DIVISION 1

PROCEDURAL RULES

**101-001-0000** Notice of Proposed Rule Changes
**101-001-0005** Uniform and Model Rules of Procedure
**101-001-0010** Insurance Plan Implementation Procedures
**101-001-0015** Disbursement of PEBB Fund Monies
**101-001-0020** Social Security Numbers

DIVISION 2

POWERS OF THE BOARD

**101-002-0005** Powers and Duties of the Board
**101-002-0010** Conduct of Meetings of the Board
**101-002-0015** Public Employees' Benefit Board Appeal Procedure and Delegation
**101-002-0020** Procedure to Appeal Determination of Coverage Issues by Insurance Carrier

DIVISION 5

RENEWAL, SCREENING AND SELECTION FOR BENEFITS AND CONSULTANTS CONTRACTS

**101-005-0010** Renewal, Screening and Selection for Benefit, Vendor and Consultant Contracts
**101-005-0020** Policy
**101-005-0030** Definitions
**101-005-0040** Procurement and Renewal Processes
**101-005-0050** Mistakes
**101-005-0060** Records Maintenance
**101-005-0070** Contract Amendments (Including Supplemental Work)
**101-005-0075** Pre-Proposal Conference
**101-005-0080** RFP Protest; Request for Change; Request for Clarification
**101-005-0090** Addenda to an RFP
**101-005-0100** Extension of Time for Acceptance of Proposal
**101-005-0105** Submission of Proposals; Format; Timing
**101-005-0110** Evaluation of Proposals
**101-005-0120** Rejection of a Proposal
**101-005-0130** Responsible Proposer
**101-005-0140** Protest of Contractor Selection, Contract Award

DIVISION 6

APPLICABLE PERSONAL SERVICE CONTRACT RULES

**101-006-0010** Applicable Personal Service Contract Rules
**101-006-0020** Renewal process for Consultant's Contracts

DIVISION 10

DEFINITIONS

**101-010-0005** Definitions

DIVISION 15

ELIGIBILITY

**101-015-0005** Eligible Individuals
**101-015-0015** Child by Affidavit
**101-015-0025** Requirements for Domestic Partnership

DIVISION 20

ENROLLMENT RULES

**101-020-0002** Effective and Termination Dates
**101-020-0005** Newly Hired and Newly Eligible Employee
**101-020-0012** Working in Two or More Positions or for Two or More PEBB Participating Organizations
**101-020-0015** Opting Out of Medical Insurance Coverage
**101-020-0018** Declining Benefits
**101-020-0020** Newborn and Adopted Child Enrollment
**101-020-0025** Removing an Ineligible Individual from Benefit Plans
**101-020-0032** Open Enrollment
**101-020-0037** Correcting Enrollment and Processing Errors
**101-020-0040** Late Enrollment
**101-020-0045** Returning to Work
**101-020-0047** Transfer
**101-020-0050** Midyear Benefit Plan Changes
**101-020-0060** Dependent Care Flexible Spending Account — Eligibility and Enrollment
**101-020-0065** Healthcare Flexible Spending Account — Eligibility and Enrollment
**101-020-0070** Life, Disability, and Accidental Death and Dismemberment Insurance — Continuation of Coverage

DIVISION 30

CONTINUATION OF INSURANCE — ACTIVE EMPLOYEES

**101-030-0005** Continuation of Group Medical and Dental Insurance Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)
**101-030-0007** Portability of Medical Insurance Coverage
**101-030-0010** Continuation of Group Medical and Dental Insurance Coverage for Injured Workers (CBIW)
**101-030-0015** Continuation of Group Medical and Dental Insurance Coverage for Employees Covered under the Federal Family Medical Leave Act (FMLA)
**101-030-0020** Continuation of Group Medical and Dental Insurance Coverage for Employees Covered under the Oregon Family Leave Act (OFLA) — ORS 659A.150-186
**101-030-0022** Continuation of Insurance Coverage for Employees on Active Military Leave (USERRA)
**101-030-0027** Non-medical Leave Without Pay (LWOP) — Continuation of Optional Insurance Plans

DIVISION 50

RETIREE RULES

**101-050-0005** Eligibility for Medical and Dental Insurance Coverage upon Retirement
**101-050-0010** Enrollment
**101-050-0015** Retiree Returning to Work for a PEBB Participating Organization in a Benefit Eligible Status
**101-050-0020** Retiree Survivor Medical and Dental Insurance Coverage
**101-050-0025** Retirees Eligible for Medicare Coverage

DIVISION 60

PEBB-PROVIDED HEALTH BENEFIT PLAN FOR LIQUOR CONTROL COMMISSION AGENTS

**101-060-0005** Definitions
**101-060-0010** Eligibility for Medical and Dental Insurance Benefits
**101-060-0015** Insurance Provision

## DIVISION 1

## PROCEDURAL RULES

**101-001-0000**
**Notice of Proposed Rule Changes**

Prior to adoption, amendment, or repeal of any rule, the Public Employees' Benefit Board (PEBB), will give notice of the intended action:

(1) In the Secretary of State's Bulletin, referred to in ORS 183.360, at least 21 days prior to the effective date;

(2) By mailing a copy of notice to persons on the PEBB mailing list established pursuant to ORS 183.335(7) at least 28 days before the effective date of the rule; and

(3) By mailing or furnishing a copy of the notice to:

(a) The Associated Press;

(b) Employee organizations certified by the Employment Relations Board if the rule affects employees represented by them;

(c) State agency heads, agency personnel managers, fiscal officers and payroll clerks, and insurance carriers;

(d) The Capitol Building Press Room;

(e) The Oregon State Bar Association; and

(f) The State Legislator who introduced legislation that caused a rule to be adopted, amended or repealed, and the chair or co-chair of all committees that reported the bill out. If notice cannot be given to the Legislator, notice will be provided to the Speaker of the House of Representatives and the President of the Senate.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 183.310 - 183.550, 192.660, 243.061 - 243.302 & 292.05
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04

**101-001-0005**
**Uniform and Model Rules of Procedure**

The Attorney General's Uniform and Model Rules of Procedure under the Administrative Procedure Act, effective January 1, 2004, are adopted as rules of procedure of the Public Employees' Benefit Board and are made a part of OAR chapter 101.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedures is available from the office of the Attorney General or the Department of Administrative Services, Public Employees' Benefit Board.]
Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 183.310 - 183.550, 192.660, 243.061 - 243.302, 292.05
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04

**101-001-0010**
**Insurance Plan Implementation Procedures**

(1) The Plan Year will be determined by the Board. Certain benefit plans and insurance policies may deviate from the Plan Year with Board approval.

(2) PEBB may conduct Open Enrollment Periods and require re-enrollment in insurance policies.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 183.310 - 550, 192.660, 243.061 - 243.302 & 292.05
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04

**101-001-0015**
**Disbursement of PEBB Fund Monies**

The Public Employees' Benefit Board Fund was created for the purpose of maintaining insurance program stabilization reserves. PEBB may disburse any or all monies in the fund for any of the following purposes:

(1) To reimburse insurers for monies due under the applicable contract (For example, when benefit plan expenses exceed premium revenues);

(2) To minimize premium increases resulting from random experience flux, inflationary variations or any other cause;

(3) To minimize impact on contributions to premiums due to benefit plan design changes;

(4) To pay for expenses critical to administration of PEBB programs (For example, data processing, benefit plan communications, etc.); and

(5) To pay for services, programs, or studies that will reduce benefit plan costs.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04

**101-001-0020**
**Social Security Numbers**

The Public Employees' Benefit Board may use Social Security numbers of participants in PEBB-sponsored benefit plans to uniquely identify the participant only if PEBB obtains consent from the participant.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 243.302
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04

## DIVISION 2

## POWERS OF THE BOARD

**101-002-0005**
**Powers and Duties of the Board**

(1) Pursuant to ORS 243.125, it will be within the powers and duties of the Board to study all matters connected with providing adequate benefit plan coverage for Eligible Employees on the best basis possible with relation both to the welfare of the employees and to the state.

(2) The Board will design benefit plans, devise specifications, analyze carrier responses to advertisements for bids and decide on the award of contracts. The Board will place emphasis on:

(a) Employee choice among high quality benefit plans;

(b) A competitive marketplace;

(c) Benefit plan performance and information;

(d) Employer flexibility in benefit plan design and contracting;

(e) Quality customer services;

(f) Creativity and innovation;

(g) Benefit plans as part of total employee compensation; and

(h) The improvement of employee health.

(3) The Board will prepare specifications, invite bids, and do acts necessary to award contracts for benefit plan coverage of Eligible Employees.

(4) The Board may retain consultants, brokers, or other advisory personnel as it determines necessary; and subject to the State Personnel Relations Law, will employ such personnel as are required to perform the functions of the Board.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 183.310 - 550, 192.660, 243.061 - 302 & 292.051
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04

**101-002-0010**
**Conduct of Meetings of the Board**

(1) The Board will select one of its appointed voting members as chairperson and another voting member as vice chairperson.

(2) Meetings will be conducted by and will be under the control of the chairperson of the Board. In the absence of the chairperson, the vice chairperson or other Board member designated by the chairperson in the absence of the vice chairperson will preside. All meetings of the Board will be conducted in the matter prescribed by and in accordance with the Oregon Public Meetings Law, ORS 192.610 to 192.690.

(3) No person will smoke any cigar or cigarette, or use tobacco in any form in meetings of the Board.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 183.310 - 550, 192.660, 243.061 - 302 & 292.051
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04

**101-002-0015**
**Public Employees' Benefit Board Appeal Procedure and Delegation**

(1) **Appeal of Administrative and Eligibility Issues to PEBB**. The following procedure will be used by individuals to request review with respect to administrative or eligibility issues:

(a) **To a Benefits Analyst**. If an individual requesting insurance coverage through PEBB receives what the individual considers an incorrect or unfair denial from the employing agency or insurance carrier, the individual may seek consideration by a Benefits Analyst. The request for consideration may be in writing or by telephone. The Benefits Analyst will review the request and make a determination within 45 days of the date of receipt of the request. If a determination cannot be made within 45 days, the individual will be notified.

(b) **To Benefits Manager**. If an individual receives a written denial of a request for consideration from the PEBB Benefits Analyst and the individual is dissatisfied with the denial, the individual may seek reconsideration of the denial by the PEBB Benefits Manager. The request for reconsideration must be made in writing and received by the Benefits Manager within 45 days of the date of the determination letter. Upon receipt of the request for reconsideration, the Benefits Manager will review the request and determine whether to deny or grant the request. The Benefits Manager will send a written notice and explanation to the individual of the Benefits Manager's decision within 30 days after receipt by the Benefits Manager of the request for reconsideration.

(c) **To Administrator or Designee**.

(A) The Benefits Manager may forward, with the consent of the Administrator or designee, a request for reconsideration from the individual to the Administrator or designee for a determination. If a request for reconsideration is forwarded from the Benefits Manager, the Administrator or designee will send a written notice and explanation to the individual of the decision within 30 days after receipt by the Benefits Manager of the request for reconsideration.

(B) If the individual is dissatisfied with the determination of the Benefits Manager, the individual may request further reconsideration by the PEBB Administrator or designee. A request for reconsideration must be made in writing and received within 60 days of the date of the determination letter by the Benefits Manager. If PEBB receives a timely written request for reconsideration of a prior determination by the Benefits Manager, the Administrator or designee will review the request and determine whether to deny or grant the request. The Administrator or designee will send a written notice and explanation to the individual of the decision within 30 days after receipt of the request for reconsideration from the individual.

(d) **To Operations Subcommittee**. The Administrator or designee may forward a request for reconsideration from the individual or the Benefits Manager to the PEBB Operations Subcommittee or the Board for review and determination. If the individual is dissatisfied with a determination of the Administrator or designee, the individual may request further reconsideration by the PEBB Operations Subcommittee. A request for reconsideration must be made in writing and received by the Operations Subcommittee within 30 days of the date of the determination letter by the Administrator or designee. If a request is forwarded to the Operations Subcommittee, or the Operations Subcommittee receives a timely request for reconsideration, the Subcommittee will review the request and determine whether to deny or grant the request. The Subcommittee will send a written notice and explanation to the individual of the Subcommittee's determination within 30 days after the next regularly scheduled meeting of the Subcommittee.

(e) **To the Board**. If an individual is dissatisfied with a determination of the Operations Subcommittee, the individual may request further reconsideration by the Board. A request for reconsideration must be made in writing and received by the Board within 30 days of the date of the determination letter by the Operations Subcommittee. A request for reconsideration may be forwarded, with the consent of the Board, by the Operations Subcommittee to the Board for review and a determination. If a request is forwarded to the Board by the Administrator or the Subcommittee, or the Board receives a timely request for reconsideration, the Board will review the request and determine whether to deny or grant the request. The Board will send a written notice and explanation to the individual of the Board's determination within 30 days after the next regularly scheduled meeting of the Board.

(f) An individual may appeal the Board's decision as provided under the Oregon Administrative Procedures Act, ORS Chapter 183.

(g) An individual will be notified of the status of his or her request for reconsideration within 15 days of receipt of the request for reconsideration by the applicable reviewing entity.

(2) **Delegation to Administrator and Staff**.

(a) The Administrator is hereby authorized to take all action necessary, desirable or convenient to administer the benefit plans of the Public Employees' Benefit Board, including but not limited to:

(A) Acting on any applications for insurance coverage or for refund of premiums.

(B) Reviewing, granting or denying requests for benefit plan coverage or other requests related to providing the benefit plans through PEBB.

(b) The Administrator may, in his or her discretion, refer for a final determination any matter to the Board or to the Operations Subcommittee.

(c) The Administrator is authorized to delegate to subordinates the authority to take any action on the Administrator's behalf.

(3) **Appeal of Contract Coverage Issues To the Insurance Carrier**. The following procedure will be used to request review of an action or determination by an insurance carrier with respect to the insurance coverage provided by the insurance carrier:

(a) If an eligible individual receives a claim denial from an insurance carrier, the eligible individual may appeal directly to the insurance carrier as described in OAR 101-002-0020. The procedure to appeal to the insurance carrier is outlined in the benefit plan's member handbook; or

(b) If the eligible individual receives a claim denial from an insurance carrier, the eligible individual may seek assistance from PEBB with his or her appeal to the insurance carrier. Upon request from the eligible individual, PEBB will verify that the insurance carrier is acting within the scope of the insurance contract. This may require that the eligible individual's request be reviewed through the insurance carrier's internal review process. Within 45 days after receipt of the request for assistance by PEBB, or such later date as may be allowed by any contractual provisions set forth between PEBB and the applicable insurance carrier, the insurance carrier will issue its determination to the Benefits Manager. The Benefits Manager will notify the eligible individual of the insurance carrier's decision within 15 days of receipt of the determination by the Benefits Manager.

(c) The Benefits Manager will review the insurance carrier's determination with the Administrator.

(d) If PEBB agrees with the insurance carrier's determination and so notifies the eligible individual, the eligible individual may appeal the insurance carrier's determination through mediation or binding arbitration.

(e) Information about mediation or binding arbitration can be obtained from the Public Employees' Benefit Board.

Stat. Auth.: ORS 243.061 - 243.302, 659A.060 - 659A.069 & 743.600 - 743.602
Stats. Implemented: ORS 183.310 - 550, 243.061 - 302, 192.660 & 292.051
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-002-0020**
**Procedure to Appeal Determination of Coverage Issues by Insurance Carrier**

(1) If an eligible individual receives a claim denial from an insurance carrier, the eligible individual may appeal directly to the insurance carrier. The procedure to appeal to the insurance carrier is outlined in the benefit plan's member handbook.

(2) If the eligible individual is dissatisfied with the result of the insurance carrier's determination as set forth in OAR 101-002-0015 above, the eligible individual may:

(a) Enter into mediation if mutually agreed to by the eligible individual and the insurance carrier;

(b) Appeal through the process of mutually binding arbitration; or

(c) Seek a remedy in the courts.

(3) If the eligible individual chooses mediation, the procedure would include the following:

(a) Mediation is not required unless both parties agree to use it.

(b) The insurance carrier and PEBB would pre-select the mediators for the period of the contract.

(c) The mediator fee will be paid by the insurance carrier, the eligible individual or both as agreed between the eligible individual and the insurance carrier.

(d) The parties will mutually agree and establish a written time deadline by which an agreement must be reached through mediation or the mediation efforts will terminate on the deadline.

(e) The mediation process is optional. There is no requirement that it precede the other dispute resolution procedures provided for in the applicable insurance contract between PEBB and the insurance carrier.

(f) The eligible individual must request mediation no later than 60 days after the appeal has been denied by the insurance carrier. If the result of the mediation process is not satisfactory to the eligible individual, the eligible individual may request to enter into binding arbitration no later than 60 days after the deadline established under the above subsection (d).

(4) If an agreement is not reached through mediation, the eligible individual may choose to appeal through the process of mutually binding arbitration or seek remedy through the court. If the eligible individual requests binding arbitration, the procedure would include the following elements:

(a) Arbitration is not required unless both parties agree to use it.

(b) The insurance carrier and PEBB will agree in advance on a panel of experienced arbitrators, the amount to be charged for the arbitration service, and whether the cost of the arbitration service is paid for by the insurance carrier, the eligible individual or both.

(c) The eligible individual chooses the arbitrator from the preselected panel of arbitrators for claims amounts up to $5,000. For claims amounts over $5,000, three arbitrators will be chosen from the pre-selected panel. The method of selection of the three is as follows: the eligible individual chooses one arbitrator, the insurance carrier chooses one, and both select the third.

(d) The costs of representation and witnesses are paid for by the insurance carrier, the eligible individual or both.

(e) The rules of evidence are broad — generally any information that would be allowed in an administrative hearing may be used in arbitration.

(f) The result would be binding on both the insurance carrier and the eligible individual. There would be no appeal to the courts.

(g) The arbitrators agree to provide expedited hearing and ruling.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 243.061 - 243.302, 659A.060 - 659A.069 & 743.600 - 743.602
Stats. Implemented: ORS 243.061 - 243.302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04

## DIVISION 5

## RENEWAL, SCREENING AND SELECTION FOR BENEFITS AND CONSULTANTS CONTRACTS

### 101-005-0010
### Renewal, Screening and Selection for Benefit, Vendor and Consultant Contracts

The Board is charged with the obligation of obtaining Benefit Plans to provide Benefits to Eligible Employees. OARs 101-005-0040 through 101-005-0140 set forth the screening, selection and renewal process to be used for all such Benefit Plan contracts. OAR 101-006-0010 sets forth the screening and selection process to be used for retaining Consultants and other Vendors. The Board has sole authority for procuring all benefits and services contemplated by ORS 243.061 through 243.302.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

### 101-005-0020
### Policy

The policy of the Board is to select Contractors in an expeditious and efficient manner that is consistent with the goal of delivering high quality Benefits and other services at a cost that is affordable to both the employees and the state, consistent with the requirements of ORS 242.135. The Board may enter into more than one contract for each type of Benefit Plan or other service sought.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.125 & 243.135(2)
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

### 101-005-0030
### Definitions

For the purposes of OARs 101-005-0010 through 101-006-0020 the following terms have the meanings indicated below.

(1) "Benefit Plan" includes, but is not limited to:

(a) Contracts for insurance or other benefit based on life; supplemental medical, supplemental dental, optical, accidental death or disability insurance; group medical, surgical, hospital, flexible spending account, or any other remedial care recognized by state law; and related services and supplies. "Benefit plan" includes comparable benefits for employees who rely on spiritual means of healing;

(b) Comparable benefits for employees who rely on spiritual means of healing;

(b) Self insurance programs managed by the Board; and

(c) Employee assistance programs.

(2) "Benefits" means those goods and services provided under Benefit Plans.

(3) "Board" means the Public Employees' Benefit Board.

(4) "Consultant" means consultants, brokers or other advisory personnel hired by the Board pursuant to ORS 243.125(5) to assist in acquiring adequate Benefit Plan coverage for eligible state employees; assist in the study of all matters connected with the provision of adequate Benefit Plan coverage for eligible state employees; assist in the development and implementation of decision-making processes; design and implement additional programs to review, monitor and assist in the improvement of Eligible Employees and their dependents' health; and provide other services as required by the Board.

(5) "Contractor" means an individual or firm selected to provide Benefits and other services with whom the Board contracts;

(6) "Eligible Employee" shall have the same definition as is described in ORS 243.105(4).

(7) "Emergency" means an unusual circumstance that creates a substantial risk of interruption of Benefit services which would that requires prompt execution of a contract to remedy the condition.

(8) "Proposal" means a competitive Proposal, binding on the Proposer and submitted in response to a Request for Proposals, where Proposal evaluation and contract award are based on criteria such as Proposer qualifications and experience, product features and characteristics, service quality and efficiency and conformance with the specifications and requirements of the solicitation. Price may be an evaluation criterion for Proposals, but will not necessarily be the predominant basis for contract award.

(9) "Proposer" means a person or entity who submits a Proposal in response to a Request for Proposals.

(10) "Renewal Contractors" means those Contractors and Vendors who provided the same or similar employee Benefit Plan or other services under a contract with the Board in the year immediately prior.

(11) "Request for Proposals" or "RFP" means the written document soliciting competitive written Proposals and setting forth the criteria and method to be used by the Board to determine the Responsible Proposers offering the best Responsive Proposals.

(12) "Responsible Proposer" shall have the meaning described in OAR 101-005-0130.

(13) "Responsive (Non-Responsive) Proposer" shall have the meaning described in OAR 101-005-0120.

(14) "Single Source" means the only vendor of a particular product or service reasonably available. If the Board chooses to procure a particular Benefit or service that is only available from one vendor, documentation must be maintained to support the determination that the product or service is available only from that one seller.

(15) "Formal Selection Procedure" "Intermediate Procurement" means the process described in OAR 101-005-0040(1).

(16) "Informal Selection Procedure" "Small Procurement" means the process described in OAR 101-005-0040(2).

(17) "Extensive Procurement" means the process of securing vendors with whom PEBB will contract for services amounting to $150,000.00 and over.

(18) "ORPIN" means the Oregon Procurement Information Network, an online service operated by the Department of Administrative Services that displays procurements and contracts issued by the State of Oregon's agencies.

(19) "Selection Committee" means the group of individuals comprised of PEBB staff, Board members, and/or constituents associated with PEBB who review, score, and recommend an Apparent Successful Proposer (ASP selected as a result of a Small, Intermediate or Extensive Procurement issued by PEBB) to the Board for approval.

(20) "Vendor" means the contractors with which PEBB will secure services that includes but is not limited to, printing and distributing Open Enrollment packets each year, newsletter construction and distribution each month, and online health information accessed by members.

Stat. Auth.: ORS 243.125(1)
Stats. Implemented: ORS 243.105(1), (2), & (4) & 243.125(5)
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0040**
**Procurement and Renewal Processes**

(1) Formal Selection Procedure Intermediate Procurement: This procedure will be used for the procurement of Benefits and other services that are contracted for under $150,000 but over $6000 in total cost. Exceptions to this procedure are specified in sections (2), (3), (4) and (5).

(a) Announcement: The Board will give notice of intent to contract for Benefits via the Vendor Information Program (VIP) System Oregon Procurement and Information Network (ORPIN), the Office of Minority, Women, and Small Emerging Business (OMWSEB), and in a trade periodical or newspaper of general circulation. The notice shall include a description of the Benefits or services sought, the scope of the services required, and a description of special requirements, if any. The notice will invite qualified prospective contractors to apply. The notice will specify when and where the application may be obtained, to whom it must be returned, and the closing date.

(b) Proposal: The Proposal from the prospective contractors will consist of a statement that describes the prospective contractor's credentials, performance data and other information sufficient to establish contractor's qualifications for providing the Benefits or services sought, as well as any other information requested in the announcement.

(c) Evaluation: The Board or its designees will evaluate the qualifications of all applicants and select prospective contractors as set forth in OAR 101-005-0110.

(d) Award of Contracts: The Board will make final selections based on the evaluation criteria including, but not limited to, applicant capability, experience, approach, compensation requirements, previous litigation and remedy applied, customer service history with PEBB, members, and clients; debarment status; and references, and will place emphasis on employee choice among high quality plans; plan performance and information; a competitive marketplace; employer flexibility in plan design and contracting; quality customer service; creativity and innovation; plan benefits as part of total employee compensation; and the improvement of employee health; and applicable vendor services benefiting PEBB.

(e) An Amendment(s) may be issued to the contract, but the cumulative Amendment(s) shall not increase the total Contract cost to a sum that is greater than twenty-five percent (25%) of the original Contract cost.

(2) Informal Selection Procedure Small Procurement: This procedure may be used at the Board's discretion, when the small procurement and informal selection procedure will not interfere with competition among prospective contractors, reduce the quality of services, is an amount less than $6000 in contract costs, or will not increase costs. The Board may contact a minimum of three prospective contractors known to the Board to be qualified to propose the sought-after services. The selection will be made by the Board based upon the factors described in paragraph (1)(d) of this rule. If three quotes are not received, the Board will make a written record of its efforts to obtain quotes.

(a) An Amendment(s) may be issued to the contract, but the cumulative Amendment(s) shall not increase the total Contract cost to greater than $6000.

(3) Single Source Procedure: PEBB may negotiate with a single source provider of Benefits if the services are available only from one contractor, or the prospective contractor has special skills uniquely required for the adequate performance of the services.

(a) An Amendment(s) may be issued to the contract, but the cumulative Amendment(s) shall not increase the total Contract cost to greater than twenty-five percent (25%) of the original Contract cost.

(4) Renewal Procedure: If the Board does not issue Small, Intermediate, or Single Source procurements to solicit formal proposals from qualified insurance carriers and Vendors, the Board may directly negotiate and enter into renewal contracts each Plan Year with Renewal Contractors and Vendors to provide Benefits and other services without following the procedures set forth in sections (1) and (2) above. The Board may renew contracts with Renewal Contractors and Vendors for as many years as the Board determines is in the best interest of the state and employees. The Board may invite renewal Proposals from those contractors who provided the same or similar employee Benefit Plan or other services in the year immediately prior. The Board will negotiate with Renewal Contractors and Vendors and enter into contracts with them after giving full consideration to the factors listed in paragraph (1)(d).

(5) Emergency Appointment Procedure: The Board may select a Benefit Plan or other service Contractor without following any of the above procedures when Emergency conditions require. In such instance, the recommended appointment and a written description of the conditions requiring the use of this appointment procedure shall be submitted to the Board. The Board will determine if an Emergency exists, declare the Emergency and negotiate a contract with the Contractor after giving full consideration to the factors listed in paragraph (1)(d).

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0050**
**Mistakes**

(1) Treatment of Mistakes. If the Board discovers certain mistakes in a Proposal after opening, but before award of the Contract, and the mistakes are not identified as those qualifying as non-responsive to the specifications of the procurement, the Board may take the following action:

(a) The Board may waive, or permit a Proposer to correct a minor informality. A minor informality is a matter of form(s) rather than substance that is evident on the face of the Proposal, or an insignificant mistake that can be waived or corrected without prejudice to other Proposers. Mistakes including, but not limited to, signatures not affixed to the proposal document, proposals sent to the incorrect address, insufficient number of proposals submitted, incorrect format, etc., will not be considered minor.

(b) The Board may correct a clerical error if the intended Proposal and the error are evident on the face of the Proposal, or other documents submitted with the Proposal, and the Proposer confirms the Board's correction in writing. A clerical error is a Proposer's error in transcribing its Proposal.

(2) Rejection for Mistakes. The Board may reject any Proposal in which a mistake is evident on the face of the Proposal and the intended correct Proposal is not evident or cannot be substantiated from documents accompanying the Proposal; i.e., documents submitted with the Proposal. In order to insure integrity of the competitive procurement process and to assure fair treatment of Proposers, mistakes discovered that are contrary to the specifications of the procurement will be carefully reviewed and will be determined, under the sole authority of the Board, to be waived or not be waived.

(3) If the Board discovers mistakes in the proposal after award, and the mistakes are not considered minor, the Board reserves the right to determine if the award will be revoked and then will re-evaluate proposals deemed to be in second, third, fourth, etc., in the standings.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.125(1)
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0060**
**Records Maintenance**

PEBB will maintain a file for seven (7) years on the selection process for all Benefits' and other services' Contracts entered on behalf of the state that will include, but will not be limited to:

(1) The method and copy of announcement;

(2) The names of firms or individuals and cost estimates considered;

(3) The basis for selection;

(4) A copy of the resulting contract and any subsequent amendments.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0070**
**Contract Amendments (Including Supplemental Work)**

An amendment for additional services that are reasonably related to the scope of work under the original Benefits Plan or other services' contract, including extra work, or change that increases the original contract price or length of time, may be made with the Contractor without re-entering the formal procurement process provided that the amendment does not materially alter such a contract.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0075**
**Pre-Proposal Conference**

(1) Unless identified in the procurement as required, the Pre-Proposal Conference will:

(a) Include voluntary attendance;

(b) Will be held in Salem, Oregon; and

(c) Will identify attendees by name and company represented;

(2) If the Pre-Proposal Conference requires mandatory attendance by prospective proposers, no remuneration will be offered to prospective proposers for attendance, travel, document preparation, etc.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0080**
**RFP Protest; Request for Change; Request for Clarification**

(1) Protest.

(a) Unless otherwise specified in the RFP, a Proposer must deliver a written protest to the Board not less than 10 (ten) calendar days prior to closing;

(b) Content of Protest. A Proposer's written protest shall include:

(A) A detailed statement of the legal and factual grounds for the protest;

(B) A description of the resulting prejudice to the Proposer; and

(C) A statement of the desired changes to the RFP.

(2) Request for Change.

(a) Unless otherwise specified in the RFP, a Proposer may request in writing a change to the Contract terms and conditions. If the RFP allows for a Proposer to make a request for changes, and unless otherwise specified in the RFP, a Proposer must deliver the written request for change to the Board not less than 10 (ten) calendar days prior to closing;

(b) A Proposer's written request for change shall include a statement of the requested changes to the Contract terms and conditions, including specifications together with the reason for the requested change.

(3) Board Response. The Board shall not consider a Proposer's request for change or protest after the deadline established for submitting such request or protest. The Board shall provide notice to the applicable entity if it entirely rejects a protest. If the Board agrees with the entity's request or protest, in whole or in part, the Board shall either issue an addendum reflecting its determination under OAR 137-030-0055 & 137-047-0430. or cancel the solicitation under OAR 137-030-0115.

(4) Extension of Closing. If the Board receives a written request for change or protest from a Proposer in accordance with this rule, the Board may extend closing if the Board determines an extension is necessary to consider the request or protest and to issue an addendum, if any, to the RFP.

(5) Clarification. Prior to the deadline for submitting a written request for change or protest, a Proposer may request that the Board clarify any provision of the RFP. The Board's clarification to a Proposer, whether orally or in writing, does not change the RFP and is not binding on the Board unless the Board amends the RFP by addendum.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0090**
**Addenda to an RFP**

(1) Issuance; Receipt. The Board may change an RFP only by written addenda. A Proposer shall provide written acknowledgement of receipt of all issued addenda with its Proposal, unless the Board otherwise specifies in the addenda.

(2) Notice and Distribution. The RFP shall specify how the Board will provide notice of addenda and how the Board will make the addenda available.

(3) Timelines; Extensions. The Board shall issue addenda within a reasonable time to allow prospective Proposers to consider the addenda in preparing their Proposals. The Board should extend the Closing if the Board determines prospective Proposers need additional time to review and respond to addenda. Except to the extent required by public interest, the Board shall not issue addenda less than 72 hours before the closing unless an addendum also extends the Closing.

(4) Request for Change or Protest. Unless a different deadline is set forth in an addendum, a Proposer may submit a written request for change or protest to the addendum by the close of the Board's next business day after issuance of the addendum.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0100**
**Extension of Time for Acceptance of Proposal**

The Board may request, orally or in writing that Proposers extend, in writing, the time during which the Board may consider their Proposal. If a Proposer agrees to such extension, the Proposal

shall continue as irrevocable, valid and binding on the Proposer for the agreed-upon extension period.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS.243.125(1)
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0105**
**Submission of Proposals; Format; Timing**

(1) All Proposals submitted as a result of a Formal Solicitation, Informal Solicitation, or Single Source Solicitation shall comply with the procurement's specifications. If portions of the Proposal to any solicitation are deemed unacceptable or non-responsive to the specifications of the solicitation, the Proposal will be deemed non-responsive and will not be given further evaluation or consideration. If a Proposal to any solicitation is delivered late, it will be deemed non-responsive to the specification of the solicitation and will be returned to the Proposer unopened.

(2) Submission of Proposals shall be in writing and shall be delivered in the written format, as required by the specifications of the solicitation. Proposals shall also be submitted electronically with the written Proposals and will be considered as a supplemental and not the sole format.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS.243.125(1)
Hist.: PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0110**
**Evaluation of Proposals**

(1) Evaluation. The evaluation process described in this rule applies to the Formal Selection Procedure set forth in OAR 101-005-0040(1). The Board and any assigned representatives, including but not limited to, PEBB stakeholders and staff, hereinafter identified as the Selection Committee, shall evaluate Proposals only in accordance with criteria set forth in the RFP and applicable law. The Board shall not divulge the names of the Selection Committee until such time as the Board has completed the cost negotiations or the Apparent Successful Proposer has been announced. The Board shall evaluate Proposals to determine the Responsible Proposer or Proposers submitting the best responsive Proposal or Proposals.

(2) Competitive Range; Protest; Award.

(a) Determining Competitive Range. If the Board does not cancel the solicitation, after the opening the Board will evaluate all Proposals in accordance with the evaluation criteria set forth in the Request for Proposals. After evaluation of all Proposals in accordance with the criteria set forth in the Request for Proposals, the Board will determine the Proposers in the competitive Range.

(b) Protesting Competitive Range. The Board shall provide written notice to all Proposers identifying Proposers in the competitive range. A Proposer that is not within the competitive range may protest the Board's evaluation and determination of the competitive range in not more than two (2) business days after the Board has sent written e-mail notice of the competitive range to all Proposers. After opening, all Proposals are open for public inspection subject to the Oregon Public Records Law.

(c) Intent to Award; Discuss or Negotiate. After the protest period provided in accordance with paragraph (2)(b) expires, or after the Board has provided a final response to any protest, whichever date is later, the Board may engage in discussions and negotiations with Proposers in the competitive range.

(3) Discussions and Negotiations. If the Board chooses to enter into discussions and negotiations with the Proposers in the competitive range, the Board shall proceed as follows:

(a) Initiating Discussions. The Board shall initiate oral or written discussions and negotiations with all of the Proposers in the competitive range regarding their Proposals.

(b) Conducting Discussions. The Board may conduct discussions and negotiations with each Proposer in the competitive range necessary to fulfill the purposes of this section, but need not conduct the same amount of discussions or negotiations with each Proposer. The Board may terminate discussions and negotiations with any Proposer in the competitive range at any time. However, the Board shall offer all Proposers in the competitive range the opportunity to discuss their Proposals with the Board before the Board notifies Proposers of the award decisions.

(A) In conducting discussions, the Board and any designated representatives:

(i) Shall treat all Proposers fairly and shall not favor any Proposer over another;

(ii) Shall not discuss Proposers' Proposals with any other Proposers and shall maintain all Proposals as confidential documents.

(iii) Shall not divulge the name(s) of the Proposers or the content of the Proposals until such time as cost negotiations are complete or an Apparent Successful Proposer has been announced.

(iv) Shall determine whether other factors, including but not limited to, Oregon residency of the primary business office and Proposer demonstration of services and products, will be used to determine the Apparent Successful Proposer, should a tie between Proposers occur.

(B) At any time during the time allowed for discussions and negotiations, the Board may:

(i) Continue discussions and negotiations with a particular Proposer or Proposers; or

(ii) Terminate discussions with a particular Proposer and continue discussions with other Proposers in the competitive range;

(C) The Board may continue discussions and negotiations with Proposers until the Board has determined which Proposer or Proposers shall be awarded contracts.

(c) Intent to Award; Protest. The Board shall provide written notice to all Proposers in the competitive range of the Board's intent to award the contracts. An unsuccessful Proposer may protest the Board's intent to award in accordance with OAR 101-005-0140. After the protest period provided in accordance with OAR 101-005-0140 expires, or after the Board has provided a final response to any protest, whichever date is later, the Board may commence final Contract execution with the successful Proposer or Proposers.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0120**
**Rejection of a Proposal**

Rejection of Proposals.

(1) The Board may reject any Proposal for Benefit Plan, Consulting or Vendor services and deem the Proposal as non-responsive upon finding that include, but is not limited to:

(a) To accept the Proposal may impair the integrity of the procurement process;

(b) Rejecting the Proposal is in the state's or employees' interest;

(c) The Proposer failed to provide information as required in the specification of by the RFP;

(d) The Proposer takes exception to the terms and conditions in the proposed contract;

(e) The Proposer offers goods and services that fail to meet the specifications of the procurement;

(f) The Proposal is late or arrives at other than the location announced in the procurement;

(g) The Proposer has been debarred as set forth in ORS 279 B.130;

(h) The Proposer is not licensed to do business in Oregon;

(i) The Proposer has not attained licensure necessary to conduct business;

(j) The Proposer has not kept in good standing any licensure required to complete the contract;

(k) The Proposer providing Consulting services cannot attain nor keep in good standing the ability to receive payment commissions from insurance carriers;

(l) The Proposer will not provide nor adhere to the certification of non-discrimination required under ORS 279A.110(4);

(m) The Proposer is found non-responsible as described in ORS 279B.110 and OAR 101-005-0130.

(2) The Board may reject all Proposals for good cause upon the Board's written finding it is in the state's or employees' interest to

do so. The Board shall notify all Proposers of the rejection of all Proposals, along with the good cause justification and finding.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0130**
**Responsible Proposer**

Before awarding a Contract, the Board must have information that indicates the Proposer meets the applicable standards of responsibility. To be a Responsible Proposer, the Board must determine that the Proposer:

(1) Is qualified legally to contract with the Board;

(2) Has supplied all necessary information in connection with the inquiry concerning responsibility. If the Proposer fails to promptly supply information requested by the Board concerning responsibility, the Board may base the determination of responsibility upon any available information, or may find the Proposer non-responsible;

(3) Is authorized to do business in Oregon;

(4) Has not been debarred as provided for in ORS 279B.130;

(5) Has the appropriate financial, material, equipment, facility and personnel resources and expertise necessary to indicate the capability of the Proposer to meet all contractual responsibilities;

(6) Has a satisfactory record of contract performance, including no current materially deficiencies in contract performance, unless the deficiencies have been corrected or expressly excused;

(7) Has a satisfactory record of business integrity, including no convictions for violations of confidentiality, monetary fraud, collusion, or the like.

(8) Form(s) of Business Entity. For purposes of this rule, the Board may investigate any entity submitting a Proposal. The investigation may include that entity's officers, directors, owners, affiliates, or any other entity acquiring ownership of the entity within the last three (3) years to determine application of this rule.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-005-0140**
**Protest of Contractor Selection, Contract Award**

(1) Purpose. An adversely affected or aggrieved Proposer must exhaust all avenues of administrative review and relief before seeking judicial review of the Board's Contractor selection or contract award decision.

(2) Notice of Intent to Award. Unless otherwise provided in the RFP, the Board shall provide written notice to all Proposers of the Board's intent to award the contract(s). The Board's award(s) shall not be final until the later of the following:

(a) Seven (7) days after the date of the notice, unless the RFP provided a different period for protest; or

(b) The Board provides a written response to all timely filed protests that denies the protests and affirms the award.

(3) Right to Protest Award. An adversely affected or aggrieved Proposer may submit to the Board a written protest of the Board's intent to award within fourteen (14) days after issuance of the notice of intent to award the contract, unless a different protest period is provided under the RFP.

(a) The Proposer's protest shall be in writing and must specify the grounds upon which the protest is based.

(b) A Proposer is adversely affected or aggrieved only if the Proposer is eligible for award of the contract as a Responsible Proposer and the Board committed a substantial violation of a provision in the RFP or of an applicable procurement statute or administrative rule, and the protesting Proposer was unfairly evaluated.

(c) The Board shall not consider a protest submitted after the time period established in this rule or such different period as may be provided in the RFP.

(4) Authority to Resolve Protests. The chairperson of the Board, or his or her designee, has the authority to settle or resolve a written protest submitted in accordance with the requirements of this rule.

(5) Decision. If a protest is not settled, the chairperson of the Board, or his or her designee, shall promptly issue a written decision on the protest. Judicial review of this decision will be available if provided by statute.

(6) Award. The successful Proposer shall promptly execute the contract after the award is final. The Board shall execute the contract only after it has obtained all applicable required documents and approvals.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.135 & 243.125
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

## DIVISION 6

## APPLICABLE PERSONAL SERVICE CONTRACT RULES

**101-006-0010**
**Applicable Personal Service Contract Rules**

The following provisions of the Department of Administrative Services' Personal Service Contracts rules listed below shall be applicable to PEBB's procurement contracts for services from Consultants or other Vendors, as that those terms are is defined in OAR 101-005-0030(4) and (18). Where the following rules refer to the "Contracting Agency" or "Agency," it shall mean the Board. Where the following rules refer to "Contractors" performing Personal Services Contracts, it shall mean Consultants and Vendors. Where the following rules refer to approval by the Division or DAS, such requirement for approval is not incorporated in these rules, nor is such approval required for the Board to obtain, renew or amend contracts with Consultants and Vendors. Where the following rules indicate that an Agency shall provide notice to DAS or provide DAS with access to its records, such provisions are not incorporated in these rules and such obligations shall not apply to the Board. Applicable rules include OAR 125-020-0210 — Contract Form(s); 125-020-0300(2) and (3) — Introduction to Screening and Selection Procedures; 125-020-0310 — Solicitation Requirements; 125-020-0320 — Formal Selection Procedures; 125-020-0330 — Informal Selection Procedures; 125-020-0335 — Selection by Negotiation; 125-020-0340 — Emergencies; 125-020-0350(1) and (3) — Sole Source; 125-020-0360 — Protest Procedures; 125-020-0400 — Contract Requirements; 125-020-0410 — Independent Contractor Status; 125-020-0440 — Tax compliance; 125-020-0510 — Contract Files; and 125-020-0520(1), (2), (4), (5), (7)(a)(A) and (7)(a)(B) — Contract Amendments.

Stat. Auth.: ORS 243.061 - 243.301
Stats. Implemented: ORS 243.125(1) & (5)
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

**101-006-0020**
**Renewal process for Consultant and Vendor Contracts**

(1) Renewal Procedure: If the Board does not issue a procurement to solicit formal proposals from Consultants and Vendors, the Board may directly negotiate and enter into renewal contracts with Renewal Contractors and Vendors to provide Consultant and other Vendor services without following the procedures set forth in OAR 101-006-0010. The Board may renew contracts with Renewal Contractors and Vendors for as many years as the Board determines is in the best interest of the state. The Board may invite renewal Proposals from those contractors who provided the same or similar Consultant and other Vendor services in the year immediately prior.

(2) The Board will negotiate with Renewal Contractors and Vendors and enter into contracts with them after giving full consideration to the following factors which include, but are not limited to: applicant capability, experience, approach, compensation requirements and references.

Stat. Auth.: ORS 243.061 - 242.301
Stats. Implemented: ORS 242.125(1) & (5)
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2005, f. 7-26-05, cert. ef. 7-29-05

## DIVISION 10

## DEFINITIONS

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

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

(1) "Actively at work" means:

(a) For medical and dental insurance coverage, an active eligible employee at work, in paid regular status, scheduled for work during the month of requested insurance coverage, or using accrued leave on the effective date of coverage.

(b) For life, disability and accidental death and dismemberment insurance coverage, an active eligible employee who is physically on the job and receiving pay for the first scheduled day of work and performing the material duties of the employee's occupation at the employer's usual place of business. If an active eligible employee is incapable of active work because of sickness, injury, or pregnancy on the day before the scheduled effective date of his or her insurance coverage or increase in insurance coverage, the insurance coverage or increase is not effective until the first of the month after the active eligible employee completes one full day of active work.

(2) "Affidavit of Dependency" means a notarized document that attests a dependent child meets the criteria in section (7).

(3) "Affidavit of Domestic Partnership" means a notarized document that attests the eligible employee and one other eligible individual meet the criteria in section (8).

(4) "Benefit amount" means the amount of money paid by a PEBB participating organization on behalf of active eligible employees for the purchase of benefit plans.

(5) "CBIW" means Continuation of Benefits for Injured Workers.

(6) "COBRA" means the federal Consolidated Omnibus Reconciliation Act.

(7) "Dependent child" means any child who meets the criteria in this section. In defining dependent child, PEBB follows Internal Revenue Code (IRC) 152 as revised by the Working Families Tax Relief Act of 2004:

(a) The child is not married and does not have a domestic partner; and

(A) Is under the age of 19 at the end of the calendar year; or

(B) Meets the IRC 152(f)(2) definition of a dependent child between the ages of 19 and up to age 24 attending school full time, excluding foreign students; or

(C) Is between the ages of 19 and up to age 24, living in the home of the eligible employee over six months of the calendar year, and the eligible employee provides over half the yearly support; or

(D) Is between the ages of 19 and up to age 24, and is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. The attending physician must submit documentation of the disability to the insurance plan for approval. Once certified, the insurance plan may review dependent certification to determine continued eligibility; or

(E) Is a child age 24 or older, and is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. Except in the case of a child who previously qualified under (a)(D) of this section, the attending physician must submit documentation of the disability to the insurance plan for approval. The insurance plan may review dependent certification to determine continued eligibility. If the child is terminated from PEBB insurance coverage after age 24 for any reason, the eligible employee cannot re-enroll the child. A disabled dependent child, age 24 or older, must also meet the following criteria:

(i) The disability must have existed prior to attaining age 24.

(ii) The child must have had continuous medical insurance coverage, group or individual, prior to attaining age 24 and until the time of the PEBB insurance effective date.

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

(c) A dependent child must also meet one of the following criteria:

(A) Is a biological child of, an adopted child of, or a child placed for adoption with the eligible employee, spouse, or domestic partner; or

(B) Is a legal ward by court decree, a dependent by Affidavit of Dependency, or is under legal guardianship of the eligible employee, spouse or domestic partner, and is living in the home of the eligible employee.

(d) A child of a domestic partner meeting 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 eligible dependent child.

(8) "Domestic partner" means an eligible employee's unmarried partner of the same or opposite sex.

(9) "Eligible employee" means and includes:

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

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

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

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

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

(12) "FTE" means full time equivalent classified job position.

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

(a) Eighty paid regular hours per month; or

(b) .5 FTE for Oregon University System (OUS) employees; or

(c) As defined by collective bargaining.

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

(15) "Ineligible individual" means an individual or employee who does not meet the definition of an eligible employee, spouse, domestic partner, or dependent child as established in this rule.

(16) "Job share" means two eligible employees sharing one full time equivalent position. Each eligible employee's percentage of the total position determines the benefit amount the employee receives. The employees need not be classified as half-time. They cannot donate their portion of the benefit amount to the other job share co-worker. The monthly benefit amount percentage remains the same regardless of individual hours worked.

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

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

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

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

(20) "Pebb.benefits" means the automated internet benefit management application sponsored by PEBB. The system allows electronic enrollment and termination of the eligible individual's benefit plans, personal information updates, and the transmittal of benefit plan data to insurance plans and payroll centers.

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

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

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

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

(25) "Reinstatement" or "reinstated" means to reactivate the benefit amount and enrollment in previous medical, dental, life, and disability insurance coverage, if available, on a guaranteed basis when returning to eligible status within a specific time frame.

(26) "Spouse" means a person of the opposite sex who is a husband or 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 spouse and a former spouse does not qualify as a dependent.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2006(Temp), f. & cert. ef. 12-14-06 thru 6-12-07; PEBB 1-2007(Temp), f. & cert. ef. 6-11-07 thru 12-8-07; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

## DIVISION 15

## ELIGIBILITY

**101-015-0005**
**Eligible Individuals**

(1) The following individuals are eligible to participate in PEBB-sponsored benefit plans:

(a) An eligible employee as defined in OAR 101-010-0005(9).

(b) A seasonal or intermittent employee as follows:

(A) An individual hired for the first time is eligible for PEBB-sponsored benefit plans if expected to work at least a 90-day continual period and work at least half-time or in a position classified as job share. The eligible employee must enroll within 60 days of their hire date or eligibility.

(B) An individual hired for the first time, working at least half-time or in a position classified as job share and not expected to work a 90-day or more continual period is eligible for PEBB-sponsored benefit plans if they work at more than a 90-day continual period. When the eligible employee submits enrollment forms, the benefits are retroactive to the first of the month following 60 days from their hire date.

(C) A previously ineligible employee returning to work is eligible for benefit plans once they accumulate a total of 60 calendar days of employment within the current or immediately previous plan year. The 60 calendar days of employment need not be consecutive.

(D) A previously enrolled employee returning within a 12-month period has all benefit plans reinstated effective the first of the month following return to employment. The returning employee may make benefit plan changes or elections within 60 days of the date of return to work.

(E) An employee returning beyond a 12-month period is a new employee.

(c) A job share employee as defined in OAR 101-010-0005(16).

(d) A family member listed by the eligible employee on the required enrollment form or the electronic equivalent.

(e) A domestic partner and the domestic partner's dependent child listed by the eligible employee on the required forms or the electronic equivalent.

(f) An appointed and elected official. Eligibility for benefit plans begins on the first day of the month following the date the official takes the oath of office and terminates on the last day of the month that the last payroll deduction is taken for the official's office.

(2) The eligible employee must maintain a valid PEBB active enrollment.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-066, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-015-0015**
**Child by Affidavit**

(1) An eligible employee may add a dependent child that is not adopted to their benefit plans. The child must meet the criteria specified in OAR 101-010-0005(7). Completed enrollment forms must be submitted within 60 days of the date of birth or the date the eligible employee, spouse, or domestic partner receives physical custody of the child and assumes financial or medical responsibility for the support and care of the child.

(2) A dependent child that is not adopted includes, but is not limited to, a foster child, a ward of the court, or the child of an eligible employee's dependent.

(3) An Affidavit of Dependency must be completed, notarized, and returned to the agency, in paper form, within five business days of the electronic enrollment date or the date forms were submitted to the agency. If not, coverage will terminate for the dependent child retroactive to the effective date.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-015-0025**
**Requirements for Domestic Partnership**

(1) An individual and eligible employee must meet all of the following criteria:

(a) Are both at least 18 years of age;

(b) Are responsible for each other's welfare and are each other's sole domestic partners;

(c) 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;

(d) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

(e) Have jointly shared the same regular and permanent residence for at least six months; and

(f) 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.

(2) 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.

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

(4) 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.

(5) An eligible employee ending a domestic partnership must complete and submit a Termination of Domestic Partnership form and updated enrollment forms to the agency within 60 days of the event for removal of the domestic partner and domestic partner's children from their benefit plans. Insurance coverage for the domestic partner and domestic partner's children ends on the last day of the month that eligibility is lost.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

## DIVISION 20

## ENROLLMENT RULES

### 101-020-0002
### Effective and Termination Dates

(1) Benefit plan enrollment date. Except as otherwise provided in OAR Chapter 101, all benefit plan changes or elections are effective with a prospective date. Insurance coverage is effective on the first of the month following the form receipt or electronic equivalent, the eligibility date, or the QSC date, whichever is later. If medical underwriting is necessary for optional plans, insurance coverage is effective the first of the month following insurance plan approval.

(2) Elections made during the open enrollment period are effective on the first day of the new plan year. If medical underwriting is necessary for optional plans, insurance coverage is effective the first of the month following insurance plan approval in the new plan year.

(3) An eligible employee, family member, domestic partner, or domestic partner's dependent child losing other group insurance coverage may enroll in PEBB insurance plans within 60 days of the date the other group insurance coverage ends. Insurance coverage will be continuous with an effective date based upon the end date of the other group insurance coverage.

(4) Benefit plan end date.

(a) If an eligible employee accumulates less than 80 paid regular hours in a month and is not within a protected leave class, CBIW, FMLA or USERRA, current insurance coverage ends the last day of that month.

(b) If an eligible employee accumulates 80 or more paid regular hours in a month and is in a leave without pay status and is not within a protected leave class, or ends employment with the state current insurance coverage ends the last day of the following month.

(5) Insurance coverage for a family member, domestic partner, or domestic partner's dependent child ends on the last day of the month that eligibility is lost.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

### 101-020-0005
### Newly Hired and Newly Eligible Employee

(1) A newly hired or newly eligible employee has 60 days from the date of hire or date of eligibility to enroll in PEBB-sponsored benefit plans. The eligible employee must be in paid regular status on the effective date of insurance coverage.

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

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

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

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

(2) An eligible employee hired after the open enrollment period and before the start of the new plan year has open enrollment rights.

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

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

### 101-020-0012
### Working in Two or More Positions or for Two or More PEBB Participating Organizations

(1) An individual working in two or more positions or for two or more PEBB participating organizations must work at least half-time to be eligible for any PEBB-sponsored benefit plans. The exception is eligible employees in job share positions. An employee is not eligible for more benefits than what one full time employee would receive.

(2) The eligible employee must enroll in benefit plans at the PEBB participating organization with the highest percentage of the FTE position.

(a) When the employee has equal FTE percentages with more than one PEBB participating organization, the employee must enroll in benefit plans through the organization with the earlier appointment date.

(b) When the employee has equal FTE percentages and simultaneous dates of employment with two or more PEBB participating organizations, the employee may choose to enroll in benefit plans through one of the organizations.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; Renumbered from 101-040-0015, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

### 101-020-0015
### Opting Out of Medical Insurance Coverage

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

(2) The eligible employee must provide proof of current coverage under another employer-sponsored group medical insurance plan if requested.

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

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

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

### 101-020-0018
### Declining Benefits

(1) An eligible employee may decline benefits by waiving their right to the benefit amount and enrollment in all of the PEBB-sponsored benefit plans.

(2) Benefits may be declined at the time of hire or meeting eligibility, consistent with a QSC, or during the open enrollment period.

(3) An eligible employee previously declining benefits may enroll in benefit plans consistent with a QSC or during the open enrollment period.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

### 101-020-0020
### Newborn and Adopted Child Enrollment

(1) An eligible employee's biological newborn child receives PEBB-sponsored medical and dental insurance coverage under the newborn's own coverage from the moment of birth through the first 31 days of life. To continue coverage the eligible employee must add the newborn child to their benefit plans within 60 days from the date of birth.

(2) An eligible employee's newly adopted child receives PEBB-sponsored medical and dental insurance coverage under the adopted child's own coverage from the date of the adoption decree or date of placement for adoption through the first 31 days pending the completion of adoption proceedings. To continue coverage the eligible

employee must add the adopted child to their benefit plans within 60 days from the date of the decree or placement.

(a) The eligible employee must submit the adoption agreement with the enrollment forms to the agency.

(b) Claims payment will not occur prior to the date of decree or placement.

(3) A request to enroll a biological newborn or newly adopted child beyond 60 days of the date of birth, adoption decree, or placement for adoption is late enrollment as specified in OAR 101-020-0040.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 1-2005, f. & cert. ef. 4-14-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0025**
**Removing an Ineligible Individual from Benefit Plans**

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

(2) An eligible employee ending a domestic partnership must complete and submit a Termination of Domestic Partnership form and enrollment update forms to the agency within 60 days of the event for removal of the domestic partner and domestic partner's children from their benefit plans. Insurance coverage for the domestic partner and domestic partner's children ends on the last day of the month that eligibility is lost.

(3) PEBB removes ineligible individuals from insurance coverage retroactive to the end of the month when eligibility was lost. The eligible employee may be responsible for claims previously paid by the benefit plans to the providers during the period of ineligibility.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0032**
**Open Enrollment**

(1) Active and other eligible employees may make benefit plan changes or elections only during the open enrollment period. Eligible employees must submit elections as instructed during the designated period.

(2) The eligible employee must maintain a valid PEBB active enrollment for eligible individuals. Insurance coverage for an eligible individual added to enrollment begins on January 1 of the new plan year. Insurance coverage for an individual removed from enrollment ends December 31 of the current plan year.

(3) An eligible employee hired after the open enrollment period and before the start of the new plan year has open enrollment rights.

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

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0037**
**Correcting Enrollment and Processing Errors**

(1) Employee enrollment errors. Enrollment errors occur when an eligible employee provides incorrect information or fails to make correct selections when making benefit plan elections. The eligible employee is responsible for identifying enrollment errors or omissions.

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

(A) PEBB must review all enrollment errors reported by the employee after 60 days of the original eligibility date or the midyear plan change date. If approved, corrections are effective the first of the month following the receipt of the request.

(B) Enrollment errors will not be considered beyond 90 days of the eligibility date or the midyear plan change date.

(b) Open enrollment period. The eligible employee has 30 days from receipt of the first paycheck or benefit statement, whichever is later, of the new plan year to request correction from the agency. If approved, corrections are effective the first day of the new plan year.

(2) Processing errors. Processing errors or omissions occur when benefit plan elections are processed incorrectly in the payroll and benefit systems or when a newly eligible employee does not receive correct enrollment information or materials within 30 days of the eligibility date.

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

(A) PEBB must review all processing errors identified after 60 days of the eligibility date or the midyear plan change date. If approved, corrections are retroactive to the first of the month following the date the paper form or electronic equivalent was first received by the agency. The agency must reconcile all premium discrepancies.

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

(b) Open enrollment period. PEBB authorizes the agency to correct processing errors identified within 45 days from the end of the open enrollment period. PEBB must review all processing errors identified after 45 days. All processing error corrections are effective the first day of the new plan year.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 1-2005, f. & cert. ef. 4-14-05; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 1-2006, f. & cert. ef. 11-28-06; Renumbered from 101-040-0080, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

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

(1) Late enrollment occurs when an eligible employee fails to enroll in benefit plans within 60 days of:

(a) The date of hire or eligibility date.

(b) The date a family member, domestic partner, or domestic partner's dependent child gains eligibility.

(c) The date of marriage to a spouse who was most recently enrolled as a domestic partner.

(d) The date of birth of the employee's biological newborn dependent child.

(2) A newly hired or newly eligible employee with late enrollment may only select available medical, dental and employee basic life insurance coverage.

(3) Excluding section (4) of this rule, PEBB must review all late enrollment requests for approval. The eligible employee must provide sufficient supporting documentation demonstrating that the inability to enroll was due to circumstances beyond the employee's control. Late enrollment of a family member, domestic partner, or domestic partner's dependent child may only be added to the employee's current medical and dental plans, if approved.

(a) If late enrollment is approved, benefit coverage is effective the first of the month following receipt of the completed forms.

(b) PEBB may deny late enrollment when the documentation does not demonstrate good and sufficient cause for late enrollment.

(4) Following receipt of the completed forms, agencies are responsible for approving the late enrollment of the employee's biological newborn children during the first twelve months of life. The

enrollment is always retroactive to the first of the month following the date of birth.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 1-2006, f. & cert. ef. 11-28-06; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0045**
**Returning to Work**

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

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

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

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

(d) Active military duty leave (USERRA). See OAR 101-030-0022.

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

(a) An employee returning to paid regular status within 12 months of the insurance coverage end date will have their previous enrollment for medical, dental, life, and disability insurance reinstated the first of the month following their return to work. The employee may make midyear plan changes within 60 days of the date they return to work.

(b) An employee returning to active or paid regular status after 12 months from the insurance coverage end date is treated as a newly hired employee.

(3) Return of an eligible employee from layoff or termination:

(a) An employee returning to work following layoff or termination of employment is not required to work at least half-time in the month they return to be eligible for benefits the following month.

(b) An employee returning to paid regular status within 12 months of the insurance coverage end date will have their previous enrollment for medical, dental, life, and disability insurance reinstated. The employee may make midyear plan changes within 60 days of the date they return to work.

(c) An employee returning to active or paid regular status after 12 months from the insurance coverage end date is treated as a newly hired employee.

(4) An employee returning to paid regular status within 30 days will have their previous coverage reinstated and may not make benefit plan changes.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302 & 659A.060-069
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0047**
**Transfer**

(1) When an eligible employee transfers from one PEBB participating organization to another, the organization losing the employee must pay the benefit amount for the month following the transfer, regardless of hours worked at that organization.

Exception: An eligible employee transfers mid-month from part-time to full time and submits enrollment forms to the gaining organization prior to the end of the month. In this case, the gaining organization pays the full benefit amount for the month following the transfer.

(2) All PEBB benefit plan elections transfer from the PEBB organization losing the employee to the organization gaining the employee without a lapse in insurance coverage.

(3) Benefit plan changes or elections are not permitted solely due to a transfer.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; Renumbered from 101-040-0020, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0050**
**Midyear Benefit Plan Changes**

(1) Eligible employees experiencing a change in family or work status during the plan year have 60 days from the date of the event to make benefit plan changes or elections. Completed enrollment forms must be submitted within the 60 days. The eligible employee may make only those elections that are consistent with the event. These events fall into three broad groups:

(a) Changes in status. For example:

(A) Changes in the eligible employee's legal marital status, such as marriage or divorce,

(B) Changes in the eligible employee's number of dependents, such as birth or adoption of a child,

(C) Changes in the employment status of the eligible employee or family member, such as the start or end of employment, or a change from part-time to full time,

(D) Changes in the eligibility of a dependent, such as attaining a certain age,

(E) Changes in the residence of the eligible employee or family member, or

(F) Changes in the eligible employee's domestic partnership.

(b) Cost or coverage changes. For example:

(A) An increase in out-of-pocket premium cost imposed by the employer, or

(B) A reduction or a loss in the spouse's or domestic partner's group insurance plan benefits.

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

(2) The Tag-a-long rule applies and means that a family member, domestic partner, or domestic partner's child previously eligible for PEBB-sponsored insurance coverage may be added to medical or dental insurance coverage or both at the same time a new family member, domestic partner, or domestic partner's child is added.

(3) The eligible employee must maintain a valid PEBB active enrollment.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0060**
**Dependent Care Flexible Spending Account — Eligibility and Enrollment**

(1) An eligible employee may enroll in the pretax Dependent Care Flexible Spending Account (Dependent Care FSA) if:

(a) Their expenses qualify for reimbursement:

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

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

(b) The employee is:

(A) Single,

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

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

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

(3) Once an employee enrolls in a pretax Dependent Care FSA, they may not change the amount of money deposited in the account, or stop the payroll deductions until the next open enrollment period unless they experience a QSC event.

(4) The pretax Dependent Care FSA is subject to the "Use It or Lose It" rule. Any funds remaining in the account beyond March 31 following the plan year will be forfeited to PEBB.

(5) An eligible employee must reenroll each year during open enrollment to continue participating in the Dependent Care FSA for the new plan year.

(6) An employee ending employment will not have a Dependent Care FSA deduction taken out of their final paycheck.

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

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; Renumbered from 101-040-0050, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0065**
**Healthcare Flexible Spending Account — Eligibility and Enrollment**

(1) An eligible employee may enroll in the pretax Healthcare Flexible Spending Account (Healthcare FSA). The Board determines the annual maximum contribution amounts.

(2) Once an employee enrolls in a pretax Healthcare FSA, they may not change the amount of money deposited in the account, or stop the payroll deductions until the next open enrollment period unless they experience a QSC event.

(3) The pretax Healthcare FSA is subject to the "Use It or Lose It" rule. Any funds remaining in the account beyond March 31 following the plan year will be forfeited to PEBB.

(4) An eligible employee must reenroll each year during open enrollment to continue participating in the Healthcare FSA for the new plan year.

(5) An employee ending employment will not have a Healthcare FSA deduction taken out of their final paycheck.

(6) An eligible employee ending employment may continue to participate in the Healthcare FSA up to the end of the current plan year through COBRA if:

(a) They have a positive balance in their account; and

(b) They self-pay contributions to the account. Contributions are paid on an after-tax basis.

(7) An eligible employee who separates from the employer and later returns to work within 12 consecutive months is not reinstated in the pretax Healthcare FSA. They may enroll within 60 days of their new hire date.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 2-2004(Temp), f. 7-13-04, cert. ef. 8-31-04 thru 2-27-05; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; Renumbered from 101-040-0055, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-020-0070**
**Life, Disability, and Accidental Death and Dismemberment Insurance — Continuation of Coverage**

(1) Optional life insurance coverage may be continued when an eligible employee separates from state service as follows:

(a) Portability. An eligible employee terminating employment, other than for disability or retirement, may continue their optional employee, spouse and domestic partner life insurance coverage at the group rate, plus billing fees. The policy remains a term life insurance policy. The employee must apply directly to the insurance carrier within 60 days of the date insurance coverage ends. Portability is not available for basic life or dependent life insurance coverage. A survivor of a covered eligible employee may continue life insurance through the carrier upon the death of the employee.

(b) Conversion Rights. An eligible employee terminating employment for any reason, including disability or retirement, or experiencing a reduction in hours to less than 80 paid regular hours in the month, may convert any life insurance coverage to individual whole life insurance policies. The employee must apply directly to the insurance carrier within 60 days of the date insurance coverage ends. A survivor of a covered eligible employee may convert life insurance coverage to whole life insurance policies through the carrier upon the death of the employee.

(c) Retiree Life Insurance Option. An eligible employee who retires may purchase the Retiree Life Insurance Option without submitting evidence of insurability. The employee must apply directly to the insurance carrier within 60 days of the date insurance coverage ends.

(d) Rollover of Optional Employee Life Insurance. When two eligible employees are married or in a domestic partnership and both are state employees, they can roll over their optional life insurance coverage to the other's life insurance coverage upon:

(A) Either one terminating employment for any reason;

(B) Either one beginning an active military leave;

(C) Divorce;

(D) Termination of their domestic partnership; or

(E) Retirement. The remaining employed eligible employee must submit the completed applicable form to their agency within 60 days of the date of the above events.

(2) There are no portability, conversion, or rollover continuation options for short term or long term disability or accidental death and dismemberment insurance coverage.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

## DIVISION 30

## CONTINUATION OF INSURANCE — ACTIVE EMPLOYEES

**101-030-0005**
**Continuation of Group Medical and Dental Insurance Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)**

COBRA allows an eligible individual losing group health plan coverage due to a qualifying event to continue their coverage for a limited time on a self-pay basis.

(1) PEBB participating organizations will issue an initial COBRA notice explaining the right to continue medical and dental insurance plans to all newly eligible employees and individuals.

(a) The notice must be mailed to the eligible employee's known address immediately following enrollment in PEBB medical or dental insurance plans. The notice must include all known eligible individuals residing at the address, including family members, a domestic partner, and a domestic partner's dependent children. Known eligible individuals residing separately from the eligible employee must be mailed a separate notice at their known address.

(b) The initial COBRA notice must be mailed to individuals becoming newly eligible due to marriage or the formation of a domestic partnership.

(2) A COBRA triggering event must cause the loss of benefit coverage. COBRA triggering events include:

(a) An involuntary reduction in hours or layoff.

(b) A strike or lockout.

(c) The beginning of an unpaid leave of absence.

(d) The termination of employment.

(e) Retirement.

(f) A dependent child no longer satisfying eligibility requirements.

(g) The loss of employer-sponsored group coverage for dependents due to Medicare eligibility.

(h) A divorce or termination of a domestic partnership.

(i) The death of the employee.

(3) All individuals losing eligibility due to a triggering event must receive a COBRA continuation notice. PEBB participating organizations will notify the PEBB Third Party Administrator (TPA) within 30 days of the date eligibility for benefit coverage is lost. The date eligibility is lost is considered the COBRA triggering event date.

(a) The PEBB TPA will mail a COBRA notice of continuation including a Certificate of Group Health Plan Coverage to each eligible individual at their last known address when eligibility for

PEBB-sponsored insurance coverage is lost. The TPA must mail the notice to each eligible individual within 14 days of receiving the notification.

(b) An eligible employee has 60 days from the receipt of the COBRA notice to activate their COBRA rights of continuation. PEBB-sponsored insurance coverage must be continuous through COBRA implementation.

(4) Generally, health plans may be continued under COBRA provisions for the following basic maximum coverage periods:

(a) 18 months after the date of the triggering event for termination or reduction in hours, section (2)(a)–(e) above; or

(b) 36 months after the date of the triggering event for other events, section (2)(f)–(h) above.

(5) An eligible employee's spouse or domestic partner who is 55 years of age or older and who loses benefit coverage due to divorce, termination of a domestic partnership, or death of the employee, section 2(h) and (i) above, may continue PEBB health insurance coverage for themselves and their dependent children beyond the general 36 month COBRA continuation period. An eligible individual may continue their PEBB health insurance coverage until they are entitled to Medicare, are covered under another group medical insurance plan, or otherwise lose eligibility.

(6) An eligible individual continuing PEBB medical or dental insurance coverage or both under COBRA provisions has the same rights as active eligible employees for making changes midyear and during the open enrollment period.

(7) An eligible employee ending employment may continue to participate in the Healthcare Flexible Spending Account through COBRA up to the end of the current plan year if:

(a) They have a positive balance in their account; and

(b) They self-pay contributions to the account. Contributions are paid on an after-tax basis.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302, 659A.060-069 & 743.600-602
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0007**
**Portability of Medical Insurance Coverage**

Some PEBB sponsored group medical insurance plans allow portability. An eligible individual enrolled in one of these medical plans may continue insurance coverage under the plan's portability provisions before, during, or at the end of the period that medical insurance coverage is provided under COBRA, if:

(1) They were continuously covered for 180 days or more under one or more PEBB sponsored group medical insurance plans and they lost eligibility for group medical insurance coverage;

(2) They are not covered by another group medical insurance plan, Medicare, or TriCare;

(3) They enroll in a continued medical insurance plan under the portability provisions within 63 days after termination of the group medical insurance coverage; and

(4) They comply with all requirements of the applicable insurance carrier for continuation of medical insurance coverage under the carrier's portability plan provisions.

Stat. Auth.: ORS 243.061-302
Stats. Implemented: ORS 243.061-302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; Renumbered from 101-030-0035, PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0010**
**Continuation of Group Medical and Dental Insurance Coverage for Injured Workers (CBIW)**

(1) The state is required by ORS 659A.060-069 to continue to pay the benefit amount for PEBB medical and dental insurance coverage in effect at the time an eligible employee has a work-related injury or illness. The benefit amount may continue for up to 12 consecutive months or until one of the events listed in ORS 659A.063, whichever occurs first.

(2) An eligible employee may continue coverage for life, short term and long term disability, and accidental death and dismemberment insurance plans for up to 12 months if they self-pay the premiums to the agency.

(3) When an employee returns to work within 12 months, they will have their previous enrollment for medical, dental, life, and disability insurance reinstated the first of the month following their return to work. The employee may make midyear plan changes within 60 days of the date they return to work.

(4) An employee returning to work will not be reinstated in any pretax Flexible Spending Accounts. They may reenroll within 60 days of the date they return to work.

(5) An employee returning to work immediately following CBIW is not required to work at least half-time in the month they return to be eligible for benefits the following month.

(6) A COBRA qualifying event occurs at the end of the CBIW continuation period if the employee has not returned to work.

Stat. Auth.: ORS 243.061-302 & 659A.060-069
Stats. Implemented: ORS 243.061-302 & 659A.060-069
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04, PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0015**
**Continuation of Group Medical and Dental Insurance Coverage for Employees Covered under the Federal Family Medical Leave Act (FMLA)**

(1) The state will continue to pay the benefit amount of the premium for PEBB medical, dental and basic life insurance coverage in effect at the time of a qualified FMLA leave of an eligible employee.

(2) An eligible employee may continue coverage for optional life, short term and long term disability, and accidental death and dismemberment insurance plans for the duration of the approved FMLA leave if they self-pay the premiums to the agency. They may also continue to make contributions to their Healthcare Flexible Spending Account (FSA).

(3) Medical, dental and basic life insurance coverage continues through the end of the month the employee returns to work with no break in coverage. An employee must return to work the first work day following the end of approved FMLA leave to have their previous enrollment for optional life, short term and long term disability, and accidental death and dismemberment insurance reinstated. The reinstatement will be retroactive to the first of the month they return to work. The employee must self-pay the premiums for the month they return to work. The employee may make midyear plan changes within 60 days of the date they return to work.

(4) An employee returning to work will not be reinstated in any pretax Flexible Spending Accounts, unless they continued to make contributions to their Healthcare FSA while on approved FMLA leave. In this case, the employee will be reinstated in the pretax Healthcare FSA. Otherwise, they may reenroll in pretax FSAs within 60 days of the date they return to work.

(5) An employee returning to work the first work day following the end of approved FMLA leave is not required to work at least half-time in the month they return to be eligible for benefits the following month.

(6) An employee returning to work beyond the first work day immediately following the end of approved FMLA leave is treated the same as if returning from leave without pay. See OAR 101-020-0045(2).

(7) A COBRA qualifying event occurs:

(a) At the end of the month that the qualified FMLA leave period ends if the employee has not returned to work.

(b) Before the end of the FMLA period if the employee informs the employer that they will not be returning to work.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0020**
**Continuation of Group Medical and Dental Insurance Coverage for Employees Covered under the Oregon Family Leave Act (OFLA) — ORS 659A.150-186**

An eligible employee who does not qualify for FMLA and who qualifies for and takes an OFLA leave, has a COBRA triggering event the date their active PEBB insurance coverage ends. See OAR 101-030-0005.

Stat. Auth.: ORS 243.061-302 & 659A.150-186
Stats. Implemented: ORS 243.061-302 & 659A.150-186
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0022**
**Continuation of Insurance Coverage for Employees on Active Military Leave (USERRA)**

(1) The state will continue to pay the benefit amount for medical, dental, and basic life insurance coverage in effect at the time an eligible employee begins active military duty. This benefit coverage will continue for the duration of the active military leave up to 24 consecutive months.

(2) An eligible employee may continue coverage for optional life and accidental death and dismemberment insurance plans for up to 24 months if they self-pay the premiums to the agency. They may also continue to make contributions to their Healthcare Flexible Spending Account (FSA) through the end of the plan year. The employee must reenroll during open enrollment to continue participating in the Healthcare FSA for the new plan year. The employee is not eligible to continue short term or long term disability insurance plans while on active military leave.

(3) Medical, dental and basic life insurance coverage continues through the end of the month the employee returns to work within 24 months with no break in coverage. An employee returning to work following active military duty will have their previous enrollment for optional life, short term and long term disability, and accidental death and dismemberment insurance reinstated. The reinstatement will be retroactive to the first of the month they return to work. The employee must self-pay the premiums for the month they return to work. The employee may make midyear plan changes within 60 days of the date they return to work.

(4) An employee returning to work will not be reinstated in any pretax Flexible Spending Accounts, unless they continued to make contributions to their Healthcare FSA while on active military leave. In this case, the employee will be reinstated in the pretax Healthcare FSA. Otherwise, they may reenroll in pretax FSAs within 60 days of the date they return to work.

(5) An employee returning to work following active military duty is not required to work at least half-time in the month they return to be eligible for benefits the following month.

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

(a) Remains in active duty status after 24 months;

(b) Is no longer in active duty status and has not returned to work after 24 months; or

(c) Terminates employment at any time during the 24-month period.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302 & 408.240
Hist.: PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0027**
**Non-medical Leave Without Pay (LWOP) — Continuation of Optional Insurance Plans**

An eligible employee who is in a non-medical LWOP status may continue coverage for optional life and accidental death and dismemberment insurance plans for up to 12 months if they self-pay the premium to the agency. The employee is not eligible to continue short term or long term disability insurance plans while on LWOP.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-030-0035** [Renumbered to **101-030-0007**]

## DIVISION 40

## SPECIAL RULES

**101-040-0015** [Renumbered to **101-020-0012**]

**101-040-0020** [Renumbered to **101-020-0047**]

**101-040-0050** [Renumbered to **101-020-0060**]

**101-040-0055** [Renumbered to **101-020-0065**]

**101-040-0080** [Renumbered to **101-020-0037**]

## DIVISION 50

## RETIREE RULES

**101-050-0005**
**Eligibility for Medical and Dental Insurance Coverage upon Retirement**

An eligible employee and their eligible individuals enrolled in PEBB plans for active employees immediately prior to retirement may continue participation in any PEBB retiree medical or dental insurance plan upon retiring until becoming Medicare eligible. Insurance coverage under the PEBB active and retiree health plans must be continuous.

(1) A retired employee must be:

(a) Receiving a service or disability retirement allowance under the Public Employees Retirement System (PERS) or under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(b) Eligible to receive a service retirement allowance under PERS and have reached earliest retirement age under ORS Chapter 238; or

(c) Eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have reached earliest retirement age under the plan or system.

(2) A retired eligible employee may elect insurance coverage for themselves. A family member, domestic partner, and domestic partner's dependent child must be covered by the employee's active plans immediately prior to the retirement to qualify for coverage under the PEBB retiree health insurance plans.

(3) A former eligible employee who elects COBRA and later becomes eligible as a retired employee will have the right to transfer the COBRA medical or dental insurance coverage to the PEBB retiree health plans at any time during or immediately following COBRA. Insurance coverage under the PEBB active, COBRA, and retiree health plans must be continuous.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302 & 659A.060-069
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-050-0010**
**Enrollment**

(1) A retired eligible employee may continue insurance coverage for themselves, a family member, a domestic partner, and a domestic partner's dependent child under the PEBB retiree health insurance plans. The retiree may choose between full time or part-time and retiree plans and may select medical only, dental only, or medical and dental insurance coverage. If the retiree does not initially enroll in both medical and dental insurance plans, they may not add the other plan at a later date. Completed enrollment forms must be submitted within 60 days of the date active employee insurance coverage is lost. Enrollment in the PEBB retiree health plans must be continuous from active employee insurance coverage to retiree plan

coverage and may be continued until any enrolled individual becomes Medicare eligible.

(2) PEBB may offer a plan change period for retiree insurance plan participants. The plan change period provides the opportunity for the retiree to only change benefit plans. During the plan change period, the retiree may not add dependents or coverage they did not already have.

(3) A retired eligible employee electing to continue PEBB health plans under COBRA will have the right to transfer the insurance coverage in place to the PEBB retiree health plans at any time during or immediately following COBRA.

(4) A retired eligible employee and their eligible individuals may continue participating in PEBB retiree medical or dental insurance plans as long as:

(a) They self-pay the premiums;

(b) They continue to meet PEBB eligibility; and

(c) PEBB continues to offer retiree insurance plan coverage.

(5) Division 20 Enrollment Rules apply to retirees in the following situations:

(a) Midyear benefit plan changes such as those resulting in the addition of a family member, domestic partner, or domestic partner's dependent child to the retiree's insurance coverage. See OAR 101-020-0050.

(b) Adding a newborn or adopted child to the retiree's insurance coverage. See OAR 101-020-0020.

(c) Removing an ineligible individual from the retiree's insurance coverage. See OAR 101-020-0025.

(d) Enrollment or processing errors. See OAR 101-020-0037.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-050-0015**
**Retiree Returning to Work for a PEBB Participating Organization in a Benefit Eligible Status**

(1) A retiree returning to work with a PEBB participating organization in a full time, half-time, or job share classification is eligible for PEBB active employee benefit plans. A retiree returning to paid regular status within 12 months will have their previous enrollment for medical, dental, life and disability insurance reinstated the first of the month following their return to work. A retiree returning to active or paid regular status after 12 months from the previously active insurance coverage end date is treated as a newly hired employee.

(2) A retiree enrolled in a PEBB non-Medicare retiree insurance plan may suspend the retiree insurance coverage when enrolled in PEBB sponsored benefit plans as an eligible employee by notifying the retiree plan administrator.

(3) A retiree with a family member, domestic partner, or domestic partner's dependent child enrolled in Medicare must enroll that individual in the employee's PEBB benefit plans.

(4) Insurance coverage must be continuous between active employee benefit plans and PEBB non-Medicare retiree insurance plans.

(5) A retiree who returns to eligible employee status, continues coverage under PEBB retiree or COBRA insurance plans, and is receiving a state premium subsidy is not eligible to opt out of benefits.

(6) A retiree returning to eligible employee status 12 months from the previously active insurance coverage end date will have guarantee issue options for life insurance coverage as long as they did not use the portability provisions in their life insurance plans upon separation from state service.

(7) A retiree returning to eligible employee status beyond 12 months of the previously active insurance coverage end date is not eligible for a second guarantee issue of long term care insurance.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061-302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 1-2005, f. & cert. ef. 4-14-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-050-0020**
**Retiree Survivor Medical and Dental Insurance Coverage**

An eligible individual enrolled in PEBB retiree medical or dental insurance plans at the time of a retiree's death may elect to continue the retiree survivor insurance coverage available through the PEBB plans as a subscriber. The eligible individual must self-pay the premiums and maintain continuous coverage.

(1) It is the responsibility of the subscriber to notify the retiree plan administrator if they do not want continued coverage.

(2) The surviving spouse or domestic partner of the retiree may continue the medical or dental retiree survivor insurance coverage as long as they remain unmarried, do not form a domestic partnership, and PEBB continues to offer the insurance plans.

(3) The surviving dependent children of the retiree, spouse or domestic partner may continue the medical or dental retiree survivor insurance coverage if they continue to meet eligibility requirements, are not adopted by a new parent, and PEBB continues to offer the insurance plans.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302 & 659A.060-069
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-050-0025**
**Retirees Eligible for Medicare Coverage**

(1) A retiree and eligible individuals enrolled in PEBB retiree insurance plans who become eligible for Medicare coverage may not continue a PEBB retiree insurance plan. The exception is for Medicare eligibility as a result of end-stage renal disease. Insurance coverage ends the last day of the month that eligibility is lost.

(2) If a retiree becomes eligible for Medicare coverage, but their currently enrolled family members, domestic partner and domestic partner's dependent children are not; these eligible individuals may continue PEBB insurance coverage as subscribers. It is the responsibility of the subscribers to notify the retiree plan administrator if they do not want continued coverage.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

## DIVISION 60

## PEBB-PROVIDED HEALTH BENEFIT PLAN FOR LIQUOR CONTROL COMMISSION AGENTS

**101-060-0005**
**Definitions**

The following definitions will apply as used in OAR chapter 101 division 60:

(1) "Eligible employee" means a retail sales agent, appointed under ORS 471.705, who is subject to an agency agreement with the Oregon Liquor Control Commission to sell distilled spirits in the Commission's agency stores. A temporary liquor agent is not considered an eligible employee for PEBB administrative purposes.

(2) "Newly eligible employee" means an agent who has signed a contract with an effective date of July 1, 1985 or later.

Stat. Auth.: ORS 243.061 - 302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-060-0010**
**Eligibility for Medical and Dental Insurance Coverage**

(1) A newly eligible employee may enroll in medical and dental insurance coverage within 60 days of their contract effective date.

Insurance coverage will be effective on the first day of the month following:

(a) The signing of the standard OLCC contract;

(b) The receipt of the completed applicable forms for enrollment in PEBB medical and dental insurance coverage; and

(c) The authorization of a monthly premium payment deduction from the contracted amount.

(2) An eligible employee not enrolling in PEBB medical and dental insurance plans during the initial 60 days following their contract effective date may apply during an open enrollment period. Enrollment of a family member, domestic partner and domestic partner's dependent child during a subsequent open enrollment period will be subject to benefit plan limitations for late enrollment of an eligible individual.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 2-2007, f. 9-28-07, cert. ef. 10-1-07

**101-060-0015**
**Insurance Provision**

PEBB may establish insurance rates consistent with the active employees' group expected actuarial experience including administrative costs.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 243.302
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2004, f. & cert. ef. 7-2-04