Your PEBB Benefits for 2019

Employee Enrollment Guide

Forms Inside

The providers in the plans below have committed to:

- Follow evidence-based treatment practices.
- Coordinate care with other providers in your plan’s network.
- Meet standards about the quality of care they provide.

What does this mean for you?

- Lower out-of-pocket costs for many plans.
- Providers who communicate with each other to ensure you get the right care at the right time.
- Easy access to providers and scheduling.

Great value menu

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly premiums¹ for:</th>
<th>Annual medical deductibles for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>subscriber / subscriber, spouse², and child(ren)</td>
<td>subscriber / subscriber, spouse², and child(ren)</td>
</tr>
<tr>
<td><strong>Kaiser Permanente NW³</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classic</td>
<td>$143 / $403</td>
<td>$300 / $900</td>
</tr>
<tr>
<td>Consumer-Directed Health Plan (CDHP) with a health savings account</td>
<td>$28 / $87</td>
<td>$1,400 / $1,400</td>
</tr>
<tr>
<td><strong>Kaiser Permanente WA</strong></td>
<td></td>
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</tr>
<tr>
<td>Classic</td>
<td>$165 / $464</td>
<td>$175 / $525</td>
</tr>
<tr>
<td>Consumer-Directed Health Plan (CDHP) with a health savings account</td>
<td>$25 / $79</td>
<td>$1,400 / $2,800</td>
</tr>
<tr>
<td>SoundChoice</td>
<td>$35 / $106</td>
<td>$125 / $375</td>
</tr>
<tr>
<td>Value</td>
<td>$88 / $252</td>
<td>$250 / $750</td>
</tr>
<tr>
<td><strong>UMP Plus</strong></td>
<td></td>
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<tr>
<td>Puget Sound High Value Network</td>
<td>$50 / $148</td>
<td>$125 / $375</td>
</tr>
<tr>
<td>UW Medicine Accountable Care Network</td>
<td>$50 / $148</td>
<td>$125 / $375</td>
</tr>
</tbody>
</table>

¹ School district, educational service district, and charter school employees, and employees who work for a city, tribal government, county, etc., must contact their personnel, payroll, or benefits office to see their monthly premiums.

² or state-registered domestic partner.

³ Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

Before you enroll...

1. Find out which medical plans serve the county you live in (see pages 31–32).

2. Contact the plan or check their provider directory to make sure your providers are in the plan’s network (see page 2).

3. Ready to pick a plan? Submit your completed Employee Enrollment/Change form to your personnel, payroll, or benefits office. Your employing agency must receive your form no later than 31 days after the date you become eligible for PEBB benefits. **Note:** UW employees must use Workday.
## Contact the Plans

<table>
<thead>
<tr>
<th>Medical Plans</th>
<th>Website addresses</th>
<th>Customer service phone numbers</th>
<th>TRS customer service phone numbers for deaf, hard of hearing, or speech impaired</th>
</tr>
</thead>
</table>
All other areas: 1-800-813-2000                              | 711                                                                 |
| Kaiser Permanente WA Classic, CDHP, SoundChoice, or Value | www.kp.org/wa/pebb            | 2018: 1-888-901-4636  
2019: 1-866-648-1928                      | 711 or TTY: 1-800-833-6388                                                                    |
| Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield | www.hca.wa.gov/ump                     | 1-888-849-3681                                      | 711                                                                 |
| UMP Plus—Puget Sound High Value Network           | www.pugetsoundhighvaluenetwork.org,  
www.hca.wa.gov/ump/plan-ump-plus | 1-855-776-9503                                      | 711                                                                 |
| UMP Plus—UW Medicine Accountable Care Network     | www.uwmedicine.org/umpplus,  
www.hca.wa.gov/ump/plan-ump-plus | 1-855-520-9500                                      | 711                                                                 |

* Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

<table>
<thead>
<tr>
<th>Dental Plans</th>
<th>Website addresses</th>
<th>Customer service phone numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeltaCare, administered by Delta Dental of Washington</td>
<td><a href="http://www.deltadentalwa.com/pebb">www.deltadentalwa.com/pebb</a></td>
<td>1-800-650-1583</td>
</tr>
<tr>
<td>Willamette Dental Group</td>
<td><a href="http://www.willamettedental.com/wapebb">www.willamettedental.com/wapebb</a></td>
<td>1-855-4DENTAL (433-6825)</td>
</tr>
<tr>
<td>Uniform Dental Plan, administered by Delta Dental of Washington</td>
<td><a href="http://www.deltadentalwa.com/pebb">www.deltadentalwa.com/pebb</a></td>
<td>1-800-537-3406</td>
</tr>
</tbody>
</table>
Contact the health plans for help with:
• Specific benefit questions.
• Checking if your provider contracts with the plan.
• Checking if your medications are covered by the plan.
• ID cards.
• Claims.

Contact your employer’s personnel, payroll, or benefits office for help with:
• Enrollment questions and procedures, and deadlines.
• Eligibility questions and changes to your account (Medicare, divorce, etc).
• Changing your name, address, and phone number.
• Finding forms. You can also find forms on HCA’s website at [www.hca.wa.gov/pebb-employee](http://www.hca.wa.gov/pebb-employee) under Forms & publications.
• Adding or removing dependents.
• Payroll deduction information.
• Eligibility complaints or appeals.
• Life and LTD insurance eligibility and enrollment questions.
• Premium surcharge questions.

The PEBB Program is saving the green
Help reduce our reliance on paper mailings—and their toll on the environment—by signing up to receive PEBB mailings by email. To sign up, go to My Account at [www.hca.wa.gov/my-account](http://www.hca.wa.gov/my-account).

Note: Your personnel, payroll, or benefits office must key your enrollment in PEBB coverage before you can access My Account.

Exception: University of Washington employees must sign up in Workday.
Table of Contents

How to “Shop the Guide” ........................................... 5

Eligibility Summary ........................................... 6
  Who’s eligible for PEBB insurance coverage? ........ 6
  Can I cover my dependents? ............................... 7
  If I die, are my surviving dependents eligible? ...... 8
  Verifying dependent eligibility ............................. 8

Valid Dependent Verification Documents ............... 9
  To enroll a spouse ........................................... 9
  To enroll a state-registered domestic partner or legal union partner .............................................. 9
  To enroll children ........................................... 9

Enrollment Summary ........................................... 10
  How do I enroll? ............................................ 10
  Which forms do I use? ..................................... 10
  Am I required to enroll in this health coverage? .... 10
  Can I enroll in two PEBB medical or dental plans? 11
  When does coverage begin? ............................... 11
  What if I’m entitled to Medicare? ......................... 12
  How much do the medical plans cost? .................. 12
  How do I pay for coverage? ............................. 13

Making Changes in Coverage ................................ 15
  How do I make changes? .................................. 15
  What changes can I make anytime? ................. 15
  What changes can I make during the PEBB Program’s annual open enrollment? .................. 15
  What is a special open enrollment? .................... 16
  What happens when a dependent loses eligibility? 18
  What happens when a dependent dies? ................. 18
  What if a National Medical Support Notice requires me to provide health plan coverage for a dependent? .................................................. 18

Waiving Medical Coverage .................................. 19
  How do I waive coverage? ............................... 19
  What if I’m already enrolled in PEBB health plan coverage? .................................................. 19
  How do I enroll after waiving coverage? .......... 19
  What happens if I don’t waive enrollment in PEBB medical? .................................................. 19

When Coverage Ends ...................................... 20
  When does PEBB insurance coverage end? .......... 20
  What are my options when coverage ends? .......... 20

PEBB Appeals ............................................... 22
  How can I appeal a decision? .......................... 22
  How can I make sure my personal representative has access to my health information? .......... 23

2019 Monthly Premiums .................................. 24

Premium Surcharges ....................................... 25

Selecting a PEBB Medical Plan ................................ 27
  How can I compare the plans? .......................... 27
  What type of plan should I select? .................... 28
  Can I enroll in a CDHP plan and Medicare Part A and Part B? .................................................. 28
  What do I need to know about the CDHP with a health savings account (HSA)? ......... 29
  What happens to my health savings account when I leave the CDHP? ......................... 30
  How do I find Summaries of Benefits and Coverage? .................................................. 30

2019 Medical Plans Available by County ............... 31

2019 Medical Benefits Comparison ....................... 33

Selecting a PEBB Dental Plan ................................ 39

Dental Benefits Comparison .............................. 40

Group Term Life and AD&D Insurance ................. 41
  What are my PEBB life and AD&D insurance options? .................................................. 41
  When can I enroll? ....................................... 41
  How do I enroll? .......................................... 41

Monthly Rates ........................................... 42

Long-Term Disability Insurance .......................... 43
  What are my PEBB long-term disability insurance options? .................................................. 43
  What is considered a disability? ......................... 43
  How much does the optional plan cost? ............ 44
  When can I enroll? ....................................... 44
  How do I enroll? .......................................... 44

Medical FSA and DCAP ..................................... 45
  What is a Medical Flexible Spending Arrangement? .................................................. 45
  What is the Dependent Care Assistance Program? .................................................. 45
  When can I enroll? ....................................... 45
  How can I enroll? .......................................... 46
  When can I change my Medical FSA or DCAP election? .................................................. 46

SmartHealth ............................................... 47

Auto and Home Insurance .................................. 48

Enrollment Forms
  2019 Employee Enrollment/Change
  2019 Employee Enrollment/Change for Medical Only Groups
  MetLife Enrollment/Change Form
  Long Term Disability (LTD) Enrollment/Change Form

2019 Premium Surcharge Help Sheet .................. 69

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.
How to “Shop the Guide”

Use this checklist to help you make informed choices about your health plans:

**Medical and dental plans**
- Find the medical plans available in your county of residence. See pages 31–32.
  *Note: PEBB dental plans do not require that you live in their service areas to enroll.*
- Compare the medical plans’ premiums (the amount you pay each month for medical coverage). See page 24.
- Compare the medical and dental plans’ benefits, and your costs when you receive care. See pages 33–38 and page 40. Determine if the medical plan is a value-based plan, which rewards providers for high-quality care and patient satisfaction. *Note: Kaiser Permanente NW, Kaiser Permanente WA, and UMP Plus plans are value-based plans.*
- Once you’ve narrowed your plan choices, find providers in the plans’ networks (or make sure your current providers, medical groups and hospitals are in the plans’ networks). Ask the providers if they:
  - Are in the plan’s network.
  - Commit to following best practices for treating patients.
  - Coordinate care with other providers in your plan’s network.
  - Are expected to meet certain measures about the quality of care they provide.

Go to [www.hca.wa.gov/pebb-employee](http://www.hca.wa.gov/pebb-employee) under ‘Find a provider’ for links to the plans’ online provider directories, or see page 2 for the plans’ customer service phone numbers.
- Compare the medical plans on other features that may be important to you, such as:
  - Access to virtual care or a 24/7 nurse advice line.
  - Online access to your provider and medical records.
  - Extended office hours for providers.
  - Whether your medications are covered by the plan. See page 2 for the plans’ websites and customer service numbers. Also see pages 27–30 for information on selecting a plan.

**Optional life and accidental death and dismemberment (AD&D) insurance**
- Review the optional life and AD&D insurance options and premiums on pages 41–42. If you decide to enroll, you will need to name a beneficiary.
  *Note: If your employer offers life and AD&D Insurance, you will be automatically enrolled in basic life and AD&D insurance at no cost to you.*

**Optional Long-term disability (LTD) insurance**
- Review the LTD insurance options and premiums on pages 43–44.
  *Note: If your employer offers long-term disability insurance, you will be automatically enrolled in basic long-term disability insurance at no cost to you.*

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**You have 31 days to enroll after you become eligible for PEBB benefits.**

If you don’t enroll in PEBB benefits by this deadline, you will be enrolled as a single subscriber in Uniform Medical Plan Classic, Uniform Dental Plan, basic life insurance, and basic LTD insurance.

*Note: Compliance with a deadline or time limit depends on when your personnel, payroll or benefits office (or applicable contracted vendor), receives your form or information, regardless of when you send it.*

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*Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.*
Who’s eligible for PEBB insurance coverage?

This guide provides a general summary of employee eligibility for benefits administered by the PEBB Program. Your employer will determine if you are eligible for PEBB benefits based on your specific employment circumstances, and whether you qualify for the employer contribution (see WAC 182-12-114 and 182-12-131). Please contact your employer’s personnel, payroll, or benefits office to find out when benefits begin once you are eligible. If you disagree with the determination, see “How can I appeal a decision?” on page 22.

Employees from an employer group under contractual agreement

Employees from an employer group such as a county, municipality, political subdivision, tribal government, school district, or educational service district obtaining PEBB benefits through a contractual agreement with the Health Care Authority (HCA), should contact their employer’s personnel, payroll, or benefits office for employee eligibility criteria.

Employees (other than higher-education faculty)

Employees (referred to in this booklet as “employees,” “subscribers,” and “enrollees”) are eligible for PEBB benefits upon employment if the employer anticipates the employee will work an average of at least 80 hours in each month and anticipates the employee will work for at least eight hours in each month for more than six consecutive months.

If the employer revises the employee’s anticipated work hours, or anticipated duration of employment, and the revision allows the employee to meet the limits listed above, the employee becomes eligible when the revision is made.

If the employer determines the employee is ineligible, and the employee later works an average of at least 80 hours per month and at least eight hours in each month for more than six consecutive months, the employee becomes eligible the first of the month following the six-month averaging period.

Employees may also “stack” or combine hours worked in more than one position to establish eligibility as long as the work is within one state agency in which the employee:

• Works two or more positions or jobs at the same time (concurrent stacking);
• Moves from one position or job to another (consecutive stacking); or
• Combines hours from a seasonal position or job with hours from a non-seasonal position or job.

Employees must notify their employer if they believe they are eligible for benefits based on stacking (see WAC 182-12-114(1)(c)).

Higher-education faculty

A higher-education faculty member is eligible for PEBB benefits if the employer anticipates they will work half-time or more for the entire instructional year or equivalent nine-month period.

If the employer doesn’t anticipate that the faculty member will work the entire instructional year or equivalent nine-month period, then the faculty member is eligible for PEBB benefits at the beginning of the second consecutive quarter or semester of employment, if the faculty member is anticipated to work (or has actually worked) half-time or more. (Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty members that work less than half-time during the summer quarter/semester.)

A faculty member who receives additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), and is anticipated to work (or has actually worked) half-time or more, becomes eligible when the revision is made.

A faculty member may become eligible by working as faculty for more than one higher-education institution. When a faculty member works for more than one higher-education institution, the faculty member must notify both employing agencies that they work at more than one institution and may be eligible for PEBB benefits through stacking.

Faculty members may continue any combination of medical, dental, and life insurance when they are between periods of eligibility and are not eligible for the employer contribution by self-paying for benefits (for a maximum of 12 months). See WAC 182-12-142 for continuation coverage information. The PEBB Program must receive the employee’s election to self-pay benefits no later than 60 days after the date the health plan coverage ends or after the postmark date on the election notice sent by the HCA, whichever is later.

Seasonal employees

Seasonal employees are eligible if they are anticipated to work, or the employer anticipates they will work, an average of at least 80 hours per month and are
anticipated to work for at least eight hours in each month of at least three consecutive months of the season. (A season means any recurring, annual period of work at a specific time of year that lasts 3 to 11 consecutive months.)

If an employer revises a seasonal employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria above, the employee becomes eligible when the revision is made.

A seasonal employee who is determined ineligible for benefits, but who later works an average of at least 80 hours per month and works for at least eight hours in each month for more than six consecutive months, becomes eligible the first of the month following the six-month averaging period.

If a seasonal employee works in more than one position or job within one state agency, the employee may stack or combine hours to establish and maintain eligibility. See WAC 182-12-114(2) for details on when a seasonal employee becomes eligible.

A benefits-eligible seasonal employee who works a season of 9 months or more:

- In any month of the season in which they are in a pay status for 8 or more hours during that month.
- May continue any combination of medical, dental and life insurance when they are in between periods of eligibility and not eligible for the employer contribution by self-paying for benefits for a maximum of 12 months. See WAC 182-12-142 for continuation coverage information. The employee's election to self-pay benefits must be received by the PEBB Program no later than 60 days from the date the health plan coverage ends or from the postmark date on the election notice sent by the PEBB Program; whichever is later.

A benefits-eligible seasonal employee who works a season of less than 9 months:

- Is not eligible for the employer contribution during the off season.
- Is eligible for the employer contribution in any month of the season in which they are in a pay status of 8 or more hours during that month.

- Your children through the last day of the month in which they become age 26, except for children with a disability.

How are children defined?
Children are defined based on the establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated. This definition includes:

- Your children
- Children of your spouse,
- Children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption,
- Children of your state-registered domestic partner, or
- Children specified in a court order or divorce decree for whom you have a legal obligation to provide support or health care coverage.

Eligible extended dependents
Children may also include extended dependents in your, your spouse’s, or your state-registered domestic partner’s legal custody or legal guardianship. An extended dependent may be your grandchild, niece, nephew, or other child for whom you, your spouse, or your state-registered domestic partner have legal responsibility as shown by a valid court order and the child’s official residence with the custodian or guardian. This does not include foster children unless you, your spouse, or your state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
Eligible children with disabilities

Eligible children also include children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the employee for support and ongoing care, provided the condition occurred before age 26. You must provide proof of the disability and dependency. The PEBB Program, with input from your medical plan (if applicable), will verify the disability and dependency of a child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child’s 26th birthday, which may require renewed proof from you. If the PEBB Program does not receive your verification within the time allowed, the child will no longer be covered and you will not be able to add the child back onto your coverage.

A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month they become capable of self support. If the child becomes capable of self-support and later becomes incapable of self-support, the child does not regain eligibility as a child with a disability.

If I die, are my surviving dependents eligible?

If you are an eligible employee, your surviving spouse, state-registered domestic partner, or dependent child may be eligible to enroll in or defer (postpone) enrollment as a survivor under PEBB retiree insurance coverage if they meet both the procedural and eligibility requirements outlined in WAC 182-12-265.

A surviving spouse, state-registered domestic partner, or dependent child who meets eligibility requirements and chooses to defer (postpone) enrollment may later enroll in a PEBB retiree health plan by meeting the requirements described in WAC 182-12-200 and 182-12-205.

All required forms must be received by the PEBB Program to enroll in or defer (postpone) as a survivor in PEBB retiree insurance coverage no later than 60 days after the later of the date of the employee’s death or the date the survivor’s PEBB insurance coverage ends.

Verifying dependent eligibility

The PEBB Program verifies the eligibility of all dependents. You must submit proof of a dependent’s eligibility within the PEBB Program’s timelines. The PEBB Program reserves the right to review a dependent’s eligibility at any time.

The PEBB Program will not enroll a dependent if the PEBB Program cannot verify the dependent’s eligibility. You can find a list of documents you must provide to verify your dependent’s eligibility on page 9. Submit the required documents with your enrollment form.
Valid Dependent Verification Documents

Dependent verification helps make sure the PEBB Program covers only people who qualify. If you want to add dependents to your coverage, you must provide documents to show they are eligible before they can be enrolled under your account.

You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and notarized.

Use the list(s) below to determine which verification document(s) to submit with your enrollment form(s). If you submit a tax return, you may submit just one copy if it includes all dependents that require verification, such as your spouse and children. Submit the document(s) with your enrollment form(s) within PEBB Program’s enrollment timelines.

To enroll a spouse

Provide a copy of (choose one):
- Most recent year’s federal tax return that lists the spouse
- Subscriber’s or spouse’s most recent year’s federal tax return if filed separately
- Proof of common residence (example: a utility bill) and marriage certificate
- Proof of financial interdependency (example: a bank statement—black out financial information) and marriage certificate
- Petition for dissolution of marriage (divorce)
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

To enroll children

Use the Extended Dependent Certification form to enroll an extended (legal) dependent child.

Provide a copy of (choose one):
- The most recent year’s federal tax return that includes the child(ren) as a dependent and listed as a son or daughter
- Birth certificate (or hospital certificate with the child’s footprints on it) showing the name of the parent who is the subscriber, the subscriber’s spouse, or the subscriber’s state-registered domestic partner
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government

**If the dependent is the subscriber’s stepchild, the subscriber must also verify the spouse or state-registered domestic partner in order to enroll the child, even if not enrolling the spouse/partner in PEBB insurance coverage.

To find forms and more information, go to www.hca.wa.gov/employee-retiree-benefits/public-employees/how-enroll, or contact your agency’s personnel, payroll, or benefits office.

To enroll a state-registered domestic partner or legal union partner

Include the Declaration of Tax Status form to enroll a non-qualified tax dependent.

Provide a copy of (choose one):
- Proof of common residence (example: a utility bill) and certificate/card of state-registered domestic partnership or legal union
- Proof of financial interdependency (example: a bank statement—black out financial information) and certificate/card of state-registered domestic partnership or legal union
- Petition for invalidity (annulment) of state-registered domestic partnership or legal union
- Petition for dissolution of domestic partnership or legal union
- Legal separation notice of domestic partnership or legal union
- Valid J-1 or J-2 visa issued by the U.S. government

*If within two years of a marriage, state-registered domestic partnership, or establishment of a legal union as defined in statute, only the marriage certificate or certification/card of state-registered domestic partnership or legal union is required. If you encounter delays in getting the marriage certificate within the time allowed, contact your personnel, payroll, or benefits office before your enrollment period ends.
Enrollment Summary

How do I enroll?
Your personnel, payroll, or benefits office must receive the following forms within the required timelines when you become eligible for PEBB benefits:

- **Employee Enrollment/Change** or **Employee Enrollment/Change for Medical Only Groups** form:
  - No later than 31 days after you become eligible for PEBB benefits

- **Long-Term Disability (LTD) Enrollment/Change Form**:
  - No later than 31 days after you become eligible for PEBB benefits

Ask your personnel, payroll, or benefits office when your eligibility and benefits begin. See “When does coverage begin?” on page 11 for more information.

If you decide to enroll in life insurance, MetLife must receive the **MetLife Enrollment/Change Form** no later than 31 days after you become eligible for PEBB benefits.

If you are requesting to enroll dependents, the PEBB Program must receive proof of your dependent’s eligibility no later than 31 days after you become eligible for PEBB benefits or the dependents will not be enrolled. A list of documents we will accept as proof is on page 9.

If your personnel, payroll, or benefits office doesn’t receive your completed form(s) and dependent verification documents (if applicable) within the 31-day election period, we will enroll you as a single subscriber in Uniform Medical Plan (UMP) Classic, Uniform Dental Plan (UDP), basic life insurance, basic long-term disability (LTD) insurance (if your employer offers these coverages), and you will be charged a tobacco use premium surcharge.

If you miss your timeline to enroll and are enrolled as a single subscriber, you will owe medical premiums and the tobacco use premium surcharge back to your effective date of eligibility of PEBB benefits. Your dependents (if any) will not be enrolled. You cannot change plans or enroll your eligible dependents until the next PEBB Program annual open enrollment (November 1–30), unless you have a special open enrollment event that allows the change.

For more information on enrollment timelines for life insurance, long-term disability insurance, Medical Flexible Spending Arrangement (FSA), Dependent Care Assistance Program (DCAP), and the SmartHealth Wellness Program, see pages 45–47. You can enroll in auto or home insurance at any time.

Which forms do I use?
You will find these forms in the back of this guide. If your employer offers PEBB medical, dental, life, and LTD insurance, complete those forms:

- **Employee Enrollment/Change form** (for medical and dental coverage)
- **Long-Term Disability (LTD) Enrollment/Change Form** (for long-term disability insurance)
- **MetLife Enrollment/Change Form and MetLife Beneficiary Designation Form** (for life insurance). If you have questions about enrollment in life insurance, please contact MetLife at 1-866-548-7139.

If your employer offers PEBB medical coverage only, complete the **Employee Enrollment/Change for Medical Only Group**

To enroll in other PEBB-sponsored benefits:

- Medical FSA or DCAP (state agency and higher-education employees)—See “Waiving Medical Coverage” on page 19 for instructions and timelines for waiving PEBB medical coverage.

Additional required forms

<table>
<thead>
<tr>
<th>If enrolling a ...</th>
<th>... then complete this form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-qualified tax dependent</td>
<td><strong>Declaration of Tax Status</strong></td>
</tr>
<tr>
<td>Dependent child with a disability (age 26 and older)</td>
<td><strong>Certification of a Child With a Disability</strong></td>
</tr>
<tr>
<td>Extended (legal) dependent child</td>
<td><strong>Extended Dependent Certification</strong></td>
</tr>
</tbody>
</table>

If you need more forms, go to www.hca.wa.gov/employee-retiree-benefits/forms-and-publications or contact your personnel, payroll, or benefits office.

For complete details on PEBB Program enrollment, refer to Chapters 182-08 and 182-12 WAC at www.hca.wa.gov/employee-retiree-benefits/rules-and-policies.

Am I required to enroll in this health coverage?
Employees may waive PEBB medical if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. You must submit the **Employee Enrollment/Change** form to waive PEBB medical. If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical coverage. If you enroll dependents, you will be enrolled in these coverages for yourself. PEBB retirees may not remain enrolled in retiree coverage if eligible for employee benefits.

See “Waiving Medical Coverage” on page 19 for instructions and timelines for waiving PEBB medical coverage.
Can I enroll in two PEBB medical or dental plans?

A person may be enrolled in only one PEBB medical or dental plan. If you and your spouse or state-registered domestic partner are both eligible for PEBB coverage, you will need to decide which of you will cover yourself and any eligible children on your medical or dental plans. For example, you could waive medical coverage for yourselves and any eligible children on your medical or dental plans. You could waive medical coverage for yourself and enroll as a dependent on your spouse’s, state-registered domestic partner’s, or parent’s medical coverage. However, you must enroll in dental, basic life insurance, and basic LTD insurance under your own account. See “Waiving Medical Coverage” on page 19.

ID cards

After you enroll, your health plan(s) will send you an identification (ID) card to show providers when you receive care. If you have questions about your ID card, contact your plan directly. The Uniform Dental Plan does not mail ID cards, but you may download one from the plan’s website.

When does coverage begin?

When newly eligible—Medical, dental, basic life insurance, and basic LTD insurance begins on the first day of the month following the date an employee becomes eligible for PEBB benefits. If the employee becomes eligible on the first working day of the month, PEBB benefits begin on that day. Contact your personnel, payroll, or benefits office for when your benefits begin, once you are eligible.

For faculty members hired on a quarter/semester to quarter/semester basis, medical, dental, basic life insurance, and basic LTD insurance begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment (or anticipated half-time or more employment). If the first day of the second consecutive quarter/semester is the first working day of the month, PEBB benefits begin on that day.

<table>
<thead>
<tr>
<th>Annual event</th>
<th>When coverage begins</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEBB Program’s annual open enrollment (November 1–30)</td>
<td>January 1 of the following year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special open enrollment events</th>
<th>When coverage begins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage or registering for a state-registered domestic partnership</td>
<td>The first of the month after the event or the date your personnel, payroll, or benefits office receives your completed enrollment form with proof of your dependent’s eligibility, whichever is later. If that day is the first of the month, coverage begins on that day.</td>
</tr>
</tbody>
</table>

| Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption | The date of birth (for newly born children), the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier (for newly adopted children). If you enroll yourself in order to enroll a newly born or newly adopted child, medical will begin the first day of the month in which the event occurs. If you enroll your eligible spouse or state-registered domestic partner to your PEBB insurance coverage due to your child’s birth or adoption, their medical coverage begins the first day of the month in which the birth or adoption occurs. Note: If the child’s date of birth or adoption is before the 16th day of the month, you pay the higher premium for the full month (if adding the child increases the premium). If the child’s date of birth or adoption is on or after the 16th, the higher premium will begin the next month. If elected, Dependent Child Life Insurance for a newly born child begins on the 14th day after birth. |

| Child becomes eligible as an extended dependent | The first day of the month following eligibility certification. |

| Other events that create a special open enrollment (see pages 16–17) | The first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form (and proof of the event that created the special open enrollment) with any other required documents, whichever is later. If that day is the first of the month, coverage begins on that day. |
Enrollment Summary

When making a change during the PEBB Program’s annual open enrollment (November 1–30) or when a special open enrollment event occurs—Coverage will begin as noted in the table on page 11. For annual open enrollment, the required form(s) and proof of your dependent’s eligibility must be received by your employing agency no later than the last day of the annual open enrollment (even if that day is not a business day).

For a special open enrollment, the completed enrollment form(s) and proof of your dependent’s eligibility and/or the event must be received by your employing agency no later than 60 days after the special open enrollment event. In many instances, the date you turn in your form affects the date that coverage begins; you may want to turn the form in sooner to avoid a delay in the enrollment or change. When the special open enrollment is for birth or adoption, the required forms and proof of your dependent’s eligibility and/or the event must be received as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the enrollment form and proof of your dependent’s eligibility and/or the event must be received no later than 12 months after the date of birth, adoption, or the date you assume legal obligation for total or partial support in anticipation of adoption. See “What is a special open enrollment?” on page 16 for more information and a list of special open enrollment events.

What if I’m entitled to Medicare?

Medicare Parts A and B

When you or your covered dependents become entitled to Medicare Part A and Part B, the person entitled to Medicare should contact the nearest Social Security office to ask about the advantages of immediate or deferred enrollment in Medicare Part B. Find contact information for your local office at www.ssa.gov/agency/contact. Be sure you understand the Medicare enrollment timelines, especially if you will be leaving employment within a few months of becoming eligible for Medicare. For employees and their enrolled spouses ages 65 and older, PEBB medical plans provide primary coverage, and Medicare coverage is ordinarily secondary. However, you may choose to waive your enrollment in PEBB medical and have Medicare as your coverage.

If you waive PEBB medical, you can reenroll during the PEBB Program’s annual open enrollment (for coverage effective January 1 of the following year), or if you have a special open enrollment event that allows the change. However, you will remain enrolled in PEBB dental, life, and long-term disability coverage (unless the employing agency does not offer these benefits).

If you retire and are eligible for PEBB retiree insurance coverage, you must enroll and maintain enrollment in Medicare Parts A and B, if entitled, to remain enrolled in a PEBB retiree health plan. Medicare will become the primary insurer, and PEBB medical becomes secondary.

Medicare Part B

In most situations, employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates employment or retires. Contact your nearest Social Security office for information on deferring or reinstating Medicare Part B. Also make sure you understand the Medicare enrollment timelines.

If your entitlement is due to a disability, contact a Social Security office regarding deferred enrollment.

Medicare Part D

Medicare Part D is available to people enrolled in Medicare Part A and/or Part B. It is a voluntary program that offers prescription drug benefits through private plans. These plans provide at least a standard level of coverage set by Medicare.

All PEBB medical plans available to employees provide creditable prescription drug coverage. This means the plans provide prescription drug benefits that are as good as or better than Medicare Part D coverage. After you become entitled to Medicare Part A and/or Part B, you can keep your PEBB coverage and not pay a late enrollment penalty if you decide to enroll in a Medicare Part D plan later. To avoid a premium penalty, you cannot be without creditable prescription drug coverage for more than 63 days.

If you do enroll in Medicare Part D, your PEBB medical plan may not coordinate prescription drug benefits with your Medicare Part D plan.

If you enroll or terminate (cancel) enrollment in Medicare Part D, you may need a “notice of creditable coverage” to prove continuous prescription drug coverage. You can call the PEBB Program at 1-800-200-1004 to request one.

For questions about Medicare Part D, call the Centers for Medicare & Medicaid Services at 1-800-633-4227 or visit www.medicare.gov.

How much do the medical plans cost?

For state agency and higher education employees, see the “2019 Monthly Premiums” on page 24. There are no employee premiums for dental, basic life insurance, and basic LTD insurance.
School district, educational service district, and charter school employees, and those who work for a city, tribal government, county, port, water district, hospital, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

In addition to your monthly premium, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage available from each plan for details.

Your premiums pay for an entire calendar month of coverage. Your employer cannot prorate the premiums for any reason, including when a member dies before the end of the month.

Some subscribers must also be charged a tobacco use premium surcharge and/or a spouse or state-registered domestic partner coverage premium surcharge in addition to their medical plan's monthly premium:

- A monthly $25-per-account tobacco use premium surcharge will apply if you or one of your enrolled dependents (ages 13 and older) uses tobacco products. You must attest to the tobacco use premium surcharge for each dependent you want to enroll. If you do not attest within the PEBB Program’s timelines or if your attestation results in incurring the premium surcharge, you will be charged the premium surcharge. If your or your dependent’s tobacco use status changes, you must reattest to the premium surcharge.

- A monthly $50 spouse or state-registered domestic partner coverage premium surcharge will apply if you enroll your spouse or state-registered domestic partner on your PEBB medical, and they have chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic. You will also be charged the premium surcharge if you enroll your spouse or state-registered domestic partner and do not attest within the PEBB Program’s timelines.

For more details on whether these surcharges will apply to you, see “Premium Surcharges” on pages 25–26.

How do I pay for coverage?

Eligible state agency and higher education institution employees may pay medical premiums with pretax dollars from their salary under the state’s premium payment plan. Internal Revenue Code Section 125 allows your employer to deduct money from your paycheck before calculating federal withholding, Social Security, and Medicare taxes. If you are not a state agency or higher-education employee, ask your personnel, payroll, or benefits office if they offer a pretax deduction benefit under their own Section 125 plan.

Why should I pay my monthly premiums with pretax dollars?

You take home more money because taxes are calculated after the premium, any applicable premium surcharges, and/or contributions are deducted. This reduces your taxable income, which lowers your taxes and saves you money.

Do I need to complete a form to have my medical premium payments withheld pretax?

No. If you are a new employee who enrolls in a medical plan, and your employer offers this benefit, your personnel, payroll, or benefits office automatically have the premiums deducted before calculating taxes. If you do not want to pay your medical premiums with pretax earnings, your personnel, payroll, or benefits office must receive your completed Premium Payment Plan Election/Change Form to waive (opt out of) participation in the premium payment plan no later than 31 days after you become eligible for PEBB benefits (see WAC 182-08-197). The form is available from your personnel, payroll, or benefits office.

Can I change my mind about having my medical premium payments withheld pretax?

You may change your participation under the state’s premium payment plan (opt out of, or revoke your election and make a new election) during the PEBB Program’s annual open enrollment or if you have an applicable special open enrollment event as described in WAC 182-08-199.

How do I pay for coverage?

Premiums and any applicable premium surcharges are automatically deducted from your paychecks before taxes unless you request otherwise. Exception: If you enroll a state-registered domestic partner and they do not qualify as an Internal Revenue Code Section 152 dependent, then the $50 monthly spouse or state-registered domestic partner coverage premium surcharge (if it applies to you) will be a post-tax deduction from your paycheck.

If you do not want your PEBB medical premiums or applicable premium surcharges paid with pretax earnings, you must complete and submit the Premium Payment Plan Election/Change Form to your personnel, payroll, or benefits office no later than 31 days after you become eligible for PEBB benefits.

(continued)
When would it benefit me not to have a pretax deduction?

If you have your premiums deducted pretax, it may also affect the following benefits:

- **Social Security**—If your base salary is under the annual maximum, Section 125 participation reduces your Social Security taxes now. However, your lifetime Social Security benefit would be calculated using the lower salary. You can find the annual maximum by visiting [www.ssa.gov/OACT/COLA/cbb.html](http://www.ssa.gov/OACT/COLA/cbb.html).

- **Unemployment compensation**—Section 125 also reduces the base salary used to calculate unemployment compensation.

To learn more about IRC Section 125 and its impact on other benefits, talk to a qualified financial planner, tax specialist, or your local Social Security Office.
Making Changes in Coverage

How do I make changes?
To make changes to your enrollment or health plan elections, your personnel, payroll, or benefits office must receive the required form(s) during the PEBB Program’s annual open enrollment or when a special open enrollment event occurs. All changes must be made within the PEBB Program’s timelines noted below. **Note:** University of Washington (UW) employees must use Workday.

What changes can I make any time?
You can make some changes during the year without a special open enrollment event.

- Change your name and/or address. Use the Employee Enrollment/Change form.
- Apply for, terminate (cancel), or change coverage amounts, and update beneficiary information for optional life and accidental death and dismemberment (AD&D) insurance. (See “Group Term Life and AD&D Insurance” on pages 41–42.)
- Apply for, terminate (cancel), or change auto or home insurance coverage. (See “Auto and Home Insurance” on page 48.)
- Remove dependent(s) from coverage due to loss of eligibility (required). Your personnel, payroll, or benefits office must receive a complete Employee Enrollment/Change form no later than 60 days after the event (WAC 182-12-262).
- Enroll in or terminate optional long-term disability coverage, or change the waiting period. Use the Long-Term Disability Enrollment/Change form.
- Change your or your dependent’s tobacco use premium surcharge attestation. Use the 2019 Premium Surcharge Change Form or log in to My Account at www.hca.wa.gov/my-account.
- Start, stop, or change your contribution to your health savings account (HSA). Use the Employee Authorization for Payroll Deduction to Health Savings Account form at www.hca.wa.gov/pebb-employee.
- Change your HSA beneficiary information. Use the Health Savings Account Beneficiary Designation form available at www.healthequity.com/pebb.

What changes can I make during the PEBB Program’s annual open enrollment?
To make any of the changes below, your personnel, payroll, or benefits office must receive the required form(s) during the PEBB Program’s annual open enrollment (November 1–30). You may also make some of these changes online during open enrollment using My Account at www.hca.wa.gov/my-account. **Exception:** UW employees must enroll through Workday.

The enrollment change will become effective January 1 of the following year.

### During the annual open enrollment, you can:

<table>
<thead>
<tr>
<th>What to do</th>
<th>By submitting this form:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change your medical or dental plans.</td>
<td>Employee Enrollment/Change form (if you have PEBB medical, dental, life, and long-term disability insurance) OR Employee Enrollment/Change for Medical Only Groups (if you have PEBB medical only)</td>
</tr>
<tr>
<td>Enroll or remove eligible dependents.</td>
<td></td>
</tr>
<tr>
<td>Enroll in a medical plan, if you previously waived PEBB medical for other employer-based group medical, a TRICARE plan, or Medicare (see “Waiving Medical Coverage” on page 19).</td>
<td>Medical Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form OR Enroll at pebb.naviabenefits.com. (Check the enrollment form for submission directions.) If enrolling for the first time you can’t enroll online, you must use the enrollment form. <strong>Exception:</strong> UW employees must use Workday.</td>
</tr>
<tr>
<td>Waive enrollment in PEBB medical if you have other employer-based group medical, a TRICARE plan, or Medicare effective January 1 (see “Waiving Medical Coverage” on page 19).</td>
<td>Premium Payment Plan Election/Change Form</td>
</tr>
<tr>
<td>Enroll or reenroll in a Medical Flexible Spending Arrangement (FSA) (PEBB benefits-eligible state agency and higher-education employees only).</td>
<td></td>
</tr>
<tr>
<td>Enroll or reenroll in the Dependent Care Assistance Program (DCAP) (PEBB benefits-eligible state agency and higher-education employees only).</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Your participation in the Medical FSA and DCAP does not automatically continue from plan year to plan year. You must enroll in this benefit annually.</td>
<td></td>
</tr>
<tr>
<td>Enroll or waive your participation under the state’s premium payment plan (see “How do I pay for coverage?” on page 13).</td>
<td></td>
</tr>
</tbody>
</table>

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.
Making Changes in Coverage

What is a special open enrollment?
A special open enrollment means a period of time after specific life events (such as a birth or marriage) when subscribers may make changes outside of the PEBB Program’s annual open enrollment. During the special open enrollment, subscribers may change health plans, enroll or remove dependents from coverage, or enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reductions plan may enroll in or revoke their election (or make a new election) under the Dependent Care Assistance Program, Medical Flexible Spending Arrangement, or the premium payment plan.

The PEBB Program allows changes outside of the PEBB Program’s annual open enrollment when certain events create a special open enrollment. The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee’s dependents, or both.

The Internal Revenue Code and Treasury Regulations require the change must correspond and be consistent with the event that affects eligibility for coverage.

You must provide proof of the event that created the special open enrollment (for example, a marriage certificate or birth certificate).

To make a change, your personnel, payroll, or benefits office must receive the appropriate Employee Enrollment/Change form and proof of the event no later than 60 days after the event that created the special open enrollment.

In many instances, the date you turn in your form affects the effective date of the change in enrollment; see the table on page 11 for effective dates. However, if adding a newly born child, newly adopted child, or child for whom the employee has assumed a legal obligation for total or partial support in anticipation of adoption, and adding the child increases your premium, your employer must receive this form and evidence of your dependent’s eligibility no later than 12 months after the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

If you get married or have a child during the year, these events allow you to change your name and/or add your newly born child to your medical coverage. Complete the Employee Enrollment/Change form and return it to your personnel, payroll, or benefits office along with proof of the event (a marriage or birth certificate) no later than 60 days after the date of the event. If adding the child increases your premium, return the form no later than 12 months after the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

If this event happens …

<table>
<thead>
<tr>
<th>Event</th>
<th>Add dependent</th>
<th>Remove dependent</th>
<th>Change PEBB medical and/or dental plan</th>
<th>Waive PEBB medical</th>
<th>Enroll after waiving PEBB medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage or registering a state-registered domestic partnership.</td>
<td>Yes¹</td>
<td>Yes²</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Child becomes eligible as an extended dependent. Also complete the Extended Dependent Certification form.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹ Employee may add only the new spouse, state-registered domestic partner, or child(ren) of the spouse or partner. Existing dependents may not be added.

² Employee may remove a dependent from PEBB insurance coverage only if the dependent enrolls in the new spouse’s or state-registered domestic partner’s plan.

For more information about the changes you can make during these events, see Policy 45-2A at www.hca.wa.gov/employee-retiree-benefits/rules-and-policies.
<table>
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<tr>
<th>If this event happens ...</th>
<th>Add dependent</th>
<th>Remove dependent</th>
<th>Change PEBB medical and/or dental plan</th>
<th>Waive PEBB medical</th>
<th>Enroll after waiving PEBB medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee or a dependent loses other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee has a change in employment status that affects their eligibility for their employer contribution toward their employer-based group health plan.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee or a dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee's dependent moves from outside the United States to live in the United States, or from within the United States to live outside of the United States.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>A court order requires the employee or any other individual to provide a health plan for an eligible child of the employee.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee or a dependent has a change in residence that affects health plan availability.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee or a dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee or a dependent becomes entitled to and enrolls in or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. <strong>Note:</strong> If waiving PEBB medical, only allowed if enrolling in Medicare. If enrolling after waiving PEBB medical, only allowed if lost eligibility for Medicare.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee's or a dependent’s current health plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Employee or a dependent experiences a disruption of care that could function as a reduction in benefits for the employee or their dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).</td>
<td>No</td>
<td>No</td>
<td>Yes, if approved by PEBB</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Employee or a dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(continued)
Making Changes in Coverage

What happens when a dependent loses eligibility?

Your personnel, payroll, or benefits office must receive your completed Employee Enrollment/Change form to remove a dependent from your account no later than 60 days after the date the dependent no longer meets PEBB eligibility criteria. Your dependent will be removed from coverage on the last day of the month they no longer meet the eligibility criteria.

Consequences for not submitting the form within 60 days of the last day of the month your dependent loses eligibility are explained in WAC 182-12-262(2)(a). The consequences may include (but are not limited to):

- The dependent may lose eligibility to continue health plan coverage under one of the continuation options described on page 20.
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- The subscriber may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

What if a National Medical Support Notice requires me to provide health plan coverage for a dependent?

When a National Medical Support Notice (NMSN) requires you to provide health plan coverage for your dependent child, you may enroll the child and request changes to their health plan coverage as directed by the NMSN. You must complete and submit an Employee Enrollment/Change form and a copy of the NMSN to your personnel, payroll, or benefits office.

If you fail to request enrollment or health plan coverage changes as directed by the NMSN, your employer or the PEBB Program may make the changes upon request of the child’s other parent or child support enforcement program.

The following options are allowed:

- The child will be enrolled under the subscriber's health plan coverage as directed by the NMSN.
- If you have previously waived PEBB medical coverage, you will be enrolled in medical as directed by the NMSN in order to enroll the child.
- The subscriber's selected health plan will be changed if directed by the NMSN.
- If the child is already enrolled under another PEBB subscriber, the child will be removed from the other health plan coverage and enrolled as directed by the NMSN.
- If the subscriber is eligible for and elects COBRA or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.
- The child will be removed the last day of the month the NMSN is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

What happens when a dependent dies?

If your covered dependent dies, you must submit an Employee Enrollment/Change form to your personnel, payroll or benefits office to remove the deceased dependent. By submitting this form, your premium may be reduced to reflect the change in coverage. For example, if the deceased individual was the only covered dependent on your account, then the premium withheld from your paycheck will be lower when they are removed.

HCA collects premiums for the entire calendar month and will not prorate them for any reason, including when a member dies before the end of the month. The deceased dependent’s coverage will end the last day of the month in which the dependent dies. Any change to your premium will be effective the first day of the following month.

If you have life insurance coverage for your dependent, or are unsure if you elected optional life insurance for the dependent, contact MetLife at 1-866-548-7139. Also consider reviewing and updating any beneficiary designations for benefits such as your life insurance beneficiaries, Department of Retirement Systems administered pension benefits, other administered deferred compensation program accounts, etc.
Waiving Medical Coverage

How do I waive coverage?
Employees may waive PEBB medical coverage if they are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical.

If your employer offers PEBB dental, basic life insurance, and basic long-term disability (LTD) insurance, you must enroll in these coverages for yourself (if eligible), regardless of whether you waive PEBB medical.

To waive enrollment in PEBB medical, your employer must receive your completed Employee Enrollment/Change form indicating that you want to waive enrollment in medical no later than 31 days after the date you become eligible for PEBB benefits, or during an annual or special open enrollment as described on pages 16–17.

If you waive PEBB medical:
- The premium surcharges will not apply to you. (See “Premium Surcharges” on pages 25–26 for more details.)
- You will not have access to SmartHealth and you will not be eligible for the $125 wellness incentive (see page 47).

What if I’m already enrolled in PEBB health plan coverage?
If you are a newly eligible employee who is already enrolled in health plan coverage as a dependent under your spouse’s, state-registered domestic partner’s, or parent’s account, you may either choose to:

1. Waive PEBB medical and stay enrolled in medical under your spouse’s, state-registered domestic partner’s, or parent’s PEBB account. You must still enroll in PEBB dental, and basic life and LTD insurance (if your employer offers them) under your own account.

To waive enrollment in PEBB medical and enroll in PEBB dental, your personnel, payroll, or benefits office must receive your completed Employee Enrollment/Change form, as well as your completed Long-Term Disability (LTD) Enrollment/Change Form to enroll in basic LTD insurance, if applicable. MetLife must also receive your completed MetLife Enrollment/Change Form to enroll in basic life insurance.

In addition, your spouse, state-registered domestic partner, or parent must also complete and submit the Employee Enrollment/Change form to remove you from their dental coverage and prevent dual enrollment in PEBB dental.

OR

2. Enroll in PEBB medical under your own account. To do this, complete the Employee Enrollment/Change form. In addition, your spouse, state-registered domestic partner, or parent will also need to complete and submit the required enrollment/ change form(s) to remove you from their PEBB account and prevent dual enrollment in PEBB health plan coverage.

How do I enroll after waiving coverage?
Once you waive PEBB medical coverage, you may enroll during the PEBB Program’s annual open enrollment (November 1–30) or if you have a qualifying special open enrollment event. Your personnel, payroll, or benefits office must receive your completed Employee Enrollment/Change form before the end of the PEBB Program’s annual open enrollment period or no later than 60 days after the special open enrollment event. In many instances (outside of the annual open enrollment), coverage will begin the first day of the month following the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form and required documents, whichever is later. If that day is the first of the month, coverage will begin on that day (see the table on page 11). You may want to turn the form in sooner so your benefits can begin and not be delayed. You must provide proof of dependent eligibility for any enrolled dependents (see “Valid Dependent Verification Documents” on page 9) and proof of the event that created the special open enrollment. For more information, see WAC 182-12-128.

What happens if I don’t waive enrollment in PEBB medical?
If your personnel, payroll, or benefits office does not receive a completed form indicating your intent to enroll or waive enrollment in PEBB medical within the required timeframes, you will be enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic, Uniform Dental Plan (UDP), basic life insurance, basic LTD insurance (if your employer offers these benefits) and a tobacco use premium surcharge will be charged. If defaulted as a single subscriber, you will owe medical premiums and the tobacco use premium surcharge back to your effective date for PEBB benefits. Your dependents (if any) will not be enrolled. If you were enrolled on your spouse’s, state-registered domestic partner’s, or your parent’s PEBB coverage, you will be removed from that account due to the default.

What if I am a retiree/rehire enrolled in PEBB retiree insurance coverage?
You cannot waive your employee medical and remain enrolled in retiree medical.

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.
When Coverage Ends

When does PEBB insurance coverage end?

PEBB insurance covers an entire month and must end as follows:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends. To remove a dependent, your personnel, payroll, or benefits office must receive a completed Employee Enrollment/Change form no later than 60 days after the date your dependent is no longer eligible.

- When you or a dependent misses a required enrollment deadline to continue PEBB benefits, or chooses not to continue enrollment in a PEBB health plan under one of the options for continuing PEBB benefits, then coverage ends on the last day of the month in which you or your dependent lost eligibility under PEBB rules.

HCA collects premiums for the entire calendar month and will not prorate them for any reason, including when a member dies before the end of the month.

What are my options when coverage ends?

You, your dependents, or both may be able to temporarily continue your PEBB insurance coverage by self-paying the premiums and any applicable premium surcharges on a post-tax basis with no contribution from your employer after eligibility for employer-paid coverage ends. You can also enroll on your spouse’s or state-registered domestic partner’s employer-paid PEBB coverage as a dependent.

Options for continuing coverage vary based on the reason eligibility is lost. The PEBB Program will mail a PEBB Continuation Coverage Election Notice booklet to you or your dependent at the address we have on file when your employer-paid coverage ends. This booklet explains the coverage options and includes enrollment forms to apply for continuation coverage.

You or your eligible dependents must submit the appropriate election form to the PEBB Program no later than 60 days from the date PEBB health plan coverage ended or from the postmark date on the PEBB Continuation Coverage Election Notice booklet, whichever is later. If the election notice is not received by the deadline, you will lose all rights to continue PEBB insurance coverage.

There are three possible continuation coverage options you and your eligible dependents may qualify for:

1. PEBB Continuation Coverage (COBRA)
2. PEBB Continuation Coverage (Unpaid Leave)
3. PEBB retiree insurance coverage

The first two options temporarily extend PEBB health plan coverage when the employee or dependent’s PEBB health plan coverage ends due to a qualifying event.

COBRA eligibility is defined in federal law and governed by federal rules.

PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types such as a layoff, approved leave of absence, educational leave, or when called to active duty in the uniformed services. This option allows you to continue life insurance and, in some instances, LTD insurance. Members who qualify for both PEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

PEBB retiree insurance coverage is available only to:

- Individuals who meet eligibility and procedural requirements in WAC 182-12-171, 182-12-180, and 182-12-211;
- Surviving dependent(s) of a PEBB benefits-eligible employee or retiree (see WAC 182-12-180 and 182-12-265); or
- The surviving dependent(s) of an emergency service worker who was killed in the line of duty (see WAC 182-12-250).

The PEBB Program administers all continuation coverage options. For information about your rights and obligations under PEBB rules and federal law, refer to:

- Your PEBB Initial Notice of COBRA and Continuation Coverage Rights booklet (mailed to you after you enroll in PEBB insurance coverage),
- The PEBB Continuation Coverage Election Notice booklet, or
- The Retiree Enrollment Guide for specific details.

You can also call the PEBB Program at 1-800-200-1004.

What happens to my Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP) funds when coverage ends?

When your PEBB insurance coverage ends or you go on unpaid leave that is not approved under the Family and Medical Leave Act (FMLA) or military leave, you are no longer eligible to contribute to your Medical FSA. Eligibility ends on the last day of the month of loss of coverage or unapproved leave. You will be able to claim expenses incurred while employed, only up to your available
funds, unless you are eligible to continue your Medical FSA coverage under PEBB Continuation Coverage (COBRA) or PEBB Continuation Coverage (Unpaid Leave), through Navia Benefit Solutions.

If you terminate employment and have unspent DCAP funds, you may continue to submit claims for eligible expenses as long as the expenses allow you to attend school full-time, look for work, or work full-time. Claims may be submitted up to your account balance and must be submitted to Navia Benefit Solutions by March 31 of the following plan year. You cannot incur expenses after December 31 of the plan year. There are no continuation coverage rights for the DCAP.

For more information on when coverage ends, see the Medical FSA Enrollment Guide or DCAP Enrollment Guide at pebb.naviabenefits.com. You can also contact Navia Benefit Solutions at 1-800-669-3539 or send an email to customerservice@naviabenefits.com.

**What happens to my Consumer-Directed Health Plan (CDHP) with a Health Savings Account (HSA) when coverage ends?**

If you enroll in a CDHP with an HSA, then later decide to switch to another type of plan, leave employment, or retire, any unspent funds in your HSA will remain unless you close your account. There is a fee for account balances below a certain threshold; contact HealthEquity for information about fees. You can use your HSA funds on qualified medical expenses, or you can leave them for the future. However, you, your employer, the PEBB Program, and others may no longer contribute to your HSA.

Contact HealthEquity with questions on how your HSA works when you switch plans, enroll in continuation coverage, or retire. If you set up automatic payroll deductions to your HSA, contact your payroll office to stop them. If you set up direct deposits to your HSA, contact HealthEquity to stop them.

See “Selecting a PEBB Medical Plan” starting on page 27 to learn more about the CDHP/HSA options.

**What happens to my life insurance when coverage ends?**

If your PEBB employee life insurance ends, you may have an opportunity to continue all or part of your coverage through a portability or conversion option. If you are eligible for these options, MetLife will send you information and an application. For more information, see “Group Term Life and AD&D insurance” on page 41–42 or contact MetLife at 1-877-275-6387.
## PEBB Appeals

### How can I appeal a decision?

If you or your dependent disagrees with a specific decision or denial, you or your dependent may file an appeal. You can find guidance on filing an appeal in chapter 182-16 WAC and at [www.hca.wa.gov/pebb-appeals](http://www.hca.wa.gov/pebb-appeals).

<table>
<thead>
<tr>
<th>If you are...</th>
<th>And you...</th>
<th>Follow these instructions and submission deadlines:</th>
</tr>
</thead>
</table>
| A current or former state agency or higher education employee (or their dependent) | Disagree with a decision **made by your employer** about your:  
• Premium surcharges  
• Eligibility for or enrollment in:  
  • Medical  
  • Dental  
  • Life insurance  
  • Long-term disability insurance  
  • Medical Flexible Spending Arrangement (FSA)  
  • Dependent Care Assistance Program (DCAP)  
And are requesting your employer’s review. | Complete Sections 1–4 of the Employee Request for Review/Notice of Appeal form and submit it to your employer’s personnel, payroll, or benefits office.  
Your employer must receive the form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing. |
| | Disagree with a review decision **made by your employer or agree that an error occurred** and are now requesting the Public Employees Benefits Board (PEBB) Program’s review of your employer’s decision. | Complete Section 8 of the Employee Request for Review/Notice of Appeal form and submit it to the PEBB Appeals Unit. The PEBB Appeals Unit must receive this form **no later than 30 calendar days** after your employer’s review decision date in Section 7 of the form. |
| | Disagree with a decision **from the PEBB Program** about:  
• Eligibility and enrollment in:  
  • Premium payment plan  
  • Medical FSA  
  • DCAP  
  • Life insurance  
  • Eligibility to participate in SmartHealth or receive a wellness incentive  
  • Eligibility and enrollment for a dependent, an extended dependent, or disabled dependent  
• Premium surcharges  
• Premium payments | Complete Sections 1–4 of the Employee Request for Review/Notice of Appeal form.  
Check with your employer to see if they need to review the form before you submit it to the PEBB Appeals Unit (see Section 8 of the form).  
The PEBB Appeals Unit must receive the form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing. |
<table>
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<tr>
<th>If you are ...</th>
<th>And you ...</th>
<th>Follow these instructions and submission deadlines:</th>
</tr>
</thead>
</table>
| A current or former employer group employee (or their dependent) of:  
  • A county  
  • A municipality  
  • A political subdivision of the state  
  • A tribal government  
  • A school district  
  • An educational service district  
  • A charter school  
  • The Washington Health Benefit Exchange  
  • An employee organization representing state civil service employees | Disagree with a decision made by your employer about:  
  • Premium surcharges  
  • Eligibility for or enrollment in:  
    • Medical  
    • Dental | Contact your employer for information on how to appeal the decision or action.  
| | Disagree with a decision made by your employer, a PEBB insurance carrier, or the PEBB Program about:  
  • Eligibility for or enrollment in:  
    • Life insurance  
    • Long-term disability insurance  
  • Eligibility to participate in SmartHealth or receive a wellness incentive | Complete Sections 1–4 of the Employee Request for Review/Notice of Appeal form.  
| | Are seeking a review of a decision made by a PEBB health plan, insurance carrier, or benefit administrator regarding the administration of:  
  • A benefit or claim  
  • Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement  
  • Life insurance premium payments | Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.  

**How can I make sure my personal representative has access to my health information?**

You must provide us with a copy of a valid power of attorney or a completed *Authorization for Release of Information* form naming your representative and authorizing him or her to access your medical records and/or PEBB Program account information, and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available at [www.hca.wa.gov/pebb-appeals](http://www.hca.wa.gov/pebb-appeals).
There are no employee premiums for dental, basic life and accidental death and dismemberment, and basic long-term disability insurance benefits. School district, educational service district, and charter school employees and employees who work for a city, tribal government, county, port, water district, hospital, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

### Monthly premium surcharges

You will be charged the following surcharges in addition to your medical premium if they apply to you.

- A monthly $25-per-account premium surcharge will apply if the subscriber or any dependent (age 13 and older) enrolled in PEBB medical uses tobacco products.
- A monthly $50 premium surcharge will apply if a subscriber enrolls a spouse or state-registered domestic partner in PEBB medical, and the spouse or state-registered domestic partner elected not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic.

See “Premium Surcharges” on pages 25–26 for more information. For more guidance on whether these surcharges apply to you, see the 2019 Premium Surcharge Help Sheet on page 69.

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### 2019 Monthly Premiums

<table>
<thead>
<tr>
<th>PEBB Medical Plans</th>
<th>Employee</th>
<th>Employee &amp; Spouse²</th>
<th>Employee &amp; Child(ren)</th>
<th>Employee, Spouse², &amp; Child(ren)</th>
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<tbody>
<tr>
<td>Kaiser Permanente NW¹ Classic</td>
<td>$143</td>
<td>$296</td>
<td>$250</td>
<td>$403</td>
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<td>Kaiser Permanente NW¹ Consumer-Directed Health Plan (with a health savings account)</td>
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<td>$49</td>
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<td>Kaiser Permanente WA Classic</td>
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<td>Kaiser Permanente WA Consumer-Directed Health Plan (with a health savings account)</td>
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<td>$44</td>
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<tr>
<td>Kaiser Permanente WA SoundChoice</td>
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<td>Kaiser Permanente WA Value</td>
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<td>Uniform Medical Plan (UMP) Classic</td>
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<td>UMP Consumer-Directed Health Plan (with a health savings account)</td>
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<td>UMP Plus—Puget Sound High Value Network</td>
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<td>$88</td>
<td>$148</td>
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<tr>
<td>UMP Plus—UW Medicine Accountable Care Network</td>
<td>$50</td>
<td>$110</td>
<td>$88</td>
<td>$148</td>
</tr>
</tbody>
</table>

¹ Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington, and select counties in Oregon.

² Or state-registered domestic partner
Premium Surcharges

In 2013, the Legislature established two premium surcharges:
• Tobacco use premium surcharge
• Spouse or state-registered domestic partner coverage premium surcharge

These surcharges are applicable if you are enrolled in a PEBB medical plan.

Tobacco use premium surcharge

You will be charged a monthly $25-per-account premium surcharge in addition to your medical plan premium if you or a dependent (age 13 or older) enrolled on your PEBB medical has used a tobacco product in the past two months (whether your enrolled dependent lives with you or not), or if you do not attest to the tobacco use premium surcharge for all enrolled dependents.

To determine whether the tobacco use surcharge applies to your account, use the 2019 Premium Surcharge Help Sheet (found on page 69) and attest by completing and submitting the 2019 Employee Enrollment/Change form or 2019 Employee Enrollment/Change for Medical Only Groups. If you do not attest for yourself or each dependent (age 13 or older) you wish to enroll in medical coverage on the form, or if the response results in incurring the premium surcharge, you will be charged the monthly $25-per-account premium surcharge in addition to your monthly medical premium.

Spouse or state-registered domestic partner coverage premium surcharge

You will be charged a monthly $50 premium surcharge in addition to your medical plan premium if you have a spouse or state-registered domestic partner enrolled on your PEBB medical, and your spouse or state-registered domestic partner elected not to enroll in another employer-based group medical insurance where the spouse’s or state registered domestic partner’s share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state-registered domestic partner in the Uniform Medical Plan (UMP) Classic (regardless of whether you enroll in UMP Classic). If you do not enroll a spouse or state-registered domestic partner on your PEBB medical, this premium surcharge does not apply to you.

If you enroll a spouse or state-registered domestic partner on your PEBB medical, use the 2019 Premium Surcharge Change Form (found at www.hca.wa.gov/pebb-employee) to your personnel, payroll, or benefits office.

If you submit a change that results in incurring the premium surcharge, the change is effective the first of the month following the status change. If that day is the first of the month, then the change begins on that day.

If the change results in the removal of the premium surcharge, the change is effective the first of the month following receipt of the attestation. If that day is the first of the month, then the change begins that day.
To attest during the PEBB Program’s annual open enrollment

During the annual open enrollment (November 1–30), you must attest to the spouse or state-registered domestic partner coverage premium surcharge if you enroll a spouse or state-registered domestic partner on your PEBB medical and you are:

• Incurring the surcharge.
• Not incurring the surcharge because the spouse’s or state-registered domestic partner’s share of medical premium through their employer-based group medical was not comparable to UMP Classic.
• Not incurring the surcharge because the benefits provided through the spouse’s or state-registered domestic partner’s employer-based group medical were not comparable to UMP Classic.

If required, you, the employee, must update your attestation by either submitting the Premium Surcharge Change Form to your personnel, payroll, or benefits office, or logging in to My Account at www.hca.wa.gov/my-account and following the instructions.

Exception: University of Washington employees must use Workday.

If your employing agency does not receive your attestation within the open enrollment timeframe, or if the response results in incurring the premium surcharge, you will be charged the monthly $50 premium surcharge in addition to your monthly medical premium effective January 1 of the following plan year. You will be charged the spouse or state-registered domestic partner coverage premium surcharge for the whole plan year unless there is a change in your spouse’s or state-registered domestic partner’s employer-based group medical that meets the requirements as described in WAC 182-08-185.

To report a change

Outside of the PEBB Program’s annual open enrollment, the following events allow you (the employee) to make a new attestation to add or remove the spouse or state-registered domestic partner coverage premium surcharge:

• When you regain eligibility for the employer contribution for PEBB benefits.
• When you submit an Employee Enrollment/Change form to add a spouse or state-registered domestic partner to your PEBB medical.
• When there is a change in your spouse’s or state-registered domestic partner’s employer-based group medical plan.
• When you submit an Employee Enrollment/Change form to enroll in a PEBB medical plan after waiving your employer coverage, and you enroll your spouse or state-registered domestic partner.

You may report the change by completing and submitting a 2019 Premium Surcharge Change Form or a 2019 Employee Enrollment/Change form to your personnel, payroll, or benefits office. In most cases, you must provide proof of the qualifying event.

If you submit a change that results in incurring the premium surcharge, the change is effective the first day of the month following the status change. If that day is the first day of the month, then the change begins on that day.

If the change results in the removal of the premium surcharge, the change is effective the first day of the month following the receipt of the attestation. If that day is the first day of the month, then the change begins that day.

For more information on the premium surcharges, visit visit www.hca.wa.gov/employee-retiree-benefits/public-employees/surcharges.
Selecting a PEBB Medical Plan

When selecting a PEBB medical plan, your options are limited based on eligibility and where you live. You must consider which medical plans are available in your county. Remember, if you cover eligible dependents, everyone must enroll in the same medical and dental plans.

- **Eligibility.** Not everyone qualifies to enroll in a Consumer-Directed Health Plan (CDHP) with a health savings account (HSA) or a UMP Plus plan. See “Can I enroll in a CDHP and Medicare Part A or Part B?” on page 28 and “What do I need to know about the CDHP with a health savings account (HSA)?” on page 29.

- **Where you live.** In most cases, you must live in the medical plan’s service area to join the plan. See “2019 Medical Plans Available by County” on pages 31–32. Be sure to contact the medical plan(s) you’re interested in to ask about provider availability in your county. If you move out of your medical plan’s service area, you may need to change your plan. You must report your new address to your personnel, payroll, or benefits office no later than 60 days after your move.

**How can I compare the medical plans?**

All medical plans cover the same basic health care services, but they vary in other ways such as provider networks, premiums, your out-of-pocket costs, and drug formularies. See a side-by-side comparison of the medical plans’ benefits and costs on pages 33–38.

**Medical plan differences to consider**

When choosing a medical plan to best meet your needs, here are some things to consider:

- **Premiums.** Premiums vary by medical plan. A higher premium doesn’t necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. See premiums for all PEBB medical plans on page 24. If you are employed by a school district, educational service district, charter school, city, county, tribal government, port, water district, hospital, or another employer group, contact your personnel, payroll, or benefits office to find your monthly premium.

- **Deductibles.** All medical plans require you to pay an annual deductible before the plan pays for covered services. Kaiser Permanente WA Classic, SoundChoice, and Value, and UMP Classic also have a separate annual deductible for some prescription drugs. Preventive care and certain other services are exempt from the medical plans’ deductibles. This means you do not have to pay your deductible before the plan pays for the service.

  **Note:** If you enroll in a CDHP, keep in mind:
  - If you cover one or more dependents, you must pay the entire family deductible before the plan begins paying benefits.
  - Although the CDHPs don’t have a separate prescription drug deductible, your prescription drug costs are subject to the CDHP annual deductible.

- **Coinsurance or copays.** Some medical plans require you to pay a fixed amount, called a copay. Other medical plans require you to pay a percentage of an allowed fee (called a coinsurance) when you receive care.

**Out-of-pocket limit.** The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Kaiser Permanente WA Classic, SoundChoice, and Value, and UMP Classic and UMP Plus have a separate out-of-pocket limit for prescription drugs.

Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges incurred during the year (such as your annual deductible, copays, and coinsurance) count toward your out-of-pocket limit. There are a few costs that do not apply toward your out-of-pocket limit (see the certificate of coverage for an individual plan for specifics):

- Monthly premiums and applicable surcharges.
- Charges above what the plan pays for a benefit.
- Charges above the plan’s allowed amount paid to a provider.
- Charges for services or treatments the plan doesn’t cover.
- Coinsurance for non-network providers.
- Prescription drug deductible and prescription drug coinsurance (Kaiser Permanente WA Classic, SoundChoice, and Value, and UMP Classic and UMP Plus).

**Referral procedures.** Some medical plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women’s health-care services.

Use an interactive comparison tool, find links to each plan’s website, or view a comparison of benefits at www.hca.wa.gov/employee-retiree-benefits/public-employees/compare-medical-plans.
Selecting a PEBB Medical Plan

Your provider. If you have a long-term relationship with your doctor or health care provider, you should verify whether they are in the plan’s network. Contact the plan before you join. Your dependents may choose the same provider, but it’s not required. Each dependent may select from any available provider in the plan’s network. After you join a medical plan, you may change your provider, although the rules vary by plan.

Paperwork. In general, PEBB medical plans don’t require you to file claims. However, UMP members (UMP Classic, UMP CDHP, or UMP Plus) may need to file a claim if they receive services from an out-of-network provider. CDHP members also should keep paperwork received from their provider or for qualified health care expenses to verify eligible payments or reimbursements from their health savings account.

Coordination with your other benefits. If you are also covered through your spouse’s or state-registered domestic partner’s comprehensive group health coverage, call the medical and/or dental plan(s) directly to ask how they will coordinate benefits.

All PEBB plans (except Premera Blue Cross Medicare Supplement Plan F) coordinate benefit payments with other group plans, Medicaid, and Medicare. This coordination ensures benefit costs are more fairly distributed when a person is covered by more than one plan. However, the amount your PEBB plan pays for benefits will not change for a particular service or treatment, even if you or a dependent have an individual medical or dental policy covering that service or treatment.

Note: If you have other comprehensive health coverage, you may not enroll in a CDHP with an HSA. Call HealthEquity at 1-877-873-8823 to ask about certain exceptions. In addition, if you enroll in a CDHP with an HSA you cannot also enroll in a Medical FSA in the same plan year.

Employees who elect both will only be enrolled in the CDHP with a HSA.

What type of plan should I select?
In general, you may choose from the plans available in the county where you live. Also see “What do I need to know about the CDHP with a health savings account (HSA)?” on page 29 to find out if you qualify to enroll.

What is a value-based plan and why should I choose one (if available in my county of residence)?
Value-based plans aim to provide high quality care at a lower cost. Providers have committed to follow evidence-based treatment practices, coordinate care with other providers in your network, and meet certain measures about the quality of care they provide. See the first page of this guide for more information.

The PEBB Program offers three types of medical plans (value-based plans noted in bold):

Consumer-directed health plans (CDHPs). CDHPs let you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax free, have a lower monthly premium than most other medical plans, a higher deductible, and a higher out-of-pocket limit.

• Kaiser Permanente NW CDHP*  
• Kaiser Permanente WA CDHP  
• UMP CDHP  

Managed-care plans. Managed-care plans may require you to select a primary care provider (PCP) within the medical plan’s network to fulfill or coordinate all of your health needs. Some outpatient specialty services are available in network participating medical offices without a referral. This type of plan may not pay benefits if you see a non-contracted provider for non-emergency services.

• Kaiser Permanente NW Classic*  
• Kaiser Permanente WA Classic  
• Kaiser Permanente WA SoundChoice  
• Kaiser Permanente WA Value

Preferred provider organization plans. PPOs allow you to self-refer to any approved provider type in most cases, but usually provide a higher level of coverage if the provider contracts with the plan.

• UMP Classic  
• UMP Plus–Puget Sound High Value Network  
• UMP Plus–UW Medicine Accountable Care Network

*Kaiser Foundation Health Plan of the Northwest, offered only in Clark and Cowlitz counties in Washington and select counties in Oregon.

Questions? Contact the medical plans or HealthEquity for questions about the HSA. Their phone numbers and websites are listed on page 2.

Can I enroll in a CDHP plan and Medicare Part A or Part B?
If you become entitled to and enroll in Medicare Part A or Part B and are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA), you should change medical plans, or you could be subject to IRS tax penalties.

The PEBB Program should receive your medical plan change request 30 days before the Medicare enrollment date. After the Medicare enrollment date, you must receive your request to change plans no later than 60 days after the Medicare enrollment date. See additional information on the next page about the CDHP.
What do I need to know about the CDHP with a health savings account (HSA)?

A consumer-directed health plan (CDHP) is a high-deductible health plan (HDHP), with a health savings account (HSA). When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some expenses and services that your health plans may not cover. (See IRS Publication 969 Health Savings Accounts and Other Tax Favored Health Plans at www.irs.gov for details.)

The HSA is set up by your health plan with HealthEquity, Inc., to pay for or reimburse your costs for qualified medical expenses.

Who is eligible?

Before you enroll in a CDHP with an HSA, some exclusions apply. You cannot enroll in a CDHP with an HSA if:

• You are enrolled in Medicare Part A or Part B or Medicaid.
• You are enrolled in another health plan that is not an HDHP—for example, on a spouse’s or state-registered domestic partner’s plan—unless the health plan coverage is limited coverage like dental, vision, or disability coverage.
• You or your spouse or state-registered domestic partner is enrolled in a Voluntary Employee Beneficiary Association Medical Expense Plan (VEBA MEP), unless you convert it to limited HRA coverage.
• You have a TRICARE plan.
• You enrolled in a Medical Flexible Spending Arrangement (FSA). This also applies if your spouse has a Medical FSA, even if you are not covering your spouse on your CDHP.

This does not apply if the Medical FSA or HSA is a limited purpose account, or for a post-deductible Medical FSA.

If you elect to enroll in both, you will only be enrolled in the HDHP with a HSA.

• You are claimed as a dependent on someone else’s tax return.

Other exclusions apply. To verify whether you qualify, check The HealthEquity Complete HSA Guidebook (at www.healthequity.com/pebb under Documents), IRS Publication 969—Health Savings Accounts and Other Tax-Favored Health Plans (at www.irs.gov), contact your tax advisor, or call HealthEquity toll-free at 1-877-873-8823.

Employer contributions

If you are eligible, your employer will contribute the following amounts to your HSA:

• $58.34 each month for an individual subscriber, up to $700.08 for the 2019 calendar year; or
• $116.67 each month for a subscriber with one or more enrolled dependents, up to $1,400.04 for the 2019 calendar year.
• $125 if you qualified for the SmartHealth wellness incentive in 2018 (from the PEBB Program).

The entire annual amount is not deposited to your HSA in January. Contributions from your employer go into your HSA in monthly installments over the year, and are deposited on or around the last day of each month. If eligible and you qualify for the SmartHealth wellness incentive, it is deposited at the end of January with your first HSA installment.

Other features of the CDHP/HSA

• If you cover one or more dependents, you must pay the entire family deductible before the CDHP begins paying benefits.
• Your prescription drug costs count toward the annual deductible and out-of-pocket maximum if you enroll in the Kaiser Permanente NW CDHP, Kaiser Permanente WA CDHP, or UMP CDHP.
• Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed and/or pay for Medicare Part B premiums.

*Kaiser Foundation Health Plan of the Northwest, offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

Subscriber contributions

You can also choose to contribute to your HSA, either through pretax payroll deductions (if available from your employer) or direct deposits to HealthEquity. You may be able to deduct your HSA contributions from your federal income taxes.

The IRS has an annual limit for contributions from all sources into an HSA. In 2019, the annual HSA contribution limit is $3,500 (subscriber only) and $7,000 (you and one or more dependents). If you are age 55 or older, you may contribute up to $1,000 more annually in addition to these limits.

To ensure you do not go beyond the maximum allowable limit, make sure to calculate your employer’s contribution amount(s) for the year, the SmartHealth wellness incentive in January (if eligible and you qualify for it), and any amount you contribute during the year.

(continued)
Selecting a PEBB Medical Plan

What happens to my health savings account when I leave the CDHP?
If you choose a medical plan that is not a CDHP you should know:

• You won't forfeit any unspent funds in your HSA after enrolling in a different plan. You can spend your HSA funds on qualified medical expenses in the future. However, you, your employer, the PEBB Program, and other individuals can no longer contribute to your HSA.

• HealthEquity will charge you a monthly fee if you have less than $2,500 in your HSA after December 31. You can avoid this charge by either ensuring you have at least $2,500 in your HSA or by spending all of your HSA funds by December 31. Other fees may apply. Contact HealthEquity for details.

You must contact HealthEquity to stop automatic direct deposits to your HSA if you previously set this up.

Are there special considerations if I enroll in a CDHP mid-year?
Yes. Enrolling in a CDHP and opening an HSA mid-year may limit the amount of contributions you (or your employer) can make in the first year.

If you have any questions about this, talk to your tax advisor.

How do I find Summaries of Benefits and Coverage?
The Affordable Care Act requires the PEBB Program and medical plans (except Medicare plans) to provide a standardized comparison tool of medical plan benefits, terms, and conditions. This tool, called the Summary of Benefits and Coverage (SBC), allows plan applicants and members to compare things like:

• What is not included in the plan's out-of-pocket limit?

• Do I need a referral to see a specialist?

• Are there services this plan doesn't cover?

The PEBB Program and medical plans must provide an SBC (or explain how to get one) at different times throughout the year, such as when someone applies for coverage, upon plan renewal, and when requested. The SBC is available upon request in your preferred language. See the chart for how to request an SBC.

---

If you want to request an SBC from your current PEBB medical plan

You can either:

• Go to your plan’s website to review it online;

• Go to www.hca.wa.gov/employee-retiree-benefits/public-employees/benefits-and-coverage-plan to review it online; or

• Call your plan’s customer service to request a paper copy at no charge.

If you want to request an SBC from another PEBB medical plan

You can either:

• Go to www.hca.wa.gov/employee-retiree-benefits/public-employees/benefits-and-coverage-plan to review it online; or

• Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge.

You can find the medical plan websites and customer service phone numbers on page 2.
2019 Medical Plans Available by County

In most cases, you must live in the medical plan's service area to join the plan. Be sure to call the medical plan(s) you are interested in to ask about provider availability in your county. If you move out of your medical plan's service area, you may need to change plans. You must report your new address to your personnel, payroll, or benefits office no later than 60 days after your move.

<table>
<thead>
<tr>
<th>Washington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente NW Classic&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Kaiser Permanente NW</td>
</tr>
<tr>
<td>Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1,2&lt;/sup&gt;</td>
</tr>
<tr>
<td>• Clark</td>
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<tr>
<td>• Cowlitz</td>
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<td></td>
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<tr>
<td>Kaiser Permanente WA Classic</td>
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<tr>
<td>Kaiser Permanente WA</td>
</tr>
<tr>
<td>Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
</tr>
<tr>
<td>• Benton</td>
</tr>
<tr>
<td>• Columbia</td>
</tr>
<tr>
<td>• Franklin</td>
</tr>
<tr>
<td>• Grays Harbor (ZIP Codes 98541, 98557,</td>
</tr>
<tr>
<td>98559, and 98568)</td>
</tr>
<tr>
<td>• Island</td>
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<tr>
<td>• King</td>
</tr>
<tr>
<td>• Kitsap</td>
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<tr>
<td>• Kittitas</td>
</tr>
<tr>
<td>• Lewis</td>
</tr>
<tr>
<td>• Lincoln (ZIP Codes 99008, 99029, 99032, and 99122)</td>
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<tr>
<td>• Mason</td>
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<tr>
<td>• Pend Oreille (ZIP Code 99180)</td>
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<tr>
<td>• Pierce</td>
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<td>• San Juan</td>
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<td>• Skagit</td>
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<td>• Snohomish</td>
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<td>• Spokane</td>
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<tr>
<td>• Stevens (ZIP Codes 99013, 99034, 99040,</td>
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<tr>
<td>99110, 99148, and 99173)</td>
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<tr>
<td>• Thurston</td>
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<td>• Walla Walla</td>
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<td>• Whitman</td>
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<td>• Yakima</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
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<tr>
<td>Note: Not all contracted providers in</td>
</tr>
<tr>
<td>Spokane County are in the SoundChoice</td>
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<tr>
<td>network. Please make sure your provider is</td>
</tr>
<tr>
<td>in-network before your visit.</td>
</tr>
<tr>
<td>• King</td>
</tr>
<tr>
<td>• Kitsap</td>
</tr>
<tr>
<td>• Pierce</td>
</tr>
<tr>
<td>• Snohomish</td>
</tr>
<tr>
<td>• Spokane</td>
</tr>
<tr>
<td>• Thurston</td>
</tr>
</tbody>
</table>

| Uniform Medical Plan (UMP) Classic         |
| UMP Consumer-Directed Health Plan (CDHP)<sup>1</sup> | Available in all Washington counties and worldwide. |
|                                                    |
| UMP Plus—Puget Sound High Value Network<sup>3</sup> |
| • King                                           |
| • Kitsap                                        |
| • Pierce                                        |
| • Snohomish                                     |
| • Spokane                                       |
| • Thurston                                      |
| • Yakima                                        |
|                                                    |
| UMP Plus—UW Medicine Accountable Care Network<sup>3</sup> |
| • King                                           |
| • Kitsap                                        |
| • Pierce                                        |
| • Skagit                                        |
| • Snohomish                                     |
| • Thurston                                      |

<sup>1</sup>You must meet certain eligibility requirements to enroll in a CDHP with a health saving account. See “What do I need to know about the CDHP with a health savings account (HSA)?” on page 29 for details.

<sup>2</sup>Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>3</sup>Employees who are enrolled in Medicare Part A and Part B are eligible for UMP Plus. Employees’ spouses and state-registered domestic partners are also eligible, even if the spouse or state-registered domestic partner is enrolled in Medicare.
## 2019 Medical Plans Available by County

<table>
<thead>
<tr>
<th>Oregon</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Kaiser Permanente NW Classic&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uniform Medical Plan (UMP) Classic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Available in all Oregon counties and worldwide.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Idaho</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Classic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Consumer-Directed Health Plan (CDHP)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Available in all Idaho counties and worldwide.</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>You must meet certain eligibility requirements to enroll in a CDHP with a health saving account. See “What do I need to know about the CDHP with a health savings account (HSA)?” on page 29 for details.

<sup>2</sup>Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.
The chart below briefly compares the per-visit costs of some in-network benefits for PEBB medical plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

<table>
<thead>
<tr>
<th>Annual Costs (You pay)</th>
<th>Medical deductible (Applies to medical out-of-pocket limit)</th>
<th>Medical out-of-pocket limit¹ (See separate prescription drug out-of-pocket limit for some plans.)</th>
<th>Prescription drug deductible</th>
<th>Prescription drug out-of-pocket limit¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser Foundation Health Plan of the Northwest</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente NW Classic²</td>
<td>$300/person $900/family</td>
<td>$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered services apply.</td>
<td>None</td>
<td>Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.</td>
</tr>
<tr>
<td>Kaiser Permanente NW CDHP³</td>
<td>$1,400/person $2,800/family*</td>
<td>$5,100/person • $10,200/family Your deductible, copays, and coinsurance for most covered services apply.</td>
<td>Prescription drug costs apply toward medical deductible.</td>
<td></td>
</tr>
</tbody>
</table>

**Kaiser Foundation Health Plan of Washington**

<table>
<thead>
<tr>
<th>Kaiser Permanente WA Classic</th>
<th>$175/person $525/family</th>
<th>$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.</th>
<th>$100/person $300/family (Tier 2 and 3 drugs only)</th>
<th>$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente WA CDHP Individual</td>
<td>$1,400/person</td>
<td>$5,100/person Your deductible and coinsurance for all covered services apply.</td>
<td>Prescription drug costs apply toward medical deductible.</td>
<td>Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.</td>
</tr>
<tr>
<td>Kaiser Permanente WA CDHP Family</td>
<td>$2,800/person $2,800/family*</td>
<td>$5,100/person • $10,200/family Your deductible and coinsurance for all covered services apply.</td>
<td>Prescription drug costs apply toward medical deductible.</td>
<td>Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.</td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
<td>$125/person $375/family</td>
<td>$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.</td>
<td>$100/person $300/family Does not apply to value and Tier 1 drugs</td>
<td>$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td>$250/person $750/family</td>
<td>$3,000/person • $6,000/family Your deductible, copays, and coinsurance for all covered services apply.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Uniform Medical Plan (UMP)³**

<table>
<thead>
<tr>
<th>UMP Classic</th>
<th>$250/person $750/family</th>
<th>$2,000/person • $4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.</th>
<th>$100/person $300/family* (Tier 2 and 3 drugs only)</th>
<th>$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.</th>
</tr>
</thead>
<tbody>
<tr>
<td>UMP CDHP</td>
<td>$1,400/person $2,800/family*</td>
<td>$4,200/person • $8,400/family ($6,850 per person in a family) Your deductible and coinsurance for most covered services apply.</td>
<td>Prescription drug costs apply toward medical deductible.</td>
<td>Prescription coinsurance applies to the medical out-of-pocket limit.</td>
</tr>
<tr>
<td>UMP Plus–PSHSVN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Plus–UW Medicine ACN</td>
<td>$125/person $375/family</td>
<td>$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered medical services apply.</td>
<td>None</td>
<td>$2,000/person Your coinsurance for all covered prescription drugs applies.</td>
</tr>
</tbody>
</table>

*Must meet family combined deductible (medical and prescription drug) before plan pays benefits.

(continued)
## 2019 Medical Benefits Comparison

<table>
<thead>
<tr>
<th>Benefits (You pay)</th>
<th>Ambulance</th>
<th>Diagnostic tests, laboratory, and x-rays</th>
<th>Durable medical equipment, supplies, and prosthetics</th>
<th>Emergency room (Copay waived if admitted)</th>
<th>Hearing</th>
<th>Home health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Health Plan of the Northwest</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente NW Classic</td>
<td>15%</td>
<td>$10</td>
<td>10%</td>
<td>15%</td>
<td>$35</td>
<td>You pay any amount over $800 every 36 months for hearing aid and rental/repair combined.</td>
</tr>
<tr>
<td>Kaiser Permanente NW CDHP</td>
<td>15%</td>
<td>15%</td>
<td>10%</td>
<td>15%</td>
<td>$30</td>
<td>You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.</td>
</tr>
<tr>
<td>Kaiser Permanente Health Plan of Washington</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td>20%</td>
<td>$0; MRI/CT/PET scan $30</td>
<td>20%</td>
<td>$250</td>
<td>Primary care $15 Specialist $30</td>
<td>$0</td>
</tr>
<tr>
<td>Kaiser Permanente WA CDHP</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>You pay any amount over $800 every 36 months for hearing aid and rental/repair combined.</td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
<td>20%</td>
<td>15%</td>
<td>15%</td>
<td>$75 + 15%</td>
<td>Primary care $0 Specialist $30</td>
<td>15%</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td>20%</td>
<td>$0; MRI/CT/PET scan $50</td>
<td>20%</td>
<td>$300</td>
<td>Primary care $20 Specialist $50</td>
<td>$0</td>
</tr>
<tr>
<td>Uniform Medical Plan (UMP)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>UMP Classic</td>
<td>20%</td>
<td>15%</td>
<td>15%</td>
<td>$75 + 15%</td>
<td>$0</td>
<td>You pay any amount over $800 every three calendar years for hearing aid and rental/repair combined. (CDHP is subject to deductible.)</td>
</tr>
<tr>
<td>UMP CDHP</td>
<td>20%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>UMP Plus–PSHVN</td>
<td>20%</td>
<td>15%</td>
<td>15%</td>
<td>$75 + 15%</td>
<td>$0</td>
<td>15%</td>
</tr>
<tr>
<td>UMP Plus–UW Medicine ACN</td>
<td>20%</td>
<td>15%</td>
<td>15%</td>
<td>$75 + 15%</td>
<td>$0</td>
<td>15%</td>
</tr>
<tr>
<td>Benefits (You pay)</td>
<td>Hospital services</td>
<td>Office visit</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Inpatient</td>
<td>Outpatient</td>
<td>Primary care</td>
<td>Urgent care</td>
<td>Specialist</td>
<td>Mental health</td>
</tr>
<tr>
<td><strong>Kaiser Foundation Health Plan of the Northwest</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Kaiser Permanente NW Classic²</td>
<td>15%</td>
<td>15%</td>
<td>$25</td>
<td>$45</td>
<td>$35</td>
<td>$25</td>
</tr>
<tr>
<td>Kaiser Permanente NW CDHP²</td>
<td>15%</td>
<td>15%</td>
<td>$20</td>
<td>$40</td>
<td>$30</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Kaiser Foundation Health Plan of Washington</strong></td>
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<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td>$150/day up to $750 maximum/ admission</td>
<td>$150</td>
<td>$15</td>
<td>$15</td>
<td>$30</td>
<td>$15</td>
</tr>
<tr>
<td>Kaiser Permanente WA CDHP</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
<td>$500/admission</td>
<td>15%</td>
<td>$0</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td>$250/day up to $1,250 maximum/ admission</td>
<td>$200</td>
<td>$30</td>
<td>$30</td>
<td>$50</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Uniform Medical Plan (UMP)³</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Classic</td>
<td>$200/day up to $600 maximum/year per person + 15% professional fees</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>UMP CDHP</td>
<td>15%</td>
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<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>UMP Plus– PSHVN</td>
<td>$200/day up to $600 maximum/year per person + 15% professional fees</td>
<td>15%</td>
<td>$0</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>UMP Plus– UW Medicine ACN</td>
<td>$200/day up to $600 maximum/year per person + 15% professional fees</td>
<td>15%</td>
<td>$0</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

¹ Premiums, charges for services in excess of a benefit, charges in excess of the plan’s allowed amount, coinsurance for out-of-network providers (UMP)³, and charges for non-covered services do not apply to the out-of-pocket limits. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

² Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

³ UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan’s allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the provider charges over the plan’s allowed amount.
### 2019 Medical Benefits Comparison

<table>
<thead>
<tr>
<th>Benefits (You pay)</th>
<th>Physical, occupational, and speech therapy (per-visit cost for 60 visits/year combined)</th>
<th>Prescription drugs Retail Pharmacy (up to a 30-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Value Tier</td>
<td>Tier 1</td>
</tr>
<tr>
<td><strong>Kaiser Foundation Health Plan of the Northwest</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente NW Classic</td>
<td>$35</td>
<td>—</td>
</tr>
<tr>
<td>Kaiser Permanente NW CDHP</td>
<td>$30</td>
<td>—</td>
</tr>
<tr>
<td><strong>Kaiser Foundation Health Plan of Washington</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td>$30</td>
<td>$5</td>
</tr>
<tr>
<td>Kaiser Permanente WA CDHP</td>
<td>10%</td>
<td>$5</td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
<td>15%*</td>
<td>$5</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td>$50</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Uniform Medical Plan (UMP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Classic</td>
<td>15%</td>
<td>5% up to $10</td>
</tr>
<tr>
<td>UMP CDHP</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>UMP Plus–PSHVN</td>
<td>15%</td>
<td>5% up to $10</td>
</tr>
<tr>
<td>UMP Plus–UW Medicine ACN</td>
<td>15%</td>
<td>5% up to $10</td>
</tr>
</tbody>
</table>

*Massage no longer included. Now a separate benefit with 16 visits per year.
<table>
<thead>
<tr>
<th>Benefits (You pay)</th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mail order (up to a 90-day supply unless otherwise noted)</td>
</tr>
<tr>
<td></td>
<td>Value tier</td>
</tr>
<tr>
<td><strong>Kaiser Foundation Health Plan of the Northwest</strong></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente NW Classic</td>
<td>—</td>
</tr>
<tr>
<td>Kaiser Permanente NW CDHP</td>
<td>—</td>
</tr>
<tr>
<td><strong>Kaiser Foundation Health Plan of Washington</strong></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td>$10</td>
</tr>
<tr>
<td>Kaiser Permanente WA CDHP</td>
<td>$10</td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
<td>$10</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Uniform Medical Plan (UMP)</strong></td>
<td></td>
</tr>
<tr>
<td>UMP Classic</td>
<td>5% up to $30</td>
</tr>
<tr>
<td>UMP CDHP</td>
<td>15%</td>
</tr>
<tr>
<td>UMP Plus–PSHVN</td>
<td>5% up to $30</td>
</tr>
<tr>
<td>UMP Plus–UW Medicine ACN</td>
<td>5% up to $30</td>
</tr>
</tbody>
</table>

*Massage no longer included. Now a separate benefit with 16 visits per year.*

(continued)
# 2019 Medical Benefits Comparison

<table>
<thead>
<tr>
<th>Benefits (You pay)</th>
<th>Preventive care</th>
<th>Spinal manipulations</th>
<th>Vision care&lt;sup&gt;5&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>See certificate of coverage or check with plan for full list of services.</td>
<td></td>
<td>Glasses and contact lenses</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of the Northwest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente NW Classic&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$0</td>
<td>$35 Maximum 12 visits/year</td>
<td>$25</td>
</tr>
<tr>
<td>Kaiser Permanente NW CDHP&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$0</td>
<td>$30 Maximum 12 visits/year</td>
<td>$20</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of Washington</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Permanente WA Classic</td>
<td>$0</td>
<td>$15 Maximum 10 visits/year</td>
<td>$15</td>
</tr>
<tr>
<td>Kaiser Permanente WA CDHP</td>
<td>$0</td>
<td>10% Maximum 10 visits/year</td>
<td>10%</td>
</tr>
<tr>
<td>Kaiser Permanente WA SoundChoice</td>
<td>$0</td>
<td>$0 Maximum 10 visits/year</td>
<td>15%</td>
</tr>
<tr>
<td>Kaiser Permanente WA Value</td>
<td>$0</td>
<td>$30 Maximum 10 visits/year</td>
<td>$30</td>
</tr>
<tr>
<td>Uniform Medical Plan (UMP)&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP Classic</td>
<td>$0</td>
<td>15% Maximum 10 visits/year</td>
<td></td>
</tr>
<tr>
<td>UMP CDHP</td>
<td>$0</td>
<td>15% Maximum 10 visits/year</td>
<td>$0 You pay any amount over $150 every 24 months for frames, lenses, and contacts combined.</td>
</tr>
<tr>
<td>UMP Plus–PSHVN</td>
<td>$0</td>
<td>15% Maximum 10 visits/year</td>
<td></td>
</tr>
<tr>
<td>UMP Plus–UW Medicine ACN</td>
<td>$0</td>
<td>15% Maximum 10 visits/year</td>
<td></td>
</tr>
</tbody>
</table>

<sup>3</sup> Contact your plan about costs for children’s vision care.

---

The information in this document is accurate at the time of printing. Contact the plans or review the certificate of coverage before making decisions.
# Selecting a PEBB Dental Plan

You and any enrolled dependents must be enrolled in the same PEBB dental plan.

## Dental Plan Options

Make sure you confirm with your dentist that they accept the **specific plan network** and **plan group**.

<table>
<thead>
<tr>
<th>Plan name</th>
<th>Plan type</th>
<th>Plan administrator</th>
<th>Plan network</th>
<th>Plan group number</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeltaCare</td>
<td>Managed-care plan</td>
<td>Delta Dental of Washington</td>
<td>DeltaCare PEBB</td>
<td>Group 3100</td>
</tr>
<tr>
<td>Willamette Dental Group Plan</td>
<td>Managed-care plan</td>
<td>Willamette Dental of Washington, Inc</td>
<td>Willamette Dental Group, P.C.</td>
<td>WA82</td>
</tr>
<tr>
<td>Uniform Dental Plan (UDP)</td>
<td>Preferred-provider plan</td>
<td>Delta Dental of Washington</td>
<td>Delta Dental PPO</td>
<td>Group 3000</td>
</tr>
</tbody>
</table>

## How do the DeltaCare and Willamette Dental Group plans work?

DeltaCare is administered by Delta Dental of Washington. Its network is DeltaCare PEBB (Group 3100).

Willamette Dental Group is underwritten by Willamette Dental of Washington, Inc. Its network is Willamette Dental Group, P.C. with dental offices in Washington, Oregon and Idaho. Willamette Dental Group administers its own dental network (WA82).

DeltaCare and Willamette Dental Group are managed-care plans. You must select and receive care from a primary care dental provider in that plan’s network. **If you choose one of these plans and seek services from a dentist not in the plan’s network, the plan will not pay your dental claims.** Before enrolling, call the plan to make sure your dentist is in the plan’s network. Do not rely solely on information from your dentist’s office.

Neither plan has an annual deductible. You don’t need to track how much you have paid out of pocket before the plan begins covering benefits. You pay a set amount (copay) when you receive dental services. Neither plan has an annual maximum that they pay for covered benefits (some specific exceptions apply).

Referrals are required from your primary care dental provider to see a specialist. You may change providers in your plan’s network at any time.

## How does the Uniform Dental Plan (UDP) work?

UDP is administered by Delta Dental of Washington. Its network is Delta Dental PPO (Group 3000).

UDP is a preferred-provider organization (PPO) plan. You can choose any dental provider, and change providers at any time. More than three out of four dentists in Washington State participate with this PPO.

When you see a network provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network.

Under UDP you pay a percentage of the plan’s allowed amount (coinsurance) for dental services after you have met the annual deductible.

UDP pays up to an annual maximum of $1,750 for covered benefits for each enrolled dependent, including preventive visits.

## Before you select a plan or provider, keep in mind:

DeltaCare and Willamette Dental Group are managed-care plans. You must choose a primary dental provider within their networks. If you do not choose a primary dental provider, one will be chosen for you. These plans will not pay claims if you see a provider outside of their network.

UDP is a preferred-provider plan. You may choose any dental provider, but will generally have lower out-of-pocket costs if you see network providers.

Check with the plan to see if your dentist is in the plan’s network. Make sure you correctly identify your dental plan’s network and group number (see table above). You can call the dental plan’s customer service (listed in the front of this booklet), or use the dental plan network’s online directory. Carefully review the selection you made before submitting your enrollment form.

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.
# Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan’s certificate of coverage or contact the plan directly. A PPO refers to a preferred-provider organization (network).

## Annual Costs

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Uniform Dental Plan (UDP) (Group 3000 Delta Dental PPO)</th>
<th>DeltaCare (Group 3100)</th>
<th>Willamette Dental Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50/person, $150/family</td>
<td>None</td>
<td>No general plan maximum</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan maximum (See specific benefits maximums below.)</th>
<th>Uniform Dental Plan (UDP) (Group 3000 Delta Dental PPO)</th>
<th>DeltaCare (Group 3100)</th>
<th>Willamette Dental Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay amounts over $1,750</td>
<td>DeltaCare: 30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member’s lifetime</td>
<td>Willamette Dental Group: Any amount over $1,000 per year and $5,000 in member’s lifetime</td>
<td></td>
</tr>
</tbody>
</table>

## Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Uniform Dental Plan (UDP) (Group 3000 Delta Dental PPO)</th>
<th>DeltaCare (Group 3100)</th>
<th>Willamette Dental Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures</td>
<td>50% PPO and out of state; 60% non-PPO</td>
<td>$140 for complete upper or lower</td>
<td></td>
</tr>
<tr>
<td>Root canals (endodontics)</td>
<td>20% PPO and out of state; 30% non-PPO</td>
<td>$10 to $150</td>
<td></td>
</tr>
<tr>
<td>Nonsurgical TMJ</td>
<td>30% of costs until plan has paid $500 for PPO, out of state, or non-PPO; then any amount over $500 in member’s lifetime</td>
<td>DeltaCare: 30% of costs, then any amount after plan has paid $1,000 per year, then any amount over $5,000 in member’s lifetime</td>
<td>Willamette Dental Group: Any amount over $1,000 per year and $5,000 in member’s lifetime</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>20% PPO and out of state; 30% non-PPO</td>
<td>$10 to $50 to extract erupted teeth</td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50% of costs until plan has paid $1,750 for PPO, out of state, or non-PPO, then any amount over $1,750 in member’s lifetime (deductible doesn’t apply)</td>
<td>Up to $1,500 copay per case</td>
<td></td>
</tr>
<tr>
<td>Orthognathic surgery</td>
<td>30% of costs until plan has paid $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member’s lifetime</td>
<td>30% of costs until plan has paid $5,000; then any amount over $5,000 in member’s lifetime</td>
<td></td>
</tr>
<tr>
<td>Periodontic services (treatment of gum disease)</td>
<td>20% PPO and out of state; 30% non-PPO</td>
<td>$15 to $100</td>
<td></td>
</tr>
<tr>
<td>Preventive/diagnostic (deductible doesn’t apply)</td>
<td>0 PPO; 10% out of state; 20% non-PPO</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Restorative crowns</td>
<td>50% PPO and out of state; 60% non-PPO</td>
<td>$100 to $175</td>
<td></td>
</tr>
<tr>
<td>Restorative fillings</td>
<td>20% PPO and out of state; 30% non-PPO</td>
<td>$10 to $50</td>
<td></td>
</tr>
</tbody>
</table>
Group Term Life and AD&D Insurance

Your life insurance benefits allow you to cover yourself, your spouse or state-registered domestic partner, and your children. As an employee, your basic life insurance covers you and pays your designated beneficiaries in the event of your death. The PEBB Program offers basic life insurance and accidental death and dismemberment (AD&D) insurance, which provides extra benefits for certain injuries or death resulting from a covered accident.

Life and AD&D insurance are available to PEBB benefits-eligible state and higher-education employees, as well as employees who work for a school district, educational service district, charter school, tribal government, or employer group that offers both PEBB medical and dental coverage.

What are my PEBB life and AD&D insurance options?
The PEBB Program offers $35,000 of basic life insurance and $5,000 basic AD&D insurance (called Basic Life and AD&D Insurance for Employees) as part of your benefits package, at no cost to you.

The PEBB Program also offers Optional Life and AD&D insurance for you to purchase:

- **Optional Life Insurance for Employees:** Increments of $10,000 up to $500,000 with no Medical Evidence of Insurability (if elected no later than 31 days after becoming eligible for PEBB benefits), to a maximum of $1,000,000 with Medical Evidence of Insurability.
- **Optional Life Insurance for Children:** If you enroll in optional life insurance for yourself, you may apply for child coverage in $5,000 increments up to $20,000. The amount you select applies to all children enrolled.
- **Optional AD&D Insurance for Employees:** You may enroll in optional AD&D coverage in increments of $10,000 up to $250,000. Optional AD&D insurance does not cover death and dismemberment from non-accidental causes. Optional AD&D insurance never requires evidence of insurability.
- **Optional AD&D Insurance for a Spouse or State-Registered Domestic Partner:** You can choose to cover your spouse or state-registered domestic partner with AD&D coverage. You may enroll in optional AD&D coverage in increments of $10,000 up to $250,000.
- **Optional AD&D Insurance for Children:** For your children, optional AD&D coverage is available in $5,000 increments up to $25,000.

When can I enroll?
You may enroll no later than 31 days after becoming eligible for PEBB benefits (generally your first day of employment) for the following coverage, without providing evidence of insurability:

- Optional Life Insurance for Employees up to $500,000.
- Optional Life Insurance for a Spouse or State-Registered Domestic Partner up to $100,000.
- Optional AD&D Insurance for Children, all amounts Guaranteed Issue in increments of $5,000 up to $20,000.

Optional AD&D insurance never requires evidence of insurability. You must provide evidence of insurability to MetLife if you:

- Apply for Optional Life Insurance after 31 days from becoming eligible for PEBB benefits.
- Request more than $500,000 in Optional Employee Life Insurance for yourself.
- Request more than $100,000 in Optional Life Insurance for your spouse or state-registered domestic partner.

MetLife must approve your request for additional levels of coverage.

How do I enroll?
Complete the MetLife Enrollment/Change Form in the back of this book. If you have any questions regarding enrollment please contact MetLife at 1-866-548-7139.

The PEBB Program offers life insurance through Metropolitan Life Insurance Company (Plan number 164995). This is a summary of benefits only. To see the certificate of coverage, either:

- Go to www.hca.wa.gov/pebb-employee under Forms and publications.
- Contact your employer’s personnel, payroll, or benefits office.

(continued)
If I leave employment, can I continue life insurance coverage?

If you’re eligible for Portability or Conversion due to termination or other reasons, MetLife will send you information and an application. Complete and mail to the address on the application.

Portability Provision
Under the Portability Provision of your PEBB employee life insurance, you can apply to continue your terminated employee Basic Life and Optional Life Insurance until age 100 if certain conditions are met. You may elect to decrease your coverage continued under the Portability Provision, but you will not be able to increase it.

The minimum amount of your life insurance that you can apply to continue under the Portability Provision is $10,000. The maximum amount will not exceed $1,000,000. You must be actively enrolled in coverage to port it.

You may also apply to continue your terminated Dependent Basic Life and your Spouse or State-Registered Domestic Partner Optional Life Insurance at the same time you apply to continue your own life insurance coverage under the Portability Provision. Dependent Life Insurance may be continued even if you (the subscriber) choose not to continue your life insurance.

To continue life insurance under the Portability Provision, you must apply to MetLife no later than 60 days after the date your PEBB employee life insurance ends due to retirement, or no later than 60 days after the date you leave office if you are an elected or appointed official as described in WAC 182-12-180(1).

Optional Accidental Death and Dismemberment (AD&D) Insurance

If you and your dependents are not eligible for coverage under the Portability Provision, you may still be eligible for the Conversion of Life Insurance Provision.

Conversion of Life Insurance Provision
Retiring employees and their dependents may be entitled to convert their life insurance to an individual policy without evidence of insurability (proof of good health).

The amount of the individual policy will be equal to (or at your option, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting.

You must apply to continue your coverage under the Conversion of Life Insurance Provision. The conversion period is 31 days after the date your PEBB employee life insurance ends due to retirement. You will have a total of 60 days to apply for conversion coverage after your employee life insurance ends.

You may contact MetLife directly at 1-866-548-7139 with any questions.

Monthly Rates

<table>
<thead>
<tr>
<th>Optional Life Insurance for Employees and Spouse or State-Registered Domestic Partner, and child(ren)</th>
<th>COST PER $1,000 PER MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Tobacco User</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Less than 25</td>
<td>$0.028</td>
</tr>
<tr>
<td>25–29</td>
<td>$0.031</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.034</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.043</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.064</td>
</tr>
<tr>
<td>45–49</td>
<td>$0.092</td>
</tr>
<tr>
<td>50–54</td>
<td>$0.143</td>
</tr>
<tr>
<td>55–59</td>
<td>$0.268</td>
</tr>
<tr>
<td>60–64</td>
<td>$0.411</td>
</tr>
<tr>
<td>65–69</td>
<td>$0.758</td>
</tr>
<tr>
<td>70+</td>
<td>$1.131</td>
</tr>
<tr>
<td>Cost for your child(ren)</td>
<td>$0.124</td>
</tr>
</tbody>
</table>

Rates are based on your age as of December 31 of the prior year.

Optional Accidental Death and Dismemberment (AD&D) Insurance

<table>
<thead>
<tr>
<th>MONTHLY COST PER $1,000 OF COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
</tr>
<tr>
<td>Dependent Spouse or State-Registered Domestic Partner</td>
</tr>
<tr>
<td>Dependent Child</td>
</tr>
</tbody>
</table>
Long-Term Disability Insurance

Long-term disability (LTD) insurance is designed to help protect you from the financial risk of lost earnings due to serious injury or illness. When you enroll in LTD coverage, it pays a percentage of your monthly earnings to you if you become disabled as defined below.

LTD insurance is available to PEBB benefits-eligible state and higher-education employees, and employees who work for a school district, educational service district, charter school, tribal government, or employer group that offers both PEBB medical and dental coverage. Exceptions: Optional LTD insurance is not available to seasonal employees who work a season that is less than nine months, or port commissioners.

What are my PEBB long-term disability insurance options?

LTD coverage has two parts:

1. The PEBB Program offers a maximum $240 monthly Basic LTD Plan benefit as part of your benefits package, at no cost to you.
2. The PEBB Program also offers Optional LTD Plan insurance for you to purchase.

LTD benefit amounts

The monthly LTD benefit is a percentage of your insured monthly predisability earnings, reduced by deductible income (such as work earnings, workers’ compensation, sick pay, Social Security, etc.).

The LTD benefit for each plan is shown below:

<table>
<thead>
<tr>
<th></th>
<th>Basic LTD</th>
<th>Optional LTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of monthly predisability earnings the plan pays</td>
<td>60% of the first $400</td>
<td>60% of the first $10,000</td>
</tr>
<tr>
<td>Minimum monthly LTD benefit</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Maximum monthly LTD benefit</td>
<td>$240</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

Waiting period before benefits become payable

Basic LTD Plan: 90 days or the period of sick leave (excluding shared leave) for which you are eligible under the employer’s sick leave plan, whichever is longer.

Optional LTD Plan: 90, 120, 180, 240, 300, or 360 days (depending on your election), or the period of sick leave (excluding shared leave) for which you are eligible under the employer’s sick leave plan, whichever is longer.

What is considered a disability?

Being unable to perform with reasonable continuity the duties of your own occupation as a result of sickness, injury, or pregnancy during the benefit waiting period and the first 24 months for which LTD benefits are payable. During this period, you are considered partially disabled if you are working but unable to earn more than 80 percent of your indexed predisability earnings.

After that, as a result of sickness, injury, or pregnancy, being unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably able through education, training, or experience. During this period, you are considered partially disabled if you are working, but unable to earn more than 60 percent of your indexed predisability earnings in that occupation and in all other occupations for which you are reasonably suited.

Maximum benefit period

For both basic and optional LTD coverage, the benefit duration is based on your age when the disability begins.

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum benefit period</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 or younger</td>
<td>To age 65, or to SSNRA* or 42 months, whichever is longer</td>
</tr>
<tr>
<td>62</td>
<td>To SSNRA* or 42 months, whichever is longer</td>
</tr>
<tr>
<td>63</td>
<td>To SSNRA* or 36 months, whichever is longer</td>
</tr>
<tr>
<td>64</td>
<td>To SSNRA* or 30 months, whichever is longer</td>
</tr>
<tr>
<td>65</td>
<td>24 months</td>
</tr>
<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69 or older</td>
<td>12 months</td>
</tr>
</tbody>
</table>

*SSNRA is Social Security Normal Retirement Age, your normal retirement age under the Federal Social Security Act as amended.

(continued)
Long-Term Disability Insurance

How much does the Optional LTD Insurance Plan cost?

Payroll deduction as a percentage of predisability earnings

<table>
<thead>
<tr>
<th>Benefit waiting period</th>
<th>Higher-education retirement plan employees</th>
<th>TRS, PERS, and other retirement plan employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 days</td>
<td>0.72%</td>
<td>0.60%</td>
</tr>
<tr>
<td>120 days</td>
<td>0.42%</td>
<td>0.36%</td>
</tr>
<tr>
<td>180 days</td>
<td>0.32%</td>
<td>0.28%</td>
</tr>
<tr>
<td>240 days</td>
<td>0.30%</td>
<td>0.27%</td>
</tr>
<tr>
<td>300 days</td>
<td>0.28%</td>
<td>0.25%</td>
</tr>
<tr>
<td>360 days</td>
<td>0.27%</td>
<td>0.24%</td>
</tr>
</tbody>
</table>

Multiply your monthly base pay (up to $10,000) by the percentage shown above for the desired benefit waiting period to calculate your optional LTD monthly premium.

When can I enroll?

You may enroll in optional LTD coverage no later than 31 days after becoming eligible for PEBB benefits (generally your first day of employment) without providing evidence of insurability.

If you apply for optional LTD coverage after 31 days, or decrease the waiting period for optional LTD coverage, you must provide evidence of insurability and your Long-Term Disability (LTD) Evidence of Insurability Form must be approved by Standard Insurance Company before your insurance becomes effective.

How do I enroll?

If applying no later than 31 days after you become eligible for PEBB benefits, complete and submit the Long Term Disability (LTD) Enrollment/Change Form (found in the back of this booklet) to your employer’s personnel, payroll, or benefits office.

If applying after 31 days, or decreasing the waiting period for optional LTD coverage, you must also complete the Long Term Disability (LTD) Evidence of Insurability Form (found at www.hca.wa.gov/ltd) and submit it to Standard Insurance Company.

For questions about enrollment, contact your employer’s personnel, payroll, or benefits office. If you have a specific question about a claim, contact Standard Insurance Company at 1-800-368-2860.

Example #1

If you are a higher-education retirement plan employee with monthly earnings of $1,000, the 90-day benefit waiting period would cost $7.20 per month.

Earnings: $1,000 per month
90-day benefit waiting period: \( \times \) 0.0072 (0.72% converts to 0.0072 when multiplying)
Monthly cost: $7.20

Example #2

If you are a TRS, PERS, or other retirement plan employee with monthly earnings of $1,000, the 90-day benefit waiting period would cost $6.00 per month.

Earnings: $1,000 per month
90-day benefit waiting period: \( \times \) 0.006 (0.6% converts to 0.006 when multiplying)
Monthly cost: $6.00

Blue ink indicates information only for subscribers who have PEBB dental, life, and long-term disability coverage.
Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)

Both the Medical FSA and DCAP are available to public employees eligible for PEBB benefits who work at state agencies, higher-education institutions, and community and technical colleges as described in Washington Administrative Code (WAC) 182-12-114 (see www.hca.wa.gov/employee-retiree-benefits/public-employees/additional-benefits).

What is a Medical Flexible Spending Arrangement (FSA)?
A Medical FSA allows you to set aside money from your paycheck on a pre-tax basis to pay for qualifying out-of-pocket health care costs for you and your qualified dependents. You can set aside as little as $240 or as much as $2,650 per calendar year. The full amount you elect to set aside for your Medical FSA is available on the first day your benefits become effective.

Note: You **cannot** enroll in both a Medical FSA and a PEBB consumer-directed health plan (CDHP) with a health savings account (HSA). If you elect to enroll in both will only be enrolled in the CDHP with a HSA.

How does the Medical FSA work?
- Your Medical FSA helps you pay for deductibles, copays, coinsurance, dental, vision, and many other expenses. You can use your Medical FSA for you, your spouse’s, or qualified dependent’s health care expenses, even if they are not enrolled in your PEBB medical or dental plan.
- To figure out how much you should contribute, estimate your out-of-pocket medical expenses for the calendar year and enroll in a Medical FSA for that amount. The more accurate you are in estimating your expenses, the better this benefit will work for you. The amount you set as your annual election cannot be changed after you enroll (after your initial allowable 31 days of enrollment) unless a special open enrollment event (qualifying event) occurs during the plan year. Common qualifying events include birth, adoption, or marriage. Your change in election amount must be consistent with the qualifying event.
- Your election amount is deducted from your pay, divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pre-tax (which reduces your taxable income), so you don’t pay Federal Insurance Contributions Act (FICA) or federal income taxes on your elected dollars.

What is the Dependent Care Assistance Program (DCAP)?
Child or elder care can be one of the largest expenses for a family. The DCAP allows you to set aside money from your paycheck on a pre-tax basis to help pay for qualifying child care or elder care expenses while you and your spouse attend school full-time, work, or look for work. A qualifying dependent must live with you and must be 12 years old or younger. A dependent age 13 or older qualifies only if they are physically or mentally incapable of self-care and regularly spends at least eight hours each day in your household. The care must be provided during the hours the parent(s) work, look for work, or attend school. You can set aside as much as $5,000 annually (single person or married couple filing joint income tax return) or $2,500 annually (married filing separate income tax return).

The total amount of your contribution cannot be more than either your earned income or your spouse’s earned income, whichever is less.

Earned income means wages, salaries, tips, and other employee compensation plus net earnings from self-employment.

How does the DCAP work?
- The DCAP helps you pay for eligible expenses including elder day care, babysitting, day care, preschool, and registration fees.
- Estimate your child or elder care expenses for the calendar year and enroll in the DCAP for that amount.
- Your election amount is deducted from your pay, and divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pre-tax (which reduces your taxable income).

When can I enroll?
You may enroll in the Medical FSA and/or the DCAP at the following times:
- **No later than 31 days** after the date you become eligible for PEBB benefits (usually on your first day of employment; see WAC 182-08-197 for details).
- **During the PEBB Program’s annual open enrollment** (November 1–30).
- **No later than 60 days** after you or an eligible dependent experiences a qualifying event that creates a special open enrollment during the year.

Before you enroll, make sure to review the Medical FSA or DCAP Enrollment guides at pebb.naviabenefits.com. You can also call Navia Benefit Solutions at 1-800-669-3539 if you have questions.

(continued)
Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)

How can I enroll?
You can download and print the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) Enrollment Form at pebb.naviabenefits.com.

To enroll as a first time subscriber in these optional benefits, you must return the form to your personnel, payroll or benefits office no later than 31 days after you become eligible for PEBB benefits.

Exception: University of Washington employees must enroll through Workday.

Employees who enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a Medical FSA in the same plan year.

When can I change my Medical FSA or DCAP election?
Once you enroll in a Medical FSA or DCAP, you can change your election only if you experience a special open enrollment event (qualifying event). (See Policy Addendum 45-2A for details.) The requested change must correspond to and be consistent with the qualifying event.

If you have a qualifying event and want to change your elections, your personnel, payroll, or benefits office must receive your completed Navia Benefit Solutions Change of Status form and proof of the event that created the special open enrollment no later than 60 days after the date of the event.

Note: University of Washington employees must submit the change through Workday.

For more information, see the Medical FSA Enrollment Guide or DCAP Enrollment Guide at pebb.naviabenefits.com.

Navia Benefit Solutions, Inc. administers the Medical FSA and DCAP
For details and forms, visit Navia Benefit Solutions at pebb.naviabenefits.com or call 1-800-669-3539.

Email questions to customerservice@naviabenefits.com

SmartHealth is the Washington State's voluntary wellness program designed to help you improve your health by participating in fun and engaging SmartHealth activities. The secure website offers tips and tools through fun activities that improve nutrition, sleep, exercise, and more. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentives.

Who is eligible to participate?
Subscribers and their spouses or state-registered domestic partners enrolled in PEBB medical coverage can participate in SmartHealth through the SmartHealth website; however, only the subscriber can qualify for the financial wellness incentives, and other SmartHealth promotions.

Note: If you waive PEBB medical coverage, you will not have access to SmartHealth.

What are the financial wellness incentives?
Eligible subscribers who participate in SmartHealth activities can qualify for two financial wellness incentives:

- A $25 Amazon.com gift card* wellness incentive, and
- Either a $125 reduction in the subscriber's 2020 PEBB medical deductible, or a one-time deposit of $125 into the subscriber's health savings account (if enrolled in a PEBB consumer-directed health plan in 2020).

How do I get started?
Follow these simple steps to earn points to qualify for the financial wellness incentives:

1. Go to www.smarthealth.hca.wa.gov and select Get started to walk through the activation process.
2. Take the SmartHealth Well-being Assessment (required to qualify for the wellness incentives). After completing the Well-being Assessment, you earn the $25 gift card wellness incentive.

How do I qualify for the financial wellness incentives?
To qualify for the $25 Amazon.com gift card* wellness incentive, the subscriber must:

- Not be enrolled in both Medicare Part A and Part B as their primary insurance, and
- Complete the SmartHealth Well-being Assessment and claim the $25 Amazon.com gift card* by December 31, 2019.

To qualify for the $125 wellness incentive, the subscriber must:

- Not be enrolled in both Medicare Part A and Part B as their primary insurance,
- Complete the SmartHealth Well-being Assessment, and
- Earn 2,000 total points within the deadline requirement.

To receive the $125 wellness incentive in 2020, the subscriber must still be enrolled in a PEBB medical plan in 2020.

The PEBB Program will work with a subscriber who cannot complete a wellness incentive requirement in order to provide an alternative requirement that will allow the subscriber to qualify for the wellness incentive or waive the requirement.

If a subscriber qualifies for the $125 wellness incentive in 2019, then becomes a retiree, or continuation coverage subscriber enrolled in Medicare Part A and Part B as their primary coverage and while enrolled in a PEBB medical plan after January 1, 2020, they will still receive the SmartHealth incentive in 2020.

Deadline requirements
When is the deadline to meet the requirements for the $25 gift card wellness incentive?
The deadline to qualify for and claim the $25 Amazon.com gift card* wellness incentive is December 31, 2019.

When is the deadline to meet the requirements for the $125 wellness incentive?

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date in January through June, your deadline to qualify for the financial incentive is September 30, 2019.

- If your PEBB medical effective date is in July or August, your deadline is 120 days from your medical effective date. Example: Sam is new to state employment and his PEBB medical effective date is July 1, 2019. Sam’s deadline to complete his SmartHealth Activities and earn his financial wellness incentive is October 29, 2019.

- If your PEBB medical effective date is in September through December, your deadline is December 31, 2019.

* The $25 Amazon.com gift card is a taxable benefit.
Auto and Home Insurance

The PEBB Program offers voluntary group auto and home insurance through its alliance with Liberty Mutual Insurance Company—one of the largest property and casualty insurance providers in the country.

What does Liberty Mutual offer?
PEBB Program members may receive a group discount of up to 12 percent off Liberty Mutual’s auto insurance rates and up to 5 percent off Liberty Mutual’s home insurance rates. In addition to the discounts, Liberty Mutual also offers:

• Discounts based on your driving record, age, auto safety features, and more.

• Convenient payment options—including automatic payroll deduction (for employees), electronic funds transfer (EFT), or direct billing at home.

• A 12-month guarantee on competitive rates.

• Prompt claims service with access to local representatives.

When can I enroll?
You can choose to enroll in auto and home insurance coverage at any time.

How do I enroll?
To request a quote for auto or home insurance, you can contact Liberty Mutual one of three ways (have your current policy handy):


• Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB Program member (client #8246).

• Call or visit one of the local offices (see box).

If you are already a Liberty Mutual policyholder and would like to save with Group Savings Plus, just call one of the local offices to find out how they can convert your policy at your next renewal.

Note: Liberty Mutual does not guarantee the lowest rate to all PEBB Program members; rates are based on underwriting for each individual, and not all applicants may qualify. Discounts and savings are available where state laws and regulations allow and may vary by state.

Contact a local Liberty Mutual office (mention client #8246):

Portland, OR 1-800-248-8320
4949 SW Meadows Rd., Suite 650,
Lake Oswego, OR 97035

Bellevue 1-800-253-5602
11711 SE 8th St. Suite 220,
Bellevue, WA 98005

Spokane 1-800-208-3044
24041 E Mission Ave
Liberty Lake, WA 99019

Tukwila 1-800-922-7013
14900 Interurban Ave., Suite 142
Tukwila, WA 98168

Tumwater 1-800-319-6523
1550 Irving Street SW, Suite 202
Tumwater, WA 98512
PEBB Program Nondiscrimination Notice and Language Access Services

The PEBB Program and its contracted health plans comply with applicable federal civil rights laws and do not discriminate (exclude people or treat them differently) on the basis of race, color, national origin, age, disability, or sex.

The PEBB Program also complies with applicable state civil rights laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained guide dog or service animal by a person with a disability.

The PEBB Program provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe this organization has failed to provide language access services or discriminated in another way...

You can file a grievance with:

<table>
<thead>
<tr>
<th>PEBB Program</th>
<th>Health Care Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HCA Compliance Officer is available to help you.</td>
<td>Division of Legal Services, Attn: HCA Compliance Officer</td>
</tr>
<tr>
<td></td>
<td>PO Box 42704</td>
</tr>
<tr>
<td></td>
<td>Olympia, WA 98504-2704</td>
</tr>
<tr>
<td></td>
<td>1-855-682-0787 (TRS: 711)</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:compliance@hca.wa.gov">compliance@hca.wa.gov</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEBB MEDICAL PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Foundation Health Plan of the Northwest</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of the Northwest Attn: Member Relations – Kaiser Civil Rights Coordinator</td>
</tr>
<tr>
<td>500 NE Multnomah, Suite 100</td>
</tr>
<tr>
<td>Portland, OR 97232</td>
</tr>
<tr>
<td>1-800-813-2000 or 503-813-2000 (TRS: 711)</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of Washington</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan of Washington Civil Rights Coordinator</td>
</tr>
<tr>
<td>Quality GNE-D1E-07</td>
</tr>
<tr>
<td>PO Box 9812</td>
</tr>
<tr>
<td>Renton, WA 98057</td>
</tr>
<tr>
<td>1-888-901-4636 or 206-630-4636 (TRS: 711)</td>
</tr>
<tr>
<td>kp.org/wa/feedback</td>
</tr>
<tr>
<td>Washington State Rx Services Attn: Appeals Unit</td>
</tr>
<tr>
<td>PO Box 40168</td>
</tr>
<tr>
<td>Portland, OR 97204-0168</td>
</tr>
<tr>
<td>1-888-361-1611 (TDD/TTY: 711)</td>
</tr>
<tr>
<td><a href="mailto:compliance@modahealth.com">compliance@modahealth.com</a></td>
</tr>
<tr>
<td>Premera Blue Cross Attn: Civil Rights Coordinator - Complaints and Appeals</td>
</tr>
<tr>
<td>PO Box 91102</td>
</tr>
<tr>
<td>Seattle, WA 98111</td>
</tr>
<tr>
<td>1-855-332-4535 (TTY: 1-800-842-5357)</td>
</tr>
<tr>
<td><a href="mailto:AppealsDepartmentInquiries@Premera.com">AppealsDepartmentInquiries@Premera.com</a></td>
</tr>
</tbody>
</table>

HCA 57-401 (10/18)
If you believe this organization has failed to provide language access services or discriminated in another way...

<table>
<thead>
<tr>
<th>You can file a grievance with:</th>
</tr>
</thead>
</table>
| **Regence BlueShield**  
(for discrimination concerns about UMP Classic, UMP Consumer-Directed Health Plan [CDHP], and UMP Plus) |
| Regence BlueShield  
Civil Rights Coordinator  
MS: CS B32B, PO Box 1271  
Portland, OR 97207-1271  
1-888-344-6347 (TRS: 711)  
CS@regence.com |
| **Regence BlueShield**  
(for discrimination concerns about UMP Classic for Medicare members) |
| Regence BlueShield  
Civil Rights Coordinator  
MS: B32AG, PO Box 1827  
Medford, OR 97501  
1-866-749-0355 (TRS: 711)  | Fax 1-888-309-8784  
medicareappeals@regence.com |

**PEBB DENTAL PLANS**

<table>
<thead>
<tr>
<th>You can file a grievance with:</th>
</tr>
</thead>
</table>
| **Delta Dental**  
(for discrimination concerns about DeltaCare and the Uniform Dental Plan) |
| Delta Dental  
Attn: Isaac Lenox, Compliance/Privacy Officer  
PO Box 75983  
Seattle, WA 98175  
1-800-554-1907 (TTY: 1-800-833-6384)  | Fax 206-729-5512  
Compliance@DeltaDentalWA.com |
| **Willamette Dental**  
*HCA will process discrimination complaints pertaining to Willamette Dental Group.* |
| Health Care Authority  
Division of Legal Services, Attn: HCA Compliance Officer  
PO Box 42704  
Olympia, WA 98504-2704  
1-855-682-0787 (TRS: 711)  | Fax 360-507-9234  
compliance@hca.wa.gov |

You can also file a civil rights complaint with:

- U.S. Department of Health and Human Services, Office for Civil Rights  
  200 Independence Avenue, SW Room 509F, HHH Building  
  Washington, D.C. 20201  
  1-800-368-1019 (TDD: 1-800-537-7697)  
  [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) (to submit complaints electronically)  
Language assistance services, including interpreters and translation of printed materials, are available free of charge. Employees: Contact your employer’s personnel, payroll, or benefits office directly. retirees, COBRA, and Continuation Coverage members only: Contact the PEBB Program at 1-800-200-1004. (TRS: 711).

Continuation Coverage members only: Contact the PEBB payroll, or benefits office directly. Retirees, COBRA, and COBRA (participant, employee, or enrollee) must contact their employer’s personnel, payroll, or benefits office directly. Employees: Contact your employer’s personnel, payroll or benefits office directly. (TRS: 711).

For translation: 1-800-200-1004 (TRS: 711).

Enrollment Forms

The following forms are available online:

**2019 Employee Enrollment/Change**

**2019 Employee Enrollment/Change for Medical Only Groups**

**2019 Enrollment/Change MetLife**
https://www.hca.wa.gov/assets/pebb/metlife-employee-enrollment.doc

**Long Term Disability (LTD) Enrollment/Change Form**

**2019 Premium Surcharge Help Sheet**