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.