



oebb

How to use the  
MyOEBB Enrollment System

[www.OEBBenroll.com](http://www.OEBBenroll.com)

# Welcome to MyOEBB!

Log on to the following website: [www.OEBBenroll.com](http://www.OEBBenroll.com)

**Welcome to MyOEBB**  
**Your Benefit Management Portal**

**Sign in**

User Name

Password

**Sign in**

[Forgot User Name or Password?](#)

New to MyOEBB? **Create your MYOEBB account**

**This site is best viewed if you have:**

- Internet Explorer 6.0 or higher
- Screen Resolution set at 1024\*728
- Pop ups are enabled
- Full size computer or laptop(some functionality may not be available on a tablet or smartphone)

## If you are new to MyOEBB:

Click **Create your MYOEBB account** if you are new to MyOEBB. MyOEBB identifies your membership and leads you through setting up two security questions, a User Name, and Password.

## If you are a returning member to MyOEBB:

**Note:** If you have enrolled before with another employer your user name and password stays the same. Enter your MyOEBB User name and MyOEBB Password: Click **Sign in**.

If you Forgot your User Name and/or Password click on [Forgot User Name or Password](#).

If you have any difficulties with your log in, please contact your employer, or call OEBB at 1-888-469-6322 for assistance.

During the initial New Hire Enrollment process you have 31 days to make your selections. Once you have made your selections and they have been verified and saved, those selections will stay in effect until the next Open Enrollment period or until you experience a [Qualified Status Change \(QSC\) event](#) such as marriage, birth, change of employment, or other family event. Contact your employer within 31 days if you believe you have experienced a qualifying event.

# Follow these steps to complete the Enrollment Process

During the Enrollment process you can review and update your personal information, add dependents, enter subscriber/dependents' ethnicity, race and Medicare eligibility information, enroll for health care benefits, and enroll for optional benefits.



If you are a newly eligible employee, click the Enroll, Change, Opt Out or Waive benefits as a newly hired employee. If you are a returning user logging in during Open Enrollment, select that option.

## Verifying Personal Information

You are now ready to verify and/or update your personal information. This includes your home phone, work phone, mobile phone, personal e-mail, work e-mail and residence address. Your mailing address is optional.

**Note:** If you find your name, gender or birth date is incorrect, contact your employer's benefits office to make corrections.

## Adding Dependents

If you are a returning user, your dependents will be listed. If you are new to OEBB, then enter your eligible dependents you wish to enroll. Eligible dependents include spouse, domestic partner, and children.

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My Home Page | Log Out Member: Fields, Strawberry Monday, August 07, 2017

**Dependent Information**

Do you have any eligible dependents you would like to enroll for coverage?

Yes

No

Add your eligible dependents on the below screen.

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**My Dependents**

Adding dependents to your record does not automatically enroll them for coverage. You must add them to your coverage by selecting the appropriate coverage tier when enrolling in Medical, Dental, and Vision plans.

**Please Note:**

- If you are enrolling a domestic partner **and** partner's children, you must add the domestic partner first.
- Early Retirees are subject to defined OEBB rules.

Current Dependents section

Relationship	Gender	Date of Birth	Last Name	First Name	Middle Name

Add new Dependents section

Relationship	Gender	Date of Birth (mm/dd/yyyy) OR (mm-dd-yyyy)	Dependent SSN (99999999)	Last Name	First Name	Middle Name

## Dependent Eligibility

Please review your dependents and make sure only eligible dependents are enrolled on your benefit plan. By answering **"YES"** to the question below and check marking the statement, you are confirming your dependents meet eligibility standards for the plan year.

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**Dependent Eligibility Verification**

**Important**

This verification screen provides an important opportunity for you to confirm whether the dependents you have enrolled in the plan meet eligibility requirements and it's important you take time to review each dependent you choose to enroll to make sure they meet plan definitions and satisfy OEBB Administrative Rules. You should also understand any dependents you enroll in the plan may be subject to a dependent eligibility verification review at any time which will require the submission of documentation to prove dependent eligibility and failure to provide sufficient documentation may result in OEBB ending coverage for your dependents. I have read and understand OAR-Division 10 concerning definitions and can find this OAR at:

[http://arcweb.sos.state.or.us/pages/rules/oars\\_100/oar\\_111/111\\_010.html](http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_010.html)

Additionally, I understand that if it is determined I enrolled or continued enrollment of an ineligible dependent, myself and my eligible dependents may lose coverage prospectively for a period of 12 months. Also, an ineligible dependent may be retroactively terminated to the date the individual is determined to have no longer been eligible, or the effective date of coverage if eligibility was never met. I have read and understand OAR-Division 80, Sections 111-080-0040, 111-080-0045 and 111-080-0050 concerning Eligibility and Policy Term Violations and can find this OAR at:

[http://arcweb.sos.state.or.us/pages/rules/oars\\_100/oar\\_111/111\\_080.html](http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_080.html)

Benefit #	Name	Relationship	Birthdate	Gender	Expiration Date	Eligible Dependent
14912	Fields, Com	Spouse	09-21-1959	M		<input checked="" type="checkbox"/>

I have read the above OARs on Eligibility Definitions and Policy Term Violations.

## Dependent Address

To ensure your dependents are in the appropriate network, please update their address to reflect where they currently live. If your dependent(s) live outside your residence, click **"Update"**.

Dependent	E Number	Name	Relationship	Birthdate	Gender	Expiration Date	Update Dependent Address
	E00314012	Fields, Corn Same address as Fields Strawberry	Spouse	09-21-1999	M		<a href="#">Update</a>

## Subscriber/Dependent Information

Complete Medicare Eligibility, Ethnicity, Race and Tobacco usage questions for yourself and your eligible dependents.

Member	Medicare Eligibility	Ethnicity	Race
Fields, Strawberry	no		<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refused (Can only pick one) <input type="checkbox"/> Unknown
Fields, Corn	no		<input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refused (Can only pick one)

## Enrolling in Medical, Vision, and Dental Benefits

Depending on your group's rules and options, you may choose to **Opt Out** of Medical coverage, but you may need to provide proof of other group insurance or you may **Waive** your medical coverage. Contact your employer's benefits office for your opt-out or waive options and rules.

## 12-month Waiting Period/Late Enrollee

If you do not enroll yourself or any eligible dependent in dental when initially eligible, then choose to enroll during an Open Enrollment period, whoever is being added to the coverage will be considered a "late enrollee". Late enrollees are subject to a 12-month waiting period on all dental plans, meaning only diagnostic and preventive care on the dental plans will be covered for the first full 12 month of coverage.



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Member: Fields, Strawberry

Monday, August 07, 2017

Summary of My Healthcare Benefits

Listed below are your current basic benefit selections and your Enrollment options:

- Select **Enroll** to enroll in your Healthcare benefits. This option will only be available to you if you have not enrolled in benefits.
- Select **Change** to change your current plans or coverage.
- **Opt Out:** An OEBB member decides not to enroll in an OEBB medical plan and receives a financial incentive from their entity for doing so. The OEBB member must provide proof of Other Group Coverage.
- **Waives:** An OEBB member decides not to enroll in an OEBB medical plan and does not receive a financial incentive for doing so.
- **Decline:** Choosing not to enroll in OEBB dental and/or vision coverage.
- **12-month Waiting Period:** If you didn't enroll yourself or a dependent in dental when initially eligible, then choose to enroll during an Open Enrollment period, you or your dependent will be considered a "late enrollee," and will be subject to a 12-month waiting period on all dental plans, meaning only diagnostic and preventative care will be covered for the first 12 months of coverage.

Summary for employee of Salem-Keizer SD 24J (New Hire)

Healthcare Premium: \$0.00 Approved Optional Premium: \$0.00 Total Premium of current coverage: \$0.00

Action	Plan Type/Plan Name	Coverage Tier	Cov. Eff. Date	Dependents
Enroll Opt Out Waive	Medical			
Enroll Decline	Vision			
Enroll Decline	Dental			

Back Continue

Select: **"Enroll"** next to Medical to start the enrollment process. Continue with Dental and Vision

Click the appropriate button to start your enrollments.

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Member: Fields, Strawberry

Monday, August 07, 2017

Summary of My Healthcare Benefits

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- **Waives:** An OEBB member decides not to enroll in an OEBB medical plan and does not receive a financial incentive for doing so.
- **Declines:** Choosing not to enroll in OEBB dental and/or vision coverage.
- **12-month Waiting Period:** If you didn't enroll yourself or a dependent in dental when initially eligible, then choose to enroll during an Open Enrollment period, you or your dependent will be considered a "late enrollee," and will be subject to a 12-month waiting period on all dental plans, meaning only diagnostic and preventative care will be covered for the first 12 months of coverage.

Summary for employee of Salem-Keizer SD 24J (New Hire)

Healthcare Premium: \$0.00 Approved Optional Premium: \$0.00 Total Premium of current coverage: \$0.00

Action	Plan Type/Plan Name	Coverage Tier	Cov. Eff. Date	End Date	Dependents
Change Opt Out Waive	Medical Moda Medical Cedar PPO Connexus Healthy Futures - Composite	Employee & Spouse	10/01/2017		<input checked="" type="checkbox"/> Corn
Change Decline	Vision Moda Vision Part - Composite	Employee & Spouse	10/01/2017		<input checked="" type="checkbox"/> Corn
Change Decline	Dental Delta Dental Premier Plan 6 - Composite	Employee & Spouse	10/01/2017		<input checked="" type="checkbox"/> Corn

Back Continue

**PLEASE VERIFY YOU HAVE SELECTED THE CORRECT PLAN AND THE APPROPRIATE DEPENDENTS HAVE COVERAGE FOR THE PLAN YEAR.**

## Enrolling in Optional and Mandatory Benefits

### Optional Benefits Selections:

Select **"Enroll"** next to the optional benefit you want, and choose your coverage amount. Continue through each optional benefit. For any plan you do not want, you will need to click on the **"Decline"** button. Contact your employer's benefits office if you have questions regarding the plan selections.

### Mandatory Benefits Selections:

Select **"Enroll"** next to the each Mandatory Basic benefit your entity has chosen. These benefits are required and you must enroll in them. Contact your employer's benefits office if you have questions regarding the plan selections.

## Beneficiaries Selections

You may select the ["Standard Designation"](#) meaning a common order of relationships designating your next of kin according to Oregon law, or you may name specific individuals if you wish.


# Benefits Statement

The Benefits Statement appears with the new plan selections. Remember, at this point the choices have been recorded, but not yet saved. You must confirm the changes at the bottom of the statement. If anything is wrong, you can click the "Edit" buttons next to each of the enrollment categories to go back to the respective sections.

My Home | [Help](#) | [Log Out](#)

**RESOURCE TOOLS**

- ▶ Carrier Information
- ▶ COBRA Web Site
- ▶ Change Password
- ▶ Contact Us
- ▶ COBRA CARs
- ▶ Forms
- ▶ Standard Medical Evidence
- ▶ LNUJM Medical Evidence
- ▶ [Open Enrollment Guide](#)



**Benefit Statement as of 08-07-2017**

**Your enrollment selections have been recorded. You must now review and save these changes below.**

Listed below are your enrollment benefit selections. If you would like to make additional changes, select **Edit** in the section you wish to change. If you are satisfied with your selections, you must **save** them below.

[Go to my Home Page](#)

**EDIT** **SUBSCRIBER INFORMATION**

<p><b>Name:</b> Strawberry Fields <b>Address:</b> 254 Fields Drive Salem, OR 97302</p>	<p><b>Benefit#:</b> 800314911 <b>DOB:</b> 09-21-1959 <b>Phone:</b> Home: 503-555-1232 Work: <b>Personal E-mail:</b> <b>Work E-mail:</b></p>
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You are enrolled in the Employee Assistance Program

**EDIT** **HEALTHCARE BENEFIT ENROLLMENTS**

Plan	Coverage Tier	2017/2018 Premium	Cov. Eff. Date	End Date	Dependent
Medical Meda Medical Order PPO Complete Health Future - Composite	Employee & Spouse		10-01-2017		Yes
Vision Meda Vision Part - Composite	Employee & Spouse		10-01-2017		Yes
Dental Delta Dental Premier Plan S - Composite	Employee & Spouse		10-01-2017		Yes
Total Current Premium:		.00			

Note: Premium information for these plans is available on the Out of Pocket Cost Sheet page.

**EDIT** **OPTIONAL BENEFIT ENROLLMENTS**

Plan	Coverage Tier	2017/2018 Premium	Cov. Eff. Date	End Date
Basic Life Plan S Basic Life-\$25,000	Employee Only - \$25,000	4.27	10-01-2017	
Optional Employee Life Optional Employee Life	Employee Only, Age 55 to 59, Amount \$100,000	43.00	10-01-2017	
<b>Total Requested Amount: Employee Only, Age 55 to 59, Amount \$110,000 * Pending Carrier's Approval * This amount includes the guarantee issue. Please complete and submit the Medical History Statement now.</b>				
Optional Spouse/Partner Life Optional Spouse/Partner Life	Spouse/Partner, Age 55 to 59, Amount \$30,000	14.25	10-01-2017	
Basic Accidental Death and Dismemberment Plan S Basic AD&D-\$25,000	Employee Only - \$25,000	.55	10-01-2017	
Optional Employee Accidental Death and Dismemberment Decided		0	10-01-2017	
Optional Spouse/Partner Accidental Death and Dismemberment Decided		0	10-01-2017	
Short Term Disability - Voluntary Decided		0	10-01-2017	
Long Term Disability - Mandatory Plan 1-Long Term Disability (Mandatory) Employee/90 Day/50%	Long Term Disability - 90 Day/80%	17.55	10-01-2017	
Employee Long Term Care (Voluntary Employee Paid) Decided		0	10-01-2017	
Spouse/Partner Long Term Care Decided		0	10-01-2017	
Total Current Premium:		79.61		

**EDIT** **DEPENDENT INFORMATION**

Dependent Name	Relationship	DOB	Benefit Number
Corn Fields	Spouse	09-21-1959	800314912

The benefit number of the subscriber should be used for billing services.

**EDIT** **DEPENDENT ELIGIBILITY VERIFICATION**

Dependent Name	Relationship	Eligibility
Corn Fields	Spouse	Yes

**EDIT** **RACE/ETHNICITY/MEDICARE INFORMATION**

Dependent Name	Relationship	Race	Primary Race	Ethnicity	Medicare
Strawberry Fields		Unknown		Unknown	No
Corn Fields	Spouse	Unknown		Unknown	No

**EDIT** **EMPLOYEE BENEFICIARY DESIGNATION**

You have selected the Standard Designation as your beneficiary.

Selection made by *Strawberry Fields* on *08-07-2017*

**EDIT** **HEALTHY FUTURES**

Plan	Participation Status	Cov. Eff. Date	End Date
Healthy Future	Employee Participant	10/01/2017	09/30/2018

**EDIT** **TOBACCO USAGE**

Strawberry Fields have never used tobacco products.  
Corn Fields have never used tobacco products.

Confirm all your coverages are correct. Click on each the checkbox to acknowledge the statement at the bottom of the page, and then click

**"I agree"**

**Confirm your Enrollment Selections**

*I declare the dependents in my OEBB electronic record and I am eligible for the coverages requested. I have read and understand the eligibility rules defined in Oregon Administrative Rule (OAR) Division 10. The full text of this rule can be found here: [http://arcweb.sos.state.or.us/pages/rules/oars\\_100/oar\\_111/111\\_010.html](http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_010.html)*

*I have read and understand OAR-Division 80, Sections 111-080-0040, 111-080-0045 and 111-080-0050 concerning Eligibility and Policy Term Violations and can find this OAR at: [http://arcweb.sos.state.or.us/pages/rules/oars\\_100/oar\\_111/111\\_080.html](http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_080.html)*

*I understand that I have 31 days to notify my employer in the event I experience a Qualified Status Change (QSC) which affects me, or my dependents eligibility. I have read and understand OAR-Division 40 concerning Enrollment and QSC's. The full text of this rule can be found here: [http://arcweb.sos.state.or.us/pages/rules/oars\\_100/oar\\_111/111\\_040.html](http://arcweb.sos.state.or.us/pages/rules/oars_100/oar_111/111_040.html)*

*I understand the benefit elections I make in my electronic record are in effect for as long as I continue to meet OEBB's eligibility requirements, or until I elect to change them subject to the provisions of OEBB's plan. I understand I cannot alter my plan selections during the plan year unless I have a QSC; then I am subject to the restrictions of the OEBB QSC's. I have reviewed and understand the Qualified Status Change (QSC) Matrix and can find the matrix at: <http://www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx>*

*I have read the benefit materials and I understand the limitations and qualifications of the OEBB benefits program. If necessary, I authorize premium payments deducted from my pay, unless I self pay premiums. If I self-pay the premiums, I agree to submit monthly payments by the date specified, or my coverage will terminate. I will not be able to reinstate coverage until the next open enrollment period or may lose OEBB eligibility altogether.*


*A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages, or financial responsibility of claims paid during the period of ineligibility..*

*This election supersedes all elections and submissions I previously made for OEBB coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that they are subject to penalty for perjury.*

**I have reviewed and agree with all my enrollment selections and acknowledge that I may be asked in the future to submit documentation to prove the eligibility for dependents I have enrolled in the plan. Selecting "I agree" is the equivalent of my signature.**

Now you'll see a prompt that informs you that you are about to approve your benefit selections and authorizations for payroll deductions (if applicable, based on entity contributions).

Message from webpage ✕

 **By saving this benefit statement, you are approving your benefit selections and authorizing deductions from your pay if necessary. You have verified all dependents - spouse or partner and/or children - have desired benefit coverages and meet the definition of an OEBB eligible dependent.**



Your Benefit Summary appears, confirming you have successfully saved your selections. You will see the red message below at the top of your benefit summary confirming you have saved your selections.

**YOUR ENROLLMENT SELECTIONS HAVE BEEN SAVED SUCCESSFULLY**

**RESOURCE TOOLS**

- ▶ Carrier Information
- ▶ OEGB Web Site
- ▶ Change Password
- ▶ Contact Us
- ▶ OEGB OARs
- ▶ Forms
- ▶ Standard Medical Evidence
- ▶ UNUM Medical Evidence
- ▶ [Open Enrollment Guide](#)

My Home Page | Log Out



**Benefit Statement as of 08-07-2017**

**YOUR ENROLLMENT SELECTIONS HAVE BEEN SAVED SUCCESSFULLY**

Listed below are your current benefit selections. If you would like to make a change due to a qualified status change, please contact your Entity Benefits Office.

**You may now:**

- **Print** a copy of your Benefit Statement
- Return to your home page

Print    [Go to my Home Page](#)

Member: Fields, Strawberry

**SUBSCRIBER INFORMATION**

Name: Strawberry Fields	Benefit#: E00314911	DOB: 09-21-1959
Address: 234 Fields Drive Salem, OR 97305	Phone: Home 503-555-1212 Work	Personal E-mail: Work E-mail:

You are enrolled in the Employee Assistance Program

*Benefit records were last updated by Strawberry Fields on 08-07-2017*

**BENEFIT ENROLLMENTS**

Plan	Coverage Tier	2017/2018 Premium	Cov. Eff. Date	End Date	Dependents
Medical Moda Medical Cedar PPO Comexus Healthy Futures - Composite	Employee & Spouse		10-01-2017		Yes
Vision Moda Vision Pearl - Composite	Employee & Spouse		10-01-2017		Yes
Dental Delta Dental Premier Plan 6 - Composite	Employee & Spouse		10-01-2017		Yes
Total Current Premium		.00			

Note: Premium information for these plans is available on the Out of Pocket Cost Sheet page.

**OPTIONAL PLAN ENROLLMENTS**

Plan	Coverage Tier	2017/2018 Premium	Cov. Eff. Date	End Date
Basic Life Plan B Basic Life-\$35,000	Employee Only - \$35,000	4.27	10-01-2017	
Optional Employee Life	Employee Only, Age 55 to 59, Amount \$100,000	43.00	10-01-2017	

## Log Out

When you're finished with your MyOEGB session, simply click "Log Out" in the top blue navigation bar.

**RESOURCE TOOLS**

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- ▶ OEGB OARs
- ▶ Forms
- ▶ Standard Medical Evidence

My Home Page    Log Out



**Benefit Statement as of 08-08-2017**

Member: Fields, Strawberry