	-49.20	-76.15	-58.75	-80.17	0*	0*	0*	0*

* In no case will the amount paid by your agency exceed the cost of premiums for medical, dental and basic life coverage.

Example Calculations for Part-time Employees Enrolling in Part-time & Retiree Plans

Calculations show e**stimated** monthly premium costs for part-time employees in the Part-time and Retiree plans.

2008 Part-time & Retiree Kaiser Permanente HMO with Part-time & Retiree Kaiser Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	668.40	895.29	768.49	915.30
Medical Rate	621.61	832.96	714.85	851.60	621.61	832.96	714.85	851.60
Dental Rate	45.69	61.23	52.54	62.60	45.69	61.23	52.54	62.60
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	668.40	895.29	768.49	915.30	668.40	895.29	768.49	915.30
Contribution - Total Rate	-42.07	-65.92	-49.96	-69.71	0*	0*	0*	0*
Employee Balance	-42.07	-65.92	-49.96	-69.71	0*	0*	0*	0*

2008 Part-time & Retiree Providence Choice PPO with Part-time & Retiree Kaiser Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	639.14	856.08	734.85	875.23
Medical Rate	592.35	793.75	681.21	811.53	592.35	793.75	681.21	811.53
Dental Rate	45.69	61.23	52.54	62.60	45.69	61.23	52.54	62.60
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	639.14	856.08	734.85	875.23	639.14	856.08	734.85	875.23
Contribution - Total Rate	-12.81	-26.71	-16.32	-29.64	0*	0*	0*	0*
Employee Balance	-12.81	-26.71	-16.32	-29.64	0*	0*	0*	0*

2008 Part-time & Retiree Regence BCBSO PPO with Part-time & Retiree Kaiser Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	682.03	913.47	784.13	933.92
Medical Rate	635.24	851.14	730.49	870.22	635.24	851.14	730.49	870.22
Dental Rate	45.69	61.23	52.54	62.60	45.69	61.23	52.54	62.60
Basic Life	1.10	1.10	1.10	1.10	1.10	1.10	1.10	1.10
Total Rate	682.03	913.47	784.13	933.92	682.03	913.47	784.13	933.92
Contribution - Total Rate	-55.70	-84.10	-65.60	-88.33	0*	0*	0*	0*
Employee Balance	-55.70	-84.10	-65.60	-88.33	0*	0*	0*	0*

2008 Part-time & Retiree Samaritan Select PPO with Part-time & Retiree Kaiser Dental								
	50% Contribution (works 50% of full time)				80% Contribution (works 80% of full time)			
	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family	Employee	Employee, Spouse/Partner	Employee, Children	Employee, Family
Subsidized Contribution	626.33	829.37	718.53	845.59	590.69	791.53	679.30	809.26
Medical Rate	590.69	791.53	679.30	809.26	45.69	61.23	52.54	62.60
Dental Rate	45.69	61.23	52.54	62.60	1.10	1.10	1.10	1.10
Basic Life	1.10	1.10	1.10	1.10	637.48	853.86	732.94	872.96
Total Rate	637.48	853.86	732.94	872.96	0*	0*	0*	0*
Contribution - Total Rate	-11.15	-24.49	-14.41	-27.37	0*	0*	0*	0*
Employee Balance	-49.20	-76.15	-58.75	-80.17	0*	0*	0*	0*

* In no case will the amount paid by your agency exceed the cost of premiums for medical, dental and basic life coverage.

2008 Employee Medical Plans Monthly Premium Rates

	Employee	Employee & Spouse/Partner	Employee & Children	Employee & Family
Kaiser Permanente HMO [1]	$734.29	$983.95	$844.44	$1,005.98
Kaiser Permanente Added Choice POS [2]	776.78	1,040.90	893.31	1,064.21
Providence Choice PPO [3]	741.84	994.05	853.12	1,016.32
Regence BCBSO PPO [3]	792.84	1,062.31	911.72	1,086.09
Samaritan Select PPO [3]	733.66	983.10	843.71	1,005.13
Kaiser Permanente Part-time & Retiree HMO [4]	621.61	832.96	714.85	851.60
Kaiser Permanente Added Choice Part-time & Retiree POS [4]	628.47	842.15	722.74	861.01
Providence Choice Part-time & Retiree PPO [5]	592.35	793.75	681.21	811.53
Regence BCBSO Part-time & Retiree PPO [5]	635.24	851.14	730.49	870.22
Samaritan Select Part-time & Retiree PPO [5]	590.69	791.53	679.30	809.26

[1] Kaiser Permanente HMO routine vision services.
[2] Routine vision services only through Kaiser Permanente HMO.
[3] Routine vision services through VSP.
[4] Vision exam only.
[5] No vision benefit.

2008 Retiree Medical Plans Monthly Premium Rates

	Retiree	Retiree & Spouse/ Partner	Retiree & Children	Retiree & Family
Kaiser Permanente HMO [1]	$737.94	$988.84	$848.63	$1,010.98
Kaiser Permanente Added Choice POS [2]	780.64	1,046.07	897.75	1,069.50
Providence Choice PPO [3]	745.53	998.99	857.37	1,021.37
Regence BCBSO PPO [3]	796.79	1,067.59	916.26	1,091.48
Samaritan Select PPO [3]	737.31	987.98	847.91	1,010.12
Kaiser Permanente Part-time & Retiree HMO [4]	624.70	837.10	718.41	855.83
Kaiser Permanente Added Choice Part-time & Retiree POS [4]	631.59	846.34	726.33	865.28
Providence Choice Part-time & Retiree PPO [5]	595.30	797.70	684.60	815.56
Regence BCBSO Part-time & Retiree PPO [5]	638.40	855.37	734.12	874.55
Samaritan Select Part-time & Retiree PPO [5]	593.63	795.46	682.68	813.28

See footnotes above.

2008 COBRA Participant Medical Plans Monthly Premium Rates

	Participant	Participant & Spouse/Partner	Participant & Children	Participant & Family
Kaiser Permanente HMO [1]	$748.89	$1,003.51	$861.22	$1,025.98
Kaiser Permanente Added Choice POS [2]	792.23	1,061.59	911.07	1,085.36
Providence Choice PPO [3]	756.59	1,013.81	870.09	1,036.53
Regence BCBSO PPO [3]	808.61	1,083.43	929.85	1,107.68
Samaritan Select PPO [3]	748.25	1,002.64	860.48	1,025.11
Kaiser Permanente Part-time & Retiree HMO [4] *	633.97	849.52	729.07	868.53
Kaiser Permanente Added Choice Part-time & Retiree POS [4] *	640.96	858.90	737.11	878.12
Providence Choice Part-time & Retiree PPO [5] *	604.13	809.53	694.76	827.66
Regence BCBSO Part-time & Retiree PPO [5] *	647.87	868.06	745.01	887.52
Samaritan Select Part-time & Retiree PPO [5] *	602.44	807.27	692.81	825.35

See footnotes on page 25

** Available only to COBRA participants who were part-time employees when they moved to COBRA status.*

2008 Other Self-pay Participant Medical Plans Monthly Premium Rates

	Participant	Participant & Spouse/Partner	Participant & Children	Participant & Family
Kaiser Permanente HMO [1]	$744.59	$994.25	$854.74	$1,016.28
Kaiser Permanente Added Choice POS [2]	787.08	1,051.20	903.61	1,074.51
Providence Choice PPO [3]	752.14	1,004.35	863.42	1,026.62
Regence BCBSO PPO [3]	803.14	1,072.61	922.02	1,096.39
Samaritan Select PPO [3]	743.96	993.40	854.01	1,015.43

See footnotes on page 25

Calculation Worksheet for Employees Who Choose to Opt Out of PEBB Medical Coverage

1. **Full-time Employees:** Enter $233.00
   Part-time Employees: Multiply $233.00 by the percentage of hours you work compared with full time. For example, if you work 75 percent of full time, your contribution amount is $174.75 ($233.00 x 0.75= $174.75). Enter the result. — 1. _____ $
2. Enter $1.10. This is the monthly premium for mandatory basic life insurance. — 2. _____ $
3. Enter the monthly premium amount for your choice of dental plan from page 27. You are required to be enrolled in at least the employee-only tier for dental coverage. You may also choose to cover eligible dependents. — 3. _____ $
4. Add lines 2 and 3, and enter the total. — 4. _____ $
5. Subtract the amount on line 4 from the amount on line 1, and enter the balance on line 5. This is the estimated amount of opt-out cash you will receive as monthly taxable income. — 5. _____ $

2008 Employee Dental Plans Monthly Premium Rates

	Employee	Employee & Spouse/Partner	Employee & Children	Employee & Family
Kaiser Permanente Traditional Dental Plan Design	$61.30	$82.14	$70.49	$83.97
ODS Preferred	68.45	91.73	78.71	93.78
ODS Traditional	74.10	99.30	85.22	101.53
Willamette Dental Group	68.20	91.39	78.43	93.43
Kaiser Permanente Part-time & Retiree	45.69	61.23	52.54	62.60
ODS Part-time & Retiree	53.32	71.46	61.33	73.06

2008 Retiree Dental Plans Monthly Premium Rates

	Retiree	Retiree & Spouse/ Partner	Retiree & Chil- dren	Retiree & Family
Kaiser Permanente Traditional Dental Plan Design	$61.60	$82.55	$70.84	$84.39
ODS Preferred	68.79	92.18	79.10	94.25
ODS Traditional	74.47	99.80	85.64	102.03
Willamette Dental Group	68.54	91.84	78.82	93.89
Kaiser Permanente Part-time & Retiree	45.92	61.53	52.80	62.91
ODS Part-time & Retiree	53.58	71.81	61.63	73.42

2008 COBRA Participant Dental Plans Monthly Premium Rates

	Participant	Participant & Spouse/Partner	Participant& Children	Participant & Family
Kaiser Permanente	$61.60	$82.55	$70.84	$84.39
ODS Preferred	68.79	92.18	79.10	94.25
ODS Traditional	74.47	99.80	85.64	102.03
Willamette Dental Group	68.54	91.84	78.82	93.89
Kaiser Permanente Part-time & Retiree *	45.92	61.53	52.80	62.91
ODS Part-time & Retiree*	54.38	72.88	62.54	74.51

** Available only to COBRA participants who were part-time employees when they moved to COBRA status.*

2008 Other Self-pay Participant Dental Plans Monthly Premium Rates

	Participant	Participant & Spouse/Partner	Participant & Children	Participant& Family
Kaiser Permanente Traditional Dental Plan Design	$61.30	$82.14	$70.49	$83.97
ODS Preferred	68.45	91.73	78.71	93.78
ODS Traditional	74.10	99.30	85.22	101.53
Willamette Dental Group	68.20	91.39	78.43	93.43

Health Fact

Using a pedometer is a fun way to track how much physical activity you are getting each day.

SECTION 3: HEALTHCARE PLANS

PEBB 2008 Medical Plans Overview

This section presents:

- Your Medical plan choices
- Prescription Drug plans
- Routine Vision Care plans
- Medical plan comparisons

What are my medical plan choices?

For 2008, PEBB offers three types of medical plans. Carefully review the plans' descriptions (pages 32-41) and service areas to see which one best fits your and your family's healthcare needs.

Health Maintenance Organization Plans

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

For 2008, PEBB sponsors the following HMO plans:

- **Kaiser Permanente** — for those who live or work in the Kaiser Permanente service area. See the plan descriptions for a list of the ZIP codes in the service area.

Preferred Provider Organization Plans

Preferred provider organization (PPO) plans offer services and benefits at two coverage levels — from preferred providers and from non-preferred providers. In a PPO, you may use any doctors you wish. If you use doctors who are preferred, you pay less. If you use providers who are not preferred, you pay more.

For 2008, PEBB sponsors the following PPO plans:

- ***Providence Choice*** — for those who live or work in Multnomah, Clackamas, Washington and Yamhill counties
- ***Regence BlueCross BlueShield of Oregon (BCBSO)*** — no matter where you live or work
- ***Samaritan Select*** — for those who live in Linn, Benton and Lincoln counties.

Each of these plans has a search function on its Web site to help you find out which doctors are preferred and non-preferred.

Choose a plan that fits your healthcare needs.

Regence calls non-preferred providers participating providers, because they participate in the plan's contracted reimbursement rates. Non-participating providers don't participate in charging those rates. Non-participating providers may balance bill you for any amounts above the plans' contracted rates.

Both Providence and Samaritan plans have select provider networks. They call non-preferred providers out-of-network providers.

Point of Service Plans

Point of Service (POS) plans have three tiers of providers: HMO, in-network, and out-of-network. You can seek care outside the HMO, but at reduced coverage levels. You must get prior authorization review before getting surgical or inpatient services.

For 2008, PEBB sponsored the following POS plans:

- **Kaiser Permanente** — for those who live or work in the Kaiser Permanente service area. See the plan descriptions for a list of the ZIP codes in the service area.

Prescription Drug Plan Design

Your Benefit Board designed the prescription drug benefit in the PPO plans to encourage members and providers to consider whether the medicine being prescribed is equally effective as others and at less cost.

Members in the full-time PPO plans have a co-pay of only $5 when using an available generic medication that is equally as effective as a drug on the plan's lists of preferred-brand medications. Members who select a preferred-brand medication have more responsibility for the cost, paying $15. Members who choose a brand drug not on the list of preferred brands – a non-preferred brand – have an even greater portion of the cost as their responsibility.

How does the non-preferred brand drug payment work in the PPO plans?

There are two types of non-preferred brand drugs — single-source and multisource. A single-source brand drug has therapeutic alternatives available — drugs that treat the problem effectively but that don't contain the same active ingredients as the preferred-brand. A multi-source brand drug has a generic equivalent available with the same active ingredients as the brand drug. Payment works differently for each.

Non-preferred, single-source brand drug: You pay the greater of $50 or 50% of the cost of the drug. However, your co-pay will never be higher than the actual cost of the drug.

Non-preferred multi-source brand drug: You pay as follows: the greater of a $50 co-payment or 50% of the cost of the brand-name drug, **plus** the difference between the generic drug cost and the brand-name drug cost. See the example calculations.

Example of Multisource Non-preferred Brand Drug Co-pay Calculation

The generic equivalent drug costs $15, and the multisource non-preferred-brand drug costs $60.

For a non-preferred multisource brand drug, you pay as follows:

1. 50% of the cost of the brand-name drug is $30. $50 is greater than that,

plus

2. the difference in cost between generic and brand is $45. Add $45 to $50. The total, $95, is higher than the actual cost of the brand drug, $60,

but

3. no more than the cost of the brand-name drug. You will never pay more than the actual cost of the drug. So, your co-pay is $60.

What are the plans' exceptions processes?

Some physicians may still prescribe a non-preferred (non-formulary) brand drug for medical reasons. For example:

- You did not have a good outcome with an alternative drug
- You are allergic to or can't tolerate an alternative drug

For these reasons, each of PEBB's medical plans has an exceptions process. If your situation meets the plan's requirements, you may be able to purchase the drug at the preferred-brand cost. See the plan descriptions for their exceptions processes.

Routine Vision Benefits

What is the routine vision benefit in Kaiser Permanente plans?

If you are in the Kaiser Permanente HMO, your routine vision care benefits are provided by a Kaiser Permanente doctor and Kaiser Permanente facilities. In the Added Choice POS Plan, you can use your eyewear allowance only at Kaiser Permanente facilities.

- HMO Plan:
  Routine exam $5
- POS Plan Routine exam:
  Kaiser Provider $10
  In-network Provider 15%
  Out-of-network Provider 30%

Both plans offer a $200 eyewear allowance. In both plans, vision eyewear is provided every 24 months or when vision changes 0.5 diopter within 12 months of the initial exam.

Call Kaiser Permanente or visit its Web site to see what doctors are in the HMO and what doctors are in the Added Choice network panel.

What is the routine vision benefit in the PPO plans?

VSP (Vision Service Plan) provides routine vision benefits in the Providence, Regence and Samaritan PPO plans according to the following schedule:

- Adults:
  Every 24 months for exam, lenses and frames.
- Children under age 17:
  Every 12 months for exam, lenses and frames.

When you get services from a VSP doctor, you pay a $10 co-payment. In addition to the $200 allowance toward the cost of materials, you get a 20 percent discount off the VSP doctor's usual and customary fees for prescription glasses.

NOTE: If you do not use the entire allowance at one time, you forfeit the balance.

A 15 percent discount applies to the doctor's professional services for all types of prescription contact lenses. Discounts are good only for 12 months after date of service of the exam and provided from the same doctor who performed the exam.

Obtaining services from a VSP doctor

When you want to get vision care services, call a VSP doctor to make an appointment. VSP does not provide a member ID card, so make sure you provide the covered member's PEBB Benefit Number. The VSP doctor will contact VSP to verify your eligibility and plan coverage and will also obtain authorization for services and materials. Call VSP or visit the Web site to find VSP doctors in your area.

Obtaining services from a Non-VSP provider

If you have an eye exam or purchase materials from an out-of-network provider, you pay the full cost of the exam and materials; the plan will reimburse you up to a maximum of $42 of the exam cost and up to $200 for materials, minus your $10 co-payment. To obtain reimbursement after you use an out-of-network provider, pay the entire bill when you receive services, then send your itemized receipts and full patient and member information to VSP.

Claims must be submitted to VSP within six months from your date of service. Submit your itemized receipt with the employee's name, PEBB Benefit Number, mailing address, patient name, date of birth, and relationship to employee to VSP. Call VSP with questions about the vision benefit.

What is the vision benefit in the Part-time and Retiree Plans?

These plans do not have a routine vision benefit, with the exception of a covered exam in the Kaiser HMO and POS plans, when given by a Kaiser provider.

Kaiser Permanente HMO Plans

Who can enroll in these plans?

You may enroll in the Kaiser Permanente plans if you are eligible and you live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the ZIP codes for the service area on page 33.

How does the plan make sure my family and I will get the best quality care?

When you enroll in Kaiser Permanente, we hope you'll choose a primary care provider. You will get to know and trust each other. You can even e-mail your provider non-urgent questions. If you have asthma, diabetes, or high cholesterol, this partnership is wider. For example, if you have diabetes, a nurse, pharmacist, and nutritionist may work with you to help you control it. You can find information about our providers online at **my.kp.org/nw/pebb**.

Our computer systems support both you and your Kaiser Permanente providers. Your electronic medical record has lab, X-ray, and other test results. It also has details about your prescriptions and your care. This means you don't have to start a visit with a long explanation, even if you're seeing a specialist for the first time. You can view most of your medical record online, and look up information in our drug and health encyclopedias. Our computer systems also offer your provider current scientific information and treatment options.

You can talk to an advice nurse 24 hours a day if you're unsure whether you need to be seen or where to go for care, or if you'd like to discuss a medical concern. Our electronic medical record enables the nurse to look up your information when you call. There's no wait for paper records to be faxed or mailed.

We have 26 medical offices throughout our service area. Fifteen are primary care medical offices that also include some specialty care. You can fill prescriptions, and get lab tests and X-rays in the same building.

How does the plan help us keep our out-of-pocket costs down?

Our HMO plan is primarily a co-payment plan without deductibles. Office visits are only $5 a visit. For a 30-day supply of prescription drugs, you pay $1 for generic drugs and $15 for brand-name drugs. By using our Mail-Delivery Pharmacy, you can order a 90-day supply of maintenance drugs for the same $1 and $15 co-payments. Your eyewear allowance is $200 every 24 months and can be used to purchase glasses, prescription sunglasses, or contact lenses from Kaiser Permanente. Co-payments for our alternative care providers are just $10 per visit.

These comprehensive benefits and low co-payments make it easier for you to budget your health care costs.

We offer free Web-based programs for eating well, exercising more, quitting tobacco, and reducing stress. In addition, we offer discounts on health clubs, community weight loss programs, and complementary care like acupuncture. If you are planning a health change, you can talk with a health consultant at no charge.

What preventive services are covered?

Our goal is to keep you as healthy as possible. We strongly promote preventive care, including routine checkups for children and adults, immunizations, women's exams, cancer screenings, and vision and hearing screenings. The timing we recommend for these services is based on scientific evidence. Regular preventive care can help you stay healthy and save you time, trouble, or even heartache down the road.

How does the plan cover emergency services — both inside and outside the service area?

You are covered for emergency care anywhere in the world. Your Medical Directory will tell you how to get emergency care both inside and outside the network of Kaiser Permanente plan hospitals. Urgent care is also covered, but not if it is provided in hospital emergency departments.

How will the plan cover my child who is attending an out-of-area college?

Kaiser Permanente offers a limited benefit to dependents who are full-time students attending a recognized United States college or vocational school. This limited benefit applies to routine, continuing, and follow-up care. Urgent or emergency care is covered under the emergency care benefit.

How does the plan's prescription drug program work, and where can I see the formulary?

For most members, formulary drugs are the best treatment. These drugs are chosen by a team of physicians and pharmacists based on their safety and effectiveness. Cost is only a factor if several drugs are similarly effective.

When a Kaiser Permanente health care provider feels a nonformulary drug is the most appropriate therapy to meet a patient's needs, the provider may request an exception. Exception criteria include that the formulary drugs have failed, or the patient's allergy or intolerance.

What is the plan's exceptions process?

Kaiser Permanente will usually arrange a one-time refill for new members who need to refill a prescription written by a doctor outside of Kaiser Permanente. New members should call the Kaiser pharmacy they want to use at least three days in advance. In some cases, they may need to see a Kaiser physician before their prescription can be refilled.

What's different in the Part-time and Retiree Plan compared with the other plan?

Retiree and part-time employee plans cost less than our full-time employee plans. For example, the office visit co-payment under these plans is $30 (versus a $5 co-payment under the full-time employee HMO plan). Generic prescription drugs are $10 generic (versus $1). These plans also have a higher annual out-of-pocket maximum, co-payments for X-rays and lab tests, co-payments for inpatient hospital stays, and do not cover eyewear or alternative care. For a detailed benefit comparison, visit my.kp.org/nw/pebb or call Membership Services at 503-813-2000 or 1-800-813-2000 (outside the Portland area).

Where can I find out more about the plan's limitations and exclusions?

For information on limitations and exclusions, visit **my.kp.org/nw/pebb** or call Membership Services at 503-813-2000 or 1-800-813-2000 (outside the Portland area).

Whom can I contact to learn more about the plan?

Visit my.kp.org/nw/pebb. You'll find more information about choosing a personal provider, our electronic medical record, our evidence-based care, programs to help you stay healthy, and more. Or call Membership Services at 503-813-2000 or 1-800-813-2000 (outside the Portland area).

What is the Kaiser Permanente service area?

The service area covers the following ZIP codes. These ZIP codes may change during the year.

Oregon

Multnomah – All ZIP codes
Clackamas – 97004 97009 97011 97013 97015 97017 97022 97023 97027 97034 97035 97036 97038 97042 97045 97049 97055 97067 97068 97070 97089 97222 97267 97268
Washington – All ZIP codes
Yamhill All ZIP codes
Linn: 97321, 322, 335, 355, 358, 360, 374, 389.
Marion – 97002 97020 97026 97032 97071 97137 97301 97302 97303 97305 97306 97307 97308 97309 97310 97311 97312 97313 97314 97317 97325 97342 97346 97352 97362 97373 97375 97381 97383 97384 97385 97392
Polk – All ZIP codes
Benton – 97330 97331 97333 97339 97370
Columbia – All ZIP codes
Hood River – 97014

Washington

Clark – All ZIP codes
Cowlitz – All ZIP codes
Lewis – 98591 98593 98596
Wahkiakum – 98612 98647
Skamania – 98639 98648

Kaiser Permanente Added Choice POS Plans

Who can enroll in these plans?

You may enroll in the Kaiser Permanente plans if you are eligible and you live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the ZIP codes for the service area on page 35.

How does the plan make sure my family and I will get the best quality care?

If you enroll in Added Choice®, the choice is yours each time you need care. Added Choice let's you choose where to get care, either from preferred provider organization (PPO) providers or other community providers (out-of-network). You can also choose your own doctor from Kaiser Permanente (in-network) and receive your care at any of our facilities. Learn more about Added Choice and Kaiser Permanente providers at **my.kp.org/nw/pebb**.

Because of the way we practice medicine, we think the best bet is to get care in network from Kaiser Permanente. Primary care and specialty doctors work as a team alongside nurses, pharmacists, and other health professionals.

Your electronic medical record has lab, X-ray, and other test results. It also has details about your prescriptions and your care. This means you don't have to start a visit with a long explanation, even if you're seeing a specialist for the first time. You can view most of your medical record online and look up information in our drug and health encyclopedias. Our computer systems also let your provider keep up with current scientific information and treatment options. You may even be able to save a visit by e-mailing your doctor.

You can talk to a Kaiser Permanent advice nurse, 24 hours a day, seven days a week, if you're unsure whether you need to be seen or where to go for care, or if you'd like to discuss a medical concern.

We have 26 medical offices throughout our service area. Fifteen are primary care medical offices that also include some specialty care. When you get care at Kaiser Permanente facilities, you don't need to file a claim. When you get out-of-network care, you may have to file a claim if your provider does not bill us directly.

How does the plan help us keep our out-of-pocket costs down?

You have the lowest out-of-pocket costs when you use Added Choice in-network benefits. In-network office visits have a flat co-payment, whether it's for a simple checkup or a more complex treatment. And there are no claims to file.

If an out-of-network doctor writes your prescriptions, you can still fill them at a Kaiser Permanente pharmacy for your in-network co-payment (if they are in stock and on the formulary).

By using in-network benefits, it's easier for you to budget your health care costs.

If your physician is part of the PPO, you'll pay a greater share of the cost, including coinsurance or co-payment. If you use an out-of-network provider who is not part of the PPO, you will pay an even greater share of the cost and higher coinsurance.

What preventive services are covered?

Our goal is to keep you as healthy as possible. We strongly promote preventive care, including routine checkups for children and adults, immunizations, women's exams, cancer screenings, and vision and hearing screenings. The timing we recommend for these services is based on scientific evidence. Regular preventive care can help you stay healthy and save you time, trouble, or even heartache down the road.

How does the plan cover emergency services – both inside and outside the service area?

You are covered for emergency care anywhere in the world. If you have an emergency, call 911 or go to the nearest emergency facility. Urgent care is also covered, but not if it is provided in hospital emergency departments. If you receive emergency or urgent care from an out-of-network provider, you need to file a claim.

How will the plan cover my child who is attending an out-of-area college?

Your college student living outside of our service area is covered for care under the out-of-network benefits and for in-network benefits if they receive care from any Kaiser Permanente facilities in our other regions.

How does the plan's prescription drug program work, and where can I see the formulary?

You can fill your prescriptions at a Kaiser Permanente pharmacy. (If they are written by a non-Kaiser Permanente provider, they must be in stock and on the formulary.) For most patients, formulary drugs are the best treatment. These drugs are chosen by a team of physicians and pharmacists based on their safety and effectiveness. Cost is only a factor if several drugs are similarly effective. Kaiser Permanente providers may request necessary exceptions.

Using your out-of-network drug benefit, you can also fill prescriptions at U.S. pharmacies associated with MedImpact. You pay the out-of-network co-payment shown on your summary of benefits.

What is the plan's exception process?

If you receive a prescription for a drug from a Kaiser Permanente HMO or Added Choice HMO provider:

- A Kaiser pharmacy will fill the prescription at the HMO co-pay if the drug is on the Kaiser formulary and in stock.
- If the drug is not on the formulary and in stock, and you and your physician will change to a formulary drug, the Kaiser pharmacy will fill it at the appropriate HMO co-pay.
- If you or your physician does not want to switch to a formulary drug, you can fill the prescription at a MedImpact pharmacy at the HMO co-pay.

Kaiser will also offer you an appointment with a Kaiser doctor to determine if continuing the non-formulary prescription is medically necessary. If it is, Kaiser will fill it at the HMO co-pay.

What's different in the Retiree and Part-time Plan compared with the other plan?

Retiree and part-time employee plans cost less than our full-time employee plans. These plans also have a higher deductible, annual out-of-pocket maximum, co-payments for X-rays, lab tests, and hospital stays, and do not cover eyewear or alternative care. For a detailed comparison, visit **my.kp.org/nw/pebb** or call Membership Services at 503-813-2000 or 1-800-813-2000 (outside the Portland area).

Where can I find out more about the plan's limitations and exclusions?

There are different limitations for in-network and out-of-network care. For more information, visit **my.kp.org/nw/pebb** or call Membership Services at 503-813-2000 or 1-800-813-2000 (outside the Portland area).

Whom can I contact to learn more about the plan?

To learn more about Kaiser Permanente and Added Choice, visit **my.kp.org/nw/pebb**. Or call Membership Services at 503-813-2000 or 1-800-813-2000 (outside the Portland area).

What is the Kaiser Permanente service area?

The service area covers the following ZIP codes, which may change during the year.

Oregon

Multnomah – All ZIP codes
Clackamas – 97004 97009 97011 97013 97015 97017 97022 97023 97027 97034 97035 97036 97038 97042 97045 97049 97055 97067 97068 97070 97089 97222 97267 97268
Washington – All ZIP codes
Yamhill – All ZIP codes
Linn: 97321, 322, 335, 355, 358, 360, 374, 389.
Marion – 97002 97020 97026 97032 97071 97137 97301 97302 97303 97305 97306 97307 97308 97309 97310 97311 97312 97313 97314 97317 97325 97342 97346 97352 97362 97373 97375 97381 97383 97384 97385 97392
Polk – All ZIP codes
Benton – 97330 97331 97333 97339 97370
Columbia – All ZIP codes
Hood River – 97014

Washington

Clark – All ZIP codes
Cowlitz – All ZIP codes
Lewis – 98591 98593 98596
Wahkiakum – 98612 98647
Skamania – 98639 98648

Providence Choice PPO Plans

Who can enroll in these plans?

You may enroll in the Providence Choice plans if you are eligible and you live or work in Multnomah, Clackamas, Washington and Yamhill counties.

How does the plan make sure my family and I will get the best quality care?

Providence Choice recognizes that the best health care is based on a close relationship with a medical expert who can advise and guide your care. That's why we encourage you to choose and work closely with a medical home provider in a Providence medical home clinic. He or she will provide medical care, suggest a specialist when needed, and arrange for tests or hospital care. Providence invests in evidence-based medicine, using research to develop best-practice guidelines. They strive to get the right care for each health plan member, at the right time and in the right setting.

How does the plan help us keep our out-of-pocket costs down?

With Providence Choice, you will have lower out-of-pocket expenses for medical care when you obtain covered services from a medical home provider or are referred by your medical home provider to a Providence Choice participating provider. The plan will cover services received from a non-participating provider or received from a participating provider without a referral, but you will be responsible for higher out-of-pocket expenses. The plans prescription drug process also holds down your out-of-pocket costs while ensuring you get the right medications for your needs.

What preventive services are covered?

Providence Choice strives to keep members well through comprehensive preventive care benefits, including:

- Routine physical exams for adults
- Well-baby and well-child care (birth to age 19)
- Routine immunizations
- Hearing exams and hearing aids,
- Annual women's gynecological exams, including pap test, pelvic and breast exams
- Mammograms
- Family planning services
- Preventive services for members who are diabetic
- Colorectal cancer screening exams
- Nutritional counseling, and
- Men's preventive care, including prostate cancer screening exams.

How does the plan cover emergency services – both inside and outside the service area?

Emergency medical services are covered anywhere, 24-hours a day, even when you are away from home. Regardless of where you seek emergency care, your co-pay will be $75. When you use a Providence Health System emergency room or urgent care clinic in the service area, information about your condition and care is available to your medical home clinic immediately via their electronic medical record system. To receive in-plan benefits, follow-up care from the emergent or urgent situation must be coordinated by your medical home provider.

How will the plan cover my child who is attending an out-of-area college?

Providence Choice offers out-of-plan benefits for covered services received by covered dependent children who live outside the service area. Out-of-area dependents do not need to select a medical home clinic; they may seek care from any provider in the community. However, they can limit out-of-pocket expense if they see a provider who participates in Providence's national provider network. Once a dependent child returns to the service area, he or she needs to use the services of a medical home provider to receive in-plan benefits.

How does the plan's prescription drug program work, and where can I see the formulary?

Providence Choice was designed to best serve members' prescription drug needs, thanks to excellent care and direction from Providence Medical Group (PMG) clinics. PMG physicians are supported by staff pharmacists who are available to meet with individual patients and recommend changes, if necessary, to current medications. Pharmacists may also clarify the use and correct dosage of drugs to improve patient knowledge and compliance. Their expertise means that PMG patients get the most effective medications to treat their conditions, not just the most advertised or subsidized by pharmaceutical companies. Providence Choice Plan members have fewer prior authorization requirements for medications their medical home providers prescribe because PMG patients get the right prescriptions the first time!

For a list of participating pharmacies or a copy of the formulary, visit the Providence Choice Web site at **www.providence.org/pebb**.

What is the plan's exceptions process?

If your physician feels there are medical reasons for using a non-formulary brand-name drug, he/she may submit an exception request to PHP. If the exception is approved, the co-payment for formulary brand-name drugs will apply. PHP has developed an automated exception process for those medications the medical home provider determines satisfy the co-pay exception criteria.

If you see an out-of-network provider, you or the provider will need to contact the plan to arrange for approval for a non-formulary drug to be covered at the preferred-brand level. The average time for prior authorization review is less than 24 hours when all the necessary information is available.

What's different in the Part-time and Retiree Plan compared with the other plan?

The Retiree and Part-time medical plan being offered to PEBB members in 2008 contains the same plan provisions, such as limitations and exclusions, as the active plan. When you receive from a Providence Choice Plan medical home provider or a Providence Choice Plan participating specialist to whom you were referred, you will typically have a $30 co-payment. Services obtained from a non-participating provider or without a referral from a medical home provider will be paid at 50%.

The plan also provides paid-in-full benefits for most preventive care services. The most you will pay for covered services in a calendar year is $2,000 per person or $6,000 per family in-plan, and $4,000 per person or $12,000 per family out-of-plan. This plan does not have a routine vision benefit. For more detail about the benefits, please call customer service or go to the Providence Choice Web site **www.providence.org/pebb** for a copy of the plan's benefit summary.

Where can I find out about the plan's limitations and exclusions?

View a list of the plans' limitations & exclusions online at **www.providence.org/pebb**, or contact customer service at the phone numbers below.

Whom can I contact to learn more about the plan?

The Providence Choice customer service staff is available to help with any questions you might have. Please contact them at:

- (503)574-7500 or **Toll free:** (800) 878-4445
- **TTY:** (503) 574-8702 or (888) 244-6642

Customer service staff members are available between 8 a.m. and 5 p.m., Monday through Friday.

Regence BlueCross BlueShield of Oregon PPO Plans

Who can enroll in these plans?

All eligible members may enroll in the Regence BlueCross BlueShield plans no matter where they live or work.

How does the plan make sure my family and I will get the best quality care?

Regence BlueCross BlueShield provides you and your family the best quality care by making sure your care is based on the latest and highest quality medical standards. We base our Medical Policy on the best scientific evidence, and we measure and give physicians feedback on how well they meet current standards for preventive care and treatment of common conditions such as asthma, high blood pressure and diabetes. We believe that the medical profession is constantly learning and that the right answers require being a partner with your doctor. We provide information for you about quality care and how to maintain your health. We support new ideas and fund pilot programs to find ways to reward the best care. You can learn more about all of this in our Medical Director's letter to you at **www.or.regence.com/pebb**.

How does the plan help us keep our out-of-pocket costs down?

Regence helps keep out-of-pocket costs down by providing tools to help you make decisions that can affect your pocketbook. On myregence.com, you can use a calculator to estimate future costs, identify which providers are preferred and less expensive to you, and see which hospitals are recommended for both quality and costs. You can also check **www.or.regence.com/pebb** for generic drug options to lower your co-pay. We also provide wellness programs, with rewards for participating and care management programs such as Advicare that will work to keep you as healthy as possible so you can save your resources for other areas of your life.

What preventive services are covered?

Regence provides 100 percent coverage when you see a preferred provider for periodic health exams, well-child checkups, routine immunizations, mammography screenings and hearing screenings. Routine women's exams are covered in full after a $10 co-payment. If you choose to see a non-preferred provider, your coverage pays at 70 percent of allowed charges.

How does the plan cover emergency services – both inside and outside the service area?

Emergency services are covered at 85 percent for preferred facilities and providers and 70 percent for non-preferred facilities and providers. If you are experiencing a medical emergency that requires emergency care (see Glossary), your coverage will pay at the preferred level regardless of whether you see a preferred provider.

How will the plan cover my child who is attending an out-of-area college?

Your children will have coverage wherever they reside. The national BlueCard program allows your dependent child to receive services from an-out-of-state provider and receive benefits at 85 percent if they receive services from preferred providers or 70 percent if they receive services from non-preferred providers. To locate a preferred Blue Provider outside of Oregon, you can call (800) 810-BLUE (2583). This number is also on the back of your Regence ID card. Or visit **www.bcbs.com** for a list of providers worldwide.

How does the plan's prescription drug program work, and where can I see the formulary?

You pay a $5 co-payment for each generic prescription medication; a $15 co-payment for each preferred medication; and $50 or 50 percent of the cost for brand-name medications (whichever is greater), plus the difference between generic and brand-name for multisource brands (see Glossary) dispensed by a participating pharmacy. If you purchase prescriptions from a non-participating pharmacy, you may be required to pay in full at the time of purchase and then submit for reimbursement. Your plan allows for a 34-day supply at a retail pharmacy and a 90-day supply through mail order. You can review the Regence Preferred brand-name medication list online at www.or.regence.com/pebb.

What is the plan's exceptions process?

You and your doctor can see if a drug is on the plan's formulary by doing a search on the Regencerx Web site. If your doctor prescribes a non-formulary drug, he or she can fill out the online Pharmacy Prior Authorization Request form on the Web site and fax it to Regence or submit it online.

The online form lets your doctor:

- See why the drug is not preferred by the plan
- Enter the formulary drugs you have tried for this condition and what your outcomes were with those drugs.

The plan may grant exceptions if formulary alternatives have failed to treat your condition or caused side effects that made you stop taking them. The plan makes exception decisions within 24 to 48 hours, when it has all needed information from your doctor.

If you are enrolled in the part-time and retiree plan, when you get an exception, the co-pay for the non-preferred drug will not apply to your deductible. The co-pay for a preferred brand drug ***does*** apply to your deductible.

What's different in the Part-time and Retiree Plan compared with the other plan?

This plan pays 50 percent, and you pay 50 percent of the first $1,000 in eligible charges. Once you have reached $1,000 in eligible charges, the plan begins to pay 80 percent of eligible charges for preferred providers and maximum annual out-of-pocket per person ($6,000 per family) for preferred providers and $4,000 out-of-pocket per person ($12,000) per family for non-preferred providers. This plan does not offer a routine vision benefit.

What if I live in a rural area?

Some areas of the state have limited preferred providers. In these counties, PEBB has arranged for resident members to receive the preferred provider level of benefits from providers who are either preferred or participating in Regence BCBSO contracts.

The designated rural counties are: Baker, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, and Wheeler.

If you see a provider who is not participating (has no arrangements with Regence to bill at a specific level), that provider may charge more than preferred or participating providers. Such a provider may bill you for amounts not reimbursed by Regence.

Where can I find out about the plan's limitations and exclusions?

Limitations and exclusions are available in the member handbook or on our Web site at **www.or.regence.com/pebb**. Click on "Benefits" and then "Limitations Applicable to Your Plan" or "General Exclusions."

Whom can I contact to learn more about the plan?

You can contact a Customer Service Representative at (800) 826-9813 (outside Portland) or (503) 220-3849 (Portland), or you can visit our Web site at **www.or.regence.com/pebb**.

Samaritan Select PPO Plans

Who can enroll in these plans?

You may enroll in these plans if you are eligible and you live in Linn, Benton and Lincoln counties.

How does the plan make sure my family and I will get the best quality care?

Samaritan Select makes sure you and your family will get the best quality of care because of who we are and what we are doing to improve health care in our region. As a division of Samaritan Health Services our mission is to build healthier communities, right here where we live.

- **Medical Home.** One of the ways we have done this for PEBB members is through our early implementation of PEBB vision elements, such as the establishment of a Medical Home. A Medical Home Provider is a personal physician, physician's assistant or nurse practitioner whom you trust. This provider will know and care about you—your health, habits, preferences, history and family. Members establish a Medical Home Provider simply by choosing a physician and letting us know whom they have chosen.
- **Health Risk Assessment.** Samaritan Select has also implemented Health Risk Assessments (HRA) and a Nurse Case Management Program. This assessment is part of the Samaritan Select vision for providing you with an integrated system of care. The information you provide helps us know how we can best meet all your health care needs.

  All information you provide is kept confidential and does not affect your benefits in any way. If indicated by your HRA, a Samaritan Select nurse will contact you as part of our Nurse Case Management programs. These programs help members to effectively manage their diseases or conditions so they can lead healthy, active lives. We do this by bringing providers together for an interdisciplinary, clinical team approach to deal with complex medical needs.
- **Wellness Classes.** Samaritan Select also offers a full schedule of health information classes, health screenings and support groups to help keep you healthy.
- **Worldwide Coverage.** Samaritan Select provides worldwide coverage to our members. If you or a covered family member needs urgent or emergency care, it will always be covered at the preferred benefit level. With Samaritan Select you can travel with confidence that your medical needs will be covered. In addition, Samaritan Select will cover you at the preferred rate through a Medical Home Provider if you temporarily live or work out of the area.

How does the plan help us keep our out-of-pocket costs down?

We help keep your out of pocket costs down with low, set co-pays for most services. A visit to a preferred provider on the full-time plan is a $10 co-pay, no matter how much the provider charges for the visit. Outpatient or office-based surgeries are also a set $10 co-pay. Despite the rising costs of health care, inpatient services are also a set co-pay: $100 per day with a $500 per calendar year maximum. We offer the lowest out-of-pocket costs by enabling you to utilize our preferred providers. Our preferred provider panel includes an extensive preferred provider panel of physicians and providers in Oregon, Idaho and southwest Washington.

What preventive services are covered?

Preventive services are covered under Samaritan Select on both the Full Time and Part Time and Retiree plans. In fact, most preventive services have no patient responsibility or out of pocket expense. Removing the co-pay from these important services is our way of encouraging you to stay healthy through a no-cost, yearly preventive exam and accompanying services.

How does the plan cover emergency services – both inside and outside the service area?

Emergency services are always covered at the preferred benefit level, anywhere you go. No prior authorization is required for emergency services. We also extend the preferred benefit level to urgent care.

How will the plan cover my child who is attending an out-of-area college?

We provide an extensive network of preferred Medical Home providers through a contracted, national network, which provides coverage for members living out of the area. Samaritan Select members can also choose to seek services from a non-preferred provider at any time.

How does the plan's prescription drug program work, and where can I see the formulary?

Our prescription drug plan provides coverage for generic and brand name drugs with a three-tier co-pay structure. We also offer two options for members who want to receive their drugs through the mail. For more information and a complete formulary listing please see our Web site: **www.samaritanselect.com**.

What is the plan's exceptions process?

You and your doctor can view the Samaritan Approved Medication List (also called preferred or covered drugs) on the plan's Web site. If it is medically necessary for you to have medication that is not on the list, your physician can fill out a medication exception form and fax it and any necessary documentation to the plan for review.

When the plan's medical reviewer has all needed information, a determination is made within three business days.

If the reviewer approves the request, Samaritan will place the approval into the claims payment system for the time frame determined by the reviewer. Your doctor will be notified.

If the exception is denied, Samaritan will notify you and your doctor within five business days. This notice will include reconsideration and appeal information. Your doctor may choose to prescribe a drug from the Approved Medication List.

What's different in the Part-time and Retiree Plan compared with the other plan?

The Retiree and Part-time plan offers a low 20 percent coinsurance for preferred providers and a 50 percent coinsurance for non-preferred providers for most services. However, most preventive services are fully covered. As on the full-time plan, emergency services are always covered at the preferred benefit level. This plan does not offer a routine vision benefit.

Where can I find out about the plan's limitations and exclusions?

You can find the complete Member Handbook as well as much more information about Samaritan Select on our Web site at **www.samaritanselect.com/storage/pdf/2006_Select_Member_Handbook.pdf**. All new Samaritan Select members receive a copy of the handbook in our new member welcome packet.

Whom can I contact to learn more about the plan?

Walk-in, telephone, or contact us via the Web. We are conveniently located at 815 NW 9th Street, Corvallis, Oregon, and our offices are open Monday through Friday, 8 a.m. to 5 p.m. to serve you. You can contact us through our Web site at www.samaritanselect.com/contact.html, or call us at (800) 569-4616 or (541) 768-6900.

2008 PEBB Healthcare Plan Comparisons

The following pages allow you to compare PEBB's 2008 healthcare options on a side-by-side basis. Comparisons are presented in the following order:

- **Full-time Medical Plans coverage available to full-time and part-time employees, retirees and other self-pay participants**
- **Part-time and Retiree Medical Plans coverage available to:**
  - Part-time employees and retirees
  - COBRA participants who were part-time employees when they elected COBRA continuation coverage.
- **Prescription Drug coverage in the Full-time Medical Plans available to:**
  - Full-time employees
  - Part-time employees
  - Retirees
  - Other self-pay participants
- **Prescription Drug coverage in the Part-time and Retiree Medical Plans available to:**
  - Part-time employees
  - Retirees
  - COBRA participants who were part-time employees when they elected COBRA continuation coverage).
- **Routine Vision Care coverage in the Full-time Medical plans available to:**
  - Full-time employees
  - Part-time employees, retirees and other self-pay participants who enroll in a full-time medical plan
- **Dental Plans coverage available to:**
  - Full-time and part-time employees, retirees and other self-pay participants (except Blind Business Enterprise Agents)

NOTE: Full-time employees may not enroll in the part-time and retiree plans.

Health Fact

Physical activity helps children stay healthy and happy.

2008 Full-time Medical Plans Comparison

	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO		Samaritan Select	
Provider Type	**HMO**	**HMO**	**Network**	**OON****	**Network**	**OON****	**Network**	**OON****	**Network**	**OON****
Individual OOP* Max	$600	$600	$1,500	$2,500	$1,000	$2,000	$1,000	$2,000	$1,000	$2,000
Family OOP Max	$1,200	$1,200	$4,500	$7,500	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Individual lifetime max	No limit	No limit	$2 million	$2 million	$2 million	$2 million	$2 million	$2 million	$2 million	$2 million
Type of Service — You pay										
Primary care office	$5	$10	$20	30%	$5	30%	15%	30%	$10	30%
Specialist office	$5	$10	15%	30%	$5	30%	15%	30%	$10	30%
X-ray and lab	$0	$0	15%	30%	$0	30%	15%	30%	$0	30%
Preventive Care[1]										
Health appraisal	$0	$0	$0	30%	$0	30%	$0	30%	$0	30%
Well-child exam	$0	$0	$0	30%	$0	30%	$0	30%	$0	30%
Women's exam	$5	$10	$15	30%	$0	30%	$10	30%	$0	30%
Immunizations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hearing exams	$5	$10	15%	30%	$5	30%	15%	30%	$10	30%
Cancer screens	$0	$0	15%	30%	$0	30%	$0	30%	$0	30%
Hospital[2]										
Ambulance	$75	$75	30%	30%	$75	$75	15%	30%	$75	$75
Inpatient/day Max	$50 $250/ admit	$100 $500/yr	15%	30%	$50 $250/ admit	30%	15%	30%	$100 $500/yr	30%
Outpatient	$5	$10	15%	30%	$5	30%	15%	30%	$10	30%
Emergency dept	$75	$75	$75	$75	$75	$75	15%	30%	$75	$75
Surgery[2]										
Inpatient/day Max	$50 $250/ admit	$100 $500/yr	15%	30%	$50 $250/ admit	30%	15%	30%	$0	30%
Outpatient Office	$5	$10	15%	30%	$5	30%	15%	30%	$10	30%
Maternity Care										
Prenatal, delivery, postpartum	$0	$0	15%	30%	$0	30%	15%	30%	$10	30%
Mental Health, Chemical Dependency[2]										
Inpatient & resident/day max	$50 $250/ admit	$100/ $500/yr	15%	30%	$50 $250/ admit	30%	15%	30%	$100 $500/yr	30%
Outpatient	$5	$10	15%	30%	$5	30%	15%	30%	$10	30%
Other[3]										
Hearing aids	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
Diabetic supplies, insulin	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Durable medical equipment	$0	$0	$0	$0	15%	30%	15%	30%	15%	30%
Alternative Care	$10	$15	$15	$15	$10	$10	30%	30%	$15	$15
Physical Therapy	$5	$10	15%	30%	$5	30%	15%	30%	15%	30%

[1] Plans cover preventive services, including screenings, on schedules and in age ranges determined by the plan.

[2] Plans may require prior authorization, pre-certification or a treatment plan.

[3] Plans may place limits on type, number, frequency, source or maximum coverage of services or devices. Plans may also limit the benefit to (or offer a better benefit for) use of plan or network facilities or resources.

* **OOP = Out of Pocket**

** **OON = Out of Network**

2008 Part-time & Retiree Medical Plans Comparison

	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO		Samaritan Select	
Provider Type	**HMO**	**HMO**	**Network**	**OON***	**Network**	**OON***	**Network**	**OON***	**Network**	**OON***
Deductible	$0	$250	$750	$1,000	$0	$0	50% of $1,000 then 20%	50% of $1,000 then 50%	50% of $1,000 then 20%	50% of $1,000 then 50%
Ind. OOP** Max	$1,500	$2,000	$3,000	$4,500	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family OOP Max	$3,000	$6,000	$9,000	$13,500	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
Ind. lifetime max	No limit	No limit	$2 million	$2 million	$2 million	$2 million	$2 million	$2 million	$2 million	$2 million
Type of Service — You pay										
Primary care office	$30	$30	30%	50%	$30	50%	20%	50%	20%	50%
Specialist office	$30	$30	30%	50%	$30	50%	20%	50%	20%	50%
X-ray and lab	$10	20%	30%	50%	20%	50%	20%	50%	20%	50%
Preventive Care[1]										
Health appraisal	$0	$30	30%	50%	$0	50%	$0	50%	$0	50%
Well-child exam	$0	$30	30%	50%	$0	50%	$0	50%	$0	50%
Women's exam	$30	$30	30%	50%	$0	50%	$10	50%	$0	50%
Immunizations	$0	$0	30%	50%	$0	50%	$0	50%	$0	50%
Hearing exams	$30	$30	30%	50%	$30	50%	20%	50%	20%	50%
Cancer screens	$10	20%	30%	50%	$0	50%	$0	50%	$0	50%
Hospital[2]										
Ambulance	$75	20%	50%	50%	$75	$75	20%	50%	20%	50%
Inpatient	$500/admit	20%	30%	50%	$500/admit	50%	20%	50%	20%	50%
Outpatient	$30	20%	30%	50%	$30	50%	20%	50%	20%	50%
Emergency dept	$100	20%	20%	20%	$100	50%	20%	50%	20%	50%
Surgery[2]										
Inpatient	$0	20%	30%	50%	$30	50%	20%	50%	20%	50%
Outpatient, Office	$30	20%	30%	50%	$30	50%	20%	50%	20%	50%
Maternity Care										
Prenatal, delivery, postpartum	$0	$30	30%	50%	$0	50%	20%	50%	20%	50%
Mental Health, Chemical Dependency[2]										
Inpatient	$500/admit	20%	30%	50%	$500/admit	50%	20%	50%	20%	50%
Residential	$50/day, $250/admit	20%	30%	50%	$500/admit	50%	20%	50%	20%	50%
Outpatient	$30	$30	30%	50%	$30	50%	20%	50%	20%	50%
Other[3]										
Routine vision	$30 - exam only					Not Covered				
Hearing aids	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
Diabetic supplies, insulin	Covered as DME & prescription drugs				$0	$0	$0	$0	$0	$0
Durable medical equipment	50%	50%	50%	50%	50%	50%	20%	50%	20%	50%
Alternative Care	Not Covered				50%		50%		50%	
Physical Therapy	$30	$30	30%	50%	$30	50%	20%	50%	20%	50%

[1] Plans cover preventive services, including screenings, on schedules and in age ranges determined by the plan.

[2] Plans may require prior authorization, pre-certification or a treatment plan.

[3] Plans may place limits on type, number, frequency, source or maximum coverage of services or devices. Plans may also limit the benefit to (or offer a better benefit for) use of plan or network facilities or resources.

* **OOP = Out of Pocket**

** **OON = Out of Network**

2008 Full-time Medical Plans Prescription Drug Comparison

Coverage	Kaiser	Kaiser Added Choice POS			Providence Choice	Regence BCBSO	Samaritan Select
		HMO	Network	OON			
Retail supply	**30-day**				**34-day**		
Pharmacies	Kaiser Only	Kaiser Only	MedImpact[1]	MedImpact[1]	Participating		Participating
Generic	$1	$5	$20	$20	$5	$5	$5
Brand	$15	$15	$20, plus[2]	$20, plus[2]	$15	$15	$15
Non preferred, Non formulary	Not Covered		$20, plus[2]	$20, plus[2]	>$50 or 50%, plus[3]	>$50 or 50%, plus[3]	>$50 or 50%, plus[3]
Mail Supply (90-day)							
Generic	$1	$10	$10	$10	$12.50	$12.50	$12.50
Brand	$15	$30	$30	$30	$37.50	$37.50	$37.50
Non preferred, Non formulary	Not Covered				>$125 or 50%, plus[3]	>$125 or 50%, plus[3]	>$125 or 50%, plus[3]

[1] May use Kaiser mail-order if drug is in stock and in formulary.

[2] Plus the difference between generic and brand.

[3] Plus the difference between generic and brand for multisource brands. Multisource brand - a brand where there is an exact generic equivalent available.

2008 Part-time and Retiree Medical Plans Prescription Drug Comparison

Coverage	Kaiser	Kaiser Added Choice POS			Providence Choice	Regence BCBSO	Samaritan Select
		HMO	Network	OON			
Retail supply	**30-day**				**34-day**		
Pharmacies	Kaiser Only	Kaiser Only	MedImpact[1]	MedImpact[1]	Participating		Participating
Generic	$10	$10	$30	$30	$10	$10	$10
Brand	$25	$25	$30, plus [2]	$30, plus [2]	20%	20%	20%
Non preferred, Non formulary	Not Covered				>$50 or 50% plus [3]	>$50 or 50% plus [3]	>$50 or 50% plus [3]
Mail Supply (90 day)							
Generic	$20	$20	$20	$20	$25	$25	$25
Brand	$50	$50	$50, plus [2]	$50, plus [2]	$62.50	$62.50	$62.50
Non preferred, Non formulary	Not Covered				$125, plus [3]	$125, plus [3]	$125, plus [3]

See footnotes above.

2008 Full-time Medical Plans Routine Vision Care Coverage Comparison

Coverage	Kaiser HMO	Kaiser Added Choice POS			VSP for Providence, Regence, Samaritan	
		HMO	Network	OON*	VSP Provider	OON* Provider
Routine Exam	$5	$10	15%	30%	$10	$10 + amount above $42
Eyewear Allowance	$200[1]	$200[1]	$200[1]	$200[1]	$200[2]	$200[2]

[1] Eyewear benefit provided every 24 months or when vision changes 0.5 diopter within 12 months of initial exam. Available through Kaiser facilities and providers only.

[2] Every 24 months for adults (17 and older); every 12 months for children (up to age 17).

* OON = Out of Network

NOTE: PEBB Part-time and Retiree plans do not offer coverage for routine vision care, with the exception of the Kaiser Part-time and Retiree plans, which cover an annual exam (only through the Kaiser Permanente HMO).

2008 Dental Plans Coverage Comparison

Plan Type	Kaiser Permanente Traditional Plan Design		Willamette Dental	ODS Traditional		ODS Preferred	
	Full-time	Part-time*		Full-time	Part-time*		
Type of Providers	**Kaiser only**	**Kaiser only**	**Willamette only**	**Any licensed**	**Any licensed**	**Preferred**	**Nonpreferred**
Annual/person max	$1,750	$1,250	None	$1,750	$1,250	$1,750	$1,750
Annual deductible (individual; family)	$50; $150	$50; $150	None	$50; $150	$50/ind.	$50; $150	$50; $150
Type of Service — You pay							
Diagnostic & preventive (cleaning, X-ray)[1]	0%	$0	$0	0%	$0	0%	10%
Basic & maint. (filling, root canal, oral surgery)	20%	50%	$0	20%	50%	20-10-0%[2]	30%
Crowns	25%	50%	$190[3]	25%	50%	25%	25%
Implants	50%	Not covered	75%	50%	Not covered	50%	50%
Bridges, Dentures	50%	50%	$190[3]	50%	50%	50%	50%
Orthodontia	50%[4]	Not covered	$1,2005[5]	50%[4]	Not covered	50%[4]	50%[4]

[1] Routine cleaning covered once per year. You may qualify for more if your dentist determines they are a appropriate and you meet specific plan criteria. X-rays covered on an age-based schedule.

[2] Decreases by 10% per calendar year if you visit preferred dentist at least once per year.

[3] Co-payment per tooth; for dentures, $190 co-payment per upper or lower denture.

[4] Limited to lifetime maximum of $1,500/person.

[5] Requires $150 co-payment prior to the start of orthodontic treatment, which applies to the total $1,200 co-payment.

*** Available only to part-time employees and retirees.**

2008 PEBB Dental Plans Overview

This section presents:

- Your dental plan choices
- Dental plan descriptions
- Dental plan comparisons

What are my dental plan choices?

For 2008, PEBB sponsors three types of dental plan designs: a traditional plan design offered by Kaiser Permanente and ODS, a preferred provider dental plan design from ODS, and a dental health maintenance organization plan design from Willamette Dental.

You may enroll different eligible dependents in your dental plan than are enrolled in your medical plan.

Kaiser Permanente Traditional Plan Design. You may enroll in this plan if you live or work (at least 50 percent of the time) in the Kaiser service area (see the list of applicable ZIP codes on page 49). The plan covers services only from Kaiser Permanente providers in Kaiser facilities. You do not have to be enrolled in the Kaiser medical plan to enroll in the Kaiser dental plan.

ODS Preferred Plan. In this plan, you pay less if you see dentists in the plan's preferred network, which includes more than 600 dentists throughout the state. If you continue to see the same dentist every year, your payment level for basic care drops every year. **Some waiting periods apply; see page 50.**

ODS Traditional Plan. In this plan, you may use any licensed dentist. **Some waiting periods apply; see page 50.**

Willamette Dental Plan. Members who enroll in this plan must access services through Willamette dental facilities for the services to be covered (see page 51 for a list of locations).

What are the dental plan design changes for 2008?

For 2008, your Benefit Board made changes to dental benefits. These changes fit the PEBB Vision for high quality, affordable healthcare. Here are the highlights.

Frequency of coverage for dental cleanings. Routine cleanings are covered once per year. For some people – for example those with advanced gum disease or diabetes or women who are pregnant – evidence indicates there may be a need for additional cleanings beyond two times per year. You may qualify for more frequent cleanings if your dentist determines they are appropriate and you meet plan-specific criteria. For example, if you have braces or gum disease, you may be eligible for up to two cleanings per year. If you are diabetic, pregnant or have had gum surgery, you may be eligible for up to four cleanings per year.

Frequency of coverage for dental X-rays. Research shows that dental X-rays for most people are not needed every year. Radiation from X-rays accumulates over a lifetime and may increase your risk of cancer. Beginning in 2008, benefits will cover bitewings every 12 months for members younger than 15 and every 24 months for those 15 or older. You may be eligible for more frequent X-rays – for example if you have had two or more crowns or fillings in the last two years.

Kaiser dental plan design. For 2008, the Board asked Kaiser Permanente to offer a plan design that is like the ODS traditional plan. This traditional plan design offers dental benefits that are in line with the latest research and that are less costly. Members will still access services through Kaiser dentists and facilities. Kaiser will also offer a traditional dental plan design for part-time employees and retirees. This plan has a deductible.

Replacement crowns and similar attachments are covered every seven years.

Dental implants are covered at member coinsurance rates of 50 percent in the Kaiser and ODS plans and 75 percent in the Willamette Dental plan.

Member coinsurance for crowns decreases from 50 percent to 25 percent in the Kaiser and ODS plans.

The annual maximum benefit in the Kaiser and ODS full-time plans increases from $1,500 to $1,750 per person. The lifetime orthodontia benefit increases in these plans from $1,000 to $1,500 per person.

The annual maximum benefit in the Kaiser and ODS part-time and Retired plans increases from $1,000 to $1,250 per person. The lifetime orthodontia benefit increases in these plans from $1,000 to $1,500 per person.

Health Fact

Dental care is an important element of overall health.

Kaiser Permanente Dental

Care is provided in Kaiser Permanente dental offices. You choose the dental office most convenient to you. Kaiser Permanente has 16 dental offices located in Metropolitan Portland and Salem, and in Vancouver and Longview, Washington. You must live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See below.

You choose your own Kaiser Permanente dentist to direct your dental care. Kaiser Permanente has more than 110 dentists. As a member, you agree to receive your care only from Kaiser Permanente providers or other providers authorized by Kaiser Permanente.

Kaiser Permanente dentists:

- Emphasize preventive care
- Provide care based on current scientific research
- Assess your risk for dental disease and develop a personalized treatment program for each member.

Orthodontic services are available at certain Kaiser Permanente dental offices in Portland, Vancouver, Longview-Kelso and Salem. These services require a referral by a Kaiser Permanente dentist.

If you require emergency care when you are outside the service area, you will be reimbursed up to $100 per incident for the following: services for relief of pain, acute infection or hemorrhage; and necessary treatment, including local anesthesia and pre-medication, due to injury.

You will receive your Kaiser Permanente identification card soon after your effective enrollment date. At about the same time, you will receive a Kaiser Permanente Dental Directory, which explains how to use the dental care services, and a member handbook (evidence of coverage), which describes your plan in detail.

Oregon

Multnomah – All ZIP codes
Clackamas – 97004 97009 97011 97013 97015 97017 97022 97023 97027 97034 97035 97036 97038 97042 97045 97049 97055 97067 97068 97070 97089 97222 97267 97268
Washington – All ZIP codes
Yamhill – All ZIP codes
Linn 97321, 322, 335, 355, 358, 360, 374, 389
Marion – 97002 97020 97026 97032 97071 97137 97301 97302 97303 97305 97306 97307 97308 97309 97310 97311 97312 97313 97314 97317 97325 97342 97346 97352 97362 97373 97375 97381 97383 97384 97385 97392
Polk – All ZIP codes
Benton – 97330 97331 97333 97339 97370
Columbia – All ZIP codes
Hood River – 97014

Washington

Clark – All ZIP codes
Cowlitz – All ZIP codes
Lewis – 98591 98593 98596
Wahkiakum – 98612 98647
Skamania – 98639 98648

ODS Dental

Traditional Plan

Under the ODS Traditional plan, you can see any licensed dentist for your services. More than 92 percent of the licensed dentists in Oregon are participating ODS providers. ODS has specific fee arrangements with participating dentists to ensure that their actual charges do not exceed their usual fees on file with ODS. Participating dentists cannot bill patients for charges over and above the fees they have filed with ODS, which helps to minimize your out-of-pocket expenses.

You are free to utilize the services of any licensed dentist, even those who are not participating providers. However, reimbursement for services of a **non-participating dentist** will be limited to the applicable percentages specified in the plan toward the prevailing fees charged by other dentists for corresponding services. Prevailing fees are defined as those that satisfy and are charged by the majority of dentists in Oregon, as determined by ODS on the basis of confidential fee listings from participating dentists.

For expensive treatment plans, ODS provides a predetermination service. Your dentist may submit a predetermination request to get an estimate of what your insurance would pay. The predetermination will be processed according to your plan's current contract and returned to your dental provider. You and your dental provider should review the information before beginning treatment.

Preferred Plan

The ODS Preferred plan allows PEBB members to access two levels of benefits depending on the dentist they choose. To access the highest level of benefits, you must receive care from an ODS preferred dentist. If you receive care from a dentist not in the ODS Preferred Provider Panel, benefits will be reduced to the out-of-network benefit level. Currently, the ODS Preferred Dental Provider Panel includes approximately 600 dentists throughout the state.

NOTE: There is a waiting period for some individuals on the ODS plans. The waiting period applies to coverage for family members if:

- You enroll previously eligible dependents during Open Enrollment.
- You remove a family member from your dental plan for any period of time and re-enroll them during Open Enrollment.
- You and your spouse or domestic partner are both eligible PEBB members enrolled individually on the dental plan. Only you currently cover your children. You add the children to your spouse's or domestic partner's dental plan during Open Enrollment.

The waiting period does not apply to family members if:

- You enroll them as soon as they are eligible (e.g., within 60 days of your date of hire).
- You enroll them because of and consistent with a midyear plan change.
- You change from one PEBB dental plan to another during Open Enrollment covering the same family members.

During the waiting period, coverage is limited to benefits for preventive dental exams and cleanings and the emergency treatment of pain for the first 12 months. Basic and major dental services are not covered for the first 12 months. Orthodontic services are not covered for the first 24 months.

ODS and Delta Dental

In addition to providing the largest network of dentists in the state, ODS is the Delta Dental Plan of Oregon, which gives members access to a network of more than 114,000 dentists nationwide. Our relationship with Delta Dental provides national coverage for PEBB members who may reside outside the state of Oregon.

To receive the maximum benefit level, members within the state of Oregon must seek services from **in-network providers**. The most current participating provider information for any state may be accessed through the ODS Web site for PEBB members at www.odscompanies.com/pebb. From the Provider Search drop down menu, select the "Delta Dental site" to begin a search. When at the Delta site, be sure you select the correct plan. Traditional and Part-time & Retiree plan members select DeltaPremier. Preferred members select DeltaPreferred when conducting a search.

Willamette Dental

The Willamette Dental Plan is a managed dental care plan. Plan members receive their dental treatment at one of the more than 60 Willamette Dental offices throughout Oregon, Washington, Idaho and Nevada (see below). You will select a primary care dentist to direct your dental care, yet you are also free to change Willamette Dental dentists or office locations at anytime.

For specialty treatment, including orthodontia, you will be referred to a Willamette Dental specialty provider. If your primary care dentist refers you to a provider outside of the Willamette Dental network then your co-payments will remain the same as listed on your Summary of Benefits.

To choose your dentist or schedule an appointment, call the Willamette Dental Appointment Center at:

Phone
(800) 461-8994
Schedule
Monday-Thursday: 7 a.m.-8 p.m. Friday: 7 a.m.-6 p.m. Saturday: 7 a.m.-4 p.m.

New patients are generally able to obtain their initial appointment within 30 days of their call to the Willamette Dental Appointment Center. Hygiene appointments generally have a wait-time of 45 days. Restorative treatment appointments generally have a wait-time of 60 days. These wait-times are averages. The length of wait-time for an appointment may vary based on your choice of provider, dental office location and your desired day or time of appointment.

Willamette Dental clinical professionals maintain one of the highest credentialing standards in the dental industry and each provider adheres to an evidence-based treatment philosophy. Their first priority is to diagnose and treat urgent conditions that pose an immediate threat to your oral health. The next priority is prevention; which means controlling the disease process, promoting wellness and helping you maintain good oral health.

At your first visit, you will receive a thorough examination that includes X-rays. Then, your dentist will develop a ***Personal Dental Care Plan*** based upon your overall dental health. Your dentist will then make recommendations for cleanings, restorations, and other preventive treatments needed to obtain optimal oral health.

Children will receive a cleaning at their first appointment and adults will receive their first cleaning after the initial appointment.

Willamette Dental provides emergency services 24 hours a day, 365 days a year. If you experience an emergency situation (pain, bleeding or swelling), then you will be able to see a dentist within approximately 24 hours if necessary.

If you have a dental emergency while traveling outside of the Willamette Dental service area, you may go to any licensed dentist to obtain emergency treatment; relief from pain, bleeding, or swelling. Upon arriving home, you will contact their Patient Relations Department at (800) 460-7644 for reimbursement up to $150. You will need to schedule your follow-up care with your Willamette Dental primary care dentist.

For more information about Willamette Dental visit www.WillametteDental.com/pebb.

Locations

Idaho
Boise
Coeur d'Alene
Idaho Falls
Meridian
Nampa
Pocatello
Twin Falls

Oregon
Albany
Beaverton
Bend
Corvallis
Eastport
Eugene
Grants Pass
Gresham
Hillsboro
Jefferson
Lincoln City
Medford
Milwaukie
North Bend
Portland
Roseburg
Salem
Springfield
Stark
Tigard
Tillamook
Tualatin

Washington
Bellevue
Bellingham
East Vancouver
Everett
Federal Way
Hazel Dell
Kent
Kennewick
Lakewood
Longview
Lynnwood
Northgate
Olympia
Pullman
Puyallup
Renton
Richland
Seattle
Silverdale
Spokane
Tumwater
Vancouver
Wenatchee
West Tacoma
Yakima

Nevada
Reno

Health Fact

Thirty minutes of exercise every day can help you maintain a healthy weight.

SECTION 4: OPTIONAL PLANS

PEBB offers eligible employees the opportunity to select optional benefits. This section provides a summary of each option:

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

The state provides no benefit amount toward the cost of optional benefits. Optional benefits are voluntary choices you purchase on your own. Monthly premium payments or deposits for these benefits are your responsibility. When optional insurance benefits become effective, the insurance premium is deducted from your pay, and your pay stub or statement shows the monthly deductions. When deposits to flexible spending accounts become effective, you will also see a deduction in your pay stub or statement.

When can I select optional benefits?

Newly hired or newly eligible employees have 60 days from the date of hire or eligibility date to enroll

Current employees may enroll or change optional benefits during Open Enrollment

You may enroll in or make changes to your benefits midyear if you experience a qualified change that affects your eligibility for those benefits.

Eligible individuals may apply for long term care insurance anytime throughout the year.

This section will help eligible employees know:

- What optional benefits are available to them
- How and when they can enroll or change benefits
- The premium rates for optional benefits
- Optional benefit plan features

Optional plan life insurance or long term care insurance may require approval of a medical history statement or evidence of insurability form.

If I'm currently enrolled for optional benefits, do I have to re-enroll during Open Enrollment?

Only for one option – flexible spending accounts. If you currently participate in flexible spending accounts and you want to continue in the coming year, you must re-enroll during Open Enrollment. If you don't re-enroll, your dependent care and healthcare flexible spending account will stop with the year's last payroll deduction.

During Open Enrollment, what is the quickest way to make changes?

The quickest and easiest way to check your benefits and make any changes is online at https://pebb.benefits.oregon.gov/members. This secure online benefit management system is available for all eligible employees to make changes during the Open Enrollment period. When you make online changes, you receive a benefit confirmation at the end of your enrollment process.

Employees have the opportunity to select optional benefits.

What if I don't have access to online enrollment?

You may enroll using paper forms. Submit 2008 enrollment forms to your agency no later than October 31. The forms are available from your agency or the PEBB Web site.

What if I want to change optional insurance benefits during the year?

Except for long term care, you must have a QSC event to enroll in or make changes to optional insurance benefits during the plan year (see page 17). You may apply to make changes to or enroll in long term care insurance at any time.

- **Life and Disability:** Complete the Life and Disability Update form. Submit the completed form to your agency.
- **Flexible Spending Accounts:** Complete the Flexible Spending Account Update form. Submit the completed form to your agency.

What are the effective dates for optional benefits?

- **Open Enrollment:** January 1 of the new plan year, unless the plan must review the medical history statement or evidence of insurability. Changes are then effective the first of the month following the carrier's approval, but no sooner than the beginning of the new plan year. Decreases need no approval and the effective date is January 1.
- **New hire or newly eligible employee:** The first of the month following your online enrollment or following your agency's receipt of your completed enrollment forms, unless the plan must review the medical history statement or evidence of insurability.
- **Midyear Change:** The first of the month following receipt of the completed form by your agency, or the date of the midyear change, whichever is later, unless the plan must review the medical history statement or evidence of insurability.

How will I know if my enrollments or changes were processed?

If you enroll online as a new hire or during Open Enrollment, print a copy of your benefit confirmation statement after you complete the online enrollment process.

If you make eligible changes during the year, you can print your statement from the online system after your agency enters the changes. All employees will see deductions for their optional benefits on their pay stub or statement.

NOTE: Life insurance and long term care insurance enrollment may be delayed pending the plan's medical approval.

Remember to review the first pay stub or statement of the new plan year, and monthly after that to confirm that enrollments and deductions are correct.

Optional Life Insurance

Beyond the $5,000 basic life insurance coverage provided for all eligible employees, you may enroll in optional life insurance coverage with The Standard Insurance Company (Standard). You must self pay for this coverage; the state does not provide a benefit amount for this coverage. Eligible employees with optional life insurance coverage who retire may be able to continue or convert their coverage (see page 58).

What types of life insurance coverage are available?

- Employee, spouse or domestic partner
- Dependent ($5,000 value limit)

Is optional employee, spouse or domestic partner life insurance considered term life?

Yes. Term life insurance means that the insurance benefit is payable only if the insured person dies during a specified period. The beneficiary receives the benefit payment if the insured person dies while covered under the policy. This type of insurance does not accumulate any kind of cash value.

How much optional employee, spouse or domestic partner life coverage can I apply for?

- You and your spouse or domestic partner receive guaranteed issue coverage of $20,000 if you enroll within 60 days of your hire date or within 60 days of initial eligibility. You do not need to submit a Medical History Statement for Guaranteed issue amounts.
- You and your spouse or domestic partner may each apply for coverage from $20,000 to $400,000 in $20,000 increments. (You must submit a Medical History Statement.)
- If your spouse or partner is also a state employee, the combined amount of coverage per person cannot exceed $400,000.

Optional Dependent Life Insurance

What is optional dependent life insurance?

PEBB offers employees the opportunity to purchase life insurance that covers **all eligible dependents**, including a domestic partner or spouse, a $5,000 benefit per dependent. You do not need to submit a medical history for this coverage.

What does it cost?

You must self pay for this coverage; the state does not provide a benefit amount toward this benefit. The total cost is $1.29 per month for any number of dependents. The premium payment is deducted monthly after taxes are deducted from your pay.

Is this considered term life insurance?

Yes. The benefit is payable if the insured dies during a specified period. This type of insurance does not accumulate cash value. You are the beneficiary.

When can I apply?

- **During Open Enrollment.** The benefit is effective January 1 of the new plan year.
- **As a newly hired employee.** The benefit is effective the first of the month following the date you enroll online or your agency receives your completed enrollment form.
- **When you experience a midyear change.** The benefit becomes effective the first of the month following the date your agency receives your completed Life and Disability Update form.

When is a medical history statement required?

It is required if you:

- Enroll after 60 days of initial eligibility
- Request coverage of more than $20,000 (if enrolling at initial eligibility), or
- Wish to increase your existing coverage.

NOTE: Applications for coverage of $100,000 or more require physical and laboratory exams coordinated by Standard, at Standard's expense.

2008 Employee & Spouse or Domestic Partner Optional Life Insurance Monthly Premium Rates

Age	Thru-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 & up
AMOUNT											
$20,000	0.89	1.04	1.33	1.48	1.63	2.52	3.70	6.96	10.80	20.72	33.60
$40,000	1.78	2.07	2.66	2.96	3.26	5.03	7.40	13.91	21.61	41.44	67.19
$60,000	2.66	3.11	4.00	4.44	4.88	7.55	11.10	20.87	32.41	62.16	100.79
$80,000	3.55	4.14	5.33	5.92	6.51	10.06	14.80	27.82	43.22	82.88	134.38
$100,000	4.44	5.18	6.66	7.40	8.14	12.58	18.50	34.78	54.02	103.60	167.98
$120,000	5.33	6.22	7.99	8.88	9.77	15.10	22.20	41.74	64.82	124.32	201.58
$140,000	6.22	7.25	9.32	10.36	11.40	17.61	25.90	48.69	75.63	145.04	235.17
$160,000	7.10	8.29	10.66	11.84	13.02	20.13	29.60	55.65	86.43	165.76	268.77
$180,000	7.99	9.32	11.99	13.32	14.65	22.64	33.30	62.60	97.24	186.48	302.36
$200,000	8.88	10.36	13.32	14.80	16.28	25.16	37.00	69.56	108.04	207.20	335.96
$220,000	9.77	11.40	14.65	16.28	17.91	27.68	40.70	76.52	118.84	227.92	369.56
$240,000	10.66	12.43	15.98	17.76	19.54	30.19	44.40	83.47	129.65	248.64	403.15
$260,000	11.54	13.47	17.32	19.24	21.16	32.71	48.10	90.43	140.45	269.36	436.75
$280,000	12.43	14.50	18.65	20.72	22.79	35.22	51.80	97.38	151.26	290.08	470.34
$300,000	13.32	15.54	19.98	22.20	24.42	37.74	55.50	104.34	162.06	310.80	503.94
$320,000	14.21	16.58	21.31	23.68	26.05	40.26	59.20	111.30	172.86	331.52	537.54
$340,000	15.10	17.61	22.64	25.16	27.68	42.77	62.90	118.25	183.67	352.24	571.13
$360,000	15.98	18.65	23.98	26.64	29.30	45.29	66.60	125.21	194.47	372.96	604.73
$380,000	16.87	19.68	25.31	28.12	30.93	47.80	70.30	132.16	205.28	393.68	638.32
$400,000	17.76	20.72	26.64	29.60	32.56	50.32	74.00	139.12	216.08	414.40	671.92

Your life insurance premium rate will increase when your age moves you into a new tier. The tier rate increases on January 1.

When can I enroll, and what are the life insurance plans' effective dates of coverage?

You must be actively at work on the effective date for life insurance to take effect. That means you must be physically on the job and receive pay for that date.

During Open Enrollment:

You may enroll in or increase employee and spouse or domestic partner coverage amounts.

- Enroll online or complete and submit enrollment forms to your agency.
- Complete and submit a medical history statement to Standard, which will approve or deny your enrollment based on your medical history.

New Hire Enrollment:

You must enroll within 60 days of your hire date.

- Enroll online, or complete and submit an enrollment form to your agency, which must be received within 60 days from your hire date.
- The first $20,000 of employee or spouse or domestic partner life coverage is guarantee issue and becomes effective the first of the month following the date you enroll online or your agency receives your completed enrollment form.
- Employee and spouse or partner life in excess of $20,000 ($40,000 to $400,000) **requires** completion of a medical history statement. Coverage is effective the first of the month following approval by Standard.

NOTE: Employee, spouse or domestic partner life insurance coverage becomes effective the first of the month following approval by Standard (no earlier than the beginning of the new plan year, if you enroll during Open Enrollment).

When can I make changes during the year?

If you experience a qualified status change, you may enroll in or increase or decrease the employee, spouse or domestic partner life insurance coverage amounts. Submit an update form to your agency. Complete and submit a medical history statement to Standard. Standard will approve or deny your enrollment based on your medical history.

Employee and spouse or partner life insurance is effective the first of the month following approval by Standard.

How is the premium deducted from my pay?

For employee life insurance, the premium is taken pretax up to the first $50,000 in coverage. This amount includes the basic life insurance premium.

For spouse or domestic partner life insurance, the premium is deducted post tax.

Who determines the beneficiaries?

You choose the beneficiaries. If you do not name your beneficiaries, the designation reverts to the standard designation. The standard designation pays benefits according to the chain of family beneficiaries established by Oregon law. It automatically accounts for such life changes as marriage, divorce, death, birth or adoption within your family.

You can make your beneficiary designations online at https://pebb.benefits.oregon.gov/members. If you choose to name your beneficiaries, you will need to enter:

- The person's (or trust's) legal name and relationship to you
- The whole-number percentage you wish the person to receive from your benefit
- Whether the person is a primary or a contingent beneficiary.

This designation will not change until you request a change.

What if my position terminates or I change employment?

If you lose benefit eligibility (for reasons other than total disability or retirement), you may continue or "port" your employee, spouse, or domestic partner life coverage. Portability rates for continued coverage are based on the existing active employee plan rates.

What if my spouse, partner or I become disabled or retire?

Employees, spouses or domestic partners who lose benefit eligibility due to a disability or retirement can convert to a whole life individual policy. A whole life policy provides coverage for an individual's whole life, rather than a specified term. You can apply for an individual policy of permanent life insurance without submitting evidence of insurability.

NOTE: You must apply for portability or conversion directly to Standard within 60 days of your coverage end date.

What are our options if we both work for the state and one of us loses benefit eligibility?

You may request that the employee, spouse or domestic partner life insurance coverage be rolled over to the active enrollment. It is not necessary to complete a medical history statement to roll over the benefit.

What happens to my premium payment if I become disabled?

If you become totally disabled before age 60 from all occupations while insured, your insurance premium payment may be waived, and your coverage may continue without further payment. For purposes of waiver of life insurance premium, insurance means the employee, spouse or domestic partner coverage (except coverage under the portability provision). Waiver of life insurance premium ends when your disability for all occupations ends, you fail to provide ongoing proof of eligibility, you fail to cooperate with the insurance company or you convert your life insurance.

What life insurance options do employees have when they retire?

The Standard Insurance Company guarantees your acceptance without submitting evidence of insurability **if** you enroll in conversion or continuation coverage within 60 days of when active coverage ends. Generally, you may enroll for an amount that does not exceed 50 percent of the amount of basic and optional life insurance in effect on the day before your retirement date. The benefit amount will decrease by percentages as you age. For conversion information, contact Standard.

If when you retire, your spouse or domestic partner is a state employee, you can roll over your current optional life insurance coverage premium to their payroll deduction for as long as your spouse or domestic partner continues state employment.

Remember, if you are enrolled for optional life insurance coverage as an employee, within 60 days of when your group coverage ends, you can:

- Continue up to 50 percent of the value of your employee life insurance without review of your medical history statement
- Convert your spouse and/or dependent life insurance to individual policies
- Convert your life insurance to individual policies
- Roll over your life insurance premium to your spouse's or domestic partner's payroll deduction if the spouse or partner works for the state.

NOTE: You must complete the Retiree Life Insurance Application and submit it directly to Standard. The application is available online at the PEBB Web site. You may also contact PEBB to request a copy of the application.

When does my optional life policy pay out?

The Standard plan pays benefits upon death from any cause (excluding suicide during the first two years of being insured).

NOTE: To file a claim, contact Standard or your agency and ask for a Life Insurance Benefit application.

What if my spouse, domestic partner or I become terminally ill?

If the insured individual becomes terminally ill (with a life expectancy of less than 12 months), he or she may elect a one-time, lump-sum benefit payment.

Are there any exclusions to my life insurance benefits?

Yes. Optional employee and spouse or domestic partner life insurance is not payable if death results from suicide or other intentionally self-inflicted injury, while sane or insane.

NOTE: This is a summary only. For details relating to the PEBB-sponsored life insurance, please review the group life insurance certificate. The certificate is available online at www.oregon.gov/das/pebb. You may also contact PEBB to request a copy of the certificate.

2008 Retiree Life Insurance Monthly Premium Rates

Age	Thru 49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 plus
AMOUNT									
$10,000	$2.70	$4.05	$4.95	$6.75	$13.50	$22.50	$33.75	$51.30	$73.80
20,000	5.40	8.10	9.90	13.50	27.00	45.00	67.50	102.60	147.60
30,000	8.10	12.15	14.85	20.25	40.50	67.50	101.25	153.90	221.40
40,000	10.80	16.20	19.80	27.00	54.00	90.00	135.00	205.20	295.20
50,000	13.50	20.25	24.75	33.75	67.50	112.50	168.75	256.50	369.00
60,000	16.20	24.30	29.70	40.50	81.00	135.00	202.50	307.80	442.80
70,000	18.90	28.35	34.65	47.25	94.50	157.50	236.25	359.10	516.60
80,000	21.60	32.40	39.60	54.00	108.00	180.00	270.00	410.40	590.40
90,000	24.30	36.45	44.55	60.75	121.50	202.50	303.75	461.70	664.20
100,000	27.00	40.50	49.50	67.50	135.00	225.00	337.50	513.00	738.00
110,000	29.70	44.55	54.45	74.25	148.50	247.50	371.25	564.30	811.80
120,000	32.40	48.60	59.40	81.00	162.00	270.00	405.00	615.60	885.60
130,000	35.10	52.65	64.35	87.75	175.50	292.50	438.75	666.90	959.40
140,000	37.80	56.70	69.30	94.50	189.00	315.00	472.50	718.20	1033.20
150,000	40.50	60.75	74.25	101.25	202.50	337.50	506.25	769.50	1107.00
160,000	43.20	64.80	79.20	108.00	216.00	360.00	540.00	820.80	1180.80
170,000	45.90	68.85	84.15	114.75	229.50	382.50	573.75	872.10	1254.60
180,000	48.60	72.90	89.10	121.50	243.00	405.00	607.50	923.40	1328.40
190,000	51.30	76.95	94.05	128.25	256.50	427.50	641.25	974.70	1402.20
200,000	54.00	81.00	99.00	135.00	270.00	450.00	675.00	1026.00	1476.00

Your life insurance premium rate will increase when your age moves you into a new tier. The tier rate increases on January 1.

Short Term Disability Insurance

PEBB sponsors short term disability insurance through Standard. This insurance may replace a portion of your income should you become disabled. **(It is available to employees, only. It is not available to seasonal and intermittent employees.)** You must self pay for this coverage; the state does not provide a benefit amount toward this benefit.

What does the short term disability insurance plan cover?

The benefit covers 60 percent of your **weekly** pre-disability earnings (not to exceed weekly earnings of $2,769), reduced by deductible income (see page 63). The maximum weekly benefit is $1,662 before reduction of deductible income. The minimum **weekly** benefit is $25 per week following reduction of deductible income. If you are disabled less than one week, the benefit is 1/7 of the weekly benefit for each day you are disabled.

How are taxes taken?

The premium is deducted from your pay after taxes. The benefit payment is not taxed.

What is the waiting period?

"Benefit Waiting Period" is the amount of time you must wait before you start receiving a weekly payment from Standard after you become disabled. Your benefit-waiting period is A, B, or C, whichever is longest.

For more information about pre-existing conditions, see the short term disability insurance certificate online at the PEBB Web sit

Short Term Disability Benefit Waiting Period	
A	7 days if your disability is caused by sickness or pregnancy.
B	0 days if your disability is caused by accidental injury.
C	The period ending the day before you were scheduled to return to work, if your disability begins while you are scheduled to be away from work. **Example:** You are on a scheduled vacation leave beginning October 1 and scheduled to return to work October 10. You injure yourself on October 5 and, because of your injury, your physician will not allow you to return to work until November 5. The last day of your benefit waiting period is October 9. You will receive disability benefits from Standard beginning October 10 through November 4, as long as you continue to be disabled.
	Weekly Coverage 60% of first $2,769 of weekly earnings minus deductible income; maximum $1,662 weekly before reduction by deductible income
	Benefit Duration Four weeks if pre-existing condition; 13 weeks maximum. If disabled for less than a week, 1/7 of benefit for each day disabled.

What is the premium rate?

The premium rate is 0.0057 x your monthly salary.

Example:

You choose enrollment in the short term disability insurance.

Your gross monthly salary (before any deductions):	$2,000.00
Rate for short term disability premium:	X 0.0057
The premium amount you pay each month:	$11.40

Long Term Disability Insurance

How does this plan work?

PEBB sponsors long term disability insurance through Standard. This insurance may replace a portion of your income should you become disabled. It is available to employees, only. **Seasonal and intermittent employees are not eligible.** You must self pay for this coverage; the state does not provide a benefit amount for this benefit.

How are taxes taken?

The premium is deducted from your pay after taxes. The benefit payment is not taxed.

What is the waiting period?

The benefit waiting period is the amount of time you must wait before you start receiving a weekly payment from Standard after you become disabled. It is either 90 or 180 days, depending on the option you choose, as shown in the table below:

How long does the benefit period last?

Your maximum benefit period is determined by your age when disability begins, as follows:

Age	Max Benefit Period
61 or younger	To age 65, or 3 years 6 months, if longer
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

SECTIO Optional

2008 Long Term Disability Insurance Overview

Monthly premium = rate X monthly salary

Option	Rate	Waiting Period	Coverage	Maximum/Minimum
1	$0.0054	90 days	60% of first $12,000	$7,200 before reduction of
2	$0.0020	180 days	minus deductible income	deductible income/ $50
3	$0.00990	90 days	66 2/3% of first $12,000	$8,000 before reduction of
4	$0.0030	180 days	minus deductible income	deductible income/ $50

Here is an example to illustrate your long term disability choices:

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

Your gross monthly salary (before any deductions):	$1,900.00
Premium:	X 0.0054
Premium amount your pay each month:	$10.26

When can I enroll in or request an increase in disability insurance?

There are three times when you may enroll or increase:

- Within 60 days of your date of hire or eligibility
- Yearly during Open Enrollment
- Within 60 days of a QSC (see page 17).

How do I enroll for disability insurance?

During Open Enrollment and as a newly hired employee or newly eligible member:

- Complete the electronic enrollment, or
- Submit an enrollment form to your agency.

If you enroll because of a QSC, you must submit an update form to your agency.

What are the effective dates of coverage?

Newly Eligible Employees: The first of the month following either completion of the electronic enrollment, or after your agency receives your enrollment form.

During Open Enrollment: the first day of the new plan year.

QSC: The first of the month after your agency receives your completed update form. The effective date can be no earlier than the date of your QSC.

What happens if I'm on leave or otherwise not working when my disability plan is scheduled to go into effect?

All disability coverage is subject to the actively at work requirement. For purposes of disability insurance, you are actively at work **if**

1. You are physically on the job **and**
2. Receiving pay for the first scheduled day of work **and**
3. Performing the material duties of your own occupation at your employer's usual place of business.

If you are incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or its increase will not become effective until the day after you complete one full day of active work as described above.

Can I continue disability when I retire or otherwise leave state service?

No. When you end employment, you end participation in PEBB's short term and long term disability plans.

NOTE: PEBB members may also be eligible for disability benefits through the Public Employees Retirement System (PERS) disability retirement plan. Contact PERS for information.

Enhanced Disability Plan Features

The Standard Insurance Company offers enhanced long term and short term disability features beginning in 2008. Review the plan certificates on the PEBB Web site for more information on the following features.

What are the new Long Term Disability features?

Rehabilitation Plan. You may be able to be in an approved rehabilitation plan, which could pay training, family care and job-related expenses.

Family Care Expense Adjustment. If you pay for a family member's care so you can go back to work, this program may help you keep more benefit dollars.

Assisted Living Benefit. Employees with severe long-term disabilities may get a one-time assisted-living benefit of up to $5,000.

Return to Work Incentive. This benefit change may increase the disability benefit you could receive when you return to work.

What are the new Short Term Disability features?

Claims by phone. In 2008 members may submit short term disability claims by telephone to Standard. Submitting these claims by telephone streamlines the claims process and helps speed payment to members.

What are the new Short and Long Term Disability features?

Reasonable Accommodation Expenses. This benefit may pay up to $25,000 of employer costs for workspace changes that help you get back on the job.

Pre-existing Condition Period. The plans will have a pre-existing condition period of 12 months of being insured with a "look back" for subsequent conditions of three months.

What are insured earnings?

For purposes of determining your payable disability benefit, insured earnings are based on your earnings in effect on your last full day of work. When your insured earnings increase (e.g., with a pay increase), your premium rate increases. Insured earnings do not include overtime pay, bonuses, or dollars received when you opt out of medical coverage.

What is deductible income?

Deductible income means other income you are eligible to receive because of your disability.

Deductible income includes:

- A portion of your earnings from work while disabled
- Sick leave or other salary continuation, including donated leave (but not including vacation or personal business leave)
- A portion of the benefits you are eligible to receive under any other group disability program. This includes state disability income benefits, including public employees retirement system
- **For members employed by the Oregon University System**, benefits you are eligible to receive under any employer-sponsored individual disability policy arranged for individuals in a common group
- Workers' compensation benefits
- Social Security benefits payable to you and your dependents.

How do I file a disability claim?

If you want to file a short term disability claim, you can call Standard beginning Jan. 1, 2008. To file a claim for long term disability benefits, please contact your agency to obtain a disability claim packet. You may also print a copy of the claim packet from PEBB's Web site.

What are the plans' limitations and exclusions?

Review the group short and long term disability insurance certificates. The certificates are available online on the PEBB Web site. You may also contact PEBB to request a copy of the insurance certificate.

Accidental Death & Dismemberment Insurance

The accidental death and dismemberment (AD&D) plan provides 24-hour coverage for accidental loss of life, limb, hand, foot, hearing, speech, sight or thumb and index finger (of the same hand). You may select a coverage amount from $50,000 to $500,000, in increments of $50,000.

Who is eligible to enroll and when?

You can purchase AD&D insurance for you alone or for you and your eligible dependents.

You may enroll:

- **Within 60 days of your date of hire.** The effective date is the first of the month following the date your agency receives the form or the date of your electronic enrollment.
- **During Open Enrollment.** The effective date will be the first of the new plan year.
- **Within 60 days of and consistent with a QSC.** The effective date is the first of the month following receipt of the correct form by your agency or the QSC event, whichever is later.

What are the benefits upon filing a claim?

The amount of coverage you elect for yourself — the principal sum — is payable as follows:

- 100 percent of the principal sum is paid for the following accidental losses:
  - Life
  - Both hands or both feet or sight of both eyes

  Or any two or more of the following accidental losses:
  - One hand or one foot
  - One hand or one foot and sight of one eye
  - Speech and hearing.
- 50 percent of the principal sum is paid for the following accidental losses:
  - Sight of one eye
  - One hand or one foot
  - Speech or hearing
- 25 percent of the principal sum is paid for accidental loss of thumb and index finger of either hand.

When a claim is filed on a dependent, the payable benefit is equal to a percentage of your employee AD&D insurance as follows:

- Spouse or domestic partner only — 50 percent
- Children only — 15 percent for each child
- Spouse or domestic partner and children — 40 percent for spouse or partner, 15 percent for each child.

The maximum benefit payable for all losses caused by the same accident will not be more than the principal sum.

What are the plan features and exclusions?

Review the insurance certificate on the PEBB Web site for details regarding plan features and exclusions.

What are the rates?

2008 Accidental Death and Dismemberment Premium Rates

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

Flexible Spending Accounts

A Flexible Spending Account (FSA) is a tax-free account that allows you to use pre-tax dollars to pay for your out-of-pocket prescriptions, medical, dental, vision or childcare expenses. As an eligible employee, you can enroll in both a Healthcare FSA and a dependent care FSA. By paying for expenses with pre-tax dollars, **you may save at least 25% on every dollar that is set aside** on money you were going to spend anyway.

FSAs help you save on taxes.

Effective January 1, 2008, ASIFlex will be the new administrator of the FSA program. ASIFlex offers next-business-day claims processing, payments by direct deposit into your bank account and a new FSA debit card (for use with the Health Care FSA only).

How do the programs work?

There are three easy steps to receiving the tax advantage allowed by the FSA program:

1) **Enroll.** You must enroll each year in the program, even if you do not want your deduction amounts to change from year-to-year.
2) **Incur expenses.** This means that you must have services provided that give rise to the expense, not just be billed or pay for an expense. You incur, expenses when you go see your doctor, fill a prescription or have childcare services provided.
3) **Submit a claim to ASIFlex for reimbursement, or use your Flex Debit Card (for Health FSA expenses only) to access your pre-tax dollars.** All reimbursements are tax-free!

Do I have to enroll each year?

Yes, if you want to take advantage of the tax savings, you must actively re-enroll in the FSA program each year during open enrollment.

NOTE: ***PEBB cannot give you tax advice. If you need additional information or assistance relating to your own tax situation, please contact an attorney, accountant or other tax advisor.***

Who is eligible for to enroll in PEBB's FSA?

- Eligible employees
- COBRA participants (for healthcare FSA only, and only if there was money in the account at the time of the COBRA event).

Who is not eligible to enroll?

- Retirees
- Other self-pay participants

When can I enroll and when is it effective?

You may enroll:

- **Within 60 days of your initial date of hire.** The account goes into effect the first day of the month following your enrollment.
- **During Open Enrollment.** The account becomes effective the first day of January.
- **Within 60 days of, and consistent with, a qualified status change (QSC).** The account goes into effect the first of the month following receipt of the form or the QSC, whichever is later.

What are some important things to remember about an FSA?

- When you enroll, you enroll for the entire plan year, so please plan accordingly.
- You may change your contribution amount midyear only within 60 days of a QSC.
- Your annual election amount is deducted evenly from each paycheck over the course of the year. Don't forget that this money will be deducted free from tax.
- Contributions to your account automatically terminate if you end employment with the state. Coverage for qualifying expenses ends at the end of the month in which you make your last contribution.
- If you terminate employment with the state, no contribution is taken from your termination pay check. Notify your payroll office as soon as you know you will be leaving state service.

- Only expenses incurred during your active participation in the FSA plans will be eligible for reimbursement after you terminate employment. *Please note that the word incurred refers to the services that are provided.*
- You must plan your expenses in advance. You forfeit any funds that you cannot use for valid expenses or file a claim for by the deadline to file. Expenses must be submitted by March 31, following the close of the previous plan year.
- PEBB has adopted the FSA grace period that extends coverage for each 12 month plan year to 14 ½ months. The FSA grace period runs from January 1 through March 15 of the new plan year. If your account is active and you have funds left on December 31, the grace period allows you to incur eligible expenses and submit claims for reimbursement using the previous year's available balance.

Healthcare FSA

How does a healthcare flexible spending account work?

A healthcare FSA helps you pay for eligible out-of-pocket healthcare expenses using pre-tax dollars to significantly increase your purchasing power. Eligible expenses include most of the medical, dental and vision services, and drug costs not fully covered in PEBB plans, as well as other expenses such as over-the-counter medications, massage therapy, chiropractic work and many more. (Please visit www.asiflex.com for a detailed list of eligible expenses and to link to IRS Publication 502 for qualifying expenses.)

Expenses for any of your tax dependents are eligible for reimbursement through the healthcare FSA program, even if the dependents are not covered in your health plans. Expenses for domestic partners are not covered unless your domestic partner qualifies as a dependent under IRS rules.

Additional Healthcare FSA Features

- The annual contribution limit for PEBB's Healthcare FSA is $5,000. If your spouse also has a healthcare FSA, your individual contribution limit is still $5,000.
- You have access to your total annual election on your first day of coverage in the healthcare FSA. (This is Jan. 1, unless you have entered the plan during the year.)
- For orthodontic expenses, you must submit a copy of the contract (treatment plan) to ASIFlex. Claims will be denied if a copy of the contract is not on file. Once the contract is on file, you may submit monthly claim forms for reimbursement as the payments are made, with proof of payment.
- Under COBRA rights, you may continue your Healthcare FSA if you have a positive balance in the account at the time of the COBRA event. All deposits made during the COBRA coverage period are made on a post-tax basis.

You may have alternative tax-related options under current IRS rules. Please see your tax professional for additional guidance.

How should I estimate how much to deposit?

Because the FSA program is an annual program, you should plan your annual election amount based upon the actual dollar amount you anticipate spending on eligible healthcare expenses in the coming plan year. Consider known, predictable, reoccurring expenses for all family members.

- You can use the worksheet and list of estimates to help decide the amount to elect.
- Ask your pharmacy and healthcare providers for a printout of your current year expenses
- Review your receipts, insurance forms, credit card statements and cancelled checks to determine your expected expenses for the upcoming year
- Consider any new expenses you are likely to incur in the coming year (such as LASIK surgery or large dental expenses such as crowns, root canals, etc.)
- Use ASIFlex's Online Tax Savings Calculator if you want an estimate of your savings

Healthcare FSA Estimate Worksheet Anticipated annual expenses for you and your dependents	Estimated amount
Coinsurance, co-payments and deductible	$
Dental expenses (crowns, root canals, routine examinations, etc.)	$
Monthly orthodontia expense (see restrictions in the above section)	$
Prescription drug expenses	$
Eyeglasses, contact lenses, solution, etc	$
Chiropractic and massage therapy expenses	$
Over-the-counter meds (Most non-vitamin and supplement items are eligible. See ASIFlex's web site for specific qualifying items.)	$
Annual Total (cannot exceed $5,000)	$
Divide by 12 (except for new hires) for monthly amount	$

Example of potential savings

A PEBB member receives a $3,000 per month salary. The after-tax take home pay amount is $2,100. The member pays $200 per month for healthcare services and supplies – dollars that taxes were paid on. Now, the actual monthly income shrinks from $2,100 to only $1,900. If the member opens a healthcare FSA, the monthly $200 spent on healthcare is not taxed. The take home pay is $1,960, which means a monthly savings of $60!

See below for complete comparison

Tax Savings Comparison		
	Without Healthcare FSA	With Healthcare FSA
Gross monthly salary	$3,000	$3,000
Pretax FSA deposit	$0	-$200
Adjusted monthly salary	$3,000	$2,800
Taxes, calculated at 30%	$900	$840
Net take-home pay	$2,100	$1,960
After tax medical expenses	$200	$0
Spendable monthly income	$1,900	$1,960
Annual Savings ($1,960-$1,900)*12 months = $720		

What medical expenses can I use my Healthcare FSA funds for?

Partial list of qualified medical expenses:

- Deductibles, co-pays & coinsurance
- Doctor's fees
- Prescription glasses & contact lenses
- Orthodontia (see specific requirements)
- LASIK surgery
- Prescription drugs & insulin
- Over-the-counter meds (used to treat an existing medical condition)
- Speech & physical therapy

Your FSA cannot be used for:

- Insurance premiums and warranties
- Cosmetic procedures (such as face lifts, teeth bleaching, veneers, hair replacement, etc.)
- Clip-on or non prescription sunglasses
- Toiletries
- Long-term care expenses
- Vitamins, supplements or nutritional supplements used for general health and not used to treat a specific medical condition

Check out www.asiflex.com for more eligible expenses or contact ASIFlex directly at (800) 659-3035 with questions.

Dependent Care FSA

How does a dependent care flexible spending account work?

A dependent care FSA helps you pay for eligible dependent care expenses with pre-income-tax salary dollars. Please note that the Dependent Care Flexible Spending Account is typically used for childcare expenses, but it can also be used to pay for expenses for older dependents who require someone to come into the home and help with day-to-day living in order for you to be gainfully employed.

You can set up a dependent care FSA if you are:

- Single with an eligible dependent, and the expenses are necessary for you to work
- Married with an eligible dependent, and the expenses are necessary for both you and your spouse to work
- Married with an eligible dependent, and your spouse is either disabled, actively seeking employment or a full-time student at least five months during the year

NOTE: Dependent Care FSA participants cannot claim expenses that they incur when they are not working.

What expenses qualify for reimbursement through a dependent care FSA?

IRS regulations specify that the following expenses qualify for reimbursement through a Dependent Care Spending Account:

- For the care and well-being of dependent children under the age of 13
- For the care of a disabled dependent of an eligible employee, who is incapable of self-care and who lives with the employee and spends at least eight hours per day in the employee's home
- Reimbursement will be made only for services already provided.

What are the Dependent Care FSA maximum participation amounts?

- If you are single: $5,000/year
- If you are married and filing taxes jointly: $5,000/year
- If you are married and filing taxes separately: $2,500/year
- If you are married with a spouse who is disabled or a full-time student: $250/month for one child in care or $500/month for two or more children.

If you or your spouse earns less than the amounts shown above, the maximum amount you may deposit is either your monthly income or your spouse's monthly income, whichever is lower.

If you and your spouse both participate in a dependent care FSA (through the same or different employers), the maximum you can contribute as a household to the Dependent Care FSA is $5,000 per year.

When you use a dependent care FSA to pay for your dependent care expenses, your use of the Federal and Oregon child care tax credits is limited. Please contact your tax advisor for more information on which program would best benefit you for day care.

You are welcome to submit claims that exceed the available balance in your account, as long as the services have already been provided; ASIFlex will automatically issue reimbursements for funds that you have already contributed through payroll. Unlike the healthcare FSA, you will only receive reimbursement up to the amount you have already contributed to the dependent care FSA.

Please note that you cannot submit claims for services that have not yet been provided. So, for example, if you want to submit claims one month at a time, you cannot submit a claim for January's childcare services until the end of January. You are welcome to submit claims as frequently as you would like (weekly, biweekly, monthly, etc.) for the service dates that have already been provided.

NOTE: For Oregon University System Employees: Your number of contributions per year is based on the number of regular paychecks you receive in the year. For more information, contact your benefits office.

How should I plan for my dependent care FSA?

Because this is a **"use it or lose it"** account, you must carefully estimate how much you will spend on dependent care during the year.

Listed below are examples of eligible and ineligible expenses. For detailed information on expenses, contact ASIFlex or review more information available at www.asiflex.com, including IRS Publication 503.

Eligible:

- A licensed or registered day care facility or nursery school
- Care provided in your home by someone who is not a tax dependent
- Before and after school care for children under the age of 13
- General day camps for children under the age of 13
- Home or day care for eligible IRS tax dependents (must spend at least eight hours per day in your home)

Ineligible:

- Educational fees or tuition (including kindergarten)
- Overnight camps
- Food, activity fees or other separately billed expenses
- Enrichment programs (such as dance, sports or music lessons)
- Care provider by an IRS tax dependent or your child under the age of 19, even if they are not your tax dependent
- Care provided that is not directly related to work

Because this is a **"use it or lose it"** account, you must carefully estimate how much you will spend on dependent care during the year.

Filing for Reimbursement

How do I access my pre-tax dollars?

You may print a copy of the claim form at the ASIFlex's Web site and submit the claim to ASIFlex via mail or toll-free fax, or you may use your Flex Debit Card to pay for certain eligible health care expenses (the Flex Debit Card cannot be used for dependent care FSA expenses). ASIFlex processes and pays claims by the business day following receipt. Authorizing payments into your bank account by direct deposit will speed up your receipt of payment. The authorization form is sent with your initial notice from ASIFlex and is available on ASIFlex's Web site.

To submit a paper claim for reimbursement for your:

Healthcare FSA. Complete a claim form and include documentation from an independent third party that includes:

1. Date(s) of service *(please note this is different from payment or billing date)*
2. Provider information
3. Description of the service
4. Amount charged
5. The name of the person for whom the service was provided

Dependent Care FSA. Complete a claim form and either:

a. Attach a receipt from the provider that includes:

1. The date of dependent care services
2. Provider information
3. Description of the service
4. Amount charged
5. The name of the person(s) for whom the service was provided

Or

b. Complete the claim form and have the dependent care provider sign the provider section on this form. No additional documentation or receipts are required if the provider signs this section.

The IRS does not accept cancelled checks or credit card receipts as proof of expense.

How do I appeal denial of an FSA claim?

If your claim is denied, you must appeal the claim denial to ASIFlex. The company will send you a notification of the denied claim with the specific reasons for the denial. The notification may advise you of what steps you might take in order to receive reimbursement for your claim or will provide explicit details as to why your claim was denied.

Your written appeal should:

- State the reasons why you believe the claim should receive approval.
- Include any additional facts and/or documents that support your claim.
- Include any comments that you wish considered during your case review.

NOTE: ***If you do not appeal within 30 days of a denial notice, you will lose your right to appeal.***

An individual who was previously not involved in your claim will review and determine the result of your appeal. The appeal decision will be made within 60 days. You will receive a notice of claim denial when the claim remains denied, which will provide:

- Specific reason(s) for the decision
- Specific plan provision(s) on which the decision is based
- A statement of your right to review (on request and at no charge) relevant documents and other information

A description of any specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on, and a copy to you free of charge upon your request.

What's the FSA grace period?

Before the FSA grace period, if you didn't incur the same level of out-of-pocket healthcare costs during the year as you had deposited in your account, you lost access to the remaining balance on Jan. 1. You could still be reimbursed for expenses you had through Dec. 31 as long as you submitted claims by the March 31 deadline. But you couldn't use leftover funds for expenses incurred after December 31.

With the new grace period, you can now incur expenses incurred through March 15 of the next plan year to use any remaining funds from the previous plan year. Please see the example below for clarification.

Example 1

Kristen has $50 remaining in her medical FSA at the end of the year and has no more expenses to submit with dates of service during the actual plan year. Two weeks after the end of the plan year, Kristen goes to her dentist and incurs a charge of $145. She submits a claim to ASIFlex. ASIFlex processes the claim, and $50 is automatically applied to the remaining balance from the previous plan year first, and $95 is applied to the new plan year's available balance.

Example 2

Kristen submits the claim for her $145 in dental expenses, but, knowing that she has a charge from the hospital for services provided during the past year, but has not received the statement yet, Kristen wants the entire $145 to be applied to the current year. Kristen includes a note with the claim packet asking to apply the entire dollar amount to the new plan year. ASIFlex's claim processor applies the entire $145 reimbursement request to the new plan year.

2008 Plan Year FSA Schedule

Event	Date
Enroll for 2008 FSA (Open Enrollment)	Oct. 1-31, 2007
Start of 2008 Plan Year	Jan. 1, 2008
End of 2008 Plan Year	Dec. 31, 2008
Start of 2009 Plan Year	Jan. 1, 2009
2008 Plan Year Grace Period	Jan. 1-March 15, 2009
2008 Plan Year Claims Deadline	Marc 31, 2009

ASIFlex Flex Debit Card

The **Flex Debit Card** is a convenience to access your **Healthcare FSA Funds** at health care providers and at retail outlets that have an IRS-approved Inventory Control System. The card only works at healthcare providers or retail outlets as described below. The dollar amount loaded on the card is tied directly to your available Health Care FSA balance, and each purchase you make with the card pays this provider from available funds in your Health Care FSA.

The IRS considers the following merchants to be healthcare providers:

- Hospitals
- Health Clinics
- Medical Labs
- Dental Offices
- Pharmacies
- Optometrists

Additionally, the card will work at retail outlets that have an Inventory Control System in place. The Inventory Control System restricts purchases with your Flex Debit Card to eligible FSA expenses. Currently, only WalMart/Sam's Club, Walgreens and drugstore.com have the Inventory Control System in place, but this list is expected to grow considerably by January 1, 2008.

As a general rule of thumb, the Flex Debit Card will not work at pharmacies located inside of a grocery store or discount store unless the Inventory Control System is in place.

How do I get a Flex Debit Card and how much does it cost?

The debit card is optional and has a restricted use, so you must complete an application if you want to receive a Flex Debit Card. The applications will be included with your welcome packet after you enroll for the Health Care FSA program, or you will be able to download them from PEBB's Web site after November 1. It usually takes about seven to 10 business days for you to receive your card once ASIFlex receives your application. There are no costs for you to receive a Flex Debit Card.

How does the Flex Debit Card work?

When you receive your card, you will activate it by calling a phone number on the card to activate use of the remaining amount in your Health Care FSA for the plan year. This means that if your available amount is $1,000 when you activate the card, your Flex Debit Card will be programmed for $1,000. The total available amount is available on the day you activate your card, subject to some daily use limits set by the card system ($2,500 per day).

Even though it's called a debit card, you must always select the "credit" option when you swipe the card to pay for an expense. **There is no PIN number to use with the card.**

If I use my Flex Debit Card, do I have to send supporting documentation to ASIFlex?

Maybe. The IRS has strict rules about how the card is used and when follow-up documentation is required. There are certain instances where the IRS requires follow-up documentation and more specific information will be provided to you in your welcome packet. However, if you use the card at any store that has the Inventory Control System in place, you should never be required to submit follow-up documentation to substantiate your purchases. If you use your card at one of these places and attempt to purchase a bottle of Tylenol (FSA eligible) and a six pack of soda (not FSA eligible), the card will pay for the Tylenol with your pre-tax dollars and then you will have to provide a separate form of payment for the soda.

That being said, for tax purposes, you should always keep all receipts for purchases you make with the Flex Debit Card in the event that you asked for documentation by ASIFlex or are audited by the IRS.

ASIFlex Contact Information

Phone: (800) 659-3035
Toll-free Fax: (866) 381-9682
Mailing Address: PO Box 6044
Columbia, MO 65205-6044

Web site: www.asiflex.com
E-mail: asi@asiflex.com

ASIFlex's Customer Service Center is available to FSA participants from 5 a.m. to 5 p.m. Pacific Time, Monday through Friday and from 7 a.m. to 11 a.m. on Saturday.

Long Term Care Insurance

Long term care insurance (LTC) covers care for substantial assistance with activities of daily living. Coverage is available for PEBB members and their enrolled family members. UnumProvident provides PEBB's LTC. You must self pay for this coverage; the state does not provide a benefit amount toward this benefit.

Coverage provides a monthly benefit based on the amount of coverage purchased. You use the money to meet the needs that you decide are most important. You never need to submit a record of your expenses, and you receive the full benefit payment even if it is larger than your expenses.

Who is Eligible?

- Eligible employees
- Spouses or domestic partners
- Parents and grandparents of the employee or of the employee's spouse or domestic partner
- Adult siblings or adult children of the employee or the employee's spouse or domestic partner
- Non-Medicare eligible retirees and retirees' spouse or domestic partner.

How do I enroll?

Applicants may enroll in, change or cancel long term care insurance at any time during the year; however:

- Newly eligible employees can enroll for a $4,000 monthly benefit with a benefit duration of six years as a guarantee issue. Application beyond this 60-day period requires submission of a medical history statement for review by the plan's underwriting.
- For $5,000 or $6,000 monthly benefit or unlimited duration coverage, all individuals, including newly eligible employees, must complete a medical history statement.
- Family member enrollment is subject to medical underwriting at all times.

To obtain an enrollment kit, contact your agency, PEBB or UnumProvident.

When does coverage go into effect?

Newly eligible employees enrolling in guarantee issue within 60 days of their eligibility date will have an effective date of the first of the month following submission of the forms or the eligibility dates, whichever is later.

Enrollments requiring medical underwriting are effective the first of the month following approval by UnumProvident.

What are the plan features?

Base Plan

- Facility benefit amount : $1,000 for three years
- Long term care in assisted living facility, adult foster care home and residential care facility at 60 percent of facility benefit amount
- Professional home care at 50 percent of facility benefit amount
- Elimination or waiting period: 90 days (satisfied only once per lifetime).

Additional Plan Options

- Facility monthly benefit amount: $2,000, $3,000, $4,000, $5,000* or $6,000*
- Benefit duration: three years, six years or unlimited*
- Total home care: 50 percent of facility benefit amount
- Inflation protection: Five percent simple uncapped yearly.

*Above the guarantee issue limits. Requires completion of UnumProvident's medical underwriting process.

Lifetime Maximum: The lifetime maximum is the maximum benefit dollar amount UnumProvident will pay over the life of your coverage. This dollar amount is based on the facility benefit amount and the benefit duration. For example, if you choose $3,000 facility benefit amount and three-year duration, your lifetime maximum is calculated as follows:

$3,000 per month x 12 months x 3 years =
$108,000 Lifetime Maximum

- **Guaranteed renewable:** for as long as you pay your premiums on time
- **Waiver of premium:** once you qualify for benefits, satisfy your elimination period, and are receiving benefits, your premium payments are waived
- **Tax-free benefit:** premium payments are not taxed.

When do I qualify for benefits?

You must meet one of the following criteria:

1. Require substantial assistance with two out of six activities of daily living (ADLs) for more than 90 days (elimination period). ADLs: bathing, toileting, dressing, transferring, continence, eating;
2. **Or** Suffer severe cognitive impairment that requires substantial supervision;

   And The ADL loss must be expected to last for a period of at least 90 days, as certified by a physician. (Recertification must occur every 12 months by a physician to confirm that the disability still exists.);

   And Care must be provided pursuant to a plan of care prescribed by a licensed healthcare practitioner.

How will I receive care?

In general, there are two ways you can receive care.

1. In a long term care facility, an assisted living facility, an adult foster care home or a residential care facility with an Alzheimer's care endorsement; or
2. At home, through professional home care, where care can be provided through a licensed home healthcare provider, or total home care, where care can be provided by anyone you choose, including family and friends.

The plan also covers respite care (see Glossary).

Does the plan have a pre-existing condition exclusion?

For guarantee issue coverage, the pre-existing condition exclusion applies. A pre-existing condition is any condition that exists for which you have received medical treatment, consultation, care or services (including diagnostic measures), or took drugs or medicines that were prescribed for the condition, during the six month period right before coverage begins.

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

What are the plan's limitations and exclusions?

For information on the plan's limitations and exclusions go online to **www.unumprovident.com/enroll/pebb**.

2008 Long Term Care Insurance Monthly Premium Rates

Rates shown are for $1,000 Monthly Facility Benefit. You may choose from $1,000 - $6,000 in Facility Monthly Benefit.
(**monthly premium** = monthly rate for plan chosen X facility monthly benefit amount per $1,000)

	Plan 1 Long Term Care Facility Professional Home Care			**Plan 2** Long Term Care Facility Professional Home Care Total Home Care			**Plan 3** Long Term Care Facility Professional Home Care Simple Inflation Uncapped			**Plan 4** Long Term Care Facility Professional Home Care Total Home Care Simple Inflation Uncapped		
Benefit Duration	**3 YR**	**6 YR**	**Unlim**	**3 YR**	**6 YR**	**Unlim**	**3 YR**	**6 YR**	**Unlim**	**3 YR**	**6 YR**	**Unlim**
AGE ↓												
18-30	2.20	2.90	4.00	3.40	4.50	6.40	3.70	4.90	6.80	5.50	7.40	10.50
31	2.20	3.00	4.00	3.40	4.60	6.50	3.80	5.00	6.90	5.60	7.60	10.70
32	2.20	3.00	4.20	3.40	4.70	6.60	3.80	5.20	7.20	5.70	7.80	11.10
33	2.30	3.10	4.20	3.50	4.80	6.70	4.00	5.50	7.30	6.00	8.10	11.40
34	2.40	3.20	4.30	3.60	4.90	6.90	4.20	5.60	7.60	6.20	8.40	11.70
35	2.50	3.30	4.50	3.70	5.10	7.10	4.30	5.90	7.90	6.40	8.70	12.20
36	2.50	3.40	4.60	3.80	5.20	7.30	4.50	6.10	8.10	6.60	9.00	12.50
37	2.60	3.60	4.80	3.90	5.40	7.60	4.70	6.40	8.60	6.90	9.40	13.10
38	2.80	3.70	4.90	4.10	5.60	7.80	5.00	6.70	8.80	7.20	9.80	13.60
39	2.90	3.80	5.20	4.30	5.80	8.20	5.20	6.90	9.20	7.50	10.10	14.10
40	3.00	4.00	5.40	4.50	6.10	8.50	5.40	7.20	9.60	7.80	10.50	14.70
41	3.10	4.10	5.60	4.70	6.30	8.90	5.70	7.50	10.10	8.20	11.00	15.30
42	3.30	4.40	5.80	4.90	6.60	9.20	5.90	7.90	10.50	8.50	11.60	16.00
43	3.40	4.60	6.10	5.10	6.90	9.60	6.20	8.20	11.00	8.90	12.00	16.60
44	3.60	4.80	6.40	5.30	7.20	10.10	6.50	8.70	11.50	9.30	12.70	17.40
45	3.80	5.10	6.70	5.60	7.60	10.60	6.90	9.10	12.10	9.80	13.20	18.30
46	3.90	5.30	7.10	5.90	8.00	11.20	7.10	9.50	12.50	10.20	13.80	19.00
47	4.10	5.60	7.40	6.20	8.50	11.80	7.40	9.90	13.00	10.60	14.50	20.00
48	4.40	5.90	7.80	6.60	9.00	12.50	7.80	10.40	13.70	11.30	15.30	21.10
49	4.60	6.10	8.10	6.90	9.40	13.10	8.10	10.80	14.30	11.80	16.00	22.10
50	4.80	6.40	8.60	7.30	10.00	14.00	8.50	11.30	14.90	12.40	16.90	23.30
51	5.10	6.80	9.00	7.80	10.50	14.80	9.00	11.90	15.70	13.10	17.70	24.60
52	5.40	7.20	9.50	8.30	11.20	15.70	9.50	12.50	16.40	13.80	18.70	25.80
53	5.80	7.60	10.10	8.80	11.90	16.70	10.00	13.10	17.20	14.60	19.70	27.40
54	6.10	8.10	10.60	9.30	12.70	17.70	10.40	13.70	18.00	15.20	20.70	28.70
55	6.50	8.60	11.10	9.90	13.50	18.70	11.00	14.50	18.70	16.10	21.70	29.80
56	6.90	9.10	11.90	10.50	14.40	20.00	11.60	15.30	19.90	16.90	23.00	31.80
57	7.40	9.80	12.70	11.30	15.40	21.40	12.40	16.30	21.00	18.00	24.40	33.70
58	7.90	10.50	13.60	12.10	16.50	23.00	13.10	17.20	22.20	18.90	25.80	35.60
59	8.60	11.20	14.60	13.00	17.70	24.60	14.00	18.40	23.50	20.30	27.50	37.90
60	9.30	12.10	15.60	13.90	18.90	26.40	15.00	19.40	25.00	21.60	29.10	40.20
61	10.10	13.20	17.00	15.00	20.70	28.80	16.20	21.10	27.10	23.10	31.60	43.50

2008 Long Term Care Insurance Monthly Premium Rates (continued)

	Plan 1 Long Term Care Facility Professional Home Care			Plan 2 Long Term Care Facility Professional Home Care Total Home Care			Plan 3 Long Term Care Facility Professional Home Care Simple Inflation Uncapped			Plan 4 Long Term Care Facility Professional Home Care Total Home Care Simple Inflation Uncapped		
Benefit Duration	3 YR	6 YR	Unlim	3 YR	6 YR	Unlim	3 YR	6 YR	Unlim	3 YR	6 YR	Unlim
AGE ↓												
62	11.10	14.50	18.60	16.40	22.50	31.30	17.70	22.90	29.20	25.00	34.10	46.90
63	12.20	15.90	20.30	17.80	24.50	34.10	19.10	24.90	31.60	26.90	36.80	50.70
64	13.40	17.40	22.10	19.40	26.70	37.10	20.80	27.00	34.10	29.00	39.60	54.40
65	15.30	19.80	25.00	21.70	29.80	41.50	23.50	30.30	38.20	32.20	43.90	60.40
66	16.90	21.90	27.80	23.60	32.60	45.40	25.80	33.30	41.90	34.80	47.70	65.70
67	18.90	24.30	30.70	25.90	35.70	49.50	28.30	36.40	45.70	37.60	51.50	70.80
68	20.90	26.90	34.00	28.20	38.90	54.10	30.80	39.60	49.80	40.60	55.70	76.60
60	23.20	29.70	37.50	30.90	42.50	59.00	33.70	43.10	54.30	43.80	59.90	82.40
70	25.70	32.90	41.40	33.70	46.50	64.50	36.80	47.20	59.20	47.30	64.80	89.10
71	28.50	36.50	46.00	37.00	51.00	70.70	40.50	51.80	64.90	51.50	70.60	97.10
72	31.60	40.50	50.80	40.50	55.90	77.20	44.60	57.00	71.20	56.00	76.80	105.00
73	35.10	44.70	55.90	44.50	61.30	84.30	48.80	62.10	77.50	60.80	83.30	113.80
74	38.80	49.50	61.60	48.70	67.10	91.90	53.60	68.20	84.60	66.00	90.40	122.80
75	46.80	59.50	74.00	58.10	80.10	109.40	63.80	80.80	100.20	77.90	106.60	144.50
76	51.40	65.30	81.20	63.20	87.20	119.10	69.10	87.60	108.70	83.80	114.70	155.60
77	56.40	71.70	89.10	68.70	94.90	129.50	75.30	95.40	118.20	90.50	123.90	168.00
78	61.90	78.60	97.40	74.80	103.30	140.70	81.50	103.10	127.50	97.20	133.30	180.30
79	68.00	86.10	106.60	81.40	112.40	152.80	88.70	112.20	138.60	104.90	144.00	194.50
80	74.70	94.50	116.70	88.60	122.30	165.90	96.00	121.20	149.40	112.80	154.60	208.50
81	82.30	103.80	128.00	96.80	133.50	180.50	105.10	132.20	162.70	122.30	167.50	225.20
82	91.30	115.00	141.40	106.60	146.90	198.00	114.70	144.20	177.00	132.70	181.90	243.80
83	100.90	126.80	155.50	117.20	161.30	216.70	125.80	157.80	193.10	144.90	198.20	264.70
84	111.20	139.40	170.30	128.40	176.70	236.10	136.40	170.90	208.40	156.50	214.10	284.70

Health Fact

Did you know gardening for 30 to 45 minutes burns about 150 calories?

SECTION 5: REQUIRED NOTICES

Continuation Coverage Rights Under COBRA

This section provides notice of your:

- Continuation coverage rights under COBRA
- Special enrollment rights
- Women's health and cancer rights
- Prescription drug coverage and Medicare
- Privacy rights from PEBB

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

COBRA continuation coverage can become available to you when you would otherwise lose your group health plan coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health plan coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. The Plan Administrator is the Public Employees' Benefit Board (PEBB), located at 775 Court Street NE, Salem, OR 97301- 3802. You can contact PEBB at (503) 373-1102 or (800) 788- 0520. COBRA continuation coverage for the Plan is administered by BenefitHelp Solutions (BHS), PO Box 67240, Portland, OR 97268-1240. You can contact BHS at (503) 765-3581 or (800) 556-3137.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your spouse or domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of that event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the employer within 60 days after the qualifying event occurs. The employer must provide this notice to BenefitHelp Solutions (BHS), PO Box 67240, Portland, OR 97268-1240. You can contact BHS at (503) 765-3581 or (800) 556-3137.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that the Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended. Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must make sure that the Plan Administrator is notified of the determination at the end of the 18-month period of COBRA continuation coverage. This notice should be sent to BenefitHelp Solutions (BHS), PO Box 67240, Portland, OR 97268-1240. Second qualifying event extension of 18-month period of continuation coverage.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being

eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation rights should be addressed to BenefitHelp Solutions (BHS), PO Box 67240, Portland, OR 97268-1240. You can contact BHS at (503) 765-3581 or (800) 556-3137, or PEBB at (503) 373-1102 or (800) 788-0520. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

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

Notice of Special Enrollment Rights

If you are declining 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 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact PEBB at (503) 373-1102 in Salem or (800) 788-0520 statewide, or e-mail inquiries.pebb@state.or.us.

Notice of Women's Health and Cancer Rights

If you or your insured dependent is receiving benefits in connection with a mastectomy and you or your insured dependent, in consultation with the attending physician, elects breast reconstruction, coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Reconstruction benefits are subject to the same provisions as any other benefit provided under the Plans.

Important Notice from the Public Employees' Benefit Board About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Public Employees' Benefit Board (PEBB) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **PEBB has determined that the prescription drug coverage offered by its medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.**

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to join a Medicare drug plan and drop your PEBB prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

If you drop your PEBB group coverage with Regence BlueCross BlueShield of Oregon PPO, Kaiser Permanente HMO or Added Choice POS, Providence Choice PPO, or Samaritan Select PPO and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription drug coverage in your area.

You should also know that if you drop or lose your coverage with PEBB and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage…

Contact the person listed below for further information. **NOTE:** You will get a notice each year. You will also get one before the next period you can join a Medicare drug plan, and if this coverage through PEBB changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	February 15, 2007
Name of Entity/Sender:	PEBB
Contact – Position/Office:	Benefits Office
Address:	775 Court St NE, Salem, OR 97301
Phone Number:	(503) 373-1102, (800) 788-0520

Public Employees' Benefit Board Notice of Privacy Practices

We Care About Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY PEBB AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Public Employees' Benefit Board (PEBB) and the PEBB sponsored benefit plans respect the privacy of personal information about all eligible employees and retirees (PEBB Members), including eligible family members (together, PEBB Participants), and will maintain confidentiality in a responsible and professional manner.

PEBB sponsors various benefit plans for the benefit of PEBB Members. Some of these benefit plans fall under the definition of "Health Plans" under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. The regulations address the privacy requirements related to the use of protected health information when PEBB is acting as a Plan Sponsor in relation to a Health Plan. PEBB is providing PEBB Members with this notice explaining how it uses, discloses and protects your medical or health information as a Plan Sponsor.

A separate Notice of Privacy Practices will be provided to you by your Health Plans.

For purposes of this notice, your **Protected Health Information ("PHI")** is information that identifies PEBB Participants and relates to a past, present or future physical or mental health condition; the provision of health care to you; or the past, present, or future payment for health care furnished to the PEBB Participant. PEBB is required by law to maintain the privacy of PHI and to provide PEBB Members with this notice of its legal duties and privacy practices with respect to PHI.

This notice does not apply to PEBB in its capacity of administering benefits that are not for health care benefits, such as life insurance, short term or long term disability insurance, long term care insurance, or accidental death & dismemberment insurance.

How information is collected and protected

As the Plan Sponsor, PEBB must collect a certain amount of PHI to provide customer service, offer new benefits, plans, products or services, administer its plans, and to fulfill legal and regulatory requirements. PEBB also collects information provided when the PEBB Member enrolls or makes changes to benefits. Examples include:

1. PHI on enrollment forms and related forms, such as name, address, date of birth, Social Security number, gender, marital status.
2. PHI about your relationship to benefit plans, including plans selected and enrollment and disenrollment information, and appeals about eligibility and contract coverage issues.
3. Information from employer about eligibility dates.
4. PHI from visits to PEBB's Web sites, such as that provided through online forms, and online information-collecting devices known as "cookies". Cookies enable the site to remember who visits so navigating the site is easier. They also permit you to access your secured information and conduct secured transactions. PEBB does not record personal or sensitive information in cookies.

This information is stored in the electronic benefit system, called "pebb.benefits". Your information is provided to the Health Plans you select for benefit coverage. The Health Plans collect and use this information to administer benefits and to pay claims for services PEBB Participants receive. PEBB ensures the security of your information through physical, technical and procedural safeguards. PEBB restricts the access to and use of confidential information by employees and has established internal policies and procedures to protect member confidential information from unauthorized disclosure.

How information is used or shared by PEBB

As the Plan Sponsor, PEBB transmits enrollment information to the Health Plans selected by the PEBB Member. Information is transmitted electronically through the pebb.benefits system. Health Plans may disclose to PEBB information on whether an individual is participating in the plan, or is enrolled or has been disenrolled from the plan.

In accordance with the HIPAA privacy regulations, PEBB provides for adequate separation between the Plan Sponsor and the Health Plans with regard to the use and disclosure of PHI. For that purpose, access to PHI for use as a Plan Sponsor is limited to the following employees or classes of employees of PEBB or designated individuals:

- Director of Operations;
- Benefit Manager;
- PEBB's Designated Consultants; and
- Internal Auditors, including representatives of the Oregon Secretary of State when performing Health Plan audits, or the Department of Justice.

Access to PHI by the employees designated above is limited to the administrative functions that the employees perform for PEBB with regard to the member's plan.

Plan administration functions that may involve PHI being provided to PEBB include the appeals under PEBB rules, where the individual asks PEBB to review a denial of insurance coverage or a PEBB Member asks PEBB to decide if the Health Plan acted in accordance with PEBB's contract. Otherwise, PEBB is not involved in individual or member appeals.

PEBB will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit administered by PEBB.

The Health Plans may disclose summary health information to PEBB, if PEBB requests summary information for the purpose of (a) obtaining, terminating, or amending the agreements for providing coverage; or (b) modifying, terminating or amending the agreements. PEBB does not have access to your PHI held by a Health Plan. If you contact PEBB and provide PHI to PEBB, PEBB will refer that information to the Plan.

Your authorization is required for uses and disclosures of PHI other than those allowed or required by law. If you provide authorization for the use and disclosure of your information and later change your mind, you may revoke the authorization.

Review and access to information

PEBB Participants have the right to access PHI held by PEBB, receive a list of disclosures PEBB has made of PHI, request restriction on use or disclosure of PHI, or correction of incorrect information. You may submit a complaint if you believe PEBB has improperly used or disclosed your PHI or if you have concerns regarding PEBB's privacy policies.

- PEBB Members may access, inspect and obtain a copy of their records through the electronic benefit system, pebb.benefits.
- PEBB Participants may ask to review any information you believe may be on file at PEBB by submitting a written request with your signature to the PEBB Benefits Manager. PEBB will respond to the request within 30 days. PEBB will either schedule an appointment for review of records on-site in the PEBB office, or will provide a photocopy of the requested record. PEBB may ask for reimbursement of copies made at your request.
- PEBB Participants may ask that PEBB restrict the use and disclosure of your individual information in the course of PEBB activities on your behalf; and to amend incorrect information held by PEBB.

PEBB Members may correct information in your PEBB file by accessing their record in the electronic benefit system, pebb.benefits during Open Enrollment, by submitting a Qualified Status Change (QSC) to your agency or to PEBB, or by filing an appeal. Any other request to correct information or to request a restriction should be made in writing to the PEBB Benefits Manager. PEBB will consider the request, although PEBB is not required to agree to the request.

- You may request an accounting of disclosures of your personal information in writing to the PEBB Benefits Manager. PEBB will provide a list of disclosures within 30 days of receipt of your request; however the list does not have to include PHI disclosures made to individuals about their own PHI or prior to the HIPAA compliance date.
- PEBB Participants have a right to receive a paper copy of this notice upon request at any time. Log on to http://oregon.gov/das/pebb/privacy.shtml to access this notice.
- If you have any questions about this notice, contact the PEBB Benefits Manager.

  PEBB Benefits Manager
  775 Court Street NE
  Salem, Oregon 97301-3802
  Phone: 504.373.1102 or 503.378.3964
  Toll-free: 800.788.0520

If you believe PEBB has inappropriately disclosed your confidential information, you may file a written complaint with the PEBB Administrator.

PEBB Administrator
775 Court Street NE
Salem, Oregon 97301-3802
Phone: 504.373.1102 or 503.378.3964
Toll-free: 800.788.0520

- You may appeal to the full Board if the issue is not resolved at the Administrator level.
- You have the right to file a complaint regarding how PEBB uses confidential information with the Privacy Officer of the State of Oregon, Department of Administrative Services (DAS).

  DAS Privacy Officer
  155 Cottage St. NE
  Salem 97301-3972
  Phone: 503.945.7296
- You may also file a written complaint with the U.S. Department of Health and Human Services; Office of Civil Rights if you believe PEBB has violated your rights.

  Office for Civil Rights, Medical Privacy Complaint Division
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW, HHH Building, Room 509H
  Phone: 866-627-7748 TTY 866-788-4989
  E-mail: OCRComplaint@hhs.gov

PEBB will not take any action against you for filing a complaint.

Changes to our notice

This notice is effective on January 1, 2008. PEBB is required to abide by the terms of this notice until it is changed. We reserve the right to change the terms of this notice and to make the new notice effective for all PHI we maintain. Once revised, we will notify you that a change has been made through the PEBB Member newsletter and post the notice on our web site at http://oregon.gov/das/pebb.privacy.shtml.

SECTION 6: GLOSSARY

Affidavit of Dependency. A written document in which an eligible employee attests that the dependent meets PEBB dependent eligibility criteria. *Available online and from PEBB or your agency.*

Affidavit of Domestic Partnership. A written document kept on file by the agency, in which an employee and another individual attest to meeting partnership criteria. *Available online and from PEBB or your agency.*

Agency. An administrative division of Oregon government that includes a payroll, personnel or university benefits office.

Benefit Amount. The amount of money paid by a PEBB participating organization on behalf of active eligible employees for the purchase of benefit plans.

Coinsurance. The cost of a covered service that is shared by the plan and by the member, typically expressed in percentages; e.g., 80% plan and 20% member. The provider typically bills the member after the plan has paid.

Co-payment (or co-pay). A fixed dollar amount (e.g., $10) paid by the member to the provider at the time of service.

Deductible. A dollar amount of expenses the member must pay before the plan pays.

Dependent child. Following is only a summary of PEBB's definition of "dependent child." See OAR 101-010-0005 for the complete rule.

A dependent child must be either:

- A biological or adopted child, or a child placed for adoption with the employee or the employee's spouse or domestic partner; or
- A legal ward by court decree; a dependent by Affidavit of Dependency; or under the legal guardianship of the employee, or the employee's spouse or domestic partner.

The child:

- May not be married or have a domestic partner
- May not qualify as a dependent under IRS rules for anyone other than the eligible member
- May be treated as a dependent for the purpose of obtaining healthcare coverage by both parents who are divorced or legally separated.

A dependent child must also meet one of the following criteria. The child:

- Is under the age of 19 at the end of the calendar year; or
- Is age 19 up to 24 and meets the IRS definition of a dependent child attending school full time (which excludes foreign students); or
- Is age 19 up to 24 and the eligible member provides or expects to provide more than half the child's support for the year, and the child lives in the eligible member's home for at least six months of the year; or
- Is age 19 up to 24 and is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability; or
- Is age 24 or older and is incapable of self-sustaining employment because of a developmental disability, mental illness or physical disability that existed before the child attained age 24. The child must have had continuous individual or group medical coverage prior to attaining age 24 and until the PEBB effective coverage date.

A child of a domestic partner who meets the definition of a dependent child is eligible to receive insurance coverage subject to imputed value tax. A valid Affidavit of Domestic Partnership must be on file with the agency for a domestic partner's child meeting the qualifications of a dependent child.

Domestic Partner. An eligible employee's unmarried partner of the same or opposite sex who, with employee, has a valid Affidavit of Domestic Partnership on file with the agency.

Emergency Care. Services and supplies furnished by a facility that are required to stabilize a patient with symptoms of such severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the individual's health (or the health of the fetus in the case of a pregnant woman) in serious jeopardy.

Formulary. A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Some institutions or health plans develop closed (i.e. restricted) formularies where only those drug products listed can be dispensed in that institution or reimbursed by the health plan. Other formularies may have no restrictions (open formulary) or may have certain restrictions such as higher patient cost-sharing requirements for off-formulary drugs.

Generic Drug. A drug whose patent has expired and that usually has a lower price than brand-name drugs still on patent. Members pay the least for generic drugs – from $1 to $10, depending on the plan, but not more than the cost of the drug.

Guarantee Issue. This means that you will not have to answer medical questions to purchase coverage up to the guarantee issue amount during this period.

Group Medical Plan or Other Group Coverage. For purposes of opting out of medical coverage: Any medical plan offered or contributed to by an employer or a former employer .

Half time. An eligible employee who works less than full time but at least:

- Assigned to a 0.5 FTE classified position and works at least 80 paid regular hours per month
- 0.5 FTE for Oregon University System (OUS) employees
- As defined by collective bargaining.

Health Maintenance Organization (HMO). A type of health plan in which members must receive all care from network providers, usually under the direction of a primary care physician (PCP), such as a family practitioner, internist or pediatrician. Members must work or reside in the HMO's service area.

Imputed Value. 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.

Maximum Benefit. The total amount payable by a plan for covered expenses. For example, the annual maximum benefit under ODS dental plans is $1,500 for the year for each person covered, and the lifetime maximum for medical care in Regence BlueCross BlueShield of Oregon medical plans is $2 million.

Medical History Statement. A form to be completed when Evidence of Insurability is required. It lists medical history statement questions to be answered by the applicant.

Member. An active employee of the employer, a COBRA or self-pay participant, or a retiree. Employees must meet the terms of eligibility outlined in the PEBB Administrative Rules.

Multisource non-preferred brand-name drug. A brand-name prescription drug not on the plan's formulary that has a generic version with the exact same therapeutic ingredient. PPO members pay the highest level of coinsurance for these drugs – the greater of $50 or 50 percent of the cost of the drug plus the difference in cost between the generic and non-preferred brand-name drug, but not more than the cost of the non-preferred brand drug. In the POS, members pay $20 plus the difference in cost between the generic and non-preferred brand-name drug. These drugs are not covered in the HMO.

Non-participating Provider. These are medical care providers and facilities that have no contract or agreement with a PPO plan. Non-participating providers generally bill members for all balances up to the billed charge that are not paid by the plan. Charges are reimbursed to members, not directly to providers.

Non-preferred brand drug. A brand-name prescription drug not on a plan's formulary. Members are responsible for a higher portion of the cost of these drugs.

Open Enrollment. A period designated by PEBB during which members are permitted to change their benefit choices.

Opt Out. An action taken by employees who are covered by another group medical plan to receive a cash payment to be determined by the Board in lieu of receiving medical insurance coverage through PEBB.

Out-of-pocket Maximum. The annual amount a member must pay for deductibles and coinsurance before the plan covers all remaining eligible expenses at 100 percent (referred to as "stop loss") for the remainder of the calendar year.

Participating Provider. For HMO plans, a medical care provider or facility that has agreed to discounted fees and other medical care management policies with the insurance company.

Participating Provider (non-preferred). These are medical care providers or facilities that have accepted the terms and conditions of the insurance company and agrees not to balance bill the participating members for covered services (non-preferred).

Plan Year. A period of 12 consecutive months as designated by the Board. Currently, the PEBB Plan Year is Jan. 1 through Dec. 31.

Portability of Medical Insurance. Ongoing medical coverage available from the employee's current medical plan after termination of coverage with the state. The employee cannot be eligible to enroll in Medicare and must have been enrolled in an Oregon-based medical group plan for at least six months immediately prior to termination of coverage; or if the employee has at least 18 months of prior medical insurance coverage with the most recent coverage being in an Oregon-based group plan.

Pre-authorization. An insurance plan requirement that covered services be approved by the plan prior to the date of service.

Pre-existing Condition. A physical or mental condition that was diagnosed or treated, or for which medication was prescribed or taken, in the six months before the effective date of coverage of a medical plan. A condition is diagnosed whenever a physician tells a person that he or she has that condition or makes an entry to that effect in the person's medical records. This diagnosis of condition applies even if the physician is examining or treating the person for a different condition. Currently, PEBB medical and dental plans elected during Open Enrollment impose no pre-existing condition limitations. However, specified benefits in certain circumstances such as transplants may impose a waiting period or limitation. For life and disability insurance coverage, it must be a mental or physical condition for which an individual has consulted a physician, received medical treatment or services or taken prescribed drugs or medication six months prior to the effective date of insurance.

Preferred Brand Drug. A brand-name drug on a plan's formulary.

Preferred Provider. For PPO (Preferred Provider Organization) plans, a medical care provider or facility that has agreed contractually to accept discounted fees as payment for covered services from the insurance company. No billing services above UCR (usual, customary and reasonable).

Preferred Provider Organization (PPO). A plan design that provides different benefit levels for services provided by preferred (network) providers and non-preferred providers who are not in the network. Members who choose care from preferred providers will pay less.

Qualified Status Change. A change in family or work status that allows limited, midyear changes to benefit plans consistent with the individual QSC.

Referral. When a provider refers a patient to another provider. In an HMO, the primary care provider makes any referrals, including those who substitute when the PCP will be unavailable, as well as any specialists who are also part of the HMO.

Respite Care. Services that provide people with temporary relief from tasks associated with caregiving (eg, in-home assistance, short nursing home stays, adult day care).

Spouse. A person of the opposite sex who is a husband or a wife. A relationship recognized as a marriage in another state 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 souse, and a former spouse does not qualify as a dependent.

Usual, Customary, Reasonable (UCR) Charges. UCR applies to fees that are:

- **Usual**. A fee that is not more than the provider's usual charge for a given service or supply.
- **Customary.** An amount within the range of usual charges for the service or supply billed by most providers of the same or similar service or supply in the service area.
- **Reasonable.** A usual or customary amount; or an amount that, because of unusual circumstances, inadequacy of data or other reasons is established on an individual basis.

Waiting Period. A designated period during which insurance benefits are excluded or limited.

- **For Dental Coverage:** In PEBB plans, a waiting period currently applies to dental insurance for the ODS dental plan policies. The waiting period applies when the spouse, domestic partner or dependent children are not enrolled when initially eligible and continuously covered on a PEBB dental policy by the employee who enrolled the individual when initially eligible. The waiting period also applies for those who are not covered for dental benefits for 12 months or more and are subsequently enrolled during Open Enrollment. The waiting period is 12 months for basic and major dental benefits and 24 months for orthodontic benefits. During the waiting period, coverage is provided for preventive services and relief of pain as defined by the plan. The waiting period is waived if the individual is added to dental coverage because of a qualified status change such as loss of other group coverage.
- **For Medical Coverage:** The medical plans may include benefit-specific waiting periods such as a 24-month exclusionary period for covered transplant procedures.

RESOURCE DIRECTORY

PEBB Resources

PEBB.Benefits
Online enrollment:
Web: https://pebb.benefits.oregon.gov/members

Public Employees' Benefit Board (PEBB)
775 Court Street NE, Salem, OR 97301-3802
Phone: (503) 373-1102, (800) 788-0520
Fax: (503) 373-1654
Web: www.oregon.gov/das/pebb
E-mail: inquires.pebb@state.or.us

ASIFlex
(Third-party Administrator for Flexible Spending Accounts)
P.O. Box 6044, Columbia, MO 65205-6044
Phone: (800) 659-3035, Fax: (866) 381-9682
Web: www.asiflex.com
E-mail: asi@asiflex.com

BenefitHelp Solutions (BHS)
(Third-party Administrator for Retiree, COBRA, Self-Pay & Semi-independent)
P.O. Box 67240, Portland, OR 97268-1230
Phone: (503) 765-3581, (800) 556-3137
Web: www.benefithelpsolutions.com
E-mail: pebb@benefithelpsolutions.com

Kaiser Permanente
(HMO, POS & Dental Plans)
500 NE Multnomah, Suite 100
Portland, OR 97232-2099
Phone: (503) 813-2000, (800) 813-2000
Web: my.kp.org/nw/pebb

Mail Order Pharmacies

Postal Prescription Service (PPS)
Phone: (800) 552-6694
Web: www.ppsrx.com

Walgreens Mail Service
Phone: (800) 797-3345
Web: www.walgreenshealth.com

The ODS Companies
(Dental Plans)
601 SW Second Avenue, Portland, OR 97204
Phone: (800) 452-1058
Web: www.odscompanies.com/pebb

Providence Choice
Administered by Providence Health Plan
(PPO Plan)
P.O. Box 3125, Portland, OR 97208-3125
Phone: (503) 574-7500, (800) 423-9470
Web: www.providence.org/pebb

Regence BlueCross BlueShield of Oregon (Regence)
(PPO Plan)
P.O. Box 1271, Portland, OR 97207-1271
Phone: (503) 220-3849, (800) 826-9813
Web: www.or.regence.com/pebb

Samaritan Select
Administered by Samaritan Health Plans
(PPO Plans)
Mailing Address: P.O. Box 1310
Corvallis, OR 97339
Physical Address: 815 NW 9th Street
Corvallis, OR 97330
Phone: (541) 768-6900, (800) 569-4616
Web: www.samaritanselect.com

The Standard Insurance Company
(Life & Disability Plans)
P.O. Box 2800, Portland, OR 97208-2800
Phone: (800) 842-1707 Disability
(800) 242-1888 General Information
Fax: (800) 227-4165
Web: www.standard.com

PEBB Resources

(continued)

UnumProvident

(Long Term Care Plan)
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122
Phone: (800) 227-4165
Web: www.unumprovident.com/enroll/pebb

VSP

(Vision Service Plan for PPO Members)
P.O. Box 997105, Sacramento, CA 95899-7105
Phone: (800) 877-7195
Web: www.vsp.com

Willamette Dental Insurance

(Dental Plan)
14025 SW Farmington Road, Suite 300
Beaverton, OR 97005
Phone: (800) 460-7644
Web: www.willamettedental.com/pebb

Other Resources

Internal Revenue Service

Phone: (800) 829-1040
Web: www.irs.gov

Medicare

Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Phone: (800) MEDICARE or (800) 633-4227
Web: www.medicare.gov

Oregon Medical Insurance Pool

C/O Regence BCBS of Oregon MSE10K
P.O. Box 1271, Portland, OR 97207-1271
Phone: (503) 225-6620, (800) 848-7280
Fax: (503) 553-5046
Web: www.omip.state.or.us

Public Employees Retirement System (PERS)

Mailing Address: P.O. Box 23700
Tigard, OR 97281-3700
Physical Address: 11410 SW 68th Parkway
Tigard, OR 97223

PERS Customer Service

Phone: (503) 598-7377, (888) 320-7377
Web: www.oregon.gov/PERS

PERS Health Insurance

Phone: (503) 224-7377, (800) 768-7377
Fax: (503) 765-3452
Fax (outside Portland): (888) 393-2943
Web: www.pershealth.com

PEBB Medical And Dental Update Form
Midyear Change Request
Instructions
www.oregon.gov/DAS/PEBB

Complete this form to make midyear changes to your medical and/or dental insurance. Please refer to the PEBB benefits handbook or web site for midyear change criteria.

- Submit one form per qualified status change (QSC).
- You will be notified of the coverage effective date.
- If you are adding an individual by affidavit, you must submit the appropriate affidavit **within 5 business days** of this enrollment. If not, coverage for the individual by affidavit will terminate retroactive to the effective date.

SECTION A - EMPLOYEE/SUBSCRIBER INFORMATION

- Complete all items in this section.
- If only a name and/or address change, complete Section A and D only.

SECTION B - QUALIFED STATUS CHANGE (QSC) INFORMATION

B.1 Select the change requested.
B.2, B.4, and B.5 Select the QSC and enter the QSC date.
Note: Processing of your request will not begin without the QSC date.
B.3 You must certify that your dependent children between the ages of 19-24 continue to meet the PEBB eligibility requirements**. If you do not certify, your dependent's enrollments will not be processed.**
.

SECTION C - COORDINATION OF BENEFITS

- Complete this section if you or your dependents have other coverage.
- You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read sign and date the form.
- Make a copy for your records and submit. **Sending your forms to the wrong address will delay your change**.

Active and Semi Independent Agency Employees:

Within 60 days of QSC to: Agency/University Payroll,
Personnel or Benefit Office

Beyond 60 days of QSC to: PEBB
775 Court Street NE
Salem, OR 97301-3802
Salem (503)-373-1102
Toll-free (800)-788-0520

COBRA and other Self-Pay Participants Only to:
BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503)-765-3581
Toll-free (800)-556-3137

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Medical And Dental Update Form
Midyear Change Request

SECTION A - EMPLOYEE/SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, University ID, Benefit #
DATE OF BIRTH (MM-DD-YYYY)		GENDER ☐ FEMALE ☐ MALE	
RESIDENCE ADDRESS ☐ New Address		CITY	STATE ZIP
		COUNTY	HOME PHONE
MAILING ADDRESS (if different from above) ☐ New Address		AGENCY	WORK PHONE
E-MAIL ADDRESS			

SECTION B - QUALIFIED STATUS CHANGE (QSC) INFORMATION

B.1 Change you are requesting to your coverage:

☐ **Add a Dependent - Complete Section B.2**

☐ **Remove a Dependent – Complete Section B.3**

☐ **Change your medical or dental plan – Complete Section B.4**

B.2 Add a dependent or domestic partner mid-year

☐ Marriage
Date:_____

☐ Met domestic partner eligibility. You must attach the Affidavit of Domestic Partnership if adding a partner or partner's children.
Date: _____

☐ Birth
Date:_____

☐ National Medical Support Notice (NMSN)
Date:_____

☐ Adoption or placement for adoption
Date:_____

☐ Dependent meets eligibility. You must attach the Affidavit of Dependency.
Date:_____

☐ Involuntary loss of other group coverage.
Date:_____

☐ Employment status change
Date:_____

☐ Other reason (describe): Date:_____
_____
_____
_____
_____

List *only* dependents added by this change. Check plan selections if applicable. Do not list current dependents.
Relationship Key: SP=Spouse, **DP**=Domestic Partner, **CH**=Employee and/or Spouse's child, **DP CH**=Domestic Partner's child, **AFF CH**=Child by Affidavit

Last Name	First Name	MI	ID Number	Birth Date	Relationship	Gender F M	Prior PEBB Member Yes No	Plan Med Dental
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐
						☐ ☐	☐ ☐	☐ ☐

B.3 Dependent certification – see instructions. Detailed eligibility information is available at www.oregon.gov/DAS/PEBB or in the 2008 PEBB Handbook.

☐ I certify that all my dependent children, between the ages of 19 – 24 meet the eligibilty requirements for enrollment in the PEBB plans.

B.4 Remove a dependent or domestic partner midyear:

☐ Divorce, Annulment Date:_____

☐ Death of a dependent Date:_____

☐ Termination of domestic partnership. Attach a Termination of Domestic Partnership form. Date:_____

☐ Dependent ceases to meet eligibility Date:_____

☐ Dependent gains other group coverage Date:_____

☐ Employment status change (describe): Date:_____

REQUIRED: NAME AND ADDRESS OF DELETED DEPENDENT(s) FOR COBRA PURPOSES:

1._____

_____

2. _____

_____

_____

B.5 Change benefits midyear:

☐ **OPT OUT OF PEBB MEDICAL PLANS** due to gaining other group medical coverage. If requested you must provide supporting documentation. **Must complete Section C**.
Date: _____

☐ **ENROLL IN PEBB MEDICAL PLANS** from opt out due to loss of other group medical coverage.
Date: _____

☐ **CHANGE MEDICAL OR DENTAL PLANS** due to:
☐ National Medical Support Notice (NMSN)
Date: _____

☐ Employment status change (i.e. full time to part time)
Date: _____

☐ Move out of current plan's service area.
Date: _____

Medical (select one):	Full-Time Plan	Part-Time Plan
☐ Opt out		
☐ Kaiser HMO	☐	☐
☐ Kaiser Added Choice	☐	☐
☐ Providence Choice PPO	☐	☐
☐ Regence BCBSO PPO	☐	☐
☐ Samaritan Select PPO	☐	☐
☐ Decline all PEBB plans		

Dental (select one):

☐ Kaiser Permanente Full-time
☐ ODS Preferred Option ☐ ODS Part-time & Retiree
☐ ODS Traditional ☐ Kaiser Part-time & Retiree
☐ Willamette

SECTION C - COORDINATION OF BENEFITS

Are any of the new dependents covered through another PEBB ☐ or another group ☐ plan? If yes, complete the following information:
☐ Medical ☐ Dental ☐ Pharmacy

Carrier	Group No
Policy No	Employer
Subscriber's Name	Effective Date: (mm-dd-yyyy)

Medicare Information – see instructions.
☐ I am covered by Medicare ☐ My dependent(s) is covered by Medicare

SECTION D - EMPLOYEE/SUBSCRIBER SIGNATURE AND AUTHORIZATION

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay, unless I self pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.

_____ _____
Employee/Subscriber Signature Date

"PEBB Use Only"

Approved By PEBB (initials): Date: Effective date: PDB updated by (initials):

PEBB Medical and Dental Enrollment Form
Non-Medicare Eligible Retiree & Non-Medicare Eligible Dependents
2008 Plan Year Instructions
www.oregon.gov/DAS/PEBB

Complete this form to enroll in retiree medical and/or dental coverage through the Public Employees' Benefit Board (PEBB) or to make a change in coverage during a Plan Change period. **If you or any of your dependents are eligible for Medicare, PEBB plan enrollment is not available.**

SECTION A - RETIREE OR SUBSCRIBER INFORMATION (subscriber is the member who is not the State of Oregon retiree but who is eligible to continue a PEBB plan)

- Complete each item in this section.
- **New Retiree only**: include your retirement date and the date your active insurance coverage terminated.

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS

- Check the box of the plan(s) you are selecting.
  B-1: Medical:
  B-2: Dental:
  Note: If you did not previously have a medical or dental plan, you cannot add a medical or dental plan during a Plan Change period.

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

- Complete each item in this section.
- You cannot add dependents during a Plan Change period.
- List all eligible dependents. **Dependents not listed will not be covered.**

SECTION D - DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

- Check the appropriate box.
  D.1: You must certify that your dependent children between the ages of 19-24 continue to meet the PEBB eligibility requirements**. If you do not certify, your dependent's enrollments will not be processed.**
  D.2: You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION E - RETIREE OR SUBSCRIBER SIGNATURE AND AUTHORIZATION

- Read this section carefully. Sign and date the form.
- Make a copy for your records and submit to:

BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503)-765-3581
Toll-free (800)-556-3137

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Medical and Dental Enrollment Form
Non-Medicare Eligible Retiree & Non-Medicare Eligible Dependents
2008 Plan Year

SECTION A - RETIREE/SUBSCRIBER INFORMATION (subscriber is not the State of Oregon retiree but eligible to continue)

☐ New Retiree	Retirement Date:	Active Coverage Term Date:	☐ Plan Change Period
☐ Subscriber (other than retiree)			

LAST	FIRST	MI	ID NUMBER (SSN, University ID, Benefit Number)

DATE OF BIRTH (MM-DD-YYYY)	GENDER ☐ FEMALE ☐ MALE		
RESIDENCE ADDRESS ☐ New Address	CITY	STATE	ZIP
	COUNTY	HOME PHONE	
MAILING ADDRESS (if different from above) ☐ New Address	AGENCY (Former)	E-MAIL ADDRESS	

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS

B-1 Medical (select one):	Full-Time Plan	Part-Time Plan
☐ No Coverage		
☐ Kaiser HMO	☐	☐
☐ Kaiser Added Choice	☐	☐
☐ Providence Choice PPO	☐	☐
☐ Regence BCBSO PPO	☐	☐
☐ Samaritan Select PPO	☐	☐

B-2 Dental (select one, only if you have had continuous dental coverage):

☐ No Coverage
☐ Kaiser Permanente Full-time
☐ ODS Part-time and Retiree
☐ ODS Preferred Option
☐ Kaiser Permanente Part-time & Retiree
☐ ODS Traditional
☐ Willamette

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

If you or a dependent is Medicare eligible, you are not eligible for PEBB coverage. List all eligible dependents you wish to cover and check plan selections. If covering a domestic partner, partner's children, or dependent by affidavit, a completed affidavit must be attached or on file. **Relationship Key**: **SP**=Spouse, **DP**=Domestic Partner, **CH**=Employee and/or Spouse's child, **DP CH**=Domestic Partner's child, **AFF CH**=Child by Affidavit

Last Name	First Name	MI	ID Number	Birth Date	Relationship	Gender F	Gender M	Prior PEBB Member Y	Prior PEBB Member N	Plan Med	Plan Dental
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

D.1 Dependent certification – see instructions. Detailed eligibility information is available at www.oregon.gov/DAS/PEBB or in the 2008 PEBB Handbook.

☐ I certify that all my dependent children, between the ages of 19 – 24 meet the eligibilty requirements for enrollment in the PEBB plans.

D.2 Medicare Information – see instructions

☐ I am covered by Medicare
☐ My dependent(s) is covered by Medicare

SECTION E - RETIREE/SUBSCRIBER SIGNATURE AND AUTHORIZATION

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. I agree to self-pay premiums. I agree to submit monthly payments by the date specified, or my coverage will terminate.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.

_____ _____

Retiree/Subscriber Signature Date

"PEBB Use Only"

Approved by PEBB (initials): Date: Effective Date: PDB updated by (initials):

PEBB Medical And Dental Enrollment Form
COBRA Participant
2008 Plan Year Instructions
www.oregon.gov/DAS/PEBB

Complete this form to make a change in coverage during Open Enrollment.

SECTION A – PARTICIPANT INFORMATION

- Complete each item in this section.

SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS

- Check the box of the plan(s) you are selecting.
  B.1: Medical:
  B.2: Dental:
  Note: COBRA part-time plans are only available to individuals who were previously enrolled in an active-part-time plan.

SECTION C – DEPENDENT INFORMATION AND PLAN SELECTION

- Complete each item in this section.
- List all eligible dependents you want to cover. **Dependents not listed on this form will not be covered.**
- If you are enrolling a domestic partner, a domestic partner's child or a child by affidavit, attach a completed Affidavit of Domestic Partnership or Affidavit of Dependency. Additional information and forms are available from BenefitHelp Solutions, the PEBB web site, and in the 2008 PEBB Handbook.

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

- Check the appropriate box.
  D.1: You must certify that your dependent children between the ages of 19-24 continue to meet the PEBB eligibility requirements**. If you do not certify, your dependent's enrollments will not be processed.**
  D.2: You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION E – PARTICIPANT SIGNATURE AND AUTHORIZATION

- Read this section carefully. Sign and date the form.
- Make a copy for your records and submit to:

BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503) 765-3581
Toll-free (800)-556-3137

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Medical And Dental Enrollment Form
COBRA Participants
2008 Plan Year

SECTION A - PARTICIPANT INFORMATION

LAST	FIRST	MI	ID NUMBER (SSN, University ID or Benefit Number)

DATE OF BIRTH (MM-DD-YYYY)

GENDER ☐ FEMALE ☐ MALE

RESIDENCE ADDRESS ☐ New Address

CITY | STATE | ZIP

COUNTY | HOME PHONE

MAILING ADDRESS (if different from above) ☐ New Address

E-MAIL

SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS

B-1 Medical (select one):	Full-Time Plan	Part-Time Plan
☐ No Coverage	☐	☐
☐ Kaiser HMO	☐	☐
☐ Kaiser Added Choice	☐	☐
☐ Providence Choice PPO	☐	☐
☐ Regence BCBSO PPO	☐	☐
☐ Samaritan Select PPO	☐	☐

B-2 Dental (select one):

☐ No Coverage
☐ Kaiser Permanente Full-time
☐ ODS Preferred Option
☐ ODS Traditional
☐ Willamette
☐ ODS Part-time and Retiree
☐ Kaiser Part-time and Retiree

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

List all eligible dependents you wish to cover and check plan selections. If covering a domestic partner, partner's children, or dependent by affidavit a completed affidavit must be attached or on file. **Relationship Key: SP**=Spouse, **DP**=Domestic Partner, **CH**=Employee and/or Spouse's child, **DP CH**=Domestic Partner's child, **AFF CH**=Child by Affidavit

Last Name	First Name	MI	ID Number	Birth Date	Relationship	Gender F	Gender M	Prior PEBB Member Y	Prior PEBB Member N	Plan Medical	Plan Dental
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

D.1 Dependent certification – see instructions. Detailed eligibility information is available at www.oregon.gov/DAS/PEBB or in the 2008 PEBB Handbook.

☐ I certify that all my dependent children, between the ages of 19 – 24 meet the eligibilty requirements for enrollment in the PEBB plans.

D.2 Medicare Information – see instructions.

☐ I am covered by Medicare
☐ My dependent(s) is covered by Medicare

SECTION E – PARTICIPANT SIGNATURE AND AUTHORIZATION

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. I agree to self-pay premiums. I agree to submit monthly payments by the date specified, or my coverage will terminate.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.

_____ _____

Participant Signature | Date

"PEBB Use Only"

Approved by PEBB (initials): Date: Effective date: PDB updated by (initials):

PEBB Medical And Dental Enrollment Form
Self Pay Participants
2008 Plan Year Instructions
www.oregon.gov/DAS/PEBB

Complete this form to enroll for medical and dental coverage through the Public Employees' Benefit Board (PEBB) or to make a change in coverage during Open Enrollment.

SECTION A – PARTICIPANT INFORMATION

- Complete each item in this section.
- Continuing participation: check the Open Enrollment box.

SECTION B – MEDICAL AND DENTAL PLAN ELECTIONS (You must have medical to enroll in dental)

- Check the box for the plan(s) you are selecting.
  B-1: Medical:
  Note: Blind Business Enterprise Participants: medical plan enrollment **only.**
  B-2: Dental:
  .

SECTION C – DEPENDENT INFORMATION AND PLAN SELECTION

- Complete each item in this section.
- List all eligible dependents. **Dependents not listed will not be covered.**
- If you are enrolling a domestic partner, a domestic partner's child or a child by affidavit, attach a completed Affidavit of Domestic Partnership or Affidavit of Dependency. Additional information and forms are available from BenefitHelp Solutions, the PEBB web site, and in the 2008 PEBB Handbook.

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

- Check the appropriate box.
  D.1: You must certify that your dependent children between the ages of 19-24 continue to meet the PEBB eligibility requirements. **If you do not certify, your dependent's enrollments will not be processed.**
  D.2: You must attach a copy of the Medicare card for each individual enrolled in Medicare.

SECTION E – PARTICIPANT SIGNATURE AND AUTHORIZATION

- Read this section carefully. Sign and date the form.
- Make a copy for your records and submit to:

BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503) 765-3581
Toll-free (800) 556-3137

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Medical And Dental Enrollment Form
Self Pay Participants
2008 Plan Year

SECTION A - PARTICIPANT INFORMATION

☐ New Participant—provide the date you became eligibile:	☐ OLCC Agent ☐ Post Docs/J1 Visa ☐ Blind Business Enterprise ☐ Foster Parent – you must attach a copy of the Foster Parent Certificate	☐ Open Enrollment

LAST	FIRST	MI	ID NUMBER (SSN, University ID, Benefit Number)

DATE OF BIRTH (MM-DD-YYYY)	GENDER ☐ FEMALE ☐ MALE		
RESIDENCE ADDRESS ☐ New Address	CITY	STATE	ZIP
	COUNTY	HOME PHONE	
MAILING ADDRESS (if different from above) ☐ New Address	AGENCY		
E-MAIL			

SECTION B - MEDICAL AND DENTAL PLAN ELECTIONS (Must have Medical Coverage to enroll in a Dental Plan):

B-1 Medical (select one):

☐ No Coverage
☐ Kaiser HMO
☐ Kaiser Added Choice
☐ Providence Choice PPO
☐ Regence BCBSO PPO
☐ Samaritan Select PPO

B-2 Dental (select one): Not all participants are eligible for dental. Please see instructions.

☐ No Coverage
☐ Kaiser Permanente
☐ Willamette
☐ ODS Preferred Option
☐ ODS Traditional

SECTION C - DEPENDENT INFORMATION AND PLAN SELECTION

List all eligible dependents you wish to cover and check plan selections. If covering a domestic partner, partner's children, or dependent by affidavit, a completed affidavit must be attached or on file**. Relationship Key**: **SP**=Spouse**, DP**=Domestic Partner, **CH**=Employee and/or Spouse's child, **DP CH**=Domestic Partner's child, **AFF CH**=Child by Affidavit

Last Name	First Name	MI	ID Number	Birth Date	Relationship	Gender F	Gender M	Prior PEBB Member Y	Prior PEBB Member N	Plan Med	Plan Dental
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐
						☐	☐	☐	☐	☐	☐

SECTION D – DEPENDENT CHILDREN CERTIFICATION AND MEDICARE INFORMATION

D.1 Dependent certification –see instructions. Detailed eligibity information is availabe at www.oregon.gov/DAS/PEBB or in the 2008 PEBB Handbook.

☐ I certify that all my dependent children, between the ages of 19 – 24 meet the eligiblity requirements for enrollment in the PEBB plans.

D.2 Medicare Information – see instructions.

☐ I am covered by Medicare
☐ My dependent(s) is covered by Medicare

SECTION E - PARTICIPANT SIGNATURE AND AUTHORIZATION

I declare that the individuals listed on the enrollment form and I are eligible for the coverage requested. I understand the benefit elections made on this application are in effect for as long as I continue to meet PEBB's eligibility requirements, or until I elect to change them subject to the provisions of PEBB's plan. I have read the benefit materials and I understand the limitations and qualifications of the PEBB benefits program. If necessary, I authorize premium payments deducted from my pay, unless I self pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages.

This form supersedes all forms and submissions I previously made for PEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.

_____ _____

Participant Signature Date

"PEBB Use Only"

Approved by PEBB (initials): Date: Effective date: PDB updated by (initials):

PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

775 Court Street NE
Salem, OR 97301-3802
www.oregon.gov/das/pebb

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