FAQ for Members
Oregon State Continuation of Coverage Laws

Updated May 17, 2017

Background

On June 23, 2011, the Oregon Legislature passed Senate Bill 89-B, which expands state continuation of health insurance to allow spouses* and dependents of an affected employee to *independently* elect state continuation, even if the employee is ineligible. The measure also clarifies Oregon law to ensure that Oregonians who lose group health coverage because of a reduction of hours are eligible for state continuation. It also requires the insurer to provide notification and certain documents to an employee and eligible dependents.

Oregon state continuation applies to groups that are not subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which generally means employers of 19 or fewer employees and churches. Stand alone dental, vision, or prescription drug coverage need not be offered under state continuation provisions.

*The term “spouse” in this document includes registered domestic partners.

General Information

What are the “qualifying events” that allow for continuation of coverage?
A formerly covered employee, certificate holder, or subscriber (referred to as a “covered employee”) or formerly covered spouse or child (referred to as a “qualified dependent”) is eligible to continue coverage if their coverage was terminated because:

- The covered employee’s employment was voluntarily or involuntarily terminated;
- The covered employee’s work hours were reduced;
- The covered employee became eligible for Medicare;
- A qualified dependent lost dependent child status;
- Termination of membership in the group (i.e., termination association membership); and
- Dissolution of marriage with, or death of, a covered employee.

Who is eligible for continuation of coverage (independently or as a family)?
A covered employee who lost coverage due to a qualifying event may continue coverage if they were:

- Covered under the group health plan the day before a qualifying event; and
- Was continuously covered under the plan during the three-month period ending on the date of the qualifying event; and
- At the time of the qualifying event, was not eligible for Medicare.

A qualified dependent who lost coverage due to a qualifying event may continue coverage if they were:

- Covered under the group insurance policy on the day before a qualifying event; and
- At the time of the qualifying event, was not eligible for Medicare.

A child born to or adopted by a covered employee during the period of continuation of coverage may be added to the covered employee's coverage if done so within 31 days of the birth, adoption, or placement for adoption.

How much does it cost to continue coverage and how would I pay it?
To continue coverage, the covered employee and/or qualified dependent are responsible for paying the premium. Premiums are to be paid to the former employer/policyholder who will, in turn, pay PacificSource.

- To determine the correct amount, contact your former employer/policyholder for continuation coverage premium rates. Continuation premium amounts should be the same as the employer remits to PacificSource for active employees and their dependents, if any.
- The initial premium payment and completed Continuation Election Form must reach the employer/policyholder within 31 days after the last day of coverage under the plan or within 10 days of receipt of this letter, whichever is later.
- Subsequent premium payments must reach the employer/policyholder no later than 31 days after the premium due date.

What coverage may be continued?

- Only the medical coverage under which the covered employee and qualified dependent was covered the day before the qualifying event may be continued. Continuation of dental or vision coverage is not available.
- You should contact the employer/policyholder for information about any additional coverage for which you may be eligible.

How long can coverage be continued?

- Coverage may be continued for a period of nine months; or
- Until the covered employee or qualified dependent becomes covered under another medical plan or program that did not cover the person on the day before the qualifying event, whichever comes first.

If I choose to continue my coverage, who should I contact with questions regarding claims?

- If you have questions about how we paid your claims, we encourage you to call Customer Service at (888) 977-9299 or email cs@pacificsource.com.
- If we deny all or part of your claim while you are on continuation of coverage and you disagree with us, you have the same right to appeal our decision as an active employee. You may appeal our decision by writing to: PacificSource, Attn: Grievance Review, PO Box 7068, Springfield, OR 97475-0068. Your initial appeal must be filed within 180 days of receiving notice of a denial or reduction in benefits. We will respond to your concerns within 30 days.

Oregon Insurance Division – Consumer Advocacy Division
If you feel you need additional assistance with resolving any insurance issue, you may contact:

- An Oregon Insurance Division Consumer Advocate at: (888) 947-7984; or
- Email: cp.ins@state.or.us

If you have any questions regarding this letter or the enclosed election form, please contact our Billing and Enrollment team at (866) 999-5583 or membership@pacificsource.com.