

Your PEBB Benefits for 2019

Employee Enrollment Guide

Forms Inside



Washington State
Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Now serving

Great coverage. Great networks of care. Great price.

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

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

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

Medical Plans	Website addresses	Customer service phone numbers	TRS customer service phone numbers for deaf, hard of hearing, or speech impaired
Kaiser Permanente NW Classic or CDHP*	my.kp.org/wapebb	Portland area: 503-813-2000 All other areas: 1-800-813-2000	711
Kaiser Permanente WA Classic, CDHP, SoundChoice, or Value	kp.org/wa/pebb	1-866-648-1928	711 or TTY: 1-800-833-6388
Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield	hca.wa.gov/ump	1-888-849-3681	711
UMP Plus—Puget Sound High Value Network	pugetsoundhighvaluenetwork.org hca.wa.gov/ump/plan-ump-plus	1-855-776-9503	711
UMP Plus—UW Medicine Accountable Care Network	uwmedicine.org/umpplus 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.

Dental Plans	Website addresses	Customer service phone numbers
DeltaCare, administered by Delta Dental of Washington	deltadentalwa.com/pebb	1-800-650-1583
Willamette Dental Group	willamettedental.com/wapebb	1-855-4DENTAL (433-6825)
Uniform Dental Plan, administered by Delta Dental of Washington	deltadentalwa.com/pebb	1-800-537-3406

Additional contacts		Website addresses	Customer service phone numbers
Auto and Home Insurance	Liberty Mutual Insurance Company	hca.wa.gov/employee-retiree-benefits/employees/auto-and-home-insurance	1-800-706-5525
Health Savings Account Trustee	HealthEquity	healthequity.com/pebb	1-877-873-8823 TRS: 711
Life Insurance	Metropolitan Life (MetLife)	mybenefits.metlife.com/wapebb	1-866-548-7139
Long-Term Disability (LTD) Insurance	Standard Insurance Company	n/a	1-800-368-2860
Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)	Navia Benefit Solutions	pebb.naviabenefits.com	1-800-669-3539
SmartHealth	Limeade	smarthealth.hca.wa.gov	1-855-750-8866

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 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 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.

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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 33–40. 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 (then confirm their status with the plan).
 - 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 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 42–43. **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. Remember to name a beneficiary on the enrollment form.

Optional long-term disability (LTD) insurance

- Review the LTD insurance options and premiums on pages 44–45. **Note:** If your employer offers LTD insurance, you will be automatically enrolled in basic LTD insurance at no cost to you.

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 and AD&D insurance](#), and [basic LTD insurance](#). You will be charged a tobacco use premium surcharge.

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.



Need more help making decisions?

For general information and resources to help make informed health care decisions, visit Own Your Health’s website at ownyourhealthwa.org.

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call 1-800-200-1004 (TRS: 711).

Eligibility Summary

Are you a K-12 employee?

Starting in 2020, eligible employees of K-12 school districts, represented members of educational service districts, and charter schools will receive their health insurance and other benefits through the School Employees Benefits Board (SEBB) Program. Visit hca.wa.gov/sebb-employee to learn more.

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 personnel, payroll, or benefits office to find out when benefits begin once you are eligible. If you disagree with the determination, see "PEBB Appeals" on page 22.

For complete details on PEBB eligibility and enrollment, refer to Chapters 182-08 and 182-12 Washington Administrative Code (WAC) at hca.wa.gov/pebb-rules.

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

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.

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

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

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission.

A higher-education faculty member is eligible for PEBB benefits upon employment 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, in which they are 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 who 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 meets the criteria listed above, 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, they must notify all employing agencies that they 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 by enrolling in and self-paying for PEBB Continuation Coverage (Unpaid Leave) (for a

maximum of 12 months). See WAC 182-12-142 for continuation coverage information. The PEBB Program must receive the faculty's election to self-pay benefits **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.

Seasonal employees

"Seasonal employee" means an employee hired to work during a recurring, annual season of three months or more, and who is anticipated to return each season to perform similar work.

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 (combine) hours to establish and maintain eligibility. See WAC 182-12-114(2) for details on when a seasonal employee becomes eligible. Please

notify your employer if you believe you are eligible through stacking.

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 pay status for 8 or more hours during that month, and through the off season after each season worked.
- Eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

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.
- May continue any combination of medical, **dental and life insurance** when they are in between periods of eligibility by enrolling in and self-paying for PEBB Continuation Coverage (Unpaid Leave) (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** 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.

Elected and full-time appointed officials

Legislators are eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches

of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

Justices and judges

A justice of the Supreme Court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

Can I cover my dependents?

You may enroll the following dependents (as described in WAC 182-12-260):

- Your legal spouse.
- Your state-registered domestic partner as defined in RCW 26.60.020(1), and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Strict requirements apply to these partnerships, including that one partner is 62 or older and you live in the same residence.
- 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.

(continued)

Eligibility Summary

- 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 the child is enrolled in PEBB medical), 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. These verifications will 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.

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.

You must notify the PEBB Program in writing when your child with a disability is no longer eligible. The PEBB Program must receive notice **no later than 60 days** after the date your child is no longer eligible.

If I die, are my surviving dependents eligible?

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.

The PEBB Program must receive all required forms 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.

If your surviving spouse, state-registered domestic partner, or dependent child does not meet the eligibility requirements outlined above, they may be eligible to continue health plan enrollment in PEBB Continuation Coverage (COBRA) as described in WAC 182-12-146. See "What are my options when coverage ends?" on page 20.

Verifying dependent eligibility

When you add a dependent to your PEBB coverage, their eligibility must be verified before they will be enrolled. You must submit proof of their eligibility within the PEBB Program's timelines. The PEBB Program reserves the right to review a dependent's eligibility at any time.

If a dependent's eligibility cannot be verified, they will not be enrolled. 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.

If enrolling an extended dependent or a dependent child with a disability age 26 or older, you must complete the required dependent certification form (in addition to the enrollment form) and submit them to the address on the form. You can find these forms at hca.wa.gov/employee-retiree-benefits/public-employees/dependent-verification.

Valid dependent verification documents

Dependent verification helps make sure the PEBB Program covers only people who qualify. If you want to enroll 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 find forms and more information, go to hca.wa.gov/employee-retiree-benefits/public-employees/how-enroll, or contact your agency's personnel, payroll, or benefits office.

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 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 state-registered domestic partnership or legal union
- Legal separation notice of state-registered 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.

To enroll children

Use the *Extended Dependent Certification* form to enroll an extended (legal) dependent child. For all other children, provide a copy of one of the documents listed below with your enrollment form:

- The most recent year's federal tax return that includes dependent child(ren). **Note:** You can submit one copy of your tax return if it includes all dependents that require verification.
- 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 or partner in PEBB insurance coverage.

Enrollment summary

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 optional 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 (or applicable contracted vendor) doesn’t receive your completed form(s) and dependent verification documents (if applicable) within the 31-day election period, you will be enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic, [Uniform Dental Plan \(UDP\)](#), [basic life and AD&D 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 the date your enrollment was effective. 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 41–48. You can enroll in auto or home insurance at any time.

Which forms do I use?

You will find forms in the back of this guide. If your employer offers PEBB medical, dental, life, and LTD insurance, complete these 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 Groups form](#).

To enroll in other PEBB-sponsored benefits:

- Medical FSA or DCAP (state agency and higher-education employees only) — Visit [pebb.naviabenefits.com](#). **Note:** University of Washington employees must enroll through Workday.

- Auto/home insurance — Visit [hca.wa.gov/employee-retiree-benefits/public-employees/auto-and-home-insurance](#) to find a local office or call Liberty Mutual Insurance Company at 1-800-706-5525.

If you enroll the dependents shown in the box below, you must also submit the additional required forms within 31 days of when you become eligible.

If enrolling a then also complete this form
Non-qualified tax dependent	Declaration of Tax Status
Dependent child with a disability (age 26 and older)	Certification of a Child With a Disability
Extended (legal) dependent child	Extended Dependent Certification

If you need more forms, go to [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 [hca.wa.gov/pebb-rules](#).

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 your employer offers PEBB [dental](#), [basic life and AD&D insurance](#), and [basic LTD insurance](#), 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 and AD&D insurance, and basic LTD insurance under your own account.** See “Waiving Medical Coverage” on page 19.

When does coverage begin?

When newly eligible, medical, **dental, basic life and AD&D insurance, and basic LTD insurance** begins on the first day of the month following the date you become eligible for PEBB benefits. If you become eligible on the first working day of the month, PEBB

benefits begin on that day. Once you are eligible, contact your personnel, payroll, or benefits office to learn when your benefits begin.

For faculty members hired on a quarter/semester to quarter/semester basis, medical, **dental, basic life and AD&D 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.

When making a change, coverage will begin as noted in the table below.

Annual event	When coverage begins
PEBB Program’s annual open enrollment (November 1–30)	January 1 of the following year
Special open enrollment events	When coverage begins
Marriage or registering for a state-registered domestic partnership	The first of the month after the date of marriage or registration 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.
Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption	<p>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).</p> <p>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 birth or adoption occurs.</p> <p>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.</p> <p>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.</p> <p>If elected, Dependent Child Life Insurance for a newly born child begins on the 14th day after birth.</p>
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.

(continued)

Enrollment summary

For the PEBB Program's annual open enrollment (November 1 through 30), your employer must receive the required form(s) and proof of your dependent's eligibility no later than November 30 (even if that day is not a business day).

For a special open enrollment, your employer must receive the completed enrollment form(s) and proof of your dependent's eligibility and/or the event no later than 60 days after the special open enrollment event.

In many cases, 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, submit the required forms and proof of your dependent's eligibility and/or the event as soon as possible to ensure timely payment of claims. If adding the child increases the premium, your employer must receive the enrollment form and proof of your dependent's eligibility and/or the event 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.

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.

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 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 usually 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 if the employer offers these benefits.](#)

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

In most cases, employees and their spouses can elect to defer Medicare enrollment, without penalty, up to the date the employee terminates employment or retires. If you are receiving a monthly Social Security

benefit, you cannot defer Medicare Part A. Contact your nearest Social Security office for information on deferring or reinstating Medicare. 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 medicare.gov.

How much will my monthly premiums be?

For state agency and higher education employees, see the “2019 Monthly Premiums” on page 24. [There are no employee premiums for dental, basic life and AD&D 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 each plan’s certificate of coverage 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.

You may also be charged one or both of the following premium surcharges in addition to your monthly medical 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 status for each dependent you want to enroll. If you do not attest within the PEBB Program’s timelines or if your attestation shows the surcharge applies to you, you will be charged the surcharge. If your or your dependent’s tobacco use status changes, you must reattest.
- A monthly **\$50 spouse or state-registered domestic partner coverage premium surcharge** will apply if you enroll your spouse or

state-registered domestic partner, 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. If you enroll a spouse or state-registered domestic partner and do not attest within the PEBB Program’s timelines, or if your attestation results in you incurring the premium surcharge, you will be charged the surcharge in addition to your monthly medical premium.

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 contained in the Salary Reduction Plan under Internal Revenue Code Section 125. 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.

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, then the portion of your monthly premiums for your partner’s coverage and the \$50 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 want to pay premiums for your state-registered domestic partner with pretax earnings, complete and submit the *Declaration of Tax Status* form to your personnel, payroll, or benefits office no later than 31 days after you become eligible for PEBB benefits.

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. However, if you have a state-registered domestic partner on your PEBB account, you will pay the portion of the monthly premium for your state-registered domestic partner on a post-tax basis until you complete the *Declaration of Tax Status* form.

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.

(continued)

Enrollment summary

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.

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 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.

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.

Making changes in coverage

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, 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, 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 last day of the month the dependent loses eligibility (WAC 182-12-262). If a dependent child with a disability loses eligibility, the notice must be provided to the PEBB Program, in writing (WAC 182-12-260).

- 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 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 hca.wa.gov/pebb-employee.

- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available at healthequity.com/pebb.

What changes can I make during the PEBB Program’s annual open enrollment?

To make any of the changes described in the table 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 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:	By submitting this form:
<ul style="list-style-type: none"> • Change your medical or dental plans. • Enroll or remove eligible dependents. • Enroll in a medical plan, if you previously waived PEBB medical for other employer-based group medical, a TRICARE plan, or Medicare. • Waive enrollment in PEBB medical if you have other employer-based group medical, a TRICARE plan, or Medicare effective January 1. <p>See “Waiving Medical Coverage” on page 19.</p>	<p><i>Employee Enrollment/Change</i> form (if you have PEBB medical, dental, life, and long-term disability insurance)</p> <p>OR</p> <p><i>Employee Enrollment/Change for Medical Only Groups</i> (if you have PEBB medical only)</p>
<ul style="list-style-type: none"> • Enroll or reenroll in a Medical Flexible Spending Arrangement (FSA) (PEBB benefits-eligible state agency and higher-education employees only). • Enroll or reenroll in the Dependent Care Assistance Program (DCAP) (PEBB benefits-eligible state agency and higher-education employees only). <p>Note: 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.</p>	<p><i>Medical Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form</i></p> <p>OR</p> <p>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.</p> <p>Exception: UW employees must use Workday.</p>
<p>Enroll or waive your participation under the state’s premium payment plan (see “How do I pay for coverage?” on page 13).</p>	<p><i>Premium Payment Plan Election/Change Form</i></p>

(continued)

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.

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.

Depending on the special open enrollment event, subscribers may change health plans, change their spousal attestation, 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 also be able to 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.

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 enrolling 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 this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical
Marriage or registering a state-registered domestic partnership.	Yes ¹	Yes ²	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption.	Yes	Yes	Yes	Yes	Yes
Child becomes eligible as an extended dependent. Also complete the <i>Extended Dependent Certification</i> form.	Yes	No	Yes	No	Yes
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).	Yes	No	Yes	No	Yes
Employee has a change in employment status that affects their eligibility for their employer contribution toward their employer-based group health plan.	Yes	Yes	Yes	Yes	Yes
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.	Yes	Yes	Yes	Yes	Yes

If this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical
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.	Yes	Yes	No	Yes	Yes
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.	Yes	Yes	No	Yes	Yes
A court order requires the employee or any other individual to provide a health plan for an eligible child of the employee.	Yes	Yes	Yes	No	Yes
Employee or a dependent has a change in residence that affects health plan availability.	No	No	Yes	No	No
Employee or a dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Yes	Yes
Employee or a dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or a state CHIP.	Yes	No	Yes	No	Yes
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. Note: If waiving PEBB medical, only allowed if enrolling in Medicare. If enrolling after waiving PEBB medical, only allowed if lost eligibility for Medicare.	No	No	Yes	Yes	Yes
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).	No	No	Yes	No	No
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).	No	No	Yes, if approved by PEBB	No	No
Employee or a dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.	No	No	No	Yes	Yes

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 hca.wa.gov/pebb-rules.

(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 they no longer meet PEBB eligibility criteria. If a dependent child with a disability is no longer eligible, written notice must be provided to the PEBB Program. Your dependent will be removed from coverage on the last day of the month they no longer meet the 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 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 person was the only 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.

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

You may enroll the child and request changes to their health plan coverage as directed by the National Medical Support Notice (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.

Changes to health plan coverage or enrollment will begin the first day of the month following the date the NMSN is received. If the NMSN is received on the first day of the month, the change or enrollment begins on that day. If removing the child is required, 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.

Waiving medical 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 and AD&D insurance, and basic long-term disability (LTD) insurance, you will be enrolled in these coverages (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 PEBB medical coverage no later than 31 days after the date you become eligible for PEBB benefits, or during an annual open enrollment 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 48).

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, basic life and AD&D insurance, and LTD insurance (if your employer

offers them) under your own account.

To waive enrollment in PEBB medical, your personnel, payroll, or benefits office must receive your completed *Employee Enrollment/Change* form no later than 31 days after the date you become eligible for PEBB benefits.

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. Your personnel, payroll, or benefits office must receive this form no later than 31 days after the date you become eligible for PEBB benefits. 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 special open enrollment events, coverage will begin the first day of the month after the date of the event or the date your personnel, payroll, or benefits office receives your 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 will 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 your completed form to enroll or waive enrollment within the required timeframes, you will be defaulted (automatically enrolled) as a single subscriber in Uniform Medical Plan (UMP) Classic, [Uniform Dental Plan \(UDP\)](#), [basic life and AD&D insurance](#), and [basic LTD insurance](#) (if your employer offers these benefits). A tobacco use premium surcharge will be charged.

If defaulted as a single subscriber, you will owe UMP Classic medical premiums and the tobacco use premium surcharge back to your coverage 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.

What if I am a retiree/rehire enrolled in PEBB retiree insurance coverage?

You cannot waive your employee medical to stay enrolled in PEBB retiree insurance coverage, even if you are enrolled in Medicare.

When coverage ends

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 enrolling in PEBB Continuation Coverage and self-paying the premiums and any applicable premium surcharges on a post-tax basis after your eligibility for employer-paid coverage ends. Your employer will make no contribution toward the premiums. 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. When your employer-paid coverage ends, the PEBB Program will mail a *PEBB Continuation Coverage*

Election Notice booklet to you or your dependent at the address we have on file. This notice explains the coverage options and includes enrollment forms to apply for continuation coverage.

You or your eligible dependents must submit the appropriate 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.

PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and also includes coverage for some members who are not qualified beneficiaries under federal COBRA continuation coverage. COBRA eligibility is defined in federal law and governed by federal rules.

PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types. These events include 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).
- 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 responsibilities under PEBB rules and federal law, refer to these documents:

- 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.
- The *Retiree Enrollment Guide*.

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 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 42–43 or contact MetLife at 1-866-548-7139.

PEBB Appeals

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 hca.wa.gov/pebb-appeals.

If you are...	And you...	Follow these instructions and submission deadlines:
<p>A current or former state agency or higher education employee (or their dependent)</p>	<p>Disagree with a decision made by your employer about your:</p> <ul style="list-style-type: none"> • Premium surcharges • Eligibility for or enrollment in: <ul style="list-style-type: none"> • Medical • Dental • Life and AD&D insurance • Long-term disability insurance • Medical Flexible Spending Arrangement (FSA) • Dependent Care Assistance Program (DCAP) <p>And are requesting your employer’s review.</p>	<p>Complete Sections 1–4 of the <i>Employee Request for Review/Notice of Appeal</i> form and submit it to your employer’s personnel, payroll, or benefits office.</p> <p>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.</p>
	<p>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.</p>	<p>Complete Section 8 of the <i>Employee Request for Review/Notice of Appeal</i> 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.</p>
	<p>Disagree with a decision from the PEBB Program about:</p> <ul style="list-style-type: none"> • Eligibility and enrollment in: <ul style="list-style-type: none"> • Premium payment plan • Medical FSA • DCAP • Life and AD&D 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 	<p>Complete Sections 1–4 of the <i>Employee Request for Review/Notice of Appeal</i> 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).</p> <p>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.</p>

If you are ...	And you ...	Follow these instructions and submission deadlines:
<p>A current or former employer group employee (or their dependent) of:</p> <ul style="list-style-type: none"> • 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 	<p>Disagree with a decision made by your employer about:</p> <ul style="list-style-type: none"> • Premium surcharges • Eligibility for or enrollment in: <ul style="list-style-type: none"> • Medical • Dental 	<p>Contact your employer for information on how to appeal the decision or action.</p>
	<p>Disagree with a decision made by your employer, a PEBB insurance carrier, or the PEBB Program about:</p> <ul style="list-style-type: none"> • Eligibility for or enrollment in: <ul style="list-style-type: none"> • Life and AD&D insurance • Long-term disability insurance • Eligibility to participate in SmartHealth or receive a wellness incentive 	<p>Complete Sections 1–4 of the <i>Employee Request for Review/Notice of Appeal</i> form.</p> <p>The PEBB Appeals Unit must receive this form no later than 30 calendar days after the date of the initial denial notice or decision you are appealing.</p>
<p>A current or former state agency or higher education employee (or their dependent), or employer group employee (or their dependent)</p>	<p>Are seeking a review of a decision made by a PEBB health plan, insurance carrier, or benefit administrator regarding the administration of:</p> <ul style="list-style-type: none"> • A benefit or claim • Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement • Life insurance premium payments 	<p>Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal the decision.</p>

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 them 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 hca.wa.gov/pebb-appeals.

2019 Monthly Premiums

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.

PEBB Medical Plans	Employee	Employee & Spouse ²	Employee & Child(ren)	Employee, Spouse ² , & Child(ren)
Kaiser Permanente NW ¹ Classic	\$143	\$296	\$250	\$403
Kaiser Permanente NW ¹ Consumer-Directed Health Plan (with a health savings account)	\$28	\$66	\$49	\$87
Kaiser Permanente WA Classic	\$165	\$340	\$289	\$464
Kaiser Permanente WA Consumer-Directed Health Plan (with a health savings account)	\$25	\$60	\$44	\$79
Kaiser Permanente WA SoundChoice	\$35	\$80	\$61	\$106
Kaiser Permanente WA Value	\$88	\$186	\$154	\$252
Uniform Medical Plan (UMP) Classic	\$107	\$224	\$187	\$304
UMP Consumer-Directed Health Plan (with a health savings account)	\$25	\$60	\$44	\$79
UMP Plus—Puget Sound High Value Network	\$50	\$110	\$88	\$148
UMP Plus—UW Medicine Accountable Care Network	\$50	\$110	\$88	\$148

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

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 75.

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 apply if you are enrolled in a PEBB medical plan. When you enroll a dependent on your PEBB medical coverage, you must attest on your enrollment form to whether the tobacco use and spouse or state-registered domestic partner coverage premium surcharges apply, if applicable. See the *2019 Premium Surcharge Help Sheet* on page 75 for more details.

Tobacco use premium surcharge

You will be charged a monthly \$25-per-account premium surcharge in addition to your medical 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 this dependent lives with you or not), or if you do not attest to this surcharge for each enrolled dependent.

To determine whether this surcharge applies to your account, use the *2019 Premium Surcharge Help Sheet* (found on page 75) and attest by completing and submitting the *2019 Employee Enrollment/Change form* or *Employee Enrollment/Change for Medical Only Groups*.

To report a change

If you or your enrolled dependent's tobacco use changes, or:

- You or your dependent who is **18 years and older and uses tobacco products** enrolls in your PEBB medical plan's free tobacco cessation program.
- Your dependent who is **13–17 years old and uses tobacco products** accesses the tobacco cessation resources for teens mentioned in the *2019 Premium Surcharge Help Sheet*.

You may report the change one of two ways:

- Go to *My Account* at hca.wa.gov/my-account. **Exception:** University of Washington employees must use Workday.
- Complete and submit a *2019 Premium Surcharge Change Form* (found at 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.

Spouse or state-registered domestic partner coverage premium surcharge

You will be charged a monthly \$50 premium surcharge in addition to your medical premium if you enroll a spouse or state-registered domestic partner on your PEBB medical, and one of the following applies:

- That person chose not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.
- You do not attest for the spouse or state-registered domestic partner you wish to enroll.
- Your response results in incurring the premium surcharge.

Use the *2019 Premium Surcharge Help Sheet* (found on page 75) to determine whether this surcharge applies to your

account. Then attest by completing and submitting the *Employee Enrollment/Change form* or *Employee Enrollment/Change for Medical Only Groups*.

If you do not enroll a spouse or state-registered domestic partner, this surcharge does not apply to you. 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 .

Do I need to attest during the PEBB Program's annual open enrollment?

During November 1–30, you must attest (or re-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 hca.wa.gov/my-account and following the instructions. **Exception:** University of Washington employees must use Workday.

(continued)

Premium surcharges

If your personnel, payroll, or benefits office 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 starting January 1 of the next plan year. You will be charged the 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 your attestation. If that day is the first day of the month, then the change begins on that day.

For more information on the premium surcharges, visit 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 premium 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 healthcare services.

Your provider. If you have a long-term relationship with your doctor or health care provider, you should check 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.

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Selecting a PEBB Medical Plan

Paperwork. In general, PEBB medical plans don't require you to file claims. However, UMP members 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, but 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 an HSA?

A consumer-directed health plan (CDHP) is a high-deductible health plan 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. The HSA is set up by your health plan with HealthEquity, Inc., to pay for or reimburse your costs for qualified medical expenses.

See IRS Publication 969 Health Savings Accounts and Other Tax Favored Health Plans at [irs.gov](https://www.irs.gov) for details.

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 CDHP 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 [healthequity.com/pebb](https://www.healthequity.com/pebb) under Documents), IRS Publication 969—*Health Savings Accounts and Other Tax-Favored Health Plans* (at [irs.gov](https://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.

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.

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 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.

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Selecting a PEBB Medical Plan

What happens to my HSA 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 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 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.

Washington			
Kaiser Permanente NW Classic² Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)^{1,2}	<ul style="list-style-type: none"> • Clark • Cowlitz 		
Kaiser Permanente WA Classic Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)¹ Kaiser Permanente WA Value	<ul style="list-style-type: none"> • Benton • Columbia • Franklin • Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Kittitas 	<ul style="list-style-type: none"> • Lewis • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) • Mason • Pend Oreille (ZIP Code 99180) • Pierce • San Juan • Skagit 	<ul style="list-style-type: none"> • Snohomish • Spokane • Stevens (ZIP Codes 99013, 99034, 99040, 99110, 99148, and 99173) • Thurston • Walla Walla • Whatcom • Whitman • Yakima
Kaiser Permanente WA SoundChoice Note: Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.	<ul style="list-style-type: none"> • King • Kitsap • Pierce 	<ul style="list-style-type: none"> • Snohomish • Spokane • Thurston 	
Uniform Medical Plan (UMP) Classic UMP Consumer-Directed Health Plan (CDHP)¹	Available in all Washington counties and worldwide.		
UMP Plus—Puget Sound High Value Network³	<ul style="list-style-type: none"> • King • Kitsap 	<ul style="list-style-type: none"> • Pierce • Snohomish • Spokane 	<ul style="list-style-type: none"> • Thurston • Yakima
UMP Plus—UW Medicine Accountable Care Network³	<ul style="list-style-type: none"> • King • Kitsap 	<ul style="list-style-type: none"> • Pierce • Skagit 	<ul style="list-style-type: none"> • Snohomish • Thurston
<p>¹You 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.</p> <p>²Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.</p> <p>³Employees 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.</p>			

(continued)

2019 Medical Plans Available by County

Oregon	
<p>Kaiser Permanente NW Classic² Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)^{1,2}</p>	<ul style="list-style-type: none"> • Benton (ZIP Codes: 97330, 97331, 97333, 97339, and 97370, 97456) • Clackamas (ZIP Codes: 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, 97267, 97268, and 97269) • Columbia • Hood River (ZIP Code: 97014) • Lane (ZIP Codes: 97401, 97402, 97403, 97404, 97405, 97408, 97409, 97419, 97424, 97426, 97431, 97437, 97438, 97440, 97448, 97451, 97452, 97454, 97455, 97461, 97475, 97477, 97478, 97487, and 97489) • Linn • Marion (ZIP Codes: 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383, 97384, 97385, and 97392) • Multnomah • Polk • Washington • Yamhill
<p>Kaiser Permanente WA Classic Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)¹ Kaiser Permanente WA Value</p>	<ul style="list-style-type: none"> • Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
<p>Uniform Medical Plan (UMP) Classic UMP Consumer-Directed Health Plan (CDHP)¹</p>	<p>Available in all Oregon counties and worldwide.</p>

Idaho	
<p>Kaiser Permanente WA Classic Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)¹ Kaiser Permanente WA Value</p>	<ul style="list-style-type: none"> • Kootenai • Latah
<p>UMP Classic UMP Consumer-Directed Health Plan (CDHP)¹</p>	<p>Available in all Idaho counties and worldwide.</p>

¹You 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.

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

2019 Medical Benefits Comparison

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.

Annual Costs (You pay)	Medical deductible Applies to medical out-of-pocket limit	Medical out-of-pocket limit ¹ (See separate prescription drug out-of-pocket limit for some plans.)	Prescription drug deductible	Prescription drug out-of-pocket limit ¹
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Classic²	\$300/person \$900/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for most covered services apply.	None	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.
Kaiser Permanente NW CDHP²	\$1,400/person \$2,800/family*	\$5,100/person • \$10,200/family Your deductible, copays, and coinsurance for most covered services apply.	Prescription drug costs apply toward medical deductible.	
Kaiser Foundation Health Plan of Washington				
Kaiser Permanente WA Classic	\$175/person \$525/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for all covered services apply.	\$100/person \$300/family (Tier 2 and 3 drugs only)	\$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
Kaiser Permanente WA CDHP Individual	\$1,400/person	\$5,100/person Your deductible and coinsurance for all covered services apply.	Prescription drug costs apply toward medical deductible.	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.
Kaiser Permanente WA CDHP Family	\$2,800/person \$2,800/family*	\$5,100/person • \$10,200/family Your deductible and coinsurance for all covered services apply.		
Kaiser Permanente WA SoundChoice	\$125/person \$375/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for all covered services apply.	\$100/person \$300/family Does not apply to value and Tier 1 drugs	\$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
Kaiser Permanente WA Value	\$250/person \$750/family	\$3,000/person • \$6,000/family Your deductible, copays, and coinsurance for all covered services apply.		
Uniform Medical Plan (UMP)³				
UMP Classic	\$250/person \$750/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.	\$100/person \$300/family* (Tier 2 and 3 drugs only)	\$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
UMP CDHP	\$1,400/person \$2,800/family*	\$4,200/person • \$8,400/family (\$6,850 per person in a family) Your deductible and coinsurance for most covered services apply.	Prescription drug costs apply toward medical deductible.	Prescription coinsurance applies to the medical out-of-pocket limit.
UMP Plus–PSHVN	\$125/person \$375/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.	None	\$2,000/person Your coinsurance for all covered prescription drugs applies.
UMP Plus–UW Medicine ACN				

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

(continued)

2019 Medical Benefits Comparison

Benefits (You pay)	Ambulance Air or ground, per trip	Diagnostic tests, laboratory, and x-rays	Durable medical equipment, supplies, and prosthetics	Emergency room (Copay waived if admitted)	Hearing		Home health
					Routine annual exam	Hardware	
Kaiser Foundation Health Plan of the Northwest							
Kaiser Permanente NW Classic ²	15%	\$10	10%	15%	\$35	You pay any amount over \$800 every 36 months for hearing aid and rental/repair combined.	15%
Kaiser Permanente NW CDHP ²	15%	15%	10%	15%	\$30	You pay any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	15%
Kaiser Foundation Health Plan of Washington							
Kaiser Permanente WA Classic	20%	\$0; MRI/CT/PET scan \$30	20%	\$250	Primary care \$15 Specialist \$30	You pay any amount over \$800 every 36 months for hearing aid and rental/repair combined.	\$0
Kaiser Permanente WA CDHP	10%	10%	10%	10%	10%		10%
Kaiser Permanente WA SoundChoice	20%	15%	15%	\$75 + 15%	Primary care \$0 Specialist \$30		15%
Kaiser Permanente WA Value	20%	\$0; MRI/CT/PET scan \$50	20%	\$300	Primary care \$20 Specialist \$50		\$0
Uniform Medical Plan (UMP)³							
UMP Classic	20%	15%	15%	\$75 + 15%	\$0	You pay any amount over \$800 every three calendar years for hearing aid and rental/repair combined. (CDHP is subject to deductible.)	15%
UMP CDHP	20%	15%	15%	15%	15%		15%
UMP Plus– PSHVN	20%	15%	15%	\$75 + 15%	\$0		15%
UMP Plus– UW Medicine ACN	20%	15%	15%	\$75 + 15%	\$0		15%

Benefits (You pay)	Hospital services		Office visit					
	Inpatient	Outpatient	Primary care	Urgent care	Specialist	Mental health	Chemo-therapy	Radiation
Kaiser Foundation Health Plan of the Northwest								
Kaiser Permanente NW Classic ²	15%	15%	\$25	\$45	\$35	\$25	\$0	\$0
Kaiser Permanente NW CDHP ²	15%	15%	\$20	\$40	\$30	\$20	\$0	\$0
Kaiser Foundation Health Plan of Washington								
Kaiser Permanente WA Classic	\$150/day up to \$750 maximum/admission	\$150	\$15	\$15	\$30	\$15	\$30	\$30
Kaiser Permanente WA CDHP	10%	10%	10%	10%	10%	10%	10%	10%
Kaiser Permanente WA SoundChoice	\$500/admission	15%	\$0	15%	15%	15%	15%	15%
Kaiser Permanente WA Value	\$250/day up to \$1,250 maximum/admission	\$200	\$30	\$30	\$50	\$30	\$50	\$50
Uniform Medical Plan (UMP)³								
UMP Classic	\$200/day up to \$600 maximum/year per person + 15% professional fees	15%	15%	15%	15%	15%	15%	15%
UMP CDHP	15%	15%	15%	15%	15%	15%	15%	15%
UMP Plus–PSHVN	\$200/day up to \$600 maximum/year per person + 15% professional fees	15%	\$0	15%	15%	15%	15%	15%
UMP Plus–UW Medicine ACN	\$200/day up to \$600 maximum/year per person + 15% professional fees	15%	\$0	15%	15%	15%	15%	15%

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 out-of-network provider charges over the plan's allowed amount.

(continued)

2019 Medical Benefits Comparison

Benefits (You pay)	Physical, occupational, and speech therapy (per-visit cost for 60 visits/year combined)	Prescription drugs Retail Pharmacy (up to a 30-day supply)					
		Value Tier	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Kaiser Foundation Health Plan of the Northwest							
Kaiser Permanente NW Classic ²	\$35	—	\$15	\$40	\$75	50% up to \$150	—
Kaiser Permanente NW CDHP ²	\$30	—	\$15	\$40	\$75	50% up to \$150	—
Kaiser Foundation Health Plan of Washington							
Kaiser Permanente WA Classic	\$30	\$5	\$20	\$40	50% up to \$250	—	—
Kaiser Permanente WA CDHP	10%	\$5	\$20	\$40	50% up to \$250	—	—
Kaiser Permanente WA SoundChoice	15%*	\$5	\$15	\$60	50%	\$150	50% up to \$400
Kaiser Permanente WA Value	\$50	\$5	\$25	\$50	50%	\$150	50% up to \$400
Uniform Medical Plan (UMP)³							
UMP Classic	15%	5% up to \$10	10% up to \$25	30% up to \$75	50% (Non-specialty drugs only)	—	—
UMP CDHP	15%	15%	15%	15%	15% (Non-specialty drugs only)	—	—
UMP Plus— PSHVN	15%	5% up to \$10	10% up to \$25	30% up to \$75	50% (Non-specialty drugs only)	—	—
UMP Plus— UW Medicine ACN	15%	5% up to \$10	10% up to \$25	30% up to \$75	50% (Non-specialty drugs only)	—	—

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

Benefits (You pay)	Prescription drugs				
	Mail order (up to a 90-day supply unless otherwise noted)				
	Value tier	Tier 1	Tier 2	Tier 3	Tier 4
Kaiser Foundation Health Plan of the Northwest					
Kaiser Permanente NW Classic ²	—	\$30	\$80	\$150	50% up to \$150
Kaiser Permanente NW CDHP ²	—	\$30	\$80	\$150	50% up to \$150
Kaiser Foundation Health Plan of Washington					
Kaiser Permanente WA Classic	\$10	\$40	\$80	50% up to \$750	—
Kaiser Permanente WA CDHP	\$10	\$40	\$80	50% up to \$750	—
Kaiser Permanente WA SoundChoice	\$10	\$30	\$120	50%	—
Kaiser Permanente WA Value	\$10	\$50	\$100	50%	—
Uniform Medical Plan (UMP)³					
UMP Classic	5% up to \$30	10% up to \$75	30% up to \$225	50% (Specialty drugs: up to \$150 [up to a 30-day supply only]; Non-specialty drugs: no cost-limit)	—
UMP CDHP	15%	15%	15%	15% (Specialty drugs: up to a 30-day supply only)	—
UMP Plus–PSHVN	5% up to \$30	10% up to \$75	30% up to \$225	50% (Specialty drugs: up to \$150 [up to a 30-day supply only]; Non-specialty drugs: no cost-limit)	—
UMP Plus–UW Medicine ACN	5% up to \$30	10% up to \$75	30% up to \$225	50% (Specialty drugs: up to \$150 [up to a 30-day supply only]; Non-specialty drugs: no cost-limit)	—

(continued)

2019 Medical Benefits Comparison

Benefits (You pay)	Preventive care See certificate of coverage or check with plan for full list of services.	Spinal manipulations	Vision care ⁵	
			Exam (annual)	Glasses and contact lenses
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Classic ²	\$0	\$35 Maximum 12 visits/year	\$25	You pay any amount over \$150 every 24 months for frames, lenses, and contacts combined.
Kaiser Permanente NW CDHP ²	\$0	\$30 Maximum 12 visits/year	\$20	
Kaiser Foundation Health Plan of Washington				
Kaiser Permanente WA Classic	\$0	\$15 Maximum 10 visits/year	\$15	You pay any amount over \$150 every 24 months for frames, lenses, and contacts combined.
Kaiser Permanente WA CDHP	\$0	10% Maximum 10 visits/year	10%	
Kaiser Permanente WA SoundChoice	\$0	\$0 Maximum 10 visits/year	15%	
Kaiser Permanente WA Value	\$0	\$30 Maximum 10 visits/year	\$30	
Uniform Medical Plan (UMP)³				
UMP Classic	\$0	15% Maximum 10 visits/year	\$0 You pay any amount over \$65 for contact lens fitting fees.	You pay any amount over \$150 every two calendar years for frames, lenses, and contacts combined.
UMP CDHP	\$0	15% Maximum 10 visits/year		
UMP Plus–PSHVN	\$0	15% Maximum 10 visits/year		
UMP Plus–UW Medicine ACN	\$0	15% Maximum 10 visits/year		

⁵ Contact your plan about costs for children's vision care.

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 .				
Plan name	Plan type	Plan administrator	Plan network	Plan group number
DeltaCare	Managed-care plan	Delta Dental of Washington	DeltaCare PEBB	Group 3100
Willamette Dental Group Plan	Managed-care plan	Willamette Dental of Washington, Inc	Willamette Dental Group, P.C.	WA82
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 3000

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 these things in mind:

DeltaCare and Willamette Dental Group are managed-care plans. You must choose a primary dental provider within their networks. For the DeltaCare plan, 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. So before you enroll in one of these plans, be sure to check whether they have providers near you.

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.

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	Uniform Dental Plan (UDP) (Group 3000 Delta Dental PPO)	DeltaCare (Group 3100)	Willamette Dental Group
Deductible	\$50/person, \$150/family	None	
Plan maximum (See specific benefits maximums below.)	You pay amounts over \$1,750	No general plan maximum	

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

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 a Spouse or State-Registered Domestic Partner:** If you are enrolled in Optional Life Insurance for Employees, you may apply for amounts of optional life insurance for your spouse or state-registered domestic partner in increments of \$5,000 up to \$500,000 with \$100,000 of guaranteed issue,

not to exceed one-half the amount of the Optional Life Insurance for Employees that you get for yourself).

- **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. Children are no longer eligible for this coverage when they turn 26.
- **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 nonaccidental 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. Children are no longer eligible for this coverage when they turn 26. Contact MetLife about this coverage if your child is approaching age 26.

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 Life 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 any amount of Optional Life Insurance, Spouse/State-Registered Domestic Partner Life Insurance, or Dependent 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.

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 hca.wa.gov/pebb-employee under Forms and publications.
- Contact your personnel, payroll, or benefits office.
- Go to metlife.com/wshca under Documents.

How do I enroll?

Complete your enrollment directly with MetLife at mybenefits.metlife.com/wapebb or using the MetLife Enrollment/Change Form in the back of this book and submit to MetLife via the instructions on the form. If you have any questions about enrollment, please contact MetLife at 1-866-548-7139.

(continued)

Group Term Life and AD&D Insurance

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. When Porting or Converting your employee life insurance coverage, your coverage will become an individual policy that is not tied to the PEBB Program.

Portability Provision

Under the Portability Provision of your PEBB employee life insurance, you can apply to continue your employee Basic Life and Optional Life Insurance on an individual policy (not connected to the PEBB Program) until age 100 if certain conditions are met.

You must be actively enrolled to have the opportunity to continue all or part of your coverage through portability.

You may also apply to continue your 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 and Spouse/State-Registered Domestic Partner 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 within 60 days after the date your PEBB employee life insurance ends, including when you move to PEBB retiree term life insurance.

Conversion of Life Insurance Provision

You may convert your Basic Life, Optional Life, Spouse/State-Registered Domestic Partner, or Dependent Life Insurance to an individual policy. The amount of the individual policy will be equal to (or if you choose, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting. You can convert any amount of life insurance that you have not ported.

You must apply to continue your coverage under the Conversion of Life Insurance Provision. You have 60 days to apply for conversion coverage after your employee life insurance ends.

If you have questions, please call MetLife at 1-866-548-7139.

Monthly Rates

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

Optional Life Insurance for Employees and Spouse or State-Registered Domestic Partner, and child(ren)		
Age	Monthly cost per \$1,000	
	Non-Tobacco User	Tobacco User
Less than 25	\$0.028	\$0.037
25–29	\$0.031	\$0.043
30–34	\$0.034	\$0.057
35–39	\$0.043	\$0.066
40–44	\$0.064	\$0.073
45–49	\$0.092	\$0.111
50–54	\$0.143	\$0.170
55–59	\$0.268	\$0.317
60–64	\$0.411	\$0.482
65–69	\$0.758	\$0.929
70+	\$1.131	\$1.510
Cost for your child(ren)	\$0.124	\$0.124

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

Optional Accidental Death and Dismemberment (AD&D) Insurance	
	Monthly cost per \$1,000
Employee	\$0.019
Dependent Spouse or State-Registered Domestic Partner	\$0.019
Dependent Child(ren)	\$0.016

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.

The PEBB Program offers long-term disability (LTD) insurance through Standard Insurance Company. This is a summary. To see details of this benefit, read the LTD plan booklet, or to get forms:

- Visit hca.wa.gov/ltd.
- Contact your employer's personnel, payroll, or benefits office.

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:

	Basic LTD	Optional LTD
% of monthly predisability earnings the plan pays	60% of the first \$400	60% of the first \$10,000
Minimum monthly LTD benefit	\$50	\$50
Maximum monthly LTD benefit	\$240	\$6,000

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 pre-disability 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 pre-disability 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.

Age	Maximum benefit period
61 or younger	To age 65, or to SSNRA* or 42 months, whichever is longer
62	To SSNRA* or 42 months, whichever is longer
63	To SSNRA* or 36 months, whichever is longer
64	To SSNRA* or 30 months, whichever is longer
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

*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 Optional LTD Insurance cost?

Payroll deduction is a percentage of your pre-disability earnings. Multiply your monthly base pay (up to \$10,000) by the percentage shown in the table below for the desired benefit waiting period to calculate your optional LTD monthly premium.

Benefit waiting period	Higher-education retirement plan employees	TRS, PERS, and other retirement plan employees
90 days	0.72%	0.60%
120 days	0.42%	0.36%
180 days	0.32%	0.28%
240 days	0.30%	0.27%
300 days	0.28%	0.25%
360 days	0.27%	0.24%

Below are some examples to help you calculate the cost of Optional LTD insurance.

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

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 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.

The PEBB Program offers long-term disability (LTD) insurance through Standard Insurance Company. **This is a summary.** To see the LTD plan booklet or to get forms:

- Go to hca.wa.gov/ltd.
- Contact your employer's personnel, payroll, or benefits office.

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 hca.wa.gov/employee-retiree-benefits/public-employees/additional-benefits).

Navia Benefit Solutions, Inc. administers the Medical FSA and DCAP for the PEBB Program. For details and forms, visit pebb.naviabenefits.com or call 1-800-669-3539. Email questions to customerservice@naviabenefits.com.

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, you 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.
- 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 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)

How can I enroll?

You can download and print the Medical FSA and 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 have a qualifying life event that creates a special open enrollment. The requested change must correspond to and be consistent with the qualifying event. For example, you cannot reduce your annual election if you get married; you can only increase it.

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.

To learn more about special enrollments, find PEBB Program Administrative Policy 45-2 and Addendum 45-2A Special Open Enrollment Matrix at hca.wa.gov/pebb-rules.

SmartHealth

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.
- 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 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.

How do I get started?

Follow these simple steps to earn points to qualify for the financial wellness incentives:

1. Go to 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. You do not earn SmartHealth points for completing your PEBB medical plan's health assessment.

Note: If you don't have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the Well-being Assessment by phone.

3. Complete other activities on SmartHealth's website to earn 2,000 total points by the applicable deadline to qualify for the \$125 wellness incentive.

Deadline requirements

The deadline to qualify for and claim the \$25 Amazon.com gift card* wellness incentive is December 31, 2019.

The deadline to meet the requirements for the \$125 wellness incentive is as follows:

- 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. For 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 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 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):

- Look for auto/home insurance on the PEBB Program's website at hca.wa.gov/employee-retiree-benefits/public-employees/auto-and-home-insurance.
- 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

Olympia 1-360-705-0600
400 Union Ave SE, Suite 253
Olympia, WA 98501

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:
PEBB Program <i>You can file a grievance in person, by mail, fax, or email, or online at hca.wa.gov/about-hca/non-discrimination-statement. If you need help filing a grievance, the HCA ADA/Nondiscrimination Coordinator is available to help.</i>	Health Care Authority Enterprise Risk Management Office Attn: HCA ADA/Nondiscrimination Coordinator PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) Fax 360-507-9234 compliance@hca.wa.gov
PEBB MEDICAL PLANS	
Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest Attn: Member Relations – Kaiser Civil Rights Coordinator 500 NE Multnomah, Suite 100 Portland, OR 97232 1-800-813-2000 or 503-813-2000 (TRS: 711)
Kaiser Foundation Health Plan of Washington	Kaiser Foundation Health Plan of Washington Civil Rights Coordinator Quality GNE-D1E-07 PO Box 9812 Renton, WA 98057 1-866-648-1928 or 206-630-4636 (TRS: 711) Fax 206-901-6205 kp.org/wa/feedback
Washington State Rx Services (for discrimination concerns about prescription-drug benefits for Uniform Medical Plan [UMP])	Washington State Rx Services Attn: Appeals Unit PO Box 40168 Portland, OR 97204-0168 1-888-361-1611 (TRS: 711) Fax 1-866-923-0412 compliance@modahealth.com
Premera Blue Cross (for discrimination concerns about Medicare Supplement Plan F and the Centers of Excellence Program for UMP Classic and UMP CDHP members)	Premera Blue Cross Attn: Civil Rights Coordinator - Complaints and Appeals PO Box 91102 Seattle, WA 98111 1-855-332-4535 (TTY: 1-800-842-5357) Fax 425-918-5592 AppealsDepartmentInquiries@Premera.com

If you believe this organization has failed to provide language access services or discriminated in another way...	You can file a grievance with:
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	
Delta Dental (for discrimination concerns about DeltaCare and the Uniform Dental Plan)	Delta Dental Attn: Elizabeth Peterson, 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 of Washington, Inc. (for discrimination concerns about Willamette Dental Group Plan)	Member Services Department 6950 NE Campus Way Hillsboro, OR 97124 1-855-433-6825 (TRS:711) Fax 503-952-2684 memberservices@willamettedental.com

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)
ocrportal.hhs.gov/ocr/portal/lobby.jsf (to submit complaints electronically)
hhs.gov/ocr/office/file/index.html (to find complaint forms online)

[English] 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).

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በገጻ ይገኛል። ተቀጣሪዎች፣ የቀጣሪዎችን ሰራተኛ፣ የደግሞ ወይም ጥቅማ-ጥቅም ክፍያ ጽ/ቤትን በቀጥታ ያነጋግሩ። ጡረታ የወጡ፣ COBRA እና ቀጣይነት ያለው ሽፋን አባላት ብቻ፣ የPEBB ፕሮግራምን በ1-800-200-1004. (TRS: 711) ያነጋግሩ።

[Arabic] خدمات المساعدة في اللغات، بما في ذلك المترجمين الفوريين وترجمة المواد المطبوعة، متوفرة مجاناً للموظفين: اتصل بمكتب شؤون العاملين بالشركة، أو مكتب المرتبات أو الاستحقاقات مباشرة للمقاعدين، وأعضاء التغطية المستمرة فقط: اتصل ببرنامج PEBB على الرقم 1-800-200-1004. (TRS: 711).

[Burmese] ဘာသာပြန်နှင့်သို့သမျှနှင့်ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်း ဝါခြင်း ဝါ ဝင်ဘာသာစကား ထောင့်ဝန်ဆောင်မှုများ ဝါ ခမ့်ရန်ပင်ပါသည်။ ဝါသည်။ လုပ်သမားများ- သင့်အလုပ်ရင်၏ ဝါရေး ရရှိရန် လစာ သို့မဟုတ် ဝါးစားဝင်ဆိုင်ရာ ရုံးသို့ ဝါ ဝါရိုက်ကံ ဝါ သွယ်ဝါ။ ဝါဝင်သည့်များ COBRA နှင့် ဝါလ် ဝါး ဝါးဝင်သည့် ဝါဝင်များသာလျှင်- PEBB ဝါရိုက်ခံသို့ 1-800-200-1004. (TRS: 711) ဝါးဝင် ဝါရိုက်ပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្ទាល់មាត់ និង ការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ និយោជក៖ សូមទាក់ទងការិយាល័យបុគ្គលិកនិយោជករបស់អ្នក ការិយាល័យបញ្ជីប្រាក់ខែ ការិយាល័យអគ្គប្រយោជន៍ដោយផ្ទាល់។ អ្នកចូលនិវត្តន៍, COBRA, និងសមាជិក Continuation Coverage ប៉ុណ្ណោះ៖ សូមទាក់ទងកម្មវិធី PEBB តាមលេខ 1-800-200-1004. (TRS: 711)។

[Chinese] 免费提供语言协助服务，包括口译员和印制资料翻译。雇员：直接联系雇主的私人、工资或福利办公室。仅限退休人员、COBRA 和持续承保成员：联系 PEBB 计划处，电话为 1-800-200-1004 (TRS: 711)。

[Korean] 통역 서비스와 인쇄 자료 번역을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 직원: 고용주의 인사, 급여 또는 수당을 관리하는 사무소에 직접 문의하십시오. 퇴직자, COBRA 및 Continuation Coverage 회원만 해당: 1-800-200-1004, TRS: 711 로 PEBB 프로그램에 문의하십시오.

[Laotian] ການບໍລິການດ້ານພາສາ ລວມທັງນາຍແປພາສາ ທີ່ ມາດຕະການສາມາດມີ, ມີໄວ້ໃຫ້ຝຣັດໂດຍບໍ່ຄິດຄ່າ. ພະນັກງານ: ຕິດຕໍ່ ຫາພະແນກທະບຽນພິລອອນນາຍຳຈັງ, ພະແນກບັນຊີເງິນເດືອນ, ຫລື ຫ້ອງການສະໄໝດິດການໂດຍກົງໃດ. ຜູ້ອອກບັນຊີງານ, COBRA, ທີ່ ການຄຸ້ມກັນທີ່ດຳເນີນຕໍ່ປະສາລະສະມາຊິກເດີມນັ້ນ: ຕິດຕໍ່ຫາໂຄງການ PEBB ໄດ້ທີ່ເລກ 1-800-200-1004 (TRS: 711).

[Oromo] Tajajilwwan gargaarsa afaanii, turjumaanaafi i waantota maxxanfaman kan hiikan bilisaan jiru. Hojjetoota: Kallattiidhaan peeroolii personeelii ykn waajira faayidaawwanii hojjechiisaa kee qunnamii. COBRA fimiseensota Haguuggii Itti fufinsaa qofa: Sagantaa PEBB 1-800-200-1004 (TRS: 711) irratti qunnamuu dandeessu.

[Persian] خدمات کمک زبانی، از جمله مترجم شفاهی و ترجمه اسناد مدارک (مطالب) چایی، بصورت رایگان ارائه خواهد شد. قابل توجه کارگران: با بخش پرسنل کارفرمای خود لیست حقوق، یا اداره رفاه مستقیماً تماس بگیرید. باز نشستگان، COBRA، و اعضای که دارای طرح ادامه پوشش بیمه هستند فقط با برنامه PEBB با شماره 1-800-200-1004 (TRS: 711) تماس بگیرید.

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਸਮੇਤ—ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। ਮੁਲਾਜ਼ਮ: ਆਪਣੇ ਰੁਜ਼ਗਾਰਦਾਤਾ ਦੇ ਮੁਲਾਜ਼ਮ, ਪੇਅਰੋਲ, ਜਾਂ ਲਾਭ ਵਾਲੇ ਦਫ਼ਤਰ ਨਾਲ ਸਿੱਧਾ ਸੰਪਰਕ ਕਰਨ। ਸੇਵਾ-ਮੁਕਤ ਮੁਲਾਜ਼ਮ, COBRA (ਕੋਬਰਾ), ਅਤੇ ਸਿਰਫ ਵੱਟੀਨਿਊਏਸ਼ਨ ਕਵਰੇਜ ਮੈਂਬਰ: 1-800-200-1004. (TRS: 711)ਉਤੇ PEBB ਪ੍ਰੋਗਰਾਮ ਨਾਲ ਸੰਪਰਕ ਕਰਨ।

[Romanian] Serviciile de asistență lingvistică, inclusiv cele de interpretariat și de traducere a materialelor imprimate, sunt disponibile gratuit. Angajați: Contactați biroul pentru personal, salarii sau beneficii al angajatorului dvs. în mod direct. Numai pentru pensionari, membri COBRA sau Continuation Coverage: Contactați Programul PEBB la 1-800-200-1004. (TRS: 711).

[Russian] Языковая поддержка, в том числе услуги переводчиков и перевод печатных материалов, доступна бесплатно. Наемные работники: обратитесь непосредственно в отдел кадров, бухгалтерию или социальный отдел вашего работодателя. Только пенсионеры, пользователи COBRA или программ продленного страхового покрытия: обратитесь в программу PEBB отдел по телефону 1-800-200-1004. (TRS: 711).

[Somali] Adeego caawimaad luuqada ah, ay ku jirto turjubaano afka ah iyo turjumid lagu sameeyo waraaqaha la daabaco, ayaa lagu helayaa lacag la'aan. Shaqaalaha: La xiriiir shaqaalaha qofka aad u shaqaysid, liiska mushaarka shaqaalaha, ama si toos ah xafiiska dheefaha. Dadka hawlgabka ah, COBRA, iyo kaliya xubnaha Sii wadista Ceymiska: Kalaxiriir Barnaamijka PEBB lambarkan 1-800-200-1004. (TRS: 711).

[Spanish] Hay servicios de asistencia con idiomas, incluyendo intérpretes y traducción de materiales impresos, disponibles sin costo. Empleados: Comuníquense directamente con la oficina de personal, nómina o beneficios de su empleador. Sólo para jubilados y miembros de COBRA y cobertura continua: Comuníquense con el Programa PEBB al 1-800-200-1004. (TRS: 711).

[Swahili] Huduma za msaada wa lugha, ikiwa ni pamoja na wakalimani na tafsiri ya nyaraka zilizochapishwa, zinapatikana bure bila ya malipo. Wafanyakazi: wasiliana moja kwa moja na ofisi ya utumishi ya mwajiri wako, ofisi ya malipo, au ya mafa. Wastaafu, wanachama wa COBRA na wenye bima ya kuendelea tu: Wasiliana na Programu ya PEBB kwa nambari 1-800-200-1004. (TRS: 711).

[Tagalog] Mga serbisyong tulong sa wika, kabilang ang mga tagapagsalin at pagsasalin ng nakalimbag na mga kagamitan, ay magagamit ng walang bayad. Mga empleyado: Makipag-ugnay nang direkta sa mga tauhan, payroll, o tanggapan ng mga benepisyo ng iyong employer. Mga Pensonado, COBRA, at mga kasapi ng Continuation Coverage lamang: Makipag-ugnay sa Program ng PEBB sa 1-800-200-1004. (TRS: 711).

[Tigrigna] ተርጓሚትን ልምድ ዝተፀሓፉ ማተርፎላት ትርጉምን ሓዊሱ ናይ ቋንቋ ሓዝ ግልጋሎት፣ ብዘይ ምንም ክፍሊት ይርከቡ። ሰራተኛታት፣ ንናይ መስርሒኻ ወልታዊ ዝርዝር ደግሞ ወይ ቤት ጽሕፈት ጥቕምታት ብቐጥታ ርኽቡ። ጡረተኛታት፣ COBRA፣ ኣባላት መቐጸልታ ሽፋን ጥራሕ፣ ንመደብ PEBB ብ1-800-200-1004 ርኽቡ (TRS: 711)።

[Ukrainian] Мовна підтримка, у тому числі послуги перекладачів та переклад друкованих матеріалів, доступна безкоштовно. Наймані робітники: зверніться безпосередньо до відділу кадрів, бухгалтерії або соціального відділу вашого роботодавця. Лише пенсіонери, користувачі COBRA або програм продовженого страхового покриття: зверніться у програму PEBB за телефоном 1-800-200-1004. (TRS: 711).

[Vietnamese] Các dịch vụ trợ giúp ngôn ngữ, bao gồm thông dịch viên và bản dịch tài liệu in, hiện có miễn phí. Người lao động: Liên hệ trực tiếp với phòng nhân sự, tiền lương, hoặc phúc lợi của sở làm quý vị. Chỉ những người ήδη hưu, các thành viên COBRA, và thành viên chương trình Bảo Hiểm Tiệp Tục: Liên hệ với Chương Trình PEBB theo số 1-800-200-1004. (TRS: 711).

Enrollment Forms

The following forms are available online:

2019 Employee Enrollment/Change

www.hca.wa.gov/assets/pebb/50-400-2019.pdf

2019 Employee Enrollment/Change for Medical Only Groups

www.hca.wa.gov/assets/pebb/52-030-2019.pdf

2019 Enrollment/Change MetLife

<https://www.hca.wa.gov/assets/pebb/metlife-employee-enrollment.doc>

Long Term Disability (LTD) Enrollment/Change Form

www.standard.com/eforms/7533d_377661oe.pdf

2019 Premium Surcharge Help Sheet

www.hca.wa.gov/assets/pebb/50-226-2019.pdf