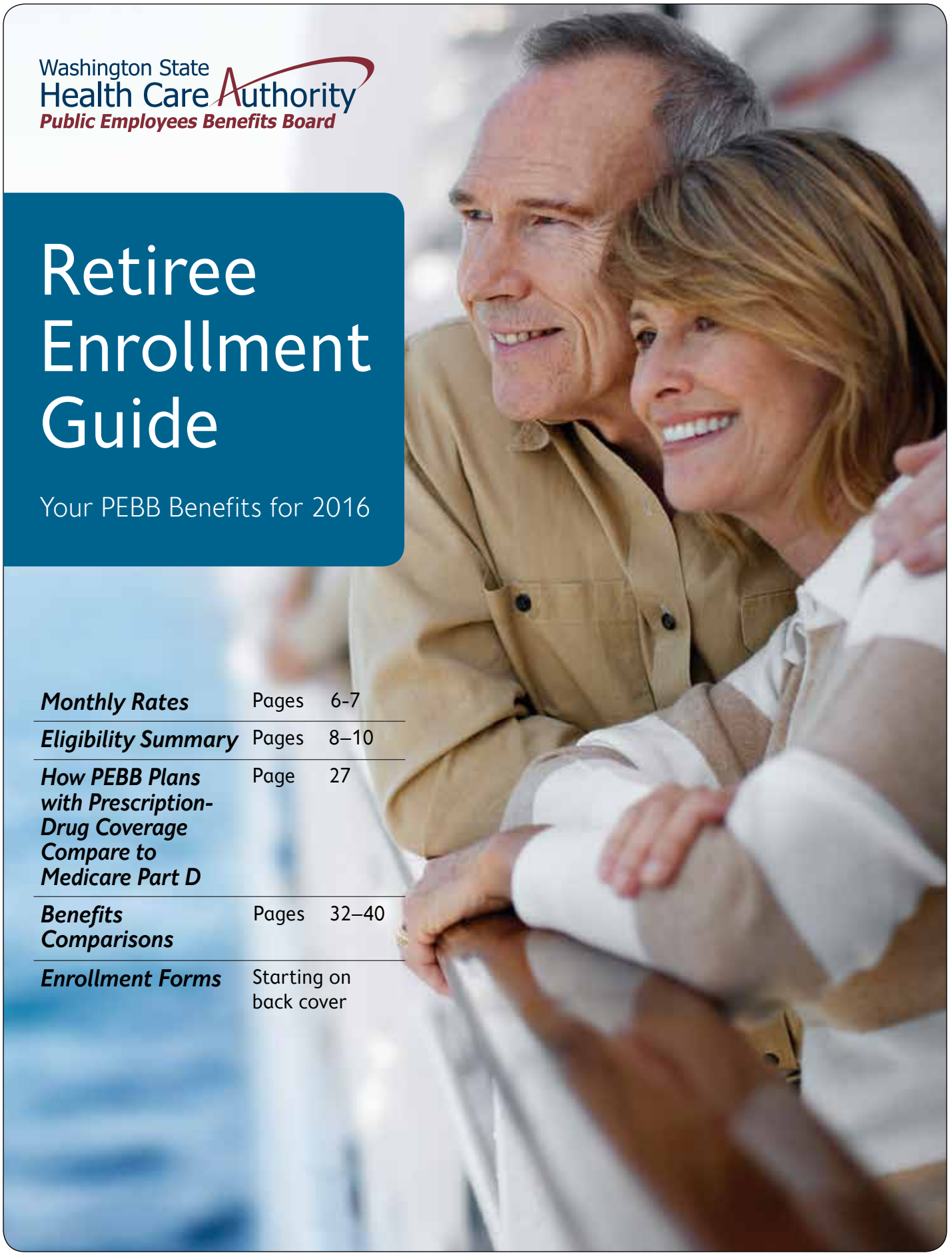
Washington State Health Care Authority
Public Employees Benefits Board

Retiree Enrollment Guide

Your PEBB Benefits for 2016



HCA 51-205 (11/15)

Washington State Health Care Authority
Public Employees Benefits Board

Addition to the *2016 Retiree Enrollment Guide*

Important information about life insurance coverage

In 2016, the PEBB Program offers Retiree Term Life Insurance through ReliaStar Life Insurance Company (ReliaStar). Effective January 1, 2017, Metropolitan Life Insurance (MetLife) will be the PEBB Program's new life insurance carrier. MetLife coverage is only available to retirees who are **eligible** to enroll and who **do** enroll in PEBB Retiree Term Life Insurance in 2016.

You must enroll in Retiree Term Life Insurance with ReliaStar in 2016 to have the opportunity to enroll in (and increase) retiree term life insurance with MetLife in 2017.

- **To enroll in Retiree Term Life Insurance with ReliaStar through December 31, 2016:** You must complete "Section 7: Retiree Term Life Insurance Election" in the enclosed *2016 Retiree Coverage Election/Change* form and submit it to the PEBB Program by the deadline.
- **To enroll in Retiree Term Life Insurance with MetLife starting January 1, 2017:** If you enroll in Retiree Term Life Insurance through ReliaStar in 2016, you may also choose **one** of these two options to continue your Retiree Term Life Insurance with MetLife in 2017:
  1. **If you want to increase your coverage amount effective January 1, 2017:** See "Retiree Term Life Insurance starting January 1, 2017" on the back of this insert for coverage amounts and monthly costs. Complete and return **both** the enclosed MetLife form and the *2016 Retiree Coverage Election/Change* form and submit them to the PEBB Program by the required deadline.
  2. **If you choose not to increase your coverage amount for 2017:** You will be automatically enrolled in the MetLife Legacy Retiree Term Life Insurance plan in 2017 (described below).

  You must contact MetLife to request and complete a Beneficiary Designation form. **Your beneficiary choice will not transfer from ReliaStar to MetLife**.

MetLife Retiree Term Life Insurance

Legacy Retiree Term Life Insurance

If you enroll in Retiree Term Life Insurance for 2016, but choose not to increase your coverage amount with MetLife by also submitting the MetLife form to the PEBB Program by the 60-day deadline for you to

continued

enroll in PEBB retiree coverage—your coverage amount will be rolled over automatically to MetLife on January 1, 2017. You will remain in Legacy Retiree Term Life and **will not** be able to switch to Retiree Term Life Insurance in the future.

Below is what you will continue to pay in 2017 if you remain in Legacy Retiree Term Life Insurance. The coverage amount will decrease as you age; however, the monthly cost will remain the same from January 1, 2017 through December 31, 2018. The monthly cost may increase after 2018.

Age at death	Amount of insurance	Monthly cost
Under 65	$3,000	$7.75
65 through 69	$2,100	$7.75
70 and over	$1,800	$7.75

Retiree Term Life Insurance effective January 1, 2017

Note: You must complete the enclosed MetLife form to enroll in the coverage below.

The new MetLife benefit will not decrease as you age; however, the monthly cost increases as your age.

Your age	Monthly cost for $5,000 coverage	Monthly cost for $10,000 coverage	Monthly cost for $15,000 coverage	Monthly cost for $20,000 coverage
45-49	$0.87	$1.74	$2.61	$3.48
50-54	$1.34	$2.67	$4.01	$5.34
55-59	$2.50	$5.00	$7.50	$10.00
60-64	$3.84	$7.67	$11.51	$15.34
65-69	$7.38	$14.76	$22.14	$29.52
70-74	$11.97	$23.94	$35.91	$47.88
75-79	$19.41	$38.81	$58.22	$77.62
80-84	$31.43	$62.86	$94.29	$125.72
85-89	$50.90	$101.79	$152.69	$203.58
90-94	$82.45	$164.89	$247.34	$329.78
95+	$133.57	$267.14	$400.71	$534.28

More information

For questions about your life insurance benefit or premiums starting in January 2017, please call MetLife Customer Service at 1-866-548-7139.

To learn more about MetLife Retiree Term Life Insurance, visit:

- Health Care Authority's website at **www.hca.wa.gov/public-employee-benefits/retirees/life-insurance**
- MetLife's website at **www.metlife.com/wshca-retirees**

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM FOR RETIREE PLAN

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Washington State Health Care Authority	164995			

YOUR ENROLLMENT INFORMATION (To be Completed by the Retiree)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Term Life Insurance

☐ Basic Life [1]
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

GEF09-1
FW

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
MetLife Recordkeeping Center, P.O. Box 14406, Lexington, KY 40512-4406.
Fax (859) 825-6719 Email: Southfield_RES@metlife.com

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW

BENEFICIARY DESIGNATION FOR RETIREE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Retiree.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I understand that if I do not enroll for life coverage during the initial enrollment period, evidence of insurability satisfactory to MetLife may be required to enroll for such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
3. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Retiree	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

This booklet contains information you need about benefits, monthly premiums, and the plans available to you.

Important requirements to remember:

- **You have 60 days after the date your employer-paid insurance coverage or continuous COBRA coverage ends to enroll in or defer (postpone) PEBB retiree insurance coverage**. If the PEBB Program doesn't receive your completed *Retiree Coverage Election/Change* form within the required timeframe, you could lose your right to enroll.
- If you wish to enroll family members on your PEBB retiree insurance coverage, you must provide documents that verify their eligibility within PEBB's timelines, or they will not be enrolled. This applies to retirees not entitled to Medicare Part A and Part B, and any retiree enrolling a registered domestic partner.
- If eligible, you and/or your family member(s) must enroll and maintain enrollment in both Medicare Part A and Part B to qualify for PEBB retiree coverage. If you don't, you and/or your family member(s) will no longer be eligible for enrollment in PEBB retiree coverage.
- We will not enroll you until we receive your first premium payment unless you choose to have your premiums deducted from your monthly pension check.

If you want additional information about Public Employees Benefits Board (PEBB) coverage

Call the PEBB Program
360-725-0440 or toll-free at 1-800-200-1004
Monday through Friday, 8 a.m. to 5 p.m.

Fax documents to the PEBB Program
360-725-0771

Write to the PEBB Program
Health Care Authority, P.O. Box 42684 Olympia, WA 98504-2684

Visit our office
Health Care Authority, 626 8th Avenue SE, Olympia, WA, 98501.

Go online
www.hca.wa.gov/pebb for forms, publications, and information updates

Paying your premiums

Mail first premium payments to:	**For automatic bank account withdrawals:**
Health Care Authority P.O. Box 42695 Olympia, WA 98504-2695	An *Electronic Debit Service Agreement* form is provided in the back of this booklet.

To obtain this document in another format (such as Braille or audio), call 1-800-200-1004.
TTY users may call through the Washington Relay service by dialing 711.

Contact Information

Contact the health plans for help with:	Contact the PEBB Program at 1-800-200-1004 for help with:
• Specific benefit questions. • Verifying if your doctor or other provider contracts with the plan. • Verifying if your medications are listed in the plan's drug formulary. • ID cards and claims.	• Eligibility questions and changes (Medicare, divorce, etc.). • Changing your name, address, or phone number. • Adding or removing dependents. • Finding forms. • Eligibility complaints or appeals.

Medical plans	Website addresses	Customer service phone numbers	TTY customer service phone numbers
Group Health Classic, Medicare, Sound Choice, or Value	**www.ghc.org/pebb**	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Group Health Options Inc. (CDHP)	**www.ghc.org/pebb**	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente Classic, CDHP, or Senior Advantage	**www.my.kp.org/nw/wapebb**	503-813-2000 or 1-800-813-2000 Medicare members: 1-877-221-8221	711
Medicare Supplement Plan F (Group), administered by Premera Blue Cross	**www.premera.com**	1-800-817-3049	1-800-842-5357
Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield	**www.hca.wa.gov/ump**	1-888-849-3681	711
UMP Plus – Puget Sound High Value Network, administered by Regence BlueShield	**www.pugetsoundhighvaluenetwork.org**	1-855-776-9503	711
UMP Plus – UW Medicine Accountable Care Network, administered by Regence BlueShield	**www.uwmedicine.org/umpplus**	1-855-520-9500	711

Dental plans	Website addresses	Customer service phone numbers
DeltaCare, administered by Delta Dental of Washington	**www.deltadentalwa.com/pebb**	1-800-650-1583
Uniform Dental Plan, administered by Delta Dental of Washington	**www.deltadentalwa.com/pebb**	1-800-537-3406
Willamette Dental of Washington, Inc.	**www.WillametteDental.com/WApebb**	1-855-433-6825

Additional contacts			
Health savings account (HSA) trustee	HealthEquity, Inc.	**www.healthequity.net/pebb**	1-877-873-8823 TTY: 711
Voluntary Employee Beneficiary Association (VEBA) Trust	Meritain Health	**www.veba.org**	1-888-828-4953
SmartHealth	Limeade	**www.smarthealth.hca.wa.gov**	1-855-750-8866
Life insurance	ReliaStar Life Insurance Company	**www.hca.wa.gov/pebb/pages/life_retired.aspx**	1-866-689-6990
Auto and home insurance	Liberty Mutual Insurance Company	**www.hca.wa.gov/pebb/pages/auto_home.aspx**	1-800-706-5525

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 **www.hca.wa.gov/pebb** and select *My Account*.

Welcome to Retirement!

The Public Employees Benefits Board (PEBB) Program, administered by the Health Care Authority (HCA), is pleased to offer continued choice, access, value, and stability in benefits. The PEBB Program purchases and coordinates health insurance benefits for eligible public employees and retirees, so you can expect to receive competitive benefits from one of the largest health care purchasers in the state.

Who determines the benefits?

The Legislature establishes how much state money is available to spend on benefits. Then the PEB Board establishes eligibility requirements and approves benefit designs for insurance and other benefits. The Board meets regularly to review benefit and eligibility issues, and plan for the future. For a schedule of PEB Board meetings, go to **www.hca.wa.gov/pebb**.

Who purchases the benefits?

The HCA purchases benefits within the funding approved by the Legislature. The HCA contracts with insurance companies and manages its own self-insured plans, the Uniform Medical Plan and Uniform Dental Plan, to provide a choice of quality health care options and responsive customer service to its members.

Inside this booklet you will find…

- Information on who can enroll.
- Enrollment requirements.
- Monthly premiums and surcharges.
- Basic information about your medical and dental coverage and life, auto, and home insurance options.
- Plans available in your county.

The benefits comparisons in this guide are brief summaries. For more details about a plan's benefits, refer to the plan's certificate of coverage. You may request a copy of the certificate of coverage from your health plan after you enroll, or you can find it on the plan's website. Some information described in this guide is based on federal or state laws. We have attempted to describe them accurately but if there are differences, the laws will govern.

The contents of this booklet are accurate at the time of printing. You may call the PEBB Program at 1-800-200-1004 for questions on eligibility or enrollment and you can go to **www.hca.wa.gov/pebb** for updates to laws or rules or to find more information. If you have questions not answered in this booklet, you can reach a benefits representative Monday through Friday between 8 a.m. and 5 p.m. Pacific Time.

Where to find laws and rules

You can find the Public Employees Benefits Board's existing law in chapter 41.05 of the Revised Code of Washington, and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of the Washington Administrative Code (WAC). A link to the WAC is available on the PEBB's website and at **www.leg.wa.gov**.

Table of Contents

Special Requirements

1. To qualify for the Medicare rate, at least one covered family member must be enrolled in both Part A and Part B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan or Kaiser Permanente Senior Advantage must complete and sign the *Medicare Advantage Plan Election Form* (form C) to enroll in one of these plans.

For more information on these requirements, contact your health plan's customer service department.

Medical Plans

Members not eligible for Medicare (or enrolled in Part A only)	**Subscriber Only**	**Subscriber and Spouse***	**Subscriber and Child(ren)**	**Full Family**
Group Health Classic	$610.78	$1,215.53	$1,064.34	$1,669.09
Group Health CDHP	522.80	1,034.28	920.99	1,374.14
Group Health SoundChoice	538.09	1,070.15	937.14	1,469.20
Group Health Value	573.99	1,141.95	999.96	1,567.92
Kaiser Permanente Classic	637.32	1,268.61	1,110.79	1,742.08
Kaiser Permanente CDHP	530.09	1,048.36	933.38	1,393.32
UMP Classic	576.78	1,147.53	1,004.84	1,575.59
UMP CDHP	522.47	1,033.62	920.42	1,373.24
UMP Plus–PSHVN	552.40	1,098.77	962.18	1,508.55
UMP Plus–UW Medicine ACN	552.40	1,098.77	962.18	1,508.55

Members enrolled in Part A and Part B of Medicare:	**Subscriber Only**	**Subscriber and Spouse***		**Subscriber and Child(ren)**		**Full Family**		
	1 Medicare eligible	*1 Medicare eligible*	*2 Medicare eligible*	*1 Medicare eligible*	*2 Medicare eligible*	*1 Medicare eligible*	*2 Medicare eligible*	*3 Medicare eligible*
Group Health Classic	N/A†	$740.65	N/A†	$589.46	N/A†	$1,194.21	$719.33	N/A†
Group Health Medicare Plan	$135.90	N/A†	$265.77	N/A†	$265.77	N/A†	N/A†	$395.64
Group Health SoundChoice	N/A†	667.96	N/A†	534.95	N/A†	1,067.01	664.82	N/A†
Group Health Value	N/A†	703.86	N/A†	561.87	N/A†	1,129.83	691.74	N/A†
Kaiser Permanente Senior Advantage	158.70	789.99††	311.37	632.17††	311.37	1,263.46††	784.84††	464.04
UMP Classic	267.89	838.64	529.75	695.95	529.75	1,266.70	957.81	791.61

* or registered domestic partner

(continued)

† If a Group Health subscriber is enrolled in Medicare Part A and Part B but covers a family member not eligible for Medicare, the family member must enroll in a Group Health Classic, SoundChoice, or Value plan and the subscriber pays a combined Medicare and non-Medicare rate.

†† If a Kaiser Permanente subscriber is enrolled in Medicare Part A and Part B but covers a family member not eligible for Medicare, the family member will be enrolled in Kaiser Permanente Classic. The subscriber will pay the combined Medicare and non-Medicare rate shown for Kaiser Permanente Senior Advantage.

Medicare Supplement Plan F (Group), administered by Premera Blue Cross

	Subscriber Only	Subscriber and Spouse*			Subscriber and Child(ren)	Full Family		
	1 Medicare eligible	*1 Medicare eligible***	*2 Medicare eligible: 1 retired, 1 disabled*	*2 Medicare eligible*	*1 Medicare eligible***	*1 Medicare eligible***	*2 Medicare eligible: 1 retired, 1 disabled***	*2 Medicare eligible***
Plan F Age 65 or older, eligible by age	$109.86	$680.61	$312.87	$213.69	$537.92	$1,108.67	$740.93	$641.75
Plan F Under age 65, eligible by disability	209.04	779.79	312.87	412.05	637.10	1,207.85	740.93	840.11

*or registered domestic partner

** If a Medicare supplement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP) Classic. The rates shown reflect the total due, including premiums for both plans.

Medicare rates shown above have been reduced by the state-funded contribution up to the lesser of $150 or 50 percent of plan premium per retiree per month.

Monthly Premium Surcharges

The following surcharges will be billed in addition to the medical plan premiums due from subscribers. **These surcharges do not apply if the subscriber is also enrolled in Medicare Part A and Part B.**

- A monthly $25-per-account surcharge will apply if the subscriber or one or more of the enrolled family members (age 13 or older) use tobacco products.
- A monthly $50 surcharge will apply if a subscriber enrolls a spouse or registered domestic partner, and the spouse or partner has chosen not to enroll in medical coverage through his or her employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.

For more guidance on whether these surcharges apply to you, see the *2016 Premium Surcharge Help Sheet* at **www.hca.wa.gov/pebb**.

Dental Plans with Medical Plan

	Subscriber Only	Subscriber and Spouse*	Subscriber and Child(ren)	Full Family
DeltaCare, administered by Delta Dental of Washington	$39.53	$79.06	$79.06	$118.59
Uniform Dental Plan, administered by Delta Dental of Washington	44.63	89.26	89.26	133.89
Willamette Dental of Washington, Inc.	42.37	84.74	84.74	127.11

* or registered domestic partner

Retiree Life Insurance Self-Pay Rate — $7.75 per month

Eligibility Summary

Who is eligible for PEBB coverage?

This guide provides a general summary of PEBB retiree eligibility. The PEBB Program will determine your eligibility based on when your application is received and PEBB rules. If you disagree with the determination, see "How can I appeal a decision?" on page 11.

You may be eligible to enroll in PEBB plans if you are a retiring employee of a:

- PEBB-participating employer group.
- State agency.
- State higher education institution.
- Washington State school district or educational service district.

You may also be eligible to enroll in PEBB retiree insurance if you are an elected or full-time appointed state official of the legislative or executive branch of state government who voluntarily or involuntarily leaves public office.

To be eligible to enroll in PEBB retiree insurance, you must meet both the procedural requirements and all eligibility requirements of WAC 182-12-171.

Procedural requirements include:

- **You must submit a *2016 Retiree Coverage Election/Change* form (form A) to enroll or defer enrollment in PEBB retiree insurance coverage. The PEBB Program must receive the form no later than 60 days after your employer-paid coverage, COBRA coverage or continuation coverage ends.**
- If you or a dependent you wish to enroll is entitled to Medicare and your retirement date is after July 1, 1991, you must enroll in and maintain enrollment in Medicare Part A and Part B.
- If you do not enroll in PEBB retiree insurance coverage at retirement or separation from service, you are only eligible to enroll at a later date if you defer enrollment and maintain continuous enrollment in other qualifying medical coverage as described in WAC 182-12-200 and 182-12-205. **See important information about deferring retiree insurance coverage on page 19.**

In general, the eligibility requirements are:

You must be a vested member and meet the eligibility criteria to retire from a Washington State-sponsored retirement plan when your employer-paid coverage, COBRA coverage, or continuation coverage ends, unless you are an elected or appointed state official as defined under WAC 182-12-114(4).

Washington State-sponsored retirement plans include:

- Public Employees' Retirement System (PERS) 1, 2, or 3
- Public Safety Employees' Retirement System (PSERS) 2
- Teachers Retirement System (TRS) 1, 2, or 3
- Washington Higher Education Retirement Plan (for example, TIAA-CREF)
- School Employees' Retirement System (SERS) 2 and 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- Washington State Patrol Retirement System (WSPRS) 1 or 2
- State Judges/Judicial Retirement System
- Civil Service Retirement System and Federal Employees' Retirement System are considered a Washington State-sponsored retirement system for Washington State University Extension employees covered under PEBB insurance at the time of retirement or disability.

You must immediately begin to receive a monthly retirement plan payment, with the following exceptions:

- If you receive a lump sum payment instead of a monthly retirement plan payment, you are only eligible for PEBB retirement benefits if the Department of Retirement Systems offered you the choice between a lump sum actuarially equivalent payment and an ongoing monthly payment (as allowed by the plan).

- If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you meet the retirement plan's eligibility criteria, you do not have to receive a retirement plan payment to enroll in retiree insurance coverage.
- If you are an employee retiring under a Washington State higher education retirement plan (such as TIAA-CREF) and meet your plan's retirement eligibility criteria, or you are at least age 55 with 10 years of state service, you do not have to receive a monthly retirement plan payment.
- If you are an employee retiring from a PEBB-participating employer group and your employer does not participate in a Washington State-sponsored retirement system, you do not have to receive a monthly retirement plan payment. However, you do have to meet the same age and years of service requirement as if you had been employed as a member of PERS Plan 1 or Plan 2.
- If you are an elected or a full-time appointed official of the legislative or executive branches of state government, you do not have to meet the age and years of service requirement or receive a monthly retirement plan payment from a state-sponsored retirement system.

Can I cover my family members?

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

- **Your lawful spouse.**
- **Your registered domestic partner.** Effective January 1, 2010, this includes a state-registered domestic partner, or a domestic partner who qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled in your PEBB health plan or PEBB life insurance.
- **Your children up to age 26**, except for children with a disability.

How are children defined?

Children are defined as your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption, children of your registered domestic partner, children specified in a court order or divorce decree, or children defined in Washington State statutes that establish the parent-child relationship.

Children may also include extended dependents in your spouse's, or your 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 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 for whom support payments are made to you through the state Department of Social and Health Services (DSHS) foster care program.

Eligible children with disabilities

Eligible children also include children of any age with a developmental disability or physical handicap 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 evidence of the disability and evidence the condition occurred before age 26. The PEBB Program or its contracted medical plans will verify the disability and dependency of a child with a disability periodically beginning at age 26.

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

(continued)

Verifying family member eligibility

In certain cases, an individual may be eligible for enrollment as a spouse or registered domestic partner, according to Washington State statutes recognizing legal unions.

The PEBB Program verifies the eligibility of all dependents and will request proof of a dependent's eligibility. The PEBB Program will not enroll a dependent if the PEBB Program cannot verify the dependent's eligibility. You can find a list of documents you must provide to verify your dependent's eligibility on page 51.

If adding an extended dependent, or a dependent with a disability, you must complete the required dependent certification form in addition to the enrollment form. Submit the forms and documentation to the addresses listed on the forms. For more information, go to **www.hca.wa.gov/pebb**. Select "Get A Form" and then click on "Dependent Certification."

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

If I die, do my surviving dependents remain eligible for benefits?

As an eligible employee or retiree, your surviving spouse, registered domestic partner, or child may be eligible to enroll in PEBB retiree insurance if they meet both eligibility and procedural requirements outlined in WAC 182-12-265. All required forms must be received by the PEBB Program **no later than 60 days** after the date of the employee's or retiree's death.

When are dependents of emergency service employees eligible?

If you are a surviving spouse, state-registered domestic partner, or dependent child of an emergency service employee who was killed in the line of duty, you may be eligible to enroll in PEBB retiree insurance if you meet both the procedural and eligibility requirements outlined in WAC 182-12-250. All required forms enrolling or deferring retiree insurance coverage must be received by the PEBB Program **no later than 180 days** after the later of:

- The death of the emergency service worker;
- The date on the letter from the Department of Retirement Systems or the board for volunteer firefighters and reserve officers that informs the survivor that he or she is determined to be an eligible survivor;
- The last day the surviving spouse, state-registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or
- The last day the surviving spouse, state-registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

For additional information, contact the PEBB Program toll-free at 1-800-200-1004 or 360-725-0440

PEBB Appeals

How can I appeal a decision?

If you or your dependent disagrees with a PEBB decision or a PEBB denial notice, you or your dependent may file an appeal. Submit your appeal one of the following ways:

Mail: PEBB Appeals Manager
Washington State Health Care Authority
P.O. Box 42699
Olympia, WA 98504-2699

FAX: 360-725-0771

You will find guidance on filing an appeal in chapter 182-16 WAC and at **www.hca.wa.gov/pebb** or you can contact the PEBB appeals manager at 1-800-351-6827.

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

You must provide us with a copy of a valid power of attorney or a completed *Authorization for Release of Information* form naming your representative and authorizing him or her to access your medical records and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available at **www.hca.wa.gov/pebb/** or by calling the PEBB Program at 1-800-200-1004.

If you are...	And your appeal concerns...	Follow these instructions:
• An applicant for PEBB benefits • A retiree • A survivor of a deceased employee or retiree as described in Washington Administrative Code (WAC) 182-12-265 • A survivor of emergency service personnel killed in the line of duty as described in WAC 182-12-250 • A member through COBRA, Leave Without Pay (LWOP), or PEBB Extension of Coverage • The dependent of one of the above	A decision from the PEBB Program about eligibility for benefits, enrollment, premium payments, a premium surcharge, or eligibility to participate in the PEBB (SmartHealth) wellness program or receive a wellness incentive.	Complete all sections of the *Retiree/ COBRA/LWOP Notice of Appeal* form and submit it to the PEBB appeals manager as instructed above. The PEBB appeals manager must receive the form **no later than 60 calendar days** after the date of the denial notice regarding the decision you are appealing.
Seeking a review of a decision by a **PEBB health plan, insurance carrier,** or **benefit administrator**	• A benefit or claim. • Completion of the SmartHealth wellness incentive program requirements or a reasonable alternative request.	Contact the health plan, insurance carrier, or benefit administrator to request information on how to appeal its decision.

New Enrollment

How do I enroll?

It's important for the PEBB Program to receive your forms within the required timelines. As noted in the "Eligibility Summary," the PEBB Program must receive your *Retiree Coverage Election/Change* form (form A) indicating your decision to enroll or defer **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. If you miss that 60-day window, you lose all rights to enroll in PEBB retiree coverage in the future unless you regain eligibility. To regain eligibility, you would have to return to work in a PEBB or Washington State school district or educational service district benefits-eligible position and, at the time of termination, meet the enrollment and eligibility requirements of WAC 182-12-171.

Submit your completed *Retiree Coverage Election/ Change* form (form A) and any other required forms to the PEBB Program as instructed on the form (found in the back of this guide). **You must submit form A even if you decide to defer (postpone) your enrollment.** (See "Deferring Your Coverage" on page 19 for more information.)

Include any eligible dependents you wish to enroll on the form(s). If you are a retiree who is not enrolled in Medicare Part A and Part B, or you are adding a registered domestic partner, you must provide proof of your dependents' eligibility within the PEBB Program's enrollment timelines or the family members will not be enrolled. Eligibility can be established for registered domestic partners through a domestic partner registry or legal union. See page 51 for a list of documents required to verify dependents.

When do I send payment?

You must send your first premium payment before you can be enrolled, unless you choose to have your premiums and any applicable surcharges deducted from your monthly pension check. See "Paying for Benefits" on page 14 for details.

If you enroll, you must pay premiums (and any applicable surcharges) back to the date when your other coverage ended. For example, if your other coverage ends in December, but you don't submit your enrollment form until February, you must pay January and February premiums and applicable surcharges to enroll in PEBB coverage.

Can I enroll retroactively?

If the Department of Retirement Systems (DRS) determines that you are retroactively eligible for a pension benefit due to disability, or the appropriate higher education authority determines that you are retroactively eligible for a supplemental retirement plan benefit under the Higher Education Retirement Plan due to disability, you may either enroll retroactive to the date of eligibility for retirement, or prospective from the date on the determination letter sent to you.

Can I enroll on two PEBB accounts?

If you and your spouse or registered domestic partner are both independently eligible for PEBB coverage, you need to decide which of you will cover yourselves and any eligible children on your medical or dental plans. An enrolled family member may be enrolled in only one medical or dental plan. For example, you could defer PEBB retiree medical coverage for yourself (see "Deferring Your Coverage" on page 19) and enroll as a dependent on your spouse's or registered domestic partner's medical coverage.

What can I expect after I submit my enrollment form?

If you are retiring as a state employee or a higher-education institution employee, your PEBB retiree health coverage will begin on the first day of the month after your employer-paid coverage, COBRA coverage, or continuation coverage ends.

These are the steps that will occur:

1. In most cases, your employer's payroll office will cancel your employee coverage when they process your final paycheck. The PEBB Program cannot enroll you in retiree coverage until this occurs.
2. The health plan(s) that covered you as an employee will send you a cancellation letter after your payroll office cancels your employee coverage. Federal rules require us to send you a PEBB *Continuation of Coverage Election Notice* booklet; keep it for future reference.
3. If your application is incomplete, we will send you a letter requesting more information.
4. Once your payroll office cancels your employee coverage and we receive your complete information, we will enroll you in PEBB retiree health coverage. In most cases, your retiree coverage begins immediately after your current coverage ends.
5. After your enrollment begins, your health plan(s) will send you a welcome packet.

If you are a Washington State school district or educational service district retiree and meet PEBB eligibility and enrollment requirements, your coverage begins the first of the month after your school district or COBRA coverage ends.

How much do the plans cost?

The cost for your health benefits depends on which medical or dental plan you select. Premiums start on page 6. In addition to your monthly premium and any applicable surcharges, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage or *Summary of Benefits and Coverage* available from each plan.

The HCA collects premiums for the full month, and will not prorate them for any reason, including when a member dies before the end of the month. You may not have a gap in coverage so your first payment for premiums will be retroactive to the first of the month after your other coverage ends.

Some subscribers must also pay a premium surcharge:

- A monthly $25 surcharge will apply if you or one of your enrolled family members (age 13 or older) uses tobacco products.
- A monthly $50 surcharge will apply if you enroll your spouse or registered domestic partner, and the spouse or partner has chosen not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic.

These surcharges will not apply if the subscriber is enrolled in Medicare Part A and Part B. If a dependent is enrolled in Medicare Part A and Part B, but the subscriber is not, the surcharge may still apply. See the 2016 Premium Surcharge Help Sheet for more information.

How do I pay for coverage?

You can help ensure that your payments are made on time and avoid disruptions in your coverage by using pension deduction through the Department of Retirement Systems (DRS) or automatic bank account withdrawals. Here are your payment options:

- **DRS pension deduction**. Your premium and any applicable surcharges are taken from your end-of-the-month pension check. For example, if your coverage takes effect January 1, your January 31 check will show your deductions for January.
- **Automatic bank account withdrawals**. You must complete and return the *Electronic Debit Service Agreement* form to the HCA. You can find the form in the back of this booklet. Approval takes six to eight weeks, so you must continue to pay the total due shown on your invoices until you receive a letter from the HCA with your electronic debit start date.
- **A personal check or money order**. Please make your check payable to Health Care Authority and send it to:

  Health Care Authority
  P.O. Box 42695
  Olympia, WA 98504-2695

Can I use a VEBA account?

If you have a Voluntary Employees' Beneficiary Association Medical Expense Plan (VEBA MEP) account, you can set up automatic reimbursement of your qualified insurance premiums. The VEBA MEP does not pay your monthly premiums directly to the PEBB Program.

Qualified insurance premiums include medical, dental, vision, Medicare supplement, Medicare Part B, Medicare Part D, and tax-qualified long-term care insurance (subject to annual IRS limits). Retiree term-life insurance premiums are not eligible for reimbursement from your VEBA MEP account.

Note: It is important that you notify the VEBA MEP when your premiums change or if you become rehired by the employer that contributed to your account. Qualified medical care expenses and premiums you incur while you are re-employed by the employer that contributed to your account are not eligible for reimbursement from your account. Also, if you enroll in a consumer-directed health plan (CDHP) to be eligible to make or receive contributions to a Health Savings Account (HSA), you must elect "limited-purpose" VEBA MEP coverage.

Only the following types of expenses can be reimbursed from your VEBA MEP account while coverage is limited: standard dental care services (not related to a medical condition or accident), including dentures; orthodontia; and routine eye exams, contact lenses, and eyeglasses (excluding initial lenses and standard frames after

cataract surgery.) Keep in mind that electing limited-purpose VEBA MEP coverage is not the only HSA contribution eligibility requirement.

More information and forms, including the *Automatic Premium Reimbursement* form and *Limited-purpose Election* form, are available online after logging in to your account at **www.veba.org** or upon request by calling the VEBA MEP customer care center at 1-888-828-4953.

What happens if I miss a payment?

You must pay the premiums and any applicable surcharges for your PEBB coverage when due. If you pay late or do not pay in full, we will cancel your coverage back to the last day of the month in which we received your full payment for the premium and any applicable surcharges. (Partial payments are not considered full payments.) If your insurance coverage is cancelled, coverage for your dependents also will be cancelled. You cannot enroll again in PEBB coverage unless you regain eligibility.

Medicare Enrollment

What if I'm entitled to Medicare?

When you or your covered dependents become entitled to Medicare, the person entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B to remain eligible for PEBB retiree coverage.

Once you or your covered dependents enroll in Medicare Part A and Part B, you must send us a copy of either the Medicare card or a letter from the Social Security Administration **no later than 60 days** after enrolling in Medicare that shows the effective date of Medicare Part A and Part B coverage. Mail a photocopy of the Medicare card or letter to:

PEBB Program
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

We will reduce your premium to the lower Medicare rate, if applicable, and notify your health plan of your Medicare enrollment. If you were paying surcharges in addition to your premium, the surcharge(s) will automatically discontinue when you (the subscriber) enroll in Medicare Part A and Part B.

Entitlement to Medicare also qualifies as a special open enrollment event, allowing you to change your health plans. See "What is a special open enrollment?" on page 17.

Can I enroll in a CDHP and Medicare?

If you are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA) when you or your covered dependent(s) become entitled to Medicare Part A and Part B, you must take action as shown in the table below to change your coverage. The PEBB Program must receive your request **no later than 60 days** after the Medicare enrollment date.

If the person entitled to Medicare Part A and Part B is...	You must:
You (the subscriber)	Choose a new medical plan that is not a consumer-directed health plan.
Your covered family member	Either: • Choose a medical plan that is not a CDHP and keep your Medicare dependent enrolled in PEBB coverage. Your annual deductible and annual out-of-pocket maximum will restart with your new plan. OR • Remove your family member from your PEBB coverage **before** he or she enrolls in Medicare Part A and Part B. The family member will not qualify for COBRA or other continuation coverage through the PEBB Program.

How do I make changes to my account?

To make changes, such as enroll a dependent or elect a different health plan, you must complete and submit the required form(s) during the annual open enrollment or when a special open enrollment event occurs, within PEBB's timelines noted below.

Retiree subscribers may voluntarily remove an eligible dependent from insurance coverage any time during the year. In most cases, the PEBB Program will remove the dependent from insurance coverage prospectively. Insurance coverage will end on the last day of the month in which written notice is received by the PEBB Program. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.

Subscribers are required to notify the PEBB Program in writing to remove dependents **no later than 60 days** from the date the dependent no longer meets the eligibility criteria described in WAC 182-12-260. Consequences for not submitting written notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-170;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility; and
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.

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

PEBB's annual open enrollment is November 1-30. To make any of the changes below, the PEBB Program must receive the required form(s) no later than November 30. The enrollment change will become effective January 1 of the following year.

During the annual open enrollment, you can:

- Change your medical and/or dental plan.
- Add an eligible family member to your PEBB coverage. If not enrolled in Medicare Parts A and B you must also:
  - Provide proof of your family member's eligibility with your enrollment form, or they will not be enrolled.
  - Attest to the tobacco use premium surcharge and spousal coverage premium surcharge (if applicable to your account).
- Remove a family member from your PEBB coverage.
- Defer your PEBB retiree insurance coverage.
- Enroll in a health plan if you previously deferred PEBB retiree insurance coverage for other coverage. **Note:** You cannot enroll during open enrollment if there has been a gap in coverage. (See "Deferring Your Coverage" on page 19).

What is a special open enrollment?

The PEBB Program allows changes outside of the PEBB annual open enrollment when certain events create a special open enrollment. The change must be on account of and correspond to the event that affects eligibility for coverage. You must provide proof of the event that created the special open enrollment (for example, a marriage or birth certificate).

To make a change, you must submit the *Retiree Coverage Election/Change* form and any other required form(s) or documentation. The PEBB Program must receive your completed form **no later than 60 days** after the event that created the special open enrollment. However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form **no later than 12 months** after the birth or adoption.

In most cases, the change will occur the first day of the month after the date of the event or the date the PEBB Program receives your required, completed enrollment form(s), whichever is later. If that day is the first of the month, coverage begins on that date.

Premium surcharge reminder:

When you enroll a dependent as part of a special open enrollment, you must attest on your enrollment form to whether the tobacco use and spousal coverage premium surcharges apply. See the *Premium Surcharge Help Sheet* located in the back of this booklet, or online at **www.hca.wa.gov/pebb**. Select Surcharges.

(continued)

Making Changes in Coverage

If this event happens ...	These changes may be allowed:		
	Add dependent	Change medical plan	Change dental plan
Marriage or registering a domestic partnership	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption	Yes	Yes	Yes
Child becoming eligible as an extended dependent through legal custody or legal guardianship	Yes	Yes	Yes
Child becoming eligible as a dependent with a disability	Yes	Yes	Yes
Subscriber or dependent losing eligibility for other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA)	Yes	Yes	Yes
Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward employer-based group health insurance	Yes	Yes	Yes
Subscriber or dependent having a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment	Yes	No	No
Subscriber's dependent moving from outside the United States to live within the United States, or from within the United States to outside of the United States	Yes	No	No
Subscriber or dependent having a change in residence that affects health plan availability	No	Yes	Yes
A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent	Yes	Yes	Yes
Subscriber or a subscriber's dependent becoming entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or losing eligibility for coverage under Medicaid or CHIP	Yes	Yes	Yes
Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP	Yes	Yes	Yes
Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare; or enrolling (or canceling enrollment) in a Medicare Part D plan	No	Yes	Yes
Subscriber's or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA)	No	Yes	Yes
Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program)	No	Yes	Yes

Deferring Your Coverage

Deferral rights for retirees

If you choose not to enroll at retirement or separation from state service, and you want to maintain your ability to enroll in PEBB benefits in the future, you must:

- Defer (postpone or interrupt) your enrollment in PEBB retiree medical and dental coverage at or after retirement; and
- Be continuously enrolled in other medical coverage, as described below.

If you defer enrollment in a PEBB retiree health plan, you may not enroll in a PEBB dental plan during your deferral period.

Except as stated below, if you defer enrollment in a PEBB retiree health plan, you also defer enrollment for your dependents.

You may defer enrollment in PEBB retiree benefits if:

- You are continuously enrolled in a PEBB, or Washington State school district, or educational service district-sponsored medical plan as a dependent, including such coverage under COBRA or continuation coverage.
- Beginning January 1, 2001, if you are continuously enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under COBRA coverage or continuation coverage. This does not include an employer's retiree coverage.
- Beginning January 1, 2001, if you are continuously enrolled in medical coverage as a retiree or a dependent of a retiree in TRICARE or the Federal Employees Health Benefits Program. You will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Beginning January 1, 2006, if you are continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, your Medicaid coverage must include coverage for medical and hospital benefits. Your eligible dependents who are not eligible for creditable coverage under Medicaid may continue PEBB health plan enrollment.
- Beginning January 1, 2014, if you are not eligible for Medicare Part A and Part B you may defer PEBB retiree coverage if enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. You will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

Required timelines for retirees to defer

To defer enrollment in a PEBB health plan, retiring employees or enrolled retiree subscribers must submit a Retiree Coverage Election/Change form (form A) to the PEBB Program requesting to defer.

- If you are a retiring or separating employee, the PEBB Program must receive the form **no later than 60 days** after your employer-paid coverage, COBRA coverage, or continuation coverage ends. The PEBB Program will defer your enrollment the first of the month following the date your employer-paid or COBRA coverage ends.
- If you are a retiree enrolled in PEBB retiree insurance coverage, the PEBB Program must receive your election/change form before you defer coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives your form. Exception: If the form is received on the first day of the month, coverage will end on the last day of the previous month.
- If you defer enrollment in PEBB retiree coverage while enrolled in other coverage and lose such coverage, you must enroll in a PEBB retiree health plan or defer enrollment. If you don't, you will lose eligibility to enroll in PEBB retiree insurance coverage as described in WAC 182-12-205 or 182-12-200.

(continued)

- If you met substantive eligibility requirements and your employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001 and December 31, 2001, you were not required to submit a deferral form at that time. However, you must have met all other procedural requirements to have deferred your PEBB retiree medical/dental coverage.

Deferring retiree life insurance

If you have deferred your PEBB retiree health coverage and become eligible for the employer contribution toward PEBB life insurance (for example, by returning to state service), you may keep or cancel your retiree term life insurance. To do either, complete the *Life and AD&D Insurance Enrollment/Change Form* and submit it to your employer's personnel, payroll, or benefits office. If you cancel your retiree term life insurance, you must complete the *Retiree Coverage Election/Change* form to reenroll in PEBB retiree term life insurance when you are no longer eligible for PEBB employer-sponsored benefits. The PEBB Program must receive this form **no later than 60 days** after your employer-paid coverage ends.

Deferral rights for survivors of employees or retirees

A surviving spouse, registered domestic partner, or child of an employee, retiree, or Washington State school district or educational service district employee who is eligible for PEBB retiree coverage under WAC 182-12-265 may defer enrollment under one of the circumstances listed below. If a survivor defers enrollment in PEBB retiree insurance coverage, he or she may not enroll in a PEBB dental plan.

- If a survivor is continuously enrolled in a PEBB, Washington State school district, or educational service district-sponsored medical plan as a dependent, including such coverage under COBRA or continuation coverage.
- Beginning January 1, 2001, if a survivor is continuously enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under COBRA coverage or continuation coverage.
- Beginning January 1, 2001, if a survivor is continuously enrolled in medical coverage as a retiree or the dependent of a retiree in TRICARE or the Federal Employees Health Benefits Program. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Beginning January 1, 2006, if a survivor is continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the survivor's Medicaid coverage must include coverage for medical and hospital benefits. A survivor's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB health plan enrollment.
- Survivors who are not eligible for Medicare Part A and Part B may defer PEBB retiree insurance coverage if enrolled in qualified health plan coverage offered through a health benefits exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

Required timelines for survivors of employees or retirees to defer

To defer enrollment in PEBB retiree insurance coverage, a survivor must submit a *Retiree Coverage Election/Change* form (form A) to the PEBB Program:

- In the event of an employee or retiree's death, the PEBB Program must receive the form **no later than 60 days** after the death. Enrollment will be deferred effective the first of the month following the date of the death.
- If a survivor enrolls in PEBB retiree insurance coverage and is eligible to defer coverage in the future, the PEBB Program must receive the form **before** the survivor defers coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives the form. For example, if the form is received on the

first day of the month, coverage will end on the last day of the previous month.

Deferral rights for survivors of emergency services personnel

A surviving spouse, state-registered domestic partner, or dependent child of emergency services personnel killed in the line of duty who is eligible for PEBB retiree insurance coverage under WAC 182-12-250 may defer enrollment under the circumstances listed below. If a survivor defers enrollment in PEBB retiree insurance coverage, he or she may not enroll in a PEBB dental plan.

- If a survivor is continuously enrolled in a PEBB, Washington State school district, or educational service district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if a survivor is continuously enrolled in employer-based group medical insurance as an employee or the dependent of an employee, COBRA coverage or continuation coverage.
- Beginning January 1, 2001, if a survivor is continuously enrolled in medical coverage as a retiree or the dependent of a retiree in TRICARE or the Federal Employees Health Benefits Program. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Beginning January 1, 2006, if a surviving dependent is continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the surviving dependent's Medicaid coverage must include coverage for medical and hospital benefits. A survivor's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB health plan enrollment.
- Survivors who are not eligible for Medicare Part A and Part B may defer PEBB retiree insurance coverage if enrolled in qualified health plan coverage offered through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

To defer enrollment in PEBB retiree insurance, a survivor must submit a *Retiree Coverage Election/ Change* form to the PEBB Program. The form must be received by the PEBB Program **no later than 180 days** after the later of:

- The death of the emergency service worker.
- The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
- The last day the survivor was covered under any health plan through the emergency service worker's employer.
- The last day the survivor was covered under COBRA coverage from the emergency service worker's employer.

How do I enroll after deferring PEBB coverage?

If a retiree or survivor deferred enrollment in PEBB retiree coverage, he or she may enroll under the following circumstances, as long as he or she has had continuous enrollment in qualifying coverage as required.

- **During any PEBB annual open enrollment**. The PEBB Program must receive the *Retiree Coverage Election/Change* form and proof of continuous enrollment in other qualified health plan coverage no later than the last day of the PEBB Program's open enrollment period. You cannot enroll during open enrollment if there has been a gap in coverage. To return from deferral during open enrollment, your other coverage must be continuous through December 31.
- **When other qualified coverage ends**. The PEBB Program must receive the *Retiree Coverage Election/ Change* form **no later than 60 days** after the

(continued)

date other qualifying coverage ends. Enrollment will begin the first day of the month after other qualifying coverage ends. Although a retiree or survivor has 60 days to enroll, he or she must pay PEBB premiums and any applicable surcharges back to when other qualifying coverage ended. Proof of continuous enrollment in other qualifying medical coverage must list when the coverage began and ended.

A retiree or survivor has a one-time opportunity to enroll in PEBB medical and dental coverage if he or she deferred enrollment in PEBB coverage for TRICARE, the Federal Employees Health Benefits Program, or coverage through a health benefit exchange established under the Affordable Care Act.

How do I enroll after deferring PEBB coverage for Medicaid?

Retirees or survivors who defer PEBB retiree coverage while continually enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage may enroll in PEBB coverage during any PEBB annual open enrollment or if they lose their Medicaid coverage. The PEBB Program must receive the *Retiree Coverage Election/Change* form **no later than 60 days** after the date Medicaid coverage ends, or no later than the end of the calendar year when the retiree or survivor's Medicaid coverage ends, if he or she was also eligible under subsidized Medicare Part D.

Retirees or survivors who defer enrollment may enroll in a PEBB health plan if he or she receives formal notice that the Health Care Authority has determined it is more cost-effective to enroll the retiree or survivor (or his or her eligible dependent) in PEBB medical than a medical assistance program.

How do I cancel coverage?

To cancel your PEBB retiree coverage, you must submit your request in writing to:

Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684

Your insurance coverage will end on the last day of the month in which the PEBB Program receives your written notice. If your written notice is received on the first day of the month, coverage will end on the last day of the previous month.

If you are enrolled in a Medicare Advantage plan, you must also send the PEBB Program a completed PEBB *Medicare Advantage Plan Disenrollment Form* (form D). We will send form D to your plan, which will remove you from coverage on the first of the month after the plan receives the form.

If you cancel your PEBB retiree coverage, you cannot enroll again later unless you regain eligibility for PEBB coverage, for example, by returning to employment in a PEBB, Washington State school district, or educational service district benefits-eligible position.

When does PEBB coverage end?

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

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends.
- Coverage for you and your enrolled dependents ends on the last day of the month that you last paid the full premium. The PEBB Program charges a full month's premium for each calendar month of coverage. The HCA will not prorate a premium if an enrollee dies or cancels his or her coverage before the end of the month.

What are my options when coverage ends?

Options for continuing coverage vary, based on the reason you lost eligibility. You, your dependents, or both may temporarily continue your PEBB coverage by self-paying the premiums and any applicable surcharges after your eligibility ends.

The PEBB Program will mail a *PEBB Continuation of Coverage Election Notice* booklet to you or your dependents when retiree coverage ends. You or your eligible dependents must apply to the PEBB Program to continue coverage. The PEBB Program must receive the election form **no later than 60 days** after the mailing date on the *PEBB Continuation of Coverage Election Notice* booklet, or you will lose all rights to continue PEBB coverage.

Your dependents lose eligibility when you die. However, they may enroll in or continue PEBB retiree coverage even if they were not covered at the time of your death. Your other dependents may continue coverage until they are no longer eligible under PEBB rules. If your dependent child is no longer eligible under PEBB rules, he or she may continue under COBRA for up to 36 months.

Your spouse or registered domestic partner may continue coverage indefinitely as long as he or she pays the full premiums and any applicable premium surcharges in full and on time. If your spouse is no longer eligible due to divorce, he or she may continue coverage for up to 36 months under COBRA. If your registered domestic partnership ends, PEBB will offer your former domestic partner and his or her children an extension of coverage for up to 36 months.

For information about your rights and obligations go to **www.hca.wa.gov/pebb**, select *Publications* and click on *PEBB Continuation of Coverage Election Notice* booklet.

How can I compare the plans?

All medical plans, except for Premera Blue Cross Medicare Supplement Plan F, cover the same basic health care services but vary in other ways, such as provider networks, premiums, and drug formularies.

The PEBB Program offers three types of medical plans:

- **Managed-care plan.** Managed care plans may require you to select a primary care provider (PCP) within its network to fulfill or coordinate all of your health needs. The plan may not pay benefits if you see a non-contracted provider.
- **Preferred provider organization health plans.** PPO's 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.
- **Consumer-directed health plans.** CDHP's 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 plans, and a higher deductible and a higher out-of-pocket limit.

Remember, if you cover eligible dependents, everyone must enroll in the same medical and dental plans (with some exceptions, based on eligibility for Medicare Part A and Part B).

Plan differences to consider

- **Premiums.** Premiums vary by plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits (except Medicare Supplement Plan F). Generally, the classic plans have higher premiums than the value plans. However, classic plans may have lower annual deductible, copays, or coinsurance costs.
- **Deductibles.** All medical plans, except Group Health's and Kaiser Permanente's Medicare Advantage plans, require you to pay an annual deductible before the plan pays for covered services. UMP Classic also has 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 covers the service.
- **Coinsurance or copays.** Some plans require you to pay a fixed amount, called a copay. Other plans require you to pay a percentage of an allowed fee when you receive care, called a coinsurance.
- **Out-of-pocket limit.** The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. UMP Classic has 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 annual out-of-pocket limit:
  - Monthly premiums and applicable surcharges.
  - Charges above what the plan pays for a benefit.
  - Charges above the plan's allowed amount paid to a provider.
  - Charges for services or treatments the plan doesn't cover.
  - Coinsurance for non-network providers.
  - Prescription-drug deductible and prescription-drug coinsurance (UMP Classic only).
- **Eligibility.** You must be enrolled in Medicare Part A and Part B to enroll in the Medicare Advantage or Medicare Supplement plans. Also, not everyone qualifies to enroll in a CDHP with a health savings account (HSA). See "What do I need to know about the consumer-directed health plans?" on page 26.
- **Geography.** In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on page 29. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.
- **Referral procedures.** Some 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 healthcare provider, you should verify whether he or she is in the plan's network. Contact the provider or plan before you join. Your family members may choose the same provider, but it's not required. Each family member may select from any available provider in the plan's network. After you join a plan, you may change your provider, although the rules vary by plan.
- **Paperwork.** In general, PEBB plans don't require you to file claims. However, UMP Classic members may need to file a claim if they receive services from a non-network provider. CDHP members should also keep paperwork received from their provider or from 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 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 is called coordination of benefits (COB). 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.

Exception to coordination: PEBB plans that cover prescription drugs will not coordinate prescription-drug coverage with Medicare Part D. All PEBB plans cover prescription drugs except Premera Blue Cross Medicare Supplement Plan F. If you enroll in Medicare Part D, you must enroll in Premera Blue Cross Medicare Supplement Plan F or lose your PEBB retiree coverage.

You can compare some of the medical plans' benefits in this booklet on pages 32–44 and at **www.hca.wa.gov/pebb**.

What type of plan should I select?

In general, PEBB retirees may choose from the plans described in pages 32–44 in this booklet. Your options are limited to which plans are available in your county and whether you are enrolled in Medicare Part A and Part B.

Medicare options:

- Group Health Medicare Plan (Medicare Advantage or Original Medicare coordination plan)
- Kaiser Permanente Senior Advantage
- Medicare Supplement Plan F, administered by Premera Blue Cross
- UMP Classic (Medicare), administered by Regence BlueShield

Non-Medicare options:

Managed-care plans

- Group Health Classic
- Group Health Value
- Group Health SoundChoice (**Note:** At least one family member must not be enrolled in Medicare Part A and Part B.)
- Kaiser Permanente Classic

Consumer-directed health plans (CDHPs)

- Group Health CDHP
- Kaiser Permanente CDHP
- UMP CDHP, administered by Regence BlueShield

Preferred-provider plans

- UMP Classic, administered by Regence BlueShield
- UMP Plus, administered by Regence BlueShield (**Note:** Not available to retirees enrolled in Medicare Part A and Part B.)

(continued)

What do I need to know about the consumer-directed health plans?

You cannot enroll in a CDHP with a health savings account (HSA) if:

- You or your spouse or registered domestic partner is enrolled in Medicare Part A or Part B or Medicaid.
- You are enrolled in another comprehensive medical plan. For example, on a spouse's or registered domestic partner's plan.
- You or your spouse or registered domestic partner is enrolled in a Voluntary Employee Beneficiary Association (VEBA) trust account, unless you convert it to a limited VEBA.
- You have received Veterans' Administration benefits (including prescription drugs) in the three months before you enroll in a CDHP/HSA, or have TRICARE coverage.
- You enrolled in a Medical Flexible Spending Arrangement (FSA) or a Health Savings Account (HSA). 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.
- You are claimed as a dependent on someone else's tax return.

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

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

The PEBB Program contributes the following amounts to your HSA:

- $58.34 each month for an individual subscriber, up to $700.08 for the 2016 calendar year; or
- $116.67 each month for a subscriber with one or more enrolled family members, up to $1,400.04 for the 2016 calendar year.
- $125 if you qualified for a SmartHealth wellness incentive in 2015.

The contributions from the PEBB Program go into the HSA in monthly installments over the year, and are deposited on the last day of each month. The SmartHealth wellness incentive is deposited at the end of January. The entire annual amount is not deposited in your HSA on January 1.

You can also choose to contribute to your HSA through direct deposits to HealthEquity, and you may be able to deduct your HSA contributions from your federal income taxes. In 2016, the annual HSA contribution limit is $3,350 (individuals) and $6,750 (you and one or more family members). 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 **both** the PEBB Program's contribution amount(s) for the year, the SmartHealth wellness incentive in January (if eligible), and any amount you contribute.

Some other features of the CDHP/HSA:

- If you cover one or more family members, you must pay the entire family deductible before the CDHP begins paying benefits.
- Your prescription-drug costs count toward the annual deductible and out-of-pocket maximum if you enroll in the Group Health CDHP or Kaiser Permanente 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.

What happens to my health savings account when I leave the CDHP?

If you choose a medical plan that is not a CDHP you should know:

- You won't forfeit any unspent funds in your HSA after enrolling in a different plan. You can spend your HSA funds on qualified medical expenses in

the future. However, you and the PEBB Program 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.

Medicare reminder:

If you enroll in a CDHP and you or a covered family member becomes eligible for Medicare Part A or Part B during the year, you must change to another PEBB medical plan that is not a CDHP, or remove the Medicare-eligible family member from your PEBB coverage. If you change your medical plan midyear, any payments you have made toward your annual deductible and out-of-pocket maximum will not apply to your new plan. See "Can I enroll in a CDHP and Medicare?" on page 16.

What do I need to know about the Medicare Advantage and Medicare Supplement plans?

Medicare Advantage plans are available from Group Health and Kaiser Permanente, but are not available in every county (see page 29). If you are enrolled in Medicare Part A and Part B and you choose Group Health or Kaiser Permanente, you must enroll in the Medicare Advantage plan if they offer it in your county.

These plans contract with Medicare to provide all Medicare-covered benefits; however, most also cover the deductibles, coinsurance, and additional benefits not covered by Medicare. Neither the health plan nor Medicare will pay for services received outside of the plan's network except for authorized referrals and emergency care.

Group Health also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Group Health Medicare Advantage plan (called Clear Care).

Medicare Supplement Plan F, administered by Premera Blue Cross, allows the use of any Medicare-contracted physician or hospital nationwide. The plan is designed to supplement your Medicare coverage by reducing your out-of-pocket expenses and providing additional benefits. It pays some Medicare deductibles and coinsurances, but primarily supplements only those services covered by Medicare.

The PEBB Program does not offer the high-deductible Plan F shown in the *Outline of Medicare Supplement Coverage* that begins on page 41.

In Medicare Supplement Plan F, benefits such as vision, hearing exams, and routine physical exams may have limited coverage or may not be covered at all.

If you select Medicare Supplement Plan F, any eligible family members who are not entitled to Medicare will be enrolled in UMP Classic.

How do PEBB plans with prescription-drug coverage compare to Medicare Part D?

All PEBB medical plans, except Premera Blue Cross Medicare Supplement Plan F, have prescription-drug coverage that is "creditable coverage." That means it is as good or better than the standard Medicare prescription-drug coverage (Medicare Part D). So:

- These plans, on average for all plan members, meet at least what the standard Medicare prescription-drug coverage will pay.
- You can keep your PEBB coverage and not pay a late enrollment penalty if you decide to enroll in Medicare prescription-drug coverage later.
- You can enroll in a Medicare Part D plan when you first become entitled to Medicare, during the Medicare Part D open enrollment, and after you lose creditable prescription-drug coverage through your current plan. Open enrollment for Medicare Part D occurs toward the end of the year. However, joining Medicare Part D may affect your enrollment in the PEBB Program.

The PEBB Program does not offer Medicare Part D. You do not have to enroll in Medicare Part D. If you do enroll in Medicare Part D, the only PEBB medical plan that allows enrollment with Medicare Part D is Premera Blue Cross Medicare Supplement Plan F. If you are enrolled in any other PEBB medical plan, you cannot enroll in Medicare Part D and keep your PEBB coverage.

How to Find the Summaries of Benefits and Coverage

The Affordable Care Act requires the PEBB Program and medical plans to provide a standardized comparison tool of medical plan benefits, terms, and conditions. This tool, called the Summary of Benefits and Coverage (or 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/or 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 from your medical plan in Spanish, Tagalog, Chinese, and Navajo.

If you want to request an SBC from your current PEBB medical plan	If you want to request an SBC from another PEBB medical plan
You can either: • Go to your plan's website to view it online; OR • Call your plan to request a paper copy at no charge.	You can either: • Go to the plan's website to view 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 plans' websites and customer service phone numbers on page 2.

2016 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 plan(s) you are interested in to ask about provider availability in your county.

Washington			
Group Health Classic **Group Health consumer-directed health plan (CDHP)** **Group Health Value** *These plans not available to Medicare members*	• Benton • Columbia • Franklin • Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Kittitas	• Lewis • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) • Mason • Pend Oreille (ZIP Codes 99009 and 99180) • Pierce • San Juan • Skagit	• Snohomish • Spokane • Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173) • Thurston • Walla Walla • Whatcom • Whitman • Yakima
Group Health Medicare Advantage	• Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap	• Lewis • Mason (ZIP Codes 98312, 98524, 98528, 98541, 98546, 98548, 98555, 98560, 98584, 98588, and 98592) • Pierce	• San Juan • Skagit • Snohomish • Spokane • Thurston • Whatcom
Group Health Original Medicare	• Benton • Columbia • Franklin • Kittitas • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122)	• Mason* • Pend Oreille (ZIP Codes 99009 and 99180) • Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)	• Walla Walla • Whitman • Yakima * *Original Medicare is available in ZIP Codes where Medicare Advantage is not available.*
Group Health SoundChoice *Note: At least one family member must **not** be enrolled in Medicare Part A and Part B*	• King • Pierce	• Snohomish • Thurston	
Kaiser Permanente Classic **Kaiser Permanente consumer-directed health plan (CDHP)** *These plans not available to Medicare members*	• Clark • Cowlitz		
Kaiser Permanente Senior Advantage	• Clark • Cowlitz	• Lewis (ZIP Codes 98591, 98593, and 98596) • Skamania	• Wahkiakum (ZIP Codes 98612 and 98647)
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in Washington counties and nationwide.		

(continued)

2016 Medical Plans Available by County

Washington	
UMP Classic **UMP consumer-directed health plan**	Available in all Washington counties and worldwide.
UMP Plus–Puget Sound High Value Network **UMP Plus–UW Medicine Accountable Care Network** *These plans not available to Medicare members*	• King • Kitsap • Pierce • Snohomish • Thurston

Oregon			
Group Health Classic **Group Health consumer-directed health plan (CDHP)** **Group Health Original Medicare** **Group Health Value**	• Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)		
Kaiser Permanente Classic **Kaiser Permanente consumer-directed health plan (CDHP)** *These plans not available to Medicare members*	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, and 97267-69) • Columbia	• Hood River (ZIP Code 97014) • Linn (ZIP Codes 97321-22, 97335, 97348, 97355, 97358, 97360, 97374, 97377, and 97389) • Marion (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-3, 97305-14, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392)	• Multnomah • Polk • Washington • Yamhill
Kaiser Permanente Senior Advantage	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas • Columbia	• Hood River • Linn (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389)	• Marion • Multnomah • Polk • Washington • Yamhill
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in Oregon counties and nationwide.		
UMP Classic **UMP consumer-directed health plan**	Available in all Oregon counties and worldwide.		

Idaho	
Group Health Classic **Group Health consumer-directed health plan (CDHP)** **Group Health Original Medicare** **Group Health Value**	• Kootenai • Latah
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in Idaho counties and nationwide.
UMP Classic **UMP consumer-directed health plan**	Available in all Idaho counties and worldwide.

2016 Medical Benefits Cost Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB 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 out-of-pocket limit	**Medical out-of-pocket limit**[1] (See separate prescription drug out-of-pocket limit for UMP Classic.)	**Prescription drug deductible**	**Prescription drug out-of-pocket limit**[1]
Group Health				
Group Health Classic	$250/person $750/family	$2,000/person • $4,000/family Your deductible, copays, and coinsurance for all covered services apply.	None	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.
Group Health CDHP Individual	$1,400/person*	$5,100/person Your deductible and coinsurance for all covered services apply.	Prescription drug costs apply toward medical deductible.	
Group Health CDHP Family	$2,800/person $2,800/family*	$5,100/person • $10,200/family Your deductible and coinsurance for all covered services apply.		
Group Health SoundChoice	$250/person $750/family	$3,000/person • $6,000/family Your deductible, copays, and coinsurance for all covered services apply.	None	
Group Health Value	$350/person $1,050/family	$2,000/person • $4,000/family Your deductible, copays, and consurance for all covered services apply.	None	
Kaiser Permanente				
Kaiser Permanente Classic	$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 CDHP	$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.	
Uniform Medical Plan (UMP)[2]				
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 deductible.	Prescription coinsurance applies to the 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	$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.

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	
Group Health							
Group Health Classic	20%	$0; MRI/CT/PET scan $30	20%	$250	$15	You pay any amount over $800 every 36 months for hearing aid and rental/repair combined.	$0
Group Health CDHP	10%	10%	10%	10%	10%		10%
Group Health SoundChoice	20%	20%	20%	$75 + 20%	20%		$0
Group Health Value	20%	$0; MRI/CT/PET scan $40	20%	$300	$20		$0
Kaiser Permanente							
Kaiser Permanente Classic	15%	$10	20%	15%	$35	You pay any amount over $800 every 36 months for hearing aid and rental/repair combined.	15%
Kaiser Permanente CDHP	15%	15%	20%	15%	$30	You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	15%
Uniform Medical Plan (UMP)[2]							
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%

*Must meet family medical or prescription drug deductible before plan pays benefits.

[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)2, and charges for non-covered services do not apply to out-of-pocket limit. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] 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. UMP Plus members will pay 50% coinsurance for most out-of-network providers and non-network providers, plus any amount the out-of-network provider charges over the plan's allowed amount.

(continued)

2016 Medical Benefits Cost Comparison

Benefits (You pay)	**Hospital services**		**Office visit**					
	Inpatient	Outpatient	Primary care	Urgent care	Specialist	Mental health	Chemo-therapy	Radiation
Group Health								
Group Health Classic	$150/day up to $750 maximum/ admission	$150	$15	$15	$30	$15	$15	$30
Group Health CDHP	10%	10%	10%	10%	10%	10%	10%	10%
Group Health SoundChoice	$200/day up to $1,000 maximum/ admission	20%	First visit per calendar year free, then 20%	20%	20%	20%	20%	20%
Group Health Value	$200/day up to $1,000 maximum/ admission	$200	$20	$20	$40	$20	$20	$40
Kaiser Permanente								
Kaiser Permanente Classic	15%	15%	$25	$45	$35	$25	$0	$0
Kaiser Permanente CDHP	15%	15%	$20	$40	$30	$20	$0	$0
Uniform Medical Plan (UMP)[2]								
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%

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
Group Health							
Group Health Classic	$30	$5	$20	$40	50% up to $250	—	—
Group Health CDHP	10%	$5 (at Group Health facilities only)	$20	$40 ($30 at Group Health facilities)	50% up to $250	—	—
Group Health SoundChoice	20%	$5	$15	$60	50%	$150	50% up to $400
Group Health Value	$40	$5	$20	$40	50% up to $250	—	—
Kaiser Permanente							
Kaiser Permanente Classic	$35	—	$15	$40	$75	50% up to $150	—
Kaiser Permanente CDHP	$30	—	$15	$40	$75	50% up to $150	—
Uniform Medical Plan (UMP)[2]							
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)	—	—

[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)2, and charges for non-covered services do not apply to out-of-pocket limit. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] 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. UMP Plus members will pay 50% coinsurance for most out-of-network providers and non-network providers, plus any amount the out-of-network provider charges over the plan's allowed amount.

(continued)

2016 Medical Benefits Cost Comparison

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
Group Health					
Group Health Classic	$10	$40	$80	50% up to $750	—
Group Health CDHP	$10	$40	$60	50% up to $750	—
Group Health SoundChoice	$10	$30	$120	50%	—
Group Health Value	$10	$40	$80	50% up to $750	—
Kaiser Permanente					
Kaiser Permanente Classic	—	$30	$80	$150	50% up to $150
Kaiser Permanente CDHP	—	$30	$80	$150	50% up to $150
Uniform Medical Plan (UMP)[2]					
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)	—

Benefits (You pay)	**Preventive care** See certificate of coverage or check with plan for full list of services.	**Spinal manipulations**	**Vision care**[3]	
			Exam (annual)	Glasses and contact lenses
Group Health				
Group Health Classic	$0	$15	$15	You pay any amount over $150 every 24 months for frames, lenses, and contacts combined.
Group Health CDHP	$0	$20	$20	
Group Health SoundChoice	$0	20%	10%	
Group Health Value	$0	$20	$20	
Kaiser Permanente				
Kaiser Permanente Classic	$0	$35	$25	You pay any amount over $150 every 24 months for frames, lenses, and contacts combined.
Kaiser Permanente CDHP	$0	$30	$20	
Uniform Medical Plan (UMP)[2]				
UMP Classic	$0	15%	$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%		
UMP Plus–PSHVN	$0	15%		
UMP Plus–UW Medicine ACN	$0	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)2, and charges for non-covered services do not apply to out-of-pocket limit. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

[2] 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. UMP Plus members will pay 50% coinsurance for most out-of-network providers and non-network providers, plus any amount the out-of-network provider charges over the plan's allowed amount.

[3] Contact your plan about costs for children's vision care.

2016 Medicare Plan Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB 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. Group Health and Kaiser Permanente offer Medicare Advantage plans, but not in all areas. If you are in an area where a Medicare Advantage plan is not available, your plan will enroll you in its Medicare coordination plan.

Annual Costs	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Medical deductible	$0	$250/person $750/family	$0	$250/person $750/family
Medical out-of-pocket limit[1] (See separate prescription drug out-of-pocket limit for UMP Classic)	$2,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	$2,000/person Your medical deductible, copays, and coinsurance for all covered services apply.	$1,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	$2,500/person $5,000/family Your medical deductible, copays, and coinsurance for most covered services apply.
Prescription drug deductible	None	None	None	$100/person $300/family (Tier 2 and 3 drugs only)
Prescription drug out-of-pocket limit[1]	None	Prescription copays and coinsurance apply to the medical out-of-pocket limit.	None	$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Ambulance Per trip, air or ground	$150	20%	$50	20%
Diagnostic tests, laboratory, and x-rays	$0	$0 MRI/CT/PET scan $30	$0	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	$0	15%
Emergency room Copay waived if admitted	$65	$250	$50	$75 + 15%
Hearing Routine annual exam	$20	$15	$30	$0
Hardware	You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.			You pay amount over $800 every three calendar years for hearing aid and rental/repair combined.

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Hospital services Inpatient	$200/day for the first 5 days, up to $1,000 maximum/ admission	$150/day, up to $750 maximum/ admission	$500/admission	$200/day, up to $600 maximum/ admission + 15% professional fees
Outpatient	$200	$150	$50	15%
Office visit				
Primary care	$20	$15	$30	15%
Urgent care	$20	$15	$35	15%
Specialist	$20	$30	$30	15%
Mental health	$20	$15	$30	15%
Chemotherapy	$0	$15	$0	15%
Radiation	$0	$30	$0	15%
Physical, occupational, and speech therapy	$20	$30 (Per-visit cost for 60 visits/year combined)	$30	15%
Prescription drugs				
Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies				
Value tier	—	$5	—	5% up to $10
Tier 1	$20	$20	$20	10% up to $25
Tier 2	$40	$40	$40	30% up to $75
Tier 3	50% up to $250	50% up to $250	—	50%
Mail order (up to a 90-day supply)				
Value tier	—	$10	—	5% up to $30
Tier 1	$40	$40	$40	10% up to $75
Tier 2	$80	$80	$80	30% up to $225
Tier 3	50% up to $750	50% up to $750	—	50% (up to $150 for specialty drugs; no per-prescription cost-limit for non-specialty drugs)

[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 Classic), 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.

(continued)

2016 Medicare Plan Benefits Comparison

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	**Original Medicare** (coordinates with Medicare)		**Medicare**
	You pay		**You pay**	**You pay**
Preventive care	$0	$0	$0	$0
	See certificate of coverage or check with plan for full list of services.			
Spinal manipulations	$20	$15	$20	15%
Vision care[2]				
Exam (annual)	$20	$15	$30	$0 You pay any amount over $65 for contact lens fitting fees.
Glasses and contact lenses	You pay any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, and contacts combined.)			

[2] Contact your plan about copays and limits for children's vision care.

Outline of Medicare Supplement Coverage
Washington State Health Care Authority

PREMERA | BLUE CROSS

See Outlines of Coverage sections for detail about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available.

Basic Benefits included in all plans:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require subscribers to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance

Plan A	Plan B	Plan C	Plan D	Plan F & Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Hospitalization & preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization & preventive care paid at 100%; other basic benefits paid at 75%	Basic benefits, including 100% Part B coinsurance	Basic including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of pocket limit $4,940 paid at 100% after limit reached	Out of pocket limit $2,470 paid at 100% after limit reached		

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,180 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Washington State Health Care Authority

SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2016)

Eligible By Reason Of Age Subscription Charges - Per Month

PEBB Retiree		PEBB Retiree & Spouse		State Resident		State Resident & Spouse	
Plan F	$109.86	Plan F	$213.69	Plan F	$207.66	Plan F	$415.32

Eligible By Reason Of Disability Subscription Charges - Per Month

PEBB Retiree		PEBB Retiree & Spouse		State Resident		State Resident & Spouse	
Plan F	$209.04	Plan F	$412.05	Plan F	$353.01	Plan F	$706.02

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all certificates like yours in this state.

DISCLOSURES

Use this outline to compare benefits and subscription charges among plans.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The Group policy is the insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your Medicare supplement carrier.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to 7001 220th St. S.W., Mountlake Terrace, Washington 98043-2124. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and all of your payments will be returned.

CERTIFICATE REPLACEMENT

If you are replacing another health insurance certificate, do *NOT* cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

This certificate may not fully cover all of your medical costs. Neither Premera nor its producers are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Be sure to answer truthfully and completely all questions. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

F PLAN F: MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A Deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after: (while using 60 lifetime reserve days)	All but $630 a day	$630 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the plan's Basic Benefits. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(continued)

PLAN F (continued):

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $147 of Medicare approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

MEDICARE (PARTS A & B)

HOME HEALTH CARE - Medicare approved services			
Medically Necessary Skilled Care Services and Medical Supplies	100%	$0	$0
Durable Medical Equipment			
First $147 of Medicare approved amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Selecting a PEBB Dental Plan

Dental Plan Options
Make sure you confirm with your dentist that he or she accepts the **specific plan network** and **plan group**

Plan Name	Plan Type	Plan Administrator	Plan Network	Plan Group
DeltaCare Plan	Managed-care plan	Delta Dental of Washington	DeltaCare PEBB	Group 3100
Willamette Dental Group Plan	Managed-care plan	Willamette Dental Group	Willamette	N/A
Uniform Dental Plan (UDP)	Preferred-provider plan	Delta Dental of Washington	Delta Dental PPO	Group 3000

How do DeltaCare and Willamette Dental Group plans work?

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. 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.

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

Willamette Dental Group administers its own dental network. It does not have a group number.

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).

How does Uniform Dental Plan work?

UDP is a preferred-provider organization (PPO) plan. You can choose any dental provider, and change providers at any time.

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

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 family member, including preventive visits.

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

DeltaCare and Willamette Dental Group are managed-care plans. You must choose a primary dental provider within their networks.

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 your provider to see if he or she is in the plan's network and group number. Make sure you correctly identify your dental plan's network and group number (see table above). You can call the dentist, the dental plan's customer service (listed in the front of this booklet) or use the dental plan network's online directory.

Confirm the selection you've made before you submit your enrollment form.

2016 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	Preferred-provider plan	Managed-care plans	
	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 benefit maximums below.)	You pay amounts over $1,750	No general plan maximum	

Benefits	Preferred-provider plan	Managed-care plans	
	Uniform Dental Plan (UDP) *(Group 3000 Delta Dental PPO)*	**DeltaCare** *(Group 3100)*	**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	

Life Insurance

Can I purchase life insurance when I retire?

The PEBB Program provides life insurance to eligible members through ReliaStar Life Insurance Company. As a PEBB retiree, you may be eligible to purchase life insurance on a self-pay basis through the following options:

1. Portability Provision
2. Conversion of Life Insurance Provision
3. PEBB Retiree Term Life Insurance

Portability Provision

Under the Portability Provision of your PEBB employee life insurance, you can apply to continue your terminated employee Basic Life and Supplemental Life Insurance until age 70 if certain conditions are met. You may elect to decrease your coverage continued under the Portability Provision, but you will not be able to increase it.

The minimum amount of your life insurance that you can apply to continue under the Portability Provision is $5,000. The approved amount will not exceed the lesser of five times your annual earnings or $750,000.

You may also apply to continue your terminated Dependent Basic Life and your Spouse or Registered Domestic Partner Supplemental Life Insurance at the same time you apply to continue your own life insurance coverage under the Portability Provision. Dependent Life Insurance may only be continued if you (the subscriber) continue your life insurance. You may elect to decrease coverage you continue for your dependents under the Portability Provision but you will not be able to increase it.

To continue your and your dependent's life insurance under the Portability Provision, you must apply to ReliaStar Life Insurance **no later than 60 days** after the date your PEBB employee life insurance ends due to retirement.

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

Conversion of Life Insurance Provision

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

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

You must apply to continue your coverage under the Conversion of Life Insurance Provision **no later than 60 days** after the date your PEBB employee life insurance ends due to retirement.

How do I get more information or apply for the Portability or Conversion option?

This section provides a brief description of Portability and Conversion insurance options. To apply for the Portability or Conversion Provision, contact your personnel, payroll, or benefits office to complete your initial application. Both you and your employer have sections to complete on the application. Once the application has been completed, mail it to:

ReliaStar Life Insurance Company
20 Washington Avenue South, Route 4-N
Minneapolis, MN 55440-0020

ReliaStar Life administers both the portability and conversion policies and will provide you with additional information and services once the application is received. You may contact ReliaStar directly at 1-866-689-6990.

PEBB Retiree Term Life Insurance

The PEBB Program offers retiree term life insurance to subscribers who meet the eligibility and procedural requirements defined in WAC 182-12-209. Eligibility is the same as for medical and dental plans, except retiree term life insurance is only available to those who:

- Meet the PEBB Program's retiree eligibility requirements and had life insurance through the PEBB Program as an employee; or

(continued)

- Are retirees of an eligible employer group, Washington State school district, or educational service district who had life insurance through the PEBB Program as active employees; **and**
- Are not on a waiver of premium due to disability.

Your dependents are not eligible for retiree term life insurance.

If you enroll in COBRA between the time you had PEBB employee coverage and the time you become eligible for PEBB retiree coverage, you cannot enroll in retiree term life insurance. The PEBB Program does not offer life insurance to COBRA enrollees and you cannot have a break in life insurance coverage.

If you become disabled after the effective date of this insurance, you must continue making premium payments to keep your insurance in force.

This plan covers death from any cause.

What amount of insurance can I buy?

The amount of insurance paid to your beneficiary is based on your age at the time of death, according to the following schedule:

Age at death	Amount of insurance
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

This insurance has no cash value.

How much is the premium?

The cost is $7.75 per month, regardless of age. Rates are guaranteed through December 31, 2017.

How do I enroll?

Complete the *2016 Retiree Coverage Election/Change* form to elect PEBB retiree term life insurance. The PEBB Program must receive the form **no later than 60 days** after your employer-paid coverage ends. If you enroll when eligible and pay premiums on time, insurance becomes effective on your retirement date.

Who can I name as my beneficiary?

You may name any beneficiary you wish when you complete the enrollment form. If you should die with no named living beneficiary, payment will be made to your survivors in this order:

1. Spouse or domestic partner
2. Children
3. Parents
4. Estate

If you are married and wish to name someone other than your spouse or domestic partner as beneficiary, or if you have special estate planning needs, you should seek legal and tax advice before naming a beneficiary on your *2016 Retiree Coverage Election/Change* form.

How do my survivors file a claim?

If you die, your beneficiary should submit a certified death certificate as soon as possible to Voya Life Claims, P.O. Box 1548, Minneapolis, MN 55440-1548, or call them at 1-866-689-6990. Your beneficiary should also notify the PEBB Program of your death. We may share this information with the Department of Retirement Systems to better serve your survivors.

Where can I get the insurance certificate?

This is a brief summary of the retiree term life insurance plan. If you would like a copy of the complete insurance certificate, contact the PEBB Program at 1-800-200-1004 or P.O. Box 42684, Olympia, WA 98504-2684. This insurance is provided by ReliaStar Life Insurance Company, a member of the Voya™ Financial family of companies.

SmartHealth (for non-Medicare subscribers only)

SmartHealth is the state's voluntary wellness program designed to help you take steps to improve your health by participating in fun and engaging SmartHealth Activities. As you progress on your wellness journey, you can qualify for the SmartHealth financial wellness incentive.

What is the financial wellness incentive?

Subscribers who qualify for the financial wellness incentive can receive:

- A $125 reduction in the subscriber's 2017 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 2017).

Who is eligible to participate?

Subscribers and their spouses or registered domestic partners enrolled in PEBB medical coverage can participate in SmartHealth through the SmartHealth website; however, only the subsribers can quality for the $125 financial wellness incentive.

To qualify for the financial wellness incentive, the subscriber must:

- Not be enrolled in both Medicare Part A and Part B,
- Complete the SmartHeatlh Well-being Assessment, and
- Earn 2,000 total points within the PEBB Program's timelines.

To receive the incentive in 2017, the subscriber must still be enrolled in a PEBB medical plan during 2017.

If a subscriber qualifies for the incentive in 2016, and becomes entitled to Medicare Part A and Part B while enrolled in a PEBB medical plan in 2017, he or she will still receive the SmartHealth incentive in 2017.

How do I get started?

Follow these simple steps to earn points to qualify for the $125 wellness incentive:

Go to **www.smarthealth.hca.wa.gov** and select *Get started* to walk through the activation process.

1. Take the SmartHealth Well-being Assessment (**required** to qualify for the 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.

2. After completing the Well-being Assessment, complete other Activities on SmartHealth's website to earn 2,000 total points to qualify for the $125 wellness incentive.

Deadline requirements

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

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date in January through June, your deadline to qualify for the financial incentive is **September 30, 2016**.
- If your PEBB medical effective date is in July or August, your deadline is **120 days** from your medical effective date.

  Example: *Julie is new to state employment and her PEBB medical effective date is July 1, 2016. Julie's deadline to complete her SmartHealth Activities and earn her financial wellness incentive is October 29, 2016.*

- If your PEBB medical effective date is in September through December, your deadline is **December 31, 2016**.

Auto and Home Insurance

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

What does Liberty Mutual offer?

PEBB members may receive a group discount of up to 12 percent off Liberty Mutual's auto and home insurance rates. In addition to the discount, Liberty Mutual also offers:

- **Discounts** based on your driving record, age, auto safety features, and more.
- **A 12-month guarantee** on competitive rates.
- **Convenient payment options** — including automatic payroll deduction (for employees), electronic funds transfer (EFT), or direct billing at home.
- **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?

You can request a quote for auto or home insurance from Liberty Mutual one of three ways (be sure to have your current policy handy):

- Look for auto/home insurance on PEBB's website at **www.hca.wa.gov/pebb.**
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB member (client #8250).
- 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 members; rates are based on underwriting for each individual and not all participants 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 #8250):

Federal Way	**1-800-826-9183** 33915 1st Way S., Suite 203 Federal Way, WA 98003
Redmond	**1-800-253-5602** 15809 Bear Creek Parkway #120 Redmond, WA 98052
Spokane	**1-800-208-3044** 16201 E. Indiana Ave., Suite 2280 Spokane, WA 99206
Tukwila	**1-800-922-7013** 14900 Interurban Ave., Suite 142 Tukwila, WA 98168
Tumwater	**1-800-319-6523** 1500 Irving Street, Suite 202 Tumwater, WA 98512
Portland, OR	**1-800-248-8320** 650 NE Holladay St., 2nd Floor Portland, OR 97232
Outside Washington	**1-800-706-5525**

Valid Dependent Verification Documents

For retirees not enrolled in Medicare Part A and Part B, and any subscriber enrolling a family member in which eligibility is established through a domestic partner registry or legal union:

Use the list below to determine which verification document(s) to submit with your required form. You may submit one copy of your tax return if it includes all family members that require verification, such as your spouse and children.

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

Copy of document(s) needed if enrolling a spouse (choose one option):

- The most recent year's *1040 Married Filing Jointly* federal tax return that lists the spouse (black out financial information)
- The subscriber's and spouse's most recent *1040 Married Filing Separately* federal tax return (black out financial information)
- Proof of common residence (for example, a utility bill) and marriage certificate*
- Proof of financial interdependency (for 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

Copy of document(s) needed if enrolling based on a registered domestic partnership or legal union (choose one option):

- Proof of common residence (for example, a utility bill) and certificate/card of state-registered domestic partnership or legal union*
- Proof of financial interdependency (for example, a bank statement — black out financial information) and certificate/card of state-registered domestic partnership or legal union*
- Petition for invalidity (annulment) of domestic partnership or legal union
- Petition for dissolution of domestic partnership or legal union
- Legal separation notice of domestic partnership or legal union

Copy of document(s) needed if enrolling children (choose one option):

- The most recent year's federal tax return that includes the child(ren) as a dependent and listed as a son or daughter (black out financial information)
- 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 registered domestic partner**
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration

---

* If within two years of marriage, state-registered domestic partnership, or establishment of a legal union, then only the marriage certificate or certificate/card of state-registered domestic partnership or legal union is required.

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

Learn more at: www.hca.wa.gov/pebb

Completing the Retiree Forms

Please use dark ink to complete the form(s).

New enrollment or enrolling after deferral

Step 1: Check the "2016 Medical Plans Available by County" section in this guide to find the plans available to you.

Step 2: Locate your plan choice in the table on the right and complete the appropriate form(s).

Step 3: Be sure to include all eligible family members you wish to enroll.

Changing plans, and adding or removing family members

Step 1: If you're changing medical or dental plans or adding family members to your coverage, fill out the *2016 Retiree Coverage Election/Change* form (form A).

Step 2: If you are changing medical plans, check the "2016 Medical Plans Available by County" section in this guide to find the plans available to you.

Step 3: Locate your plan choice in the column on the right, and complete and submit the appropriate form(s).

If you are currently enrolled in a Medicare Advantage plan, and change to a plan that is not a Medicare Advantage plan, you will also need to complete a *PEBB Medicare Advantage Plan Disenrollment Form* (form D). You can download this form from **www.hca.wa.gov/pebb** or call the PEBB Program to request one.

Note: If you're adding a registered domestic partner to your coverage and completing form C, he or she should fill out the "spouse" section. You must also provide copies of documents that prove eligibility for your domestic partner.

If you're adding a registered domestic partner, or a domestic partner's child, to your coverage you must also complete and submit the *Declaration of Tax Status* form. You can download this form from **www.hca.wa.gov/pebb** or call the PEBB Program to request one.

Deferring or cancelling enrollment in PEBB benefits

If you're deferring or cancelling enrollment in your PEBB benefits, fill out all Sections marked required in the *2016 Retiree Coverage Election/Change* form (form A), including Section 1 (Subscriber information), Section 9 (Signature section), and if applicable, Section 7 (Retiree Term life insurance) and Section 8 (Payment authorization).

Mail the completed form to the PEBB Program at the address below. The PEBB Program must receive this form **no later than 60 days** after your employer-paid or COBRA coverage ends. You must maintain continuous enrollment in other qualifying insurance coverage.

Please see pages 19-23 in this booklet for complete information on deferring or cancelling your PEBB benefits.

Mail your forms

Complete, sign, and date the form(s) and mail them to:

PEBB Program
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

When sending payment, mail your check or money order to:

Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

Use	to enroll in or make changes to these plans:
Form A only	• Group Health Classic, CDHP, Original Medicare, SoundChoice or Value • Kaiser Permanente Classic or CDHP • Uniform Medical Plan Classic, UMP CDHP, UMP Plus-PSHVN, or UMP Plus-UW Medicine ACN
Forms A and C	• Group Health Medicare Advantage • Kaiser Permanente Senior Advantage
Forms A and B	• Medicare Supplement Plan F, administered by Premera Blue Cross

Retiree Forms Section

2016 Retiree Coverage Election/Change form (form A)
http://www.hca.wa.gov/pebb/Documents/51-403F_2016.pdf

2016 Premium Surcharge Help Sheet
http://www.hca.wa.gov/pebb/Documents/50-226_2016.pdf

Premera Blue Cross Group Medicare Supplement Enrollment Application (form B)
http://www.hca.wa.gov/pebb/documents/premeraB.pdf

Medicare Advantage Plan Election Form (form C)
http://www.hca.wa.gov/pebb/Documents/51-576_2016.pdf

Electronic Debit Service Agreement
http://www.hca.wa.gov/pebb/Documents/42-450.pdf