



August 1, 2011

[FIRST] [LAST]
[ADDRESS]
[CITY], [STATE] [ZIP]

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Voice: 503-378-6610
Toll-free (Benefits) 888-469-6322
E-mail: oebb.benefits@state.or.us



Dear [FIRST]:

Enclosed are your enrollment materials for the 2011-12 open enrollment period.
This packet contains:

- A summary of the OEBB benefit plans available to you;
- Details of 2011-12 plan changes, including expanded benefits like
 - Weight Watchers® for dependents (age restrictions may apply)
 - Hearing aids (traditional or bone-anchored) for all ages
- An overview of the MyOEBB system enhancements
- A notice relating to the dependent eligibility verification review scheduled for early 2012;
- Information on health savings accounts (HSAs) and the new vendor available for HSAs; and
- Links to helpful Web resources and contact information for the carriers.

Open enrollment begins August 15 and runs through September 15, 2011, for most educational entities. However, you should check with your employer to verify when your specific enrollment period ends. All benefit changes during this period (except those requiring further approval from the carrier) will be effective October 1, 2011.

Enrolling Yourself and Dependents in Benefits

To enroll in benefit plans, access the MyOEBB Member Module and register (if you are first-time user) or log in (if you are a returning user). Remember, you must enroll in each benefit option to receive coverage for the benefit. Enrolling in medical only will not enroll you in other plans such as dental or vision. You must also actively enroll each eligible dependent, including your spouse/domestic partner, in each plan for those individuals to have coverage.

The Web address to enroll in or change benefits is:

<https://myoebb.org/oebb!/pb.main>

Contacting OEBB for Assistance

If you need assistance with enrolling in your benefits or logging into or registering in the MyOEBB Member Module, or have any benefit-related questions, contact the OEBB member services team by calling (888) 4My-OEBB (888-469-6322), or you can e-mail OEBB at oebb.benefits@state.or.us.

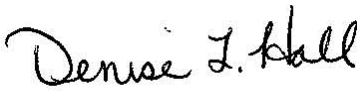
During open enrollment, OEBB member services representatives are available to assist you Monday through Friday from 7:00 a.m. to 6:00 p.m., and 7:00 a.m. to 11:59 p.m. on Thursday, September 15, 2011.

To view or download a copy of the MyOEBB instructional brochure to help you through the enrollment process, or for more information about OEBB, visit www.oregon.gov/DAS/OEBB.

Sincerely,



Joan M. Kapowich, R.N.
Administrator



Denise L. Hall
Deputy Administrator

Contacting the Carriers

To contact the carriers about specific plan details or coverage, use the information below:

BenefitHelp Solutions (COBRA)

(800) 556-2230

www.benefithelpsolutions.com/oebb

Standard Insurance Company

(866) 756-8115

www.standard.com/mybenefits/oebb

Kaiser Permanente

(866) 223-2375

my.kp.org/nw/oebb

Unum

(800) 227-4165

<https://w3.unum.com/enroll/OEBB>

ODS

(866) 923-0409

www.odscompanies.com/oebb

U.S. Bank

(877) 470-1771

www.mycdh.usbank.com

Providence Health Plan

(800) 633-1878

www.providence.org/oebb

Weight Watchers®

(866) 531-8170

www.weightwatchers.com

Reliant Behavioral Health

(866) 750-1327

www.myrbh.com

Willamette Dental Group

(800) 460-7644

www.willamettedental.com/oebb

Internet Resources

To enroll or change benefits, log on to MyOEBB at:

<https://myoebb.org/oebb!/pb.main>

To download the MyOEBB Enrollment Guide go to:

www.oregon.gov/DAS/OEBB

To download the QSC Matrix that identifies life events which allow changes outside of Open Enrollment go to:

www.oregon.gov/DAS/OEBB/docs/QSCs/QSCMatrix.pdf



IMPORTANT INFORMATION FOR 2011-12

Health Savings Account (HSA) preferred vendor – U.S. Bank

An HSA account allows those who are covered under a high deductible health plan (like OEBB's ODS Medical Plan 9) to reduce tax liability while saving money for qualified medical expenses. Effective October 1, 2011, OEBB has contracted with U.S. Bank as the preferred vendor for HSA accounts. If your employer has selected to offer this benefit, representatives from U.S. Bank will be presenting information at open enrollment meetings to explain how HSAs work and answer questions. U.S. Bank also has great tools and information on their Healthcare Payment Solutions website including an interactive HSA presentation.

For more information, please visit the Web pages listed below.

U.S. Bank FAQ page: www.mycdh.usbank.com/faq.html

U.S. Bank website (Healthcare Payment Solutions): www.mycdh.usbank.com

U.S. Bank interactive HSA presentation: <http://myusbankhsa.learncdhc.com>

Guarantee issue coverage for Unum Long Term Care plans

Unum is offering a ONE-TIME additional guaranteed issuance opportunity for optional Employee Long Term Care (LTC) insurance during the 2011 open enrollment period. This special enrollment is available to all eligible OEBB members whose employers have selected this benefit offering, **including those who were offered LTC insurance last year.**

- Employees with amounts less than the guaranteed issuance, or none at all, have the opportunity to elect up to a \$6,000 monthly benefit with a benefit duration of up to 6 years for themselves **without providing proof of medical insurability**. Rate changes may apply if you alter coverage that was previously in effect. Benefit amounts or durations exceeding these maximums are not guaranteed and proof of medical insurability will be required.
- LTC insurance at the OEBB group rate is also available for early retirees directly through Unum if their educational entity offers it to their group, but there is no guarantee issue amount – proof of medical insurability will be required.
- LTC insurance at the OEBB group rate is also available to employees', employees' spouses/domestic partners (through OEBB) and early retirees', early retirees' spouses/domestic partners, adult children and a wide variety of other family members (directly through Unum). There is no guarantee issue for these family members and proof of medical insurability will be required.

During future annual enrollment periods (Fall 2012 and later), OEBB members will be required to provide proof of medical insurability for any amount of LTC insurance. For more information, please contact Unum at 1-800-227-4165 or visit their website: <https://w3.unum.com/enroll/OEBB>.

REMINDER: There is a 12-Month Waiting Period when “Late Enrolling” in Dental and/or Vision

Don't forget ... anyone who does not enroll in **dental and/or vision** coverage when initially eligible, then chooses to enroll at a future Open Enrollment is considered a “late enrollee” and will be subject to a 12-month waiting period on those benefits, meaning only diagnostic and preventive care will be covered for the first 12 months of coverage.

If you have further questions about the 12-month waiting period, please call OEBB Member Services at 1-888-4My-OEBB (1-888-469-6322) or e-mail: oebb.benefits@state.or.us.

2011-12 PLAN ENHANCEMENTS AND CHANGES

Weight Watchers® benefit extended to dependents

Effective October 1, 2011, anyone* covered on an OEBB medical plan will be eligible to participate in Weight Watchers as a fully-covered benefit. More details about the Weight Watchers benefit can be found on the OEBB website: www.oregon.gov/OHA/OEBB/FAQWW.shtml.

**Age restrictions may apply. Call Weight Watchers' OEBB-dedicated line at (866) 531-8170 for details.*

Hearing aid coverage for all ages

Hearing aids, previously only covered for children, will be covered (up to \$4,000 every 4 years) for all ages in the 2011-12 plan year. Coverage for bone-anchored hearing aids has been added as well.

Medical Plan Design Changes

Kaiser Permanente Medical Plan Changes

Kaiser Medical Plan 1

- Primary care office visit copay will be \$15.
- Specialist office visit copay will be \$25.
- Outpatient surgery copay will be \$75.
- Covered lab & x-ray copay will be \$15.
- Urgent care visit copay will be \$35.

Kaiser Medical Plan 1A

- Deductible will be \$100.
- Plan year out-of-pocket maximum will be \$2,000 per person and \$4,000 per family.
- Covered lab & x-ray services copay will be \$20.
- Urgent care visit copay will be \$40.
- Covered hospital, outpatient surgery, and emergency department services coinsurance will be 20% after the deductible has been satisfied.

Providence Medical Plan Changes

BOTH PROVIDENCE PLANS 2 AND 2A ARE MOVING TO A "MEDICAL HOME" MODEL OF CARE. TO LEARN MORE ABOUT MEDICAL HOMES, VISIT THE PROVIDENCE WEBSITE: WWW.PROVIDENCE.ORG/HEALTHPLANS/OEBB.

Providence Medical Plan 2

- **You must declare your chosen medical home to Providence and use providers within that medical home to receive in-network benefits, even if you are continuing with a provider previously covered as a Providence in-network provider. Please declare your chosen medical home to Providence no later than October 1, 2011 to ensure correct claim processing.**
- Deductible will be \$100, whether services are received in-network, out-of-network, or a combination of both.
- Plan year out-of-pocket maximum will be \$1,200 per person (\$3,600 per family) for in-network services and \$2,400 per person (\$7,200 per family) for out-of-network services.
- Specialist office visits, covered lab work, x-rays, durable medical equipment and surgical services coinsurance will 20% in-network or 50% out-of-network, after the deductible has been satisfied.
- Urgent care services copay will \$50, both in-network and out-of-network.
- Emergency department services copay, both in-network and out-of-network, will be \$100 plus 20% coinsurance after the deductible has been satisfied.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.
- Sleep studies and imaging services (CT, PET, MRI) copay will be \$100 both in-network and out-of-network plus 20% coinsurance after the deductible has been satisfied.

Providence Medical Plan 2A

- **You must declare your chosen medical home to Providence and use providers within that medical home to receive in-network benefits, even if you are continuing with a provider previously covered as a Providence in-network provider. Please declare your chosen medical home to Providence no later than October 1, 2011 to ensure correct claim processing.**
- Deductible will be \$300, whether services are received in-network, out-of-network, or a combination of both.
- Plan year out-of-pocket maximum will be \$2,000 per person (\$6,000 per family) for in-network services and \$4,000 per person (\$12,000 per family) for out-of-network services.
- Specialist office visits, covered lab work, x-rays, durable medical equipment and surgical services coinsurance will be 20% in-network or 50% out-of-network, after the deductible has been satisfied.
- Urgent care services copay will be \$50 both in-network and out-of-network.
- Emergency department services copay, both in-network and out-of-network, will be \$100 plus 20% coinsurance after the deductible has been satisfied.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.
- Sleep studies and imaging services (CT, PET, MRI) copay will be \$100 both in-network and out-of-network plus 20% coinsurance after the deductible has been satisfied.

ODS Medical Plan Changes

ODS Medical Plan 3

- Plan year out-of-pocket maximum will be \$1,500 per person (\$4,500 per family) for in-network services and \$3,000 per person (\$9,000 per family) for out-of-network services.
- Primary care office visits copay will be \$25.
- Urgent care services copay will be \$50 both in-network and out-of-network.
- Coinsurance (after deductible and copay when applicable) will be 20% for in-network services and 50% for out-of-network services.
- Specialist office visits coinsurance will be 20% in-network and 50% out-of-network, after the deductible has been satisfied.
- Emergency department services, both in-network and out-of-network, copay will be \$100 plus 20% coinsurance after the deductible has been satisfied.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.

ODS Medical Plan 4

THIS PLAN IS MOVING TO A "COMMUNITY CARE NETWORK" MODEL, UTILIZING A CONCENTRATED NETWORK OF PROVIDERS TO DELIVER COORDINATED CARE. THIS PLAN IS ONLY AVAILABLE TO MEMBERS RESIDING IN MULTNOMAH, CLACKAMAS, YAMHILL, CLARK, MARION, POLK AND WASHINGTON COUNTIES. VIEW A COMPLETE LIST OF ELIGIBLE ZIP CODES AND PARTICIPATING PROVIDERS ON THE ODS WEBSITE: WWW.ODSCOMPANIES.COM/OEBB.

- **There are still no primary care physician requirements on this plan, but members must use Community Care network providers to receive in-network benefits.**
- Deductible will be \$300.
- Plan year out-of-pocket maximum will be \$2,000 per person (\$6,000 per family) for in-network services and \$4,000 per person (\$12,000 per family) for out-of-network services.
- Coinsurance (after deductible and copay when applicable) will remain at 20% for in-network services, but will be 50% for out-of-network services.
- No copay for specialist office visits, instead coinsurance will be 20% for in-network services and 50% for out-of-network services, after the deductible has been satisfied.
- Urgent care services copay will be \$50 both in-network and out-of-network.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.

ODS Medical Plan 5

- Deductible will be \$300.
- Plan year out-of-pocket maximum will be \$2,000 per person (\$6,000 per family) for in-network services and \$4,000 per person (\$12,000 per family) for out-of-network services.
- Coinsurance (after deductible and copay when applicable) will remain at 20% for in-network services, but will be 50% for out-of-network services.
- No copay for specialist office visits, instead coinsurance will be 20% for in-network services and 50% for out-of-network services, after the deductible has been satisfied.
- Urgent care services copay will be \$50 both in-network and out-of-network.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.

ODS Medical Plan 6

- Deductible will be \$400.
- Plan year out-of-pocket maximum will be \$2,100 per person (\$6,300 per family) for in-network services and \$4,200 per person (\$12,600 per family) for out-of-network services.
- Coinsurance (after deductible and copay when applicable) will remain at 20% for in-network services, but will be 50% for out-of-network services.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.

ODS Medical Plans 7 & 8

- Plan year out-of-pocket maximum will be \$2,200 per person (\$6,600 per family) for in-network services and \$4,400 per person (\$13,200 per family) for out-of-network services.
- Coinsurance (after deductible and copay when applicable) will remain at 20% for in-network services, but will be 50% for out-of-network services.
- Outpatient upper endoscopies will no longer be in the \$500 Additional Cost Tier. The copay will be \$100 both in-network and out-of-network, plus 20% coinsurance after the deductible has been satisfied.

ODS Medical Plan 9

- Coinsurance (after deductible and copay when applicable) will remain at 20% for in-network services, but will be 50% for out-of-network services.
- Considered Medicare “Creditable Coverage” effective October 1, 2011.
- *Not a change, but an important note: On ODS Medical Plan 9, the individual deductible and individual plan year out-of-pocket maximum only apply to a single-person enrollment. If you cover two or more people on your plan, the family deductible and family plan year maximum out-of-pocket apply. Any combination of one or more family members can meet the family deductible on this plan. The deductible must be met before benefits will be paid for any services other than preventive services received from an in-network provider.*

Pharmacy Plan Design Changes

Kaiser Permanente Pharmacy Plan Changes

- Plan year maximum out-of-pocket will be \$1,100.

Providence Pharmacy Plan Changes

- Plan year maximum out-of-pocket will be \$1,100.

ODS Pharmacy Plan Changes

ODS Pharmacy Plan A

- Plan year maximum out-of-pocket will be \$1,100.
- New options for ordering prescriptions by mail – Postal Prescription Services (PPS) and BioScrip. Wellpartner will not be available.

ODS Pharmacy Plan B

- Plan year maximum out-of-pocket will be \$1,100.
- There will no longer be a \$100 maximum copay on mail order non-preferred brand medications.
- New options for ordering prescriptions by mail – Postal Prescription Services (PPS) and BioScrip. Wellpartner will not be available.

ODS Pharmacy Plan C

- Plan year maximum out-of-pocket will be \$1,100.
- The “Value Tier” will be added, making certain medications related to the management of asthma, heart conditions, cholesterol, high blood pressure and diabetes available for a \$4 copay at retail outlets or an \$8 copay using mail order.
- New options for ordering prescriptions by mail – Postal Prescription Services (PPS) and BioScrip. Wellpartner will not be available.

Dental and Orthodontia Plan Design Changes

Kaiser Permanente Dental and Orthodontia Plan Changes

Kaiser Dental Plan 7 will be **discontinued** for 2011-12. The last day coverage will be available under this plan is September 30, 2011.

Kaiser Dental Plan 8 will have no changes for the 2011-12 plan year.

Kaiser Orthodontia Option A will be **discontinued** for 2011-12. The last day coverage will be available under this plan is September 30, 2011.

Kaiser Orthodontia Option B will have no changes for the 2011-12 plan year.

ODS Dental and Orthodontia Plan Changes

ODS Dental Plans 1 - 4 will have no changes for the 2011-12 plan year.

ODS Dental Plan 5 will be **discontinued** for 2011-12. The last day coverage will be available under this plan is September 30, 2011.

ODS Dental Plan 6

- Plan year maximum benefit will be \$1,200 per person.

ODS Orthodontia Option

- Lifetime maximum benefit will be \$1,800 per person.

Willamette Dental Plan Changes *(orthodontia coverage included in dental plan)*

Willamette Dental Plan 7 will be **discontinued** for 2011-12. The last day coverage will be available under this plan is September 30, 2011.

Willamette Dental Plan 8 will have no changes for the 2011-12 plan year.

Vision Plan Design Changes

Kaiser Permanente Vision Plan Changes

Kaiser Permanente Vision Plan 5 will no longer have a maximum benefit for routine eye exams.

ODS Vision Plan Changes

ODS Vision Plan 1 will no longer have a copayment for routine eye exams.

ODS Vision Plans 2 - 4 will have no changes for the 2011-12 plan year.

ODS Vision Plan 5 will be **discontinued** for 2011-12. The last day coverage will be available under this plan is September 30, 2011.

Effective October 1, 2011
your OEGB



benefit will also cover
dependents!

The term "dependents" includes anyone on your medical plan, including spouse/domestic partner.

Age restrictions may apply.

Call Weight Watchers at 866-531-8170 for details.

3 Ways to Participate

At Work Meetings

Coworker Support

Improve office health and morale

15 person minimum

Community Meetings

Flexible schedule

Support from others like you

Vouchers accepted nationwide

Online Subscription

Access anywhere

Customized for men or women

Free mobile device tracking

Call the OEGB-dedicated line
(866) 531-8170
to ask questions or get started.

To learn more about OEGB's Weight Watchers benefit, visit:

www.oregon.gov/OHA/OEGB/FAQWW.shtml

WEIGHT WATCHERS is the registered trademark of Weight Watchers International, Inc. and is used under license.

WHAT TO EXPECT IN THE MYOEBB SYSTEM OPEN ENROLLMENT 2011-12

DO YOU NEED TO LOG IN?

OEBB is not requiring you to log in this year, but many of **you should**. Consider the following:

ARE YOUR DEPENDENTS ELIGIBLE?

In 2012, OEBB will be conducting a dependent eligibility verification review which may require you to provide documentation that supports the dependents (including spouses/domestic partners) you have enrolled in the plan. You can take action now by logging in and verifying each dependent's eligibility during Open Enrollment (see back of this page for details). Maintaining appropriate eligibility keeps health care costs affordable for you and OEBB.

MEDICARE ELIGIBILITY

It's very important to **indicate in the MyOEBB system whether you, or any eligible dependents covered on your plan, are Medicare eligible (due to age or disability)**.

Even if you don't enroll in Medicare Parts B or D, the federal government requires OEBB medical plan carriers to report individuals who are or may be eligible for Medicare. Also, when an individual on an "early retiree" plan becomes Medicare eligible, they are no longer eligible for OEBB coverage and there are time limits associated with enrolling for Medicare Part B and D and certain Medicare supplement coverages. Certain restrictions apply to coverage continued under the federal COBRA provisions as well.

OUT-OF-AREA DEPENDENTS

If one of your covered eligible dependents lives outside of Oregon, **you must enter the out-of-area address in the MyOEBB system** to ensure out-of-area services are paid at the in-network level. OEBB will begin sending out-of-state dependents' addresses directly to the carriers electronically as of October 1, 2011. This will replace the current manual process where you need to contact your carrier to provide the dependent's address.

IS YOUR PLAN STILL AVAILABLE?

If you are currently enrolled in:

- Kaiser Dental Plan 7
- Kaiser Ortho Plan A
- ODS Dental Plan 5
- ODS Vision Plan 5, or
- Willamette Dental Plan 7

you must **log in and select another option to have coverage on October 1, 2011**.

OR, if your educational entity chose not to offer your current plan(s) in 2011-12, you must log in and select another option to have coverage on October 1, 2011.

HOW DO YOU WANT YOUR BENEFITS INFORMATION?

This year the MyOEBB system will allow you to select whether you want to receive future OEBB benefits communications electronically via e-mail, or if you would prefer to get hard copies mailed to you. **Be sure to log in and let us know which you prefer!**

SIGNIFICANT PLAN CHANGES

Three medical plans were redesigned for 2011-12 as "**Organized Systems of Care**." The provider networks under these three plans have changed. Benefits for receiving care from out-of-network providers are very limited.

- Providence Medical Plan 2
- Providence Medical Plan 2A
- ODS Medical Plan 4

If you are currently enrolled in one of these plans (and the plan is still available to you in 2011-12) and you don't log in and select a different plan, you will roll into the new plan which could affect how you access your health care. Please be sure to review all options carefully and choose the plan that will work best for you.

HAD A LIFE EVENT?

If you experienced any life changes this year (e.g., marriage, divorce, a death in the family, birth of a baby or adopted a child), you should **review all of the information** included in MyOEBB to make sure everything is up-to-date.

For example:

- Life insurance beneficiaries
- Address, phone number, e-mail address
- Covered dependents include only those who meet the eligibility criteria and who you want to cover (e.g., add or drop a spouse or domestic partner, or children from insurance). See the back of this page for eligibility requirements.

COLLECTING DATA TO IMPROVE HEALTH

OEBB will be collecting demographic data within the MyOEBB enrollment system this year. **Your responses are confidential and will not affect your benefits cost or eligibility in any way.** Collecting this data will allow Oregon Health Authority and OEBB to measure the degree of representation of diverse communities among the population. It will help us increase the effectiveness and efficiency of policies and programs and ensure equal access to quality care for all members. We appreciate your cooperation in this effort.

DEPENDENT ELIGIBILITY VERIFICATION

MAKE SURE EVERYONE YOU COVER MEETS ONE OF THESE DEFINITIONS

OEBB WILL BE CONDUCTING A DEPENDENT ELIGIBILITY VERIFICATION (DEV) REVIEW IN EARLY 2012. IF YOU HAVE ANY DEPENDENTS ON YOUR PLAN WHO DO NOT MEET ONE OF THESE DEFINITIONS, YOU MUST REMOVE THEM DURING THIS OPEN ENROLLMENT PERIOD.

DEFINITION OF "CHILD"

"Child" means and includes the following:

(a) An eligible employee's, spouse's, or domestic partner's biological son, daughter, stepson, or stepdaughter; adopted child, child placed for adoption, or legally placed child, who is 25 or younger on the first day of the month. An eligible employee must provide the required custody or legal documents to their Educational Entity showing proof of adoption, legal guardianship or other court order if enrolling a child for whom the employee, spouse, or domestic partner is not the biological parent.

Note: OEBB no longer accepts Affidavit of Dependency or notarized documents for the purpose of establishing eligibility of a child for whom the employee or spouse/ domestic partner are not the biological parent. Legal guardianship must be confirmed by a court-prepared and -signed document.

(b) A person who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. There is no age limit for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. When the dependent child is 26 years of age or older all the following requirements must be met:

- i. The disability must have existed before attaining age 26.
- ii. The employee must provide evidence to the Educational Entity or OEBB that (1) the person had health plan coverage, group or individual, prior to attaining age 26, and (2) health plan coverage continued without a gap until the OEBB health plan effective date.
- iii. The person's attending physician must submit documentation of the disability to the eligible employee's OEBB health insurance plan for review and approval. If the person receives health plan approval, the health plan may review the person's health status at any time to determine continued OEBB coverage eligibility.
- iv. The person must not have terminated from OEBB health plan coverage after attaining the age of 26.

(c) Eligibility for coverage under this rule includes people who may not be dependents under federal or state tax law and may require an Educational Entity to adjust an Eligible Employee's income based on the imputed value of the benefit.

DEFINITION OF "SPOUSE"

"Spouse" means a person of the opposite sex who is a husband or wife. Except as provided in Oregon Constitution Article XV, Section 5a, 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.

DEFINITION OF "DOMESTIC PARTNER"

"Domestic partner," unless otherwise defined by a collective bargaining agreement or documented district policy in effect on January 31, 2008, means and includes the following:

(a) An unmarried individual of the same sex who has entered into a "Declaration of Domestic Partnership" with the eligible employee that is recognized under Oregon law; or
(b) An unmarried individual of the same or opposite sex who has entered into a partnership that meets the following criteria:

- i. Both are at least 18 years of age;
- ii. Are responsible for each other's welfare and are each other's sole domestic partners;
- iii. 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;
- iv. Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;
- v. Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date the Affidavit of Domestic Partnership is signed and submitted to the Educational Entity; and
- vi. 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.
- vii. The eligible employee and domestic partner must jointly complete and submit to the Educational Entity an Affidavit of Domestic Partnership form, within five business days of the electronic enrollment date or the date the Educational Entity received the enrollment/change form. If the affidavit is not received, coverage will terminate for the domestic partner retroactive to the effective date.

(c) The domestic partner must notify the Educational Entity within 31 days of meeting all criteria as defined in 111-010-0015 (15)(b) or obtaining the "Declaration of Domestic Partnership" which is recognized under Oregon law.

(d) Educational Entities must calculate and apply applicable imputed value tax for domestic partners covered under OEBB benefit plans.

QUESTIONS?

IF YOU HAVE ANY QUESTIONS ABOUT ELIGIBILITY OR YOUR BENEFITS, PLEASE CALL OEBB MEMBER SERVICES AT 1-888-4MY-OEBB (1-888-469-6322) OR E-MAIL: OEBB.BENEFITS@STATE.OR.US