PERS Health Insurance Program (PHIP) Member Guide

A comprehensive guide to the PERS Health Insurance Program

January 1 - December 31, 2026

PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

The PERS Health Insurance Program (PHIP) offers healthcare coverage for retirees, spouses and dependents who meet the eligibility requirements. This guide will help you figure out which options are right for you.

Mission Statement

The PERS Health Insurance Program (PHIP) provides PERS retirees with high-quality, comprehensive coverage or benefits at the most cost-effective rates possible to meet retiree benefit needs.

Our core values are:

- Maintain stability of premiums
- Maintain stability of coverage
- Maintain stability of Contracted Health Plans (CHP)

This guide provides a general summary of PHIP eligibility, enrollment and program guidelines.

PHIP offers both Medicare and non-Medicare health plans as well as dental coverage to eligible PERS retirees, their spouses and dependents. All health plans include prescription drug coverage. To participate in PHIP, you must live in the United States and maintain a permanent residence (not mailing address) within a health plan's service area.

For all program materials or other information regarding PHIP, visit pershealth.com or call Customer Service at 800-768-7377. To view the complete PHIP eligibility and enrollment Oregon Administrative Rules (OAR), visit sos.oregon.gov/archives.

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General Eligibility

The information in this section briefly explains the Oregon Administrative Rule (OAR) 459-035-0020 for enrolling in PHIP health plans.

Eligibility

PHIP reviews eligibility when we receive your enrollment forms. An eligible person includes an eligible PERS retiree, spouse, dependent domestic partner, dependent or surviving spouse or dependent:

- A PERS retiree, who is receiving a PERS retirement allowance or benefit, or who has received an optional lump sum payment.
  - OPSRP disability benefit recipients are not eligible for PHIP until they are an eligible retiree under ORS 238.305, 238.315, 238.195, or 238A.400.
- An eligible spouse is the spouse of an eligible retiree. A marriage certificate is required if the spouse has a different last name than the retiree.
- An eligible dependent domestic partner, defined by IRS Code 26 USC 105(b), refers to a person who has had a relationship with and resides with a PERS retiree for at least 12 months immediately before PHIP enrollment. Also, the PERS retiree must be providing more than one-half of the financial support for the dependent domestic partner and must have claimed them on their most recent federal tax return. You will need to provide an Affidavit of Domestic Partnership and a copy of your most recent federal tax return.
- An eligible dependent is a dependent child who is less than 26 years old and meets one of the following requirements (the retiree must provide legal documentation of birth or adoption):
  - A natural child
  - A legally adopted child or a child placed in the home pending adoption (legal custody and guardianship do not apply)
  - A stepchild who resides in the household of the step-parent who is an eligible retired member
  - A grandchild, provided at the time of birth at least one of the grandchild's parents were covered under a PHIP health plan as a dependent child and must live in the household of an eligible retired member
- An eligible dependent may also be someone who is age 26 or older and has either been continuously dependent upon the retiree since childhood because of a disability or physical handicap, or has been covered under a healthcare insurance plan as the retiree's dependent for at least 24 consecutive months immediately before enrollment in a PHIP plan. In either case, the following additional requirements must be satisfied:
  - The child is not able to achieve self-support through work because of a developmental disability, mental retardation or a physical handicap as verified by a physician and accepted by the health plan.
  - The incapacity is continuous and began before the date the child would otherwise have ceased to be an eligible dependent
- An eligible surviving spouse or dependent refers to:
  - The surviving spouse or dependent of a deceased retired PERS member or
  - The surviving spouse or dependent of a deceased PERS member who was not retired but was eligible to retire at the time of death
- In no event shall an eligible person as defined in this rule be entitled to coverage as both a retiree and as a spouse or dependent.

Enrollment Opportunities

PHIP enrollment opportunities, as defined in OAR 459-035-0070, are the only times you can enroll in PHIP: Eligible retirees and their spouses or dependents who do not choose to enroll in a PHIP health plan during one of these enrollment periods will lose their opportunity to enroll in PHIP.

Effective Date of Coverage

Changes to the original requested PHIP effective date will not be allowed once the requested effective date has passed.

New Retiree

New retirees can enroll within 90 days of their PERS effective retirement date. Your PHIP coverage will begin on your retirement date (if you apply before your retirement date or the date of your PERS disability approval letter) or on the first day of the month your completed PHIP Enrollment Request Form is received (if you apply within 90 days of your retirement date or date of your PERS disability approval letter).

Work After Retirement — Loss of Employer-Sponsored Group Health Coverage

If you continue to work after your PERS retirement and have employer-sponsored group health coverage (your own or with your spouse) you may enroll in PHIP at any time, as long as you have been covered under another employer-sponsored group health plan for 24 consecutive months immediately before you enroll in PHIP.

Employer-sponsored group coverage includes:

- Coverage you had as an active or retired employee
- Coverage you had under an eligible spouse's active employment or as a retired employee
- Coverage continued through COBRA following termination of employment

COBRA coverage is secondary to Medicare, except when the Medicare beneficiary has end-stage renal disease (ESRD); and COBRA coverage is primary to Medicare during the 30-month ESRD coordination period.

For the purposes of PHIP, healthcare coverage under workers' compensation, Medicare or any other government entitlement program (including foreign healthcare) does not qualify as employer-sponsored group health coverage.

To enroll, submit your completed PHIP Enrollment Request Form 30 days prior to your employer-sponsored group coverage ending. To avoid a gap in coverage, choose your PHIP effective date as the first of the month after your employer-sponsored group coverage ends. To make sure you select the correct PHIP effective date, verify the end date of your current health plan coverage with your employer.

PHIP allows up to 30 days to enroll after loss of employer-sponsored group coverage ends. However, if your Enrollment Request Form is received after your group coverage ends (or is incomplete), your PHIP effective date will be the first of the month after we receive your completed Enrollment Request Form. Any application received after 30 days of loss of employer group coverage is considered outside of the enrollment opportunity and will be ineligible.

Initial Medicare Eligibility

PERS retirees can enroll within 90 days of initial Medicare eligibility, if enrolled in both Medicare Part A and Part B. PHIP coverage will begin on the date your Medicare coverage becomes effective — as long as we receive your complete Enrollment Request Form before the date of your initial Medicare eligibility.

If you apply after the date of your initial Medicare eligibility, PHIP coverage will begin the first day of the month after we receive your completed application. You must keep both Medicare Part A and Part B to be enrolled in a PHIP Medicare plan. Any Enrollment Request Forms received after 90 days of initial Medicare eligibility are considered outside of the enrollment opportunity and will be ineligible.

Medicare Disability

Your eligibility to enroll in Medicare Part A and Part B due to Social Security Disability, becomes effective the first day of the 25th month after your Social Security Disability benefits began. In this case, becoming Medicare-eligible due to disability is considered your initial Medicare eligibility.

You will be able to enroll within 90 days of Medicare eligibility. If you miss this opportunity, becoming Medicare-eligible at age 65 will not be a new opportunity to enroll in a PHIP health plan, unless you have had 24 months of continuous employer-sponsored coverage immediately before enrollment in PHIP.

If you are currently enrolled in a PHIP non-Medicare plan, you must complete and submit an Enrollment Request Form 30 days before becoming Medicare-eligible. If you do not submit a new Enrollment Request Form for Medicare coverage, your PHIP coverage will end.

Dependent Enrollment

An eligible spouse or dependent must enroll during any of the enrollment opportunities as the retiree. These include the retiree's date of retirement or Medicare eligibility and after the retiree has had at least 24 consecutive months of coverage under another employer-sponsored health plan. If the retiree does not enroll in PHIP upon his or her final enrollment opportunity, dependent(s) will not be eligible for PHIP coverage.

A Medicare eligible spouse can enroll in a PHIP Medicare health plan before the PERS retiree within 90 days from their initial Medicare eligibility in Medicare Part A and Part B. This is also contingent on the PERS retiree enrolling in PHIP upon their final enrollment opportunity. If the PERS retiree does not enroll in PHIP during their final enrollment opportunity, the spouse will no longer be eligible for PHIP coverage.

You must enroll your new spouse or dependent within 30 days of the family status change (e.g., birth, marriage). If your spouse has a different last name, PHIP will require a copy of the marriage certificate.

To add a new spouse and/or dependent, please complete and submit a PHIP Enrollment Request Form.

Coverage will begin the first of the month after we receive the completed PHIP Enrollment Request Form including additional documentation (e.g., birth certificate, marriage certificate).

Health Coverage After Death

If you are the PERS retiree:

- If your spouse passes away, your PHIP coverage will continue as usual. To end your spouse's coverage, please contact PHIP member services and mail a photocopy of the death certificate to PHIP and separately to the PERS Pension office.

If you are the surviving spouse or dependent child of a PERS retiree:

- If the PERS retiree passes away, your PHIP coverage will continue automatically. You will need to mail a copy of the retiree's death certificate to PHIP and also separately to the PERS Pension office. If you would like to end your coverage, please send PHIP a Disenrollment Form.

Enrollment upon death of the PERS retiree:

- If the surviving spouse is not enrolled at the time of the PERS retiree's death, the spouse may enroll within 90 days of the date of death, or by meeting other enrollment opportunities. However, if the spouse remarries, coverage cannot be extended to the new spouse.

Once disenrollment or termination occurs, you cannot re-enroll in PHIP unless you have a new enrollment opportunity.

Dental Plan Enrollment

To enroll in a PHIP dental plan, you must enroll in a PHIP medical plan during the same enrollment opportunities as the PHIP medical plan. Dependents' dental coverage must be with the same contracted dental plan as the retiree. However, the retiree can choose dental and medical plans from different Contracted Health Plans (CHP).

For Kaiser Permanente dental, you must live in the Kaiser Permanente dental plan service area.

Health Plan Options

When you pick a health or dental plan, your permanent residence (not mailing address) must be within the United States and the health plan's service area. Learn more about current PHIP plans by reviewing the benefit outline and rate information at pershealth.com.

Medicare Health Plan Options

PHIP offers Supplement, HMO, HMO-POS and PPO plan options for Medicare retirees. All Medicare eligible members, spouses and dependents must be enrolled and retain both Part A and Part B of Medicare. If you turn down Part B when first eligible and request to enroll at a later date, Medicare may charge you a penalty. If you stop paying your Part B premium, you will lose your ability to continue any of the PHIP Medicare health plans.

In addition, if you do not have Part A and Part B in place when you lose employer-sponsored group coverage, you cannot enroll in a PHIP plan. This may cause you to lose your enrollment opportunity.

When the retiree and spouse/dependent have Medicare, the coverage must be with the same Contracted Health Plan.

PHIP Medicare Advantage Plans — All Plans Include Medicare Part D Prescription Drug Coverage

Contracted Health Plan	HMO	HMO-POS	PPO
Kaiser Foundation Health Plan of the NW	Kaiser Permanente Senior Advantage		
Providence Medicare Advantage Plans	Providence Medicare Align Group Plan + RX	Providence Medicare Flex Group Plan + RX	
UnitedHealthcare®			UnitedHealthcare® Group Medicare Advantage (PPO)

PHIP Medicare Supplement Plan — Includes Medicare Part D Prescription Drug Coverage

Contracted Health Plan	Medicare Supplement Plan
Moda Health Plan, Inc.	Moda Health Supplement Plan

You can find additional information on Medicare and PHIP in the PERS Health Insurance Program (PHIP) Medicare Enrollment Guide.

Non-Medicare Health Plan Options

PHIP offers a traditional HMO and PPO plan, as well as qualified High Deductible Health Plans (HDHPs) for non-Medicare retirees. Once you become eligible for Medicare, you will not be eligible to enroll in a PHIP non-Medicare plan. If you are enrolled in a PHIP non-Medicare plan, when you become eligible for Medicare, your non-Medicare coverage will be terminated.

When the retiree and spouse/dependents are enrolling in non-Medicare coverage, the coverage must be with the same Contracted Health Plan.

The PHIP qualified High Deductible Health Plan (HDHP) can be used with a Health Saving Account (HSA). If you have other health insurance coverage such as Medicare, or private health insurance, you are not eligible for this type of plan. You are also not eligible if you are claimed on someone else's tax return.

Once enrolled in the Qualified HDHP plan, you cannot switch to the Core Value plan at any time in the future.

Health Savings Account (HSA) Basics

An HSA is a special savings account that you contribute money to, then withdraw funds to be used for qualified medical, pharmacy, dental and vision expenses. HSAs are funded by individual contributions and have annual contribution limits set by the IRS. Additionally, HSAs allow you to carry over your balance from year-to-year. Contributions cannot be directly deposited to your HSA from your pension benefit.

If you are 55 or older an additional annual catch-up contribution may be available. If you change plans or become Medicare eligible you can keep the HSA account and the money in it, which you can continue to use for qualified expenses.

You are responsible for setting up your HSA through a financial institution.

HSA and Medicare

Once you become eligible for Medicare you can no longer contribute to your HSA, but you can still cover some medical expenses with existing HSA funds. These expenses include Medicare premiums and premiums for long-term care insurance.

PHIP Non-Medicare Health Plans — All Plans Include Prescription Drug Coverage

Contracted Health Plan	HMO	PPO	HDHP*
Kaiser Foundation Health Plan of the NW	Kaiser Permanente Traditional Core Value *(no deductible)*		Kaiser Permanente Qualified HDHP *($3000 deductible)*
UnitedHealthcare®		UnitedHealthcare Select Plus Core Value *($1000 deductible)*	UnitedHealthcare Select Plus Qualified HDHP *($3000 deductible)*

* HSA Qualified. Contact a tax advisor for specific rules regarding a Health Savings Account.

Dental Plan Options

You can enroll in either dental plan. However, for Kaiser Permanente dental, you must live in the Kaiser Permanente service area.

Contracted Health Plan	Plan Type
Kaiser Foundation Health Plan of the NW	Dental Maintenance Organization (DMO)
Delta Dental Plan of Oregon	Indemnity

Exclusions and Limitations

All available health and dental plans have some exclusions and limitations. You can find this information in the Evidence of Coverage (EOC) or member benefit handbook that you receive from your health or dental plan after enrollment.

Health Coverage While Traveling

All PHIP health plans provide coverage for urgent and emergent care when you travel anywhere in the world. When you travel outside of your health plan's service area, your coverage is limited. Some plan's travel benefits have limits and exclusions. Before you travel, contact your health plan to determine how your travel benefits will work if you need services while you are away.

Kaiser Permanente

Members temporarily visiting other Kaiser Permanente regions may receive visiting member care from designated providers in those areas. Before getting care in another Kaiser Permanente area, you'll need a medical record number for the area you're visiting.

This also includes a travel benefit for necessary follow-up care from any Medicare provider outside the plan service area. Plan pays 80 percent of the Medicare allowable charge, if the provider accepts assignment. Otherwise, Kaiser Permanente will pay 80 percent of the Medicare limiting charge, if the provider does not accept assignment. The member pays 20 percent, up to a combined $1,000 annual limit.

Travel vaccines are prescribed through the Kaiser travel clinic after itinerary review.

Moda Health Plan, Inc.

The Moda Health Medicare Supplement plan provides you coverage throughout the entire United States, including the U.S. territories. When traveling outside the United States, Original Medicare usually does not provide any coverage.

This is where your Moda Health Medicare Supplement plan comes in. If you find yourself in need of urgent care, emergency, or ambulance services when you are outside the United States, Moda Health will pay 80% and you will be responsible for 20%. Coverage outside the United States is limited to a lifetime maximum of $50,000.

Providence Medicare Advantage Plans

Providence Medicare Align Group Plan + RX (HMO) includes a travel benefit for necessary follow-up care from any Medicare provider outside the plan service area. Plan pays 80 percent and the member pays 20 percent, up to a combined $1,000 annual limit.

Providence Medicare Flex Group Plan + Rx (HMO-POS) offers an out-of-network benefit that allows you to see any Medicare-approved provider. There is no annual limit on what Providence will pay for approved out-of-network services.

UnitedHealthcare

Medicare

While traveling abroad, as a member of UnitedHealthcare you are covered for emergency care and urgently needed services. This includes urgent care, emergency room and ambulance services to the nearest facility for your condition. It does not include transportation back to the United States.

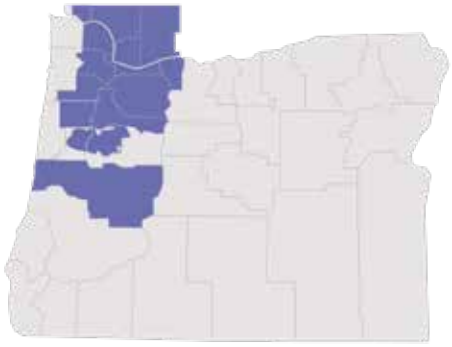
Non-Medicare

While traveling abroad, as a member of UnitedHealthcare you are covered for emergency care and ambulance services to the nearest facility. Transportation back to the United States is not covered.

If you do need services while traveling outside your plan service area or in a foreign country, it is likely that you will need to pay out of pocket for those services and submit a claim for reimbursement from your health plan when you return.

Health Plans Enrollment and Service Areas

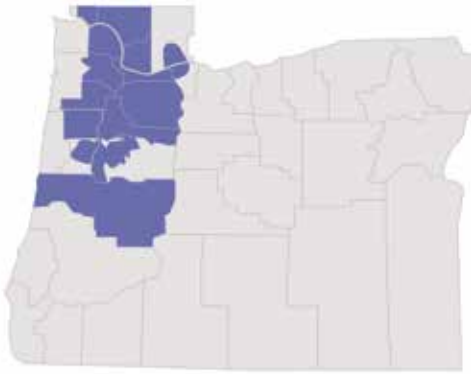
Kaiser Foundation Health Plan of the NW



Medicare Service Area

Oregon — Benton: 97321, 97330, 97331, 97333, 97339, 97370; Clackamas; Columbia; Hood River; Lane; Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97383, 97389; Marion; Multnomah; Polk; Washington; Yamhill

Washington — Clark; Cowlitz; Skamania; Wahkiakum: 98612, 98647



Non-Medicare Service Area

Oregon — Benton: 97330, 97331, 97333, 97339, 97370; Clackamas; Columbia; Hood River: 97014; Lane; Linn: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389; Marion; Multnomah; Polk; Washington; Yamhill

Washington — Clark; Cowlitz; Skamania: 98639, 98648; Wahkiakum: 98612, 98647

Dental Service Area

Oregon — Benton: 97330, 97331, 97333, 97339, 97370, 97456; Clackamas; Columbia; Hood River: 97014, 97031, 97041, 97044; Lane: 97401, 97402, 97403, 97404, 97405, 97408, 97409, 97419, 97424, 97426, 97431, 97437, 97438, 97440, 97446, 97448, 97451, 97452, 97454, 97455, 97461, 97475, 97477, 97478, 97487, 97489; Linn: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389; Marion; Multnomah; Polk; Washington; Yamhill

Washington — Clark; Cowlitz; Lewis: 98591, 98593, 98596 Skamania: 98605, 98610, 98639, 98648, 98651; Wahkiakum: 98612, 98647

KAISER PERMANENTE®

Proudly serving the Northwest for over 70 years, Kaiser Permanente offers comprehensive care that is convenient, connected, and designed to provide the prevention, wellness, and healthcare resources you need to live well. You have access to 54 offices (medical and dental) from Eugene, OR to Longview, WA; with pharmacy, lab, X-ray, dental, and vision services, so you can do more and drive less. Same-day appointments and after-hours urgent care are available for life's unexpected moments.

Kaiser Permanente Medicare Senior Advantage

Get more. More control, convenience, and quality with a plan that goes beyond Original Medicare. With care under one roof, online health management tools, worldwide emergency coverage, and comprehensive care that builds in wellness programs and supportive services to promote your total health, Kaiser Permanente's Medicare Senior Advantage plan offers comprehensive care and coverage.

Kaiser Non-Medicare Plans

Traditional Core Value (HMO plan, no deductible)

With a Kaiser Permanente Traditional Core Value plan, you don't have to keep track of deductibles or worry about paperwork for the services you receive. When you come in for care, you'll just pay a copay for most services covered by your plan.

Qualified High Deductible Health Plan (HDHP, $3,000 deductible)

With a Kaiser Permanente qualified HDHP plan, you have a lower premium and preventive care is not subject to the deductible. Most other services are subject to the deductible and then 20% coinsurance. To learn more about how the HSA pairs with the qualified HDHP, refer to page 8.*

PHIP Prescription Drug Benefit for Kaiser Permanente

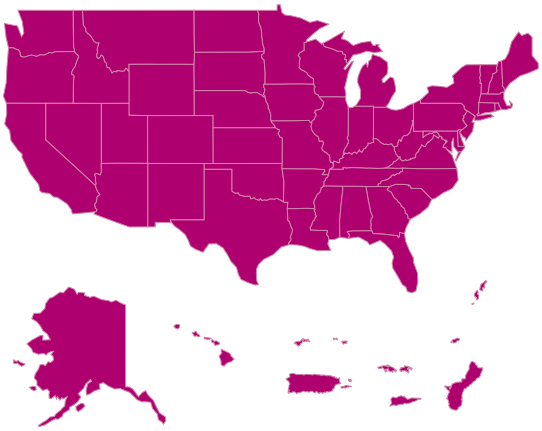
Members enrolled with Kaiser Permanente through PHIP are covered under the Kaiser prescription drug benefit. Kaiser Permanente members must use Kaiser pharmacies to obtain prescription drugs (except in Eugene service area).

Dental Plan

The Kaiser Permanente dental plan offers 21 dental offices in the Northwest region. For added convenience, you can also take advantage of our no-cost virtual dentistry options, including email, phone visits, and video visits. You must reside in the Kaiser Permanente service area to enroll in Kaiser Permanente dental coverage.

** Contact a tax advisor for specific rules regarding Health Savings Accounts (HSAs).*

Moda Health and Delta Dental Plan of Oregon



Medicare and Dental Service Area

Nationwide including the U.S. territories

Rooted in the Pacific Northwest since 1955, Moda Health and Delta Dental Plan of Oregon is dedicated to partnering with you to help you live a healthier life. We are proud to provide you with enhanced benefits, innovative programs and exceptional customer service.

Moda Health Medicare Supplement Plan

For over 30 years, Moda Health has been offering the Medicare Supplement plan to PERS members. This is a Medicare Supplement insurance program that pays secondary to Medicare. Members have the freedom to receive services from any Medicare provider nationwide and can live anywhere within the United States and U.S. territories. With this plan, there are no referrals required, no PCP requirements, and you pay nothing for Medicare covered services after your Medicare Part B deductible has been met. This plan also includes additional value-added services and discounts beyond what Medicare covers.

PHIP prescription drug benefit for Moda Health

Members in the Moda Health Medicare Supplement plan are covered under the Moda Health Part D prescription drug plan. Moda Health has a comprehensive national network with close to 63,000 participating pharmacies throughout the United States. This includes most well-known, large national and regional chains, as well as many neighborhood pharmacies.

Delta Dental Plan of Oregon

Delta Dental Plan of Oregon, a local company, gives you access to the Delta Dental Premier and PPO national networks, the country's largest dental networks. With close to 154,000 participating dentists to choose from nationwide, you can get the dental care you need wherever you are.

moda HEALTH

DELTA DENTAL®

Providence Medicare Advantage Plans

Medicare Service Area

Oregon — Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler and Yamhill

Washington — Clark, Snohomish and Spokane

Healthcare today must go beyond the essentials of coverage and doctors' visits. Join us in our shared pursuit to care for one another equitably, recognize the cultural challenges in healthcare today, and improve outcomes for all.

Providence Medicare Advantage Plans

With Providence Medicare Flex Group Plan + Rx (HMO-POS) or Providence Medicare Advantage Align Group Plan + Rx (HMO), you get all the benefits of traditional Medicare and more.

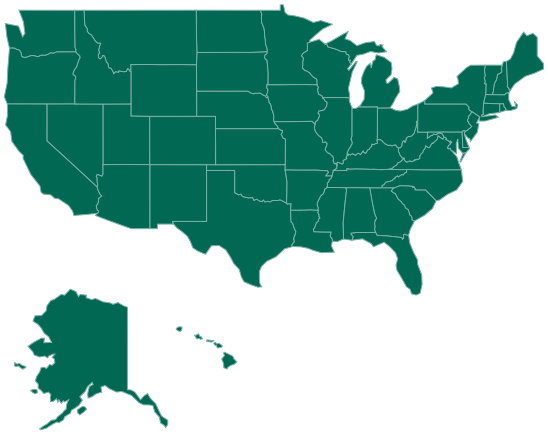
- Choose from thousands of in-network providers, both in and out of the Providence system.
- Sign up for Providence Express Care Virtual (at no cost) and visit with a provider via live secure video from your tablet, smartphone, or computer.
- Get same-day treatment at a Providence Express Care Clinic.
- Start or continue a healthy fitness routine and take advantage of a no-cost fitness center membership benefit.
- Take advantage of the routine hearing exam and hearing benefit.

PHIP Prescription Drug Benefit for Providence

Members enrolled in a Providence Medicare Advantage plan through PHIP are covered under the Providence Medicare Advantage plan Part D prescription drug benefit. Providence Medicare Advantage plan has over 34,000 participating pharmacies available for use nationwide. Most of our network pharmacies have preferred cost sharing, and member responsibility may be less when using these preferred cost-sharing pharmacies.

Providence
Medicare Advantage Plans

UnitedHealthcare



UnitedHealthcare® has been serving the people of the Northwest for more than 30 years.

We are dedicated to helping people live healthier lives by simplifying the healthcare system for everyone, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers.

UnitedHealthcare Medicare Advantage Plan

The UnitedHealthcare Group Medicare Advantage plan is a Preferred Provider Organization (PPO) plan which offers comprehensive coverage for hospital and medical services, as well as additional programs that go beyond Original Medicare.

Members have access to our national network of providers and the flexibility to see any provider (in or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of Medicare.

UnitedHealthcare Non-Medicare Plans

Select Plus Plan

The Select Plus plan options give members and their dependents the freedom to choose a network physician or specialist from the UnitedHealthcare Select Plus network without visiting a primary care physician (PCP) for a referral. Select Plus includes plan coverage for out-of-network providers. You will generally pay less for services from providers in the UnitedHealthcare network.

Core Value ($1,000 deductible)

The Select Plus Core Value plan allows you to see any provider you wish by offering both in and out of network benefits. Some services are covered with just a member copay.

Qualified High Deductible Health Plan (HDHP, $3,000 deductible)

The qualified HDHP also allows you to see any provider you wish by offering both in and out of network benefits. The HDHP pairs traditional medical benefits with a tax-qualified financial product known as a Health Savings Account (HSA). To learn more about how the HSA pairs with the qualified HDHP, refer to page 8.*

Medicare and Non-Medicare Service Area

Nationwide including the U.S. territories

PHIP Prescription Drug Benefit for UnitedHealthcare

Members enrolled with UnitedHealthcare through PHIP can choose from thousands of pharmacies across the United States, including national chain, regional, and independent local retail pharmacies.

Home Delivery Pharmacy

Home delivery prescriptions can be obtained through OptumRx, our preferred mail service pharmacy. OptumRx fills your order and mails it to you at no additional cost for standard shipping.

** Contact a tax advisor for specific rules regarding Health Savings Accounts (HSAs).*

Premium Subsidies

Retirement Health Insurance Account RHIA (Medicare)

Oregon Revised Statute (ORS) 238.420 established a trust fund called the RHIA premium subsidy. The information presented in this section is a summary of OAR 459-035-0030.

RHIA pays a $60 monthly contribution toward the cost of PHIP healthcare coverage for some PERS retirees who are eligible for Medicare. PHIP determines eligibility by verifying your pension service records. If you are eligible, the contribution will be automatically applied to your monthly premium.

To have RHIA contributions applied toward your PHIP premiums, you must:

- Be enrolled in Medicare Part A and Part B; and also meet one of these requirements:
  - Receive a PERS service or disability retirement allowance under Tier 1 or Tier 2 and have had eight or more years of qualifying service at the time of retirement; or
  - Receive a PERS disability retirement allowance calculated as if the retiree had eight or more years of creditable service and was a Tier 1 or Tier 2 retiree
- Be a surviving spouse or dependent of a deceased, eligible Tier 1 or Tier 2 retired member, as described on page 4, who is enrolled in Medicare Part A and Part B; and who also meets either of these requirements:
  - Is receiving a retirement allowance or benefit from PERS
  - Was covered under an eligible retiree member's PHIP health plan at the time of the retiree's death and the deceased member retired on or before May 1, 1991

Retiree Health Insurance Premium Account RHIPA (Non-Medicare)

ORS 238.415 established a trust fund called the RHIPA premium subsidy. The information in this section is a summary of OAR 459-035-0040.

RHIPA pays a monthly contribution toward the cost of healthcare coverage for some state of Oregon retirees who are not eligible for Medicare. This contribution applies only to PERS retirees who retire directly from a state agency and whose PERS effective retirement date is the first of the month following termination from state employment.

It does not apply to those who retire from a local government agency such as a city, county or school district.

PHIP determines eligibility by verifying your pension service records. If you are eligible, the contribution will be automatically applied to your monthly premium.

To have RHIPA contributions applied toward your PHIP premiums, you must meet the following requirements:

- Be a Tier 1 or Tier 2 retiree who is a State of Oregon employee at the time of retirement and is not eligible for Medicare, and who also:
  - Receives a PERS service or disability retirement allowance or benefit and has had eight or more years of qualifying state service at the time of retirement (only STATE service time applies toward RHIPA subsidy); or
  - Receives a PERS disability retirement allowance calculated as if the retiree had eight or more years of creditable state service and had reached the earliest service retirement age.

- Be a surviving spouse or dependent of a deceased, eligible Tier 1 or Tier 2 retired state of Oregon employee, as described on page 4, who is not eligible for Medicare and who meets one of these requirements:
  - Is receiving a retirement allowance or benefit from PERS
  - Was covered under an eligible retiree member's PHIP health plan at the time of the retiree's death and the eligible retired state employee retired on or after September 29, 1991

If you are a surviving spouse or are no longer eligible for an ongoing pension benefit, you may no longer be eligible for a premium subsidy. If you received a subsidy while not eligible, you will have to repay any funds you received while not eligible.

Premium Payment Information

Because verification is based on final pension calculations, the retiree will be sent premium invoices reflecting the full premium amount until PHIP verifies the eligibility for a premium subsidy. Once this information is verified, any refunds due will be sent automatically.

RHIPA subsidy rates will become available by November 1 of each year.

Updated information will be sent to all participating RHIPA members. If you have questions, please contact the PHIP office.

How to Enroll

During peak enrollment times (e.g., plan change, peak retirement periods, end of month), you may experience delays.

Please allow time for PHIP to process your Enrollment Request Form and notify your health plan. If you need immediate access to your health plan information, please contact PHIP Customer Service.

Enrollment

OAR 459-035-0070

You must send a completed PHIP Enrollment Request Form when you enroll for the first time, add a spouse or dependent, or make a change to your PHIP coverage.

Completed Enrollment Request Form

OAR 459-035-0080

In order to avoid a gap in coverage or losing your enrollment opportunity, please send all requested information and documentation with the completed Enrollment Request Form before your requested effective date.

If your Enrollment Request Form is missing information, your application will be considered incomplete.

If you are unable to provide the necessary information and documentation prior to your requested effective date, your effective date will change to the first of the next month.

To enroll in any PHIP health plan, you must:

- Be an eligible PERS retiree, spouse, or dependent
- Meet one of the PHIP enrollment opportunities
- Complete information about yourself
  - Include spouse or dependent information only if they are enrolling in PHIP
- Indicate your reason for applying for PHIP coverage
- Complete the Medicare information section, if Medicare-eligible
- Select a medical and dental plan (dental plan optional)
- Choose your premium payment option
- Read and answer the important questions
- Sign the form: A signature is required by all enrollees (age 18 or over)
- Submit all completed enrollment documents to PHIP prior to the requested effective date of coverage`

Additional documentation may be required. This may include a copy of your Medicare card or Letter of Entitlement, a dependent's birth certificate, adoption paperwork, PERS disability approval letter, PERS Intent to Deny Letter, Affidavit of Domestic Partnership, or marriage certificate (if last names are different).

Your coverage will start on the date described in the Enrollment Opportunities section on page 5.

After Enrollment

Annual Plan Change Period

From October 1 to November 15, you can submit paperwork to change your medical and/or dental plan to another PHIP plan available within your residing area. Changes made during this time become effective January 1 of the following year. If you're enrolled and don't want to change plans, you don't need to do anything.

You may not add dental coverage or dependents during the Plan Change Period unless you have an enrollment opportunity.

If you do need to make a change, you'll need to fill out a Disenrollment Form for the plan you are ending, and an Enrollment Request Form for the new plan. You'll need to submit both forms to PHIP before November 15.

Find forms at pershealth.com or by calling PHIP customer service.

If you do not submit a change during this period, you will be unable to change your enrollment midyear, unless you experience a family status change or new enrollment opportunity.

Snow Bird

The Snow Bird option allows members enrolled in PHIP Medicare Advantage plans to change their health plan to the Moda Health Medicare Supplement Plan or UnitedHealthcare® Group Medicare Advantage (PPO) plan while temporarily living outside their Medicare Advantage plan's service area. Members must live outside the service area for more than 60 days to use this option.

After returning to Oregon, members will be eligible to change back to their prior Medicare Advantage plan.

The Snow Bird option also applies to non-Medicare members who are enrolled in Kaiser Permanente. You have the option to change to the same plan under UnitedHealthcare.

You must fill out a Disenrollment Form for the plan you are ending and an Enrollment Request Form for the new plan before leaving the area, and again upon returning. Please contact PHIP for more information.

Health Coverage While Traveling

Before you travel, contact your health plan to determine your travel benefits. All PHIP health plans cover urgent and emergent care when you travel.

If you get medical services outside of the United States, ask for an itemized statement of care (in English, if possible). Then submit it to your health plan for reimbursement.

Moda Health Medicare Supplement foreign travel emergency coverage has a lifetime limit of $50,000.

Members temporarily visiting other Kaiser Permanente regions may receive care from designated providers in those areas.

Medicare does not provide coverage outside of the United States and U.S. territories. You may choose to buy a travel insurance policy to get health coverage abroad. Travel insurance might not include health insurance, so make sure to read your plan details carefully.

Change of Address

If you change your address, you must notify PHIP in writing. Complete, sign, date, and submit a Change of Address Form to PHIP. Address changes may be sent via mail or fax. Email requests will not be accepted.

PHIP will notify the appropriate health plan.

If you do not notify PHIP within 30 days of moving outside a service area, you may lose coverage. You must maintain a permanent residence within the United States to be eligible for PHIP. If you reside in another country, you are not eligible to keep PHIP coverage.

Premium Payments

Making monthly premium payments

You have two premium payment options:

- Deduction from your monthly PERS pension check. This ensures timely premium payment and prevents a lapse in coverage. If you choose this option, the PERS pension holder's signature is required any time an Enrollment Request Form is submitted.
- Electronic Funds Transfer (EFT) from your bank account. This also ensures timely payment and prevents a lapse in coverage.

Only one payment option is allowed per PHIP account.

Premium rates are subject to change mid-year due to Medicare requirements, such as Medicare Part D Late Enrollment Penalty (LEP) or Low Income Subsidy (Extra Help) notifications. PHIP is required to adjust premiums to account for these changes. For questions regarding premium changes due to Medicare programs, contact Medicare directly.

Late Payments

Your premium payment is due on the first of each month. If your payment is not received by then, your account will be considered delinquent.

If you do not pay your premium, your health plan coverage will be canceled.

If your coverage is canceled, you may have to pay for all claims, unless they are covered under Original Medicare.

OAR 459-035-0090 (3) If payment is by check or money order, the check or money order must be physically received by the Third Party Administrator on or before the due date. (4) Failure to make the payment by the due date shall result in termination of a person's PERS-sponsored health insurance coverage.

Disenrollment

Voluntary Disenrollment

If you would like to end your PHIP coverage, you will need to complete and send a PHIP Disenrollment Form. This is required by PHIP and Medicare.

This change will be effective on the first of the month after we receive your PHIP Disenrollment Form, unless you request a later date. If your spouse and/or dependent child (age 18 and over) are part of your plan, they will also need to sign the form.

If anyone in your family stops their dental coverage, the whole family will lose their dental coverage.

Involuntary Termination

PHIP may be required to end your coverage if you:

- Lose your Medicare Part A and/or Part B
- Sign up for another non-PHIP Medicare Advantage or Medicare Part D Prescription Drug Plan
- Fail to pay your monthly premium
- Lose your retirement status by returning to work

If your PHIP coverage ends, you may not sign up for PHIP unless you get a new enrollment opportunity. If you owe PHIP money, you will need to pay any outstanding balance before you can re-enroll.

PHIP Enrollment and Eligibility Appeals

Appeal Rights

Pursuant to Oregon Administrative Rules (OAR) 459-001-0030, if you disagree with staff's determination, you may request a review by writing to the PERS Director within 60 days after the date of this letter. Your request should include the following information:

(a) A description of the determination you want reviewed

(b) A short statement describing how and why you think the determination is wrong

(c) A statement of facts that you believe show the determination is wrong

(d) A list of any statutes, rules, or court decisions that you believe support your position

(e) A statement of the action you seek

(f) A request for review

Oregon Revised Statutes are available from the Office of Legislative Counsel, or can be located on the internet at https://www.oregonlegislature.gov/bills_laws.

Oregon Administrative Rules are available from the Oregon State Archives at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_459/459_tofc.html.

Mail appeal to:
Public Employees Retirement System
Attn: PHIP Appeals
P.O. Box 23700
Tigard, OR 97281-3700

The Director may ask a Division Administrator to act on your appeal. Your request will either be granted or denied. You will be mailed a response letter within 45 days after we receive your request.

Health Plan Appeals

If you have appeals, complaints, or grievances about your health plan benefits or claims, please send them to the health plan in which you are enrolled. Refer to your plan's Evidence of Coverage (EOC) or member benefit handbook for more information. To get a copy of these materials, please contact your health plan directly.

Contact information can be found in the resources section on page 26.

Required Notices

Women's Health and Cancer Rights Act

Beginning in 1999, federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction on the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles, coinsurance amounts and copayments that are consistent with those that apply to other benefits under the plan.

Power of Attorney or Authorization to Disclose Information

PHIP requires that a Power of Attorney or Authorization to Disclose Information be on file at the PERS Health Insurance Office for anyone acting on a member's behalf. PHIP is unable to release information to anyone who is not authorized by the PHIP member. To disclose or change information after the death of a member, please provide one of the following: executor, letter of probate or trustee documentation, or Last Will and Testament.

COBRA Continuation of Coverage

If you experience one of these qualifying events, you or your dependent may be eligible for continuation of coverage through COBRA. In accordance with federal and state of Oregon guidelines, PHIP provides opportunities for the continuation of coverage through COBRA following specific qualifying events. If you experience one of the qualifying events listed below, please contact PHIP for additional information. A qualifying event will occur if eligibility for coverage is lost because of:

- Cancelation of PERS retirement status
- The divorce or legal separation of a retiree's covered spouse; PHIP must be notified within 60 days from the signed Dissolution of Marriage document
- A spouse or dependent child no longer meeting eligibility requirements (e.g., a child reaches the maximum age limit, or a spouse loses coverage because the retiree does not enroll in PHIP upon the last enrollment opportunity)

Once COBRA has been secured, timely payment of premiums is essential.

Timely COBRA Premium Payments

Once you elect COBRA coverage, you have 45 days to pay the initial premium. After that, premiums are due the first day of each month. If your initial payment is not (postmarked or received) by the due date, your coverage will be terminated and cannot be reinstated. You have a 30-day grace period for monthly payments, after which your policy will be canceled and cannot be reinstated. The initial premium must be paid within 45 days of the date COBRA is elected. Thereafter, premiums are due the first day of each month for that month's coverage. If payment is not postmarked on or before the 45th day (for the initial premium) or the 30th day following the monthly due date, coverage will be terminated and cannot be reinstated.

Definitions

Coinsurance

Coinsurance is the portion of cost that a member will pay for healthcare services. It's usually shown as a percentage.

Contracted Health Plan (CHP)

Health plans contracted with PHIP to offer medical and/or dental benefits.

Copay/copayment

A fixed amount the member pays at the time of receiving a healthcare service. Generally, the copayment is the only cost the member will have for a service.

Deductible

The amount of money each year that members pay out of their own pocket before their health plan begins to pay.

Dental Maintenance Organization (DMO)

A dental plan that offers services through a network of dentists. DMOs require you to select a primary dentist who will work with you to manage your dental needs. You may need a referral to see a specialist. Out-of-network services may not be covered.

Employer Sponsored Group Health Plan

A plan sponsored by an employer, or by an employer in partnership with a union, that provides medical and/or dental care to two or more employees.

Evidence of Coverage (EOC)

Every year, your plan will send you an Evidence of Coverage (EOC). This document provides details about what the plan covers, how much you will pay, and other important information.

Health Maintenance Organization (HMO)

HMO plans offer healthcare services through a network of providers and hospitals at a fixed price (copay). Most HMOs require you to select a primary care provider (PCP) who will work with you to manage your healthcare needs. Under an HMO plan, you may need a referral to see a specialist. Out-of-network services may not be covered.

Health Savings Account (HSA)

An HSA can be used to help pay for qualified healthcare expenses before you meet your deductible. It is for people who are covered under a high-deductible health plan.

High Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional healthcare plan. The deductible must be paid before the plan starts to pay. A qualified HDHP may be combined with a health savings account (HSA).

Medicare Advantage (MA) Plan

Medicare Advantage (MA) plans cover medical and prescription drugs with a single premium. MA plans contract with hospitals and physicians to provide care. When you sign up for any MA plan, that plan becomes the administrator of your Medicare Part A and Part B benefits. You will continue to pay the monthly Medicare Part B premium in addition to your PHIP Medicare Advantage premium.

Medicare Supplement Plan

Medicare Supplement plan works like a Medigap plan: It fills in the gaps in Original Medicare. You can choose any physician who is a Medicare participating provider. You can live anywhere in the United States, travel outside the U.S., and still maintain coverage.

Medicare Supplement plan and Original Medicare will each pay its share of covered health care costs. You will continue to pay the monthly Medicare Part B premium in addition to your PHIP Medicare Supplement premium.

Point-of-Service (POS)

POS plans work similar to an HMO plan with a flexible network that allows care outside of the traditional HMO network. You may have a higher copay or coinsurance for using services outside of the traditional HMO network. A primary care provider (PCP) may be required. You may need a referral to see a specialist.

Preferred Provider Organization (PPO)

PPO plans give you access to a network of healthcare providers known as preferred (in-network) providers. A PPO also gives you the option of seeing non-preferred (out-of-network) providers, but with a higher copay. Usually, a PPO plan will not require you to select a primary care provider (PCP) and you may get healthcare services without needing a referral.

Primary Care Provider (PCP)

A provider who is chosen or assigned to you to coordinate all of your medical care and who recommends (refers) you to secondary care, medical or surgical specialists, if you need additional treatment.

Service Area

The area where your health plan provides coverage. You must permanently live in your health plan's service area to sign up for and remain enrolled in a plan.

Resources

Getting Assistance With Your PHIP Plan

If you are a PERS member and are considering retirement, or if you are already retired and will be turning 65 within the next 12 months, or for general eligibility and enrollment questions, you can contact PHIP in the following ways:

Online

pershealth.com

By Phone

In Portland: 503-224-7377
Toll free: 800-768-7377
TTY: 711
Monday through Friday, 7:30 a.m. to 5:30 p.m.

By Mail

PERS Health Insurance Program
P.O. Box 231299
Tigard, OR 97281-1299

By Fax

In Portland: 503-765-3452
Toll free: 888-393-2943

In Person

Call PHIP to schedule an appointment.

Additional Member Resources

Centers for Medicare and Medicaid Services (CMS)

Toll free: 800-633-4227
TTY: 877-486-2048

medicare.gov

Social Security Administration (SSA)

Toll free: 800-772-1213
TTY: 800-325-0778

ssa.gov

PERS Pension Office

Pension questions only

Online

oregon.gov/pers

By Phone

Toll free: 888-320-7377
TTY: 503-603-7766
Monday through Friday, 8:30 a.m. to 5:00 p.m.

By Mail

P.O. Box 23700
Tigard, OR 97281-3700

Contacting Your Health Plan

For questions on plan benefits, deductibles (if applicable), limitations, and exclusions, refer to your plan's EOC or benefit handbook. You can obtain either by contacting your health plan directly or from pershealth.com. **Note: For Medicare Supplement members, refer to your Traditional Medicare Supplement handbook and *Medicare & You* handbook for medical plan benefits, limits and exclusions.**

Medical

Kaiser Foundation Health Plan of the NW
(Medicare and non-Medicare)

In Portland: 503-813-2000
Toll-free: 800-813-2000
TTY: 711
Medicare Members: 877-221-8221

my.kp.org/pers

Moda Health Plan, Inc.

Toll-free: 800-962-1533
TTY: 711

modahealth.com/pers

Providence Medicare Advantage Plans

Prospective members:
In Portland: 503-574-8000
Toll-free: 800-603-2340
TTY: 711

Enrolled Medicare members:
In Portland: 503-574-8000
Toll-free: 800-603-2340
TTY: 711
providencehealthassurance.com/PHIP

UnitedHealthcare
(Medicare and non-Medicare)

Medicare plan:
Toll-free: 844-884-1850
TTY: 711

uhc.com/pers

Non-Medicare plans:
Toll-free: 844-554-5498
TTY: 711

uhc.com/pers

Pharmacy

Kaiser Foundation Health Plan of the NW
(Medicare and non-Medicare)

Mail-order pharmacy:
Toll-free: 800-548-9809
TTY: 711

my.kp.org/pers

Moda Health Plan, Inc.

Toll-free: 888-786-7509
TTY: 711

modahealth.com/pers

Providence Medicare Advantage Plans

In-Portland: 503-574-7400
Toll-free: 877-216-3644
TTY: 711

providencehealthassurance.com/PHIP

UnitedHealthcare
(Medicare and non-Medicare)

Medicare plan:
Toll-free: 844-884-1850
TTY: 711

uhc.com/pers

Non-Medicare plans:
Toll-free: 844-554-5498
TTY: 711

uhc.com/pers

Dental

Kaiser Foundation Health Plan of the NW

In Portland: 503-813-2000
Toll-free: 800-813-2000
TTY: 711

my.kp.org/pers

Delta Dental Plan of Oregon

Toll-free: 844-827-7379
TTY: 711

modahealth.com/pers

PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

P.O. Box 231299
Tigard, OR 97281-1299

PRST STD
US POSTAGE
PAID
PORTLAND, OR
PERMIT NO. 1039

Important plan information about your enrollment