Employee Enrollment Guide

Your PEBB Benefits for 2015

Washington State
Health Care Authority
Public Employees Benefits Board

Forms Inside

HCA 50-100 (12/14)

Contact the Plans

Medical Plans	Website addresses	Customer service phone numbers	TTY customer service phone numbers (deaf, hard of hearing, or speech impaired)
Group Health Classic, Value, or 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 or CDHP	www.my.kp.org/nw/wapebb	503-813-2000 or 1-800-813-2000	711
Uniform Medical Plan Classic or UMP CDHP, administered by Regence BlueShield	www.hca.wa.gov/ump	1-888-849-3681	711

Health Savings Account Trustee	Website address	Customer service phone number	TTY customer service phone number (deaf, hard of hearing, or speech impaired)
HealthEquity	www.healthequity.net/pebb	1-877-873-8823	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 Group	www.willamettedental.com/wapebb	1-855-4dental (433-6825)

Life Insurance	ReliaStar Life Insurance Company	1-866-689-6990	
Long-Term Disability (LTD) Insurance	Standard Insurance Company	1-800-368-2860	
Flexible Spending Account Dependent Care Assistance Program	Flex-Plan Services, Inc.	www.pebb.flex-plan.com	1-800-669-3539
Auto and Home Insurance	Liberty Mutual Insurance Company	www.hca.wa.gov/pebb/pages/auto_home.aspx	1-800-706-5525
SmartHealth	Limeade	www.smarthealth.hca.wa.gov (available January 1, 2015)	1-855-750-8866 (available January 2, 2015)

Contact the plans for help with:

- Specific benefit questions.
- Verifying if your doctor or other provider contracts with the plan.
- Verifying if your medications are in the plan's drug formulary.
- ID cards.
- Claims.

Contact your employer for help with:

- Enrollment questions and procedures.
- Changing your name, address, and phone number.
- Finding forms.
- Adding or removing dependents.
- Payroll deduction information.
- Eligibility complaints or appeals.
- Life and LTD insurance eligibility and enrollment questions.
- Premium surcharge questions.
- Eligibility question and changes (Medicare, divorce, etc).

Contact your personnel, payroll, or benefits office for help with:

- Eligibility complaints or appeals.

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

Table of Contents

Welcome 4

Eligibility Summary 5
- Who's eligible for PEBB coverage? 5
- Can I cover my family members? 6
- If I die, are my surviving dependents eligible? 6

PEBB Appeals 7
- How can I appeal a decision? 7
- How can I make sure my personal representative has access to my health information? 8

Enrollment Summary 9
- How do I enroll? 9
- Which forms do I use? 9
- Am I required to enroll in this health coverage? 9
- Can I enroll on two PEBB accounts? 10
- When does coverage begin? 10
- What if I'm entitled to Medicare? 11
- How much do the plans cost? 11
- How do I pay for coverage? 12

Making Changes in Coverage 13
- How do I make changes? 13
- What changes can I make during the annual open enrollment? 13
- What is a special open enrollment? 13
- What happens when a dependent loses eligibility? 15
- What if a National Medical Support Notice or court order requires a change? 15

Waiving Medical Coverage 16
- How do I waive coverage? 16
- What if I'm already enrolled in PEBB coverage? 16
- How do I enroll after waiving coverage? 16
- What happens if I don't waive PEBB coverage? 16

When Coverage Ends 17
- When does PEBB coverage end? 17
- What are my options when coverage ends? 17

2015 Monthly Premiums 19

Premium Surcharges 20

Selecting a PEBB Medical Plan 21
- How can I compare the plans? 21
- What do I need to know about the consumer-directed health plans? 22
- How do I find Summaries of Benefits and Coverage? 23

2015 Medical Plans Available by County 24

2015 Medical Benefits Comparison 26

Selecting a PEBB Dental Plan 29

Dental Benefits Comparison 30

Group Term Life and AD&D Insurance 31
- What are my PEBB life and AD&D insurance options? 31
- When can I enroll? 31
- How do I enroll? 31
- Premiums 32

Long-Term Disability Insurance 33
- What are my PEBB long-term disability insurance options? 33
- LTD benefit amounts 33
- Waiting period before benefits become payable 33
- What is considered a disability? 33
- Maximum benefit period 33
- How much does the Optional Plan cost? 34
- When can I enroll? 34
- How do I enroll? 34

FSA and DCAP 35
- What is a flexible spending arrangement? 35
- What is the Dependent Care Assistance Program? 35
- How do I enroll? 35
- When can I change my election in the FSA or DCAP? 35

SmartHealth Wellness Program 36

Auto and Home Insurance 37
- What does Liberty Mutual offer? 37
- When can I enroll? 37
- How do I enroll? 37

Valid Dependent Verification Documents 39

Enrollment Forms
- *2015 Employee Enrollment/Change*
- *2015 Employee Enrollment/Change for Medical Only Groups*
- *Life and AD&D Insurance Enrollment/Change Form*
- *Long Term Disability (LTD) Enrollment/Change Form*

2015 Premium Surcharge Help Sheet 61

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.

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

Welcome

The Public Employees Benefits Board (PEBB) Program, administered by the Health Care Authority (HCA), is pleased to offer you (the employee, as subscriber) insurance coverage that delivers 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.

If you are a state agency or higher-education employee, you have access to medical and dental coverage, life insurance, long-term disability insurance, and the option to enroll in a medical flexible spending arrangement (FSA) and Dependent Care Assistance Program (DCAP).

If you are employed by a school district, county or city government, or other employer group, your employer may offer PEBB medical only or PEBB medical, dental, life, and long-term disability insurance. The FSA and DCAP are not available to school districts and employer groups through PEBB. Check with your personnel, payroll, or benefits office to find what coverage your employer offers and what you may qualify for.

The PEBB Program also provides access to auto and homeowners' insurance.

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 PEB Board meets regularly to review benefit and eligibility issues, and plan for the future.

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 (for state agency and higher-education employees).
- Basic information about your health coverage and other insurance options.
- Medical plans available in your county.

The benefits described 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 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 federal and state laws will govern.

If you have questions not answered in this booklet, please contact your employer's personnel, payroll, or benefits office or visit PEBB's website at **www.hca.wa.gov/pebb** for updates or to find more information.

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* under *My PEBB* in the left navigation panel.

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

Where to find PEBB laws and rules

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

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

Eligibility Summary

Who's eligible for PEBB coverage?

This guide provides a general summary of employee eligibility for benefits administered by the PEBB Program. Your employer will determine if you are eligible for PEBB benefits based on your specific employment circumstances, and whether you qualify for the employer contribution (see WAC 182-12-114 and 182-12-131). If you disagree with the determination, see "How can I appeal a decision?" on page 7.

Find it here

For complete details on PEBB eligibility and enrollment, refer to Washington Administrative Code (WAC) chapter 182-12. You can find these in the *PEBB Rules and Policies* page at **www.hca.wa.gov/pebb**.

Employees

Employees (referred to in this booklet as "employees," "subscribers," or in some cases, "enrollees") are eligible for PEBB benefits upon employment if the employer anticipates the employee will work an average of at least 80 hours per month and at least 8 hours in each month for more than 6 consecutive months.

If the employer revises the employee's anticipated work hours and the employee will work an average of at least 80 hours per month and at least 8 hours in each month for more than 6 consecutive months, the employee becomes eligible when the revision is made.

If the employer determines the employee is ineligible, and the employee later works an average of at least 80 hours per month and at least 8 hours in each month for more than 6 consecutive months, the employee becomes eligible the first of the month following the six-month averaging period.

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

- Employee works two or more positions at the same time; or
- Employee moves from one position or job to another; or
- Employee combines hours from a seasonal position with hours from a non-seasonal position.

Employees must notify their employer if they believe they are eligible for benefits based on stacking.

Higher-education faculty

Faculty are eligible for PEBB benefits if the employer anticipates they will work half-time or more for the entire instructional year or equivalent nine-month period.

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

Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria above, become eligible when the revision is made.

Faculty may become eligible by working as faculty for more than one state higher-education institution. When a faculty member works for more than one higher-education institution, the faculty member must notify both of his or her employers that he or she works at more than one institution and may be eligible for PEBB benefits through stacking.

Faculty may continue any combination of medical, dental, and life insurance coverage during periods when they are not eligible for the employer contribution by self-paying for the benefits (for a maximum of 12 months). See WAC 182-12-142 for continuation coverage information.

Seasonal employees

Seasonal employees are eligible if they work, or the employer anticipates they will work, an average of at least 80 hours per month and for at least 8 hours in each month of the season. (A season is any recurring, cyclical period of work at a specific time of year that lasts 3 to 11 months.)

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

A seasonal employee who is determined ineligible for benefits, but who later works an average of at least 80 hours per month and works for at least 8 hours in each month for more than 6 consecutive months, becomes eligible the first of the month following the 6-month averaging period.

If a seasonal employee works in more than one position or job within one

(continued)

state agency, the employee may stack or combine hours to establish and maintain eligibility. See WAC 182-12-114(2) for details on when a seasonal employee becomes eligible.

A benefits-eligible seasonal employee who works a season of nine months or more is also eligible for the employer contribution through the off season following each season worked. A benefits-eligible seasonal employee who works a season of less than 9 months is not eligible for the employer contribution during the off season, but may continue enrollment between periods of eligibility for a maximum of 12 months by self-paying for the benefits. See WAC 182-12-142 for continuation coverage information.

Elected and appointed officials

Legislators are eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

Justices and judges

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

Can I cover my family members?

You may enroll the following family members (also referred to in this booklet as "dependents"):

- Your lawful spouse.
- Your registered domestic partner. (including a state-registered domestic partner as defined in RCW 26.60.020[1]), or a domestic partner who qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and has been continuously enrolled under your PEBB health plan or PEBB life insurance).
- Your children. Children are eligible up to age 26, except as described below for children with a developmental disability or physical handicap.

  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.

  In addition, children include extended dependents in your, 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 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 subscriber for support and ongoing care, provided the condition occurred before age 26. You must provide proof of the disability and proof 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.

If adding an extended dependent, or a dependent with a disability age 26 or older, you must complete the appropriate dependent certification forms in addition to your enrollment form. You can find these forms at **www.hca.wa.gov/pebb**.

The PEBB Program verifies the eligibility of all dependents and reserves the right to request proof of a dependent's eligibility. Your personnel, payroll, or benefits office must receive your completed enrollment form **no later than 60 days** after your dependent is no longer eligible.

The PEBB Program will not enroll a dependent if it cannot verify a dependent's eligibility. You can find a list of documents you must provide to verify your dependent's eligibility on page 39.

If I die, are my surviving dependents eligible?

As an eligible employee, your surviving spouse, registered domestic partner, or child may be eligible to enroll in PEBB retiree insurance if they meet both the procedural and eligibility requirements outlined in WAC 182-12-265.

PEBB Appeals

How can I appeal a decision?

If you or your dependent disagrees with a specific decision or denial, you or your dependent may file an appeal. You can find guidance on filing an appeal in chapter 182-16 WAC and at **www.hca.wa.gov/pebb** under *File an Appeal*, or contact the PEBB Appeals Manager at 1-800-351-6827 or **pebappeals@hca.wa.gov**.

If you are ...	And your appeal concerns ...	Follow these instructions:
A state agency or higher-education employee (or the dependent of one)	A decision by your employer regarding eligibility for or enrollment in: • Medical. • Dental. • Life insurance. • Long-term disability insurance. A decision by your employer regarding premium surcharges.	Submit the *Request for Review/Notice of Appeal* form to your employer. Your employer's personnel, payroll, or benefits office must receive the form **no later than 30 days** after the date of the denial notice for the decision you are appealing.
	A decision by your employer in response to a request for a review (for example, after the employer completes and returns Section 5 on the *Request for Review/Notice of Appeal* form to you).	Submit the *Request for Review/Notice of Appeal* form to the PEBB Program. Be sure to sign and date Section 6 of the form. The PEBB Program must receive the form **no later than 30 days** after the date of the employer's denial notice for the decision you are appealing.

	A decision from the Public Employees Benefits Board (PEBB) Program regarding:
	• Eligibility and enrollment in:
	  • Premium payment plan.
	  • Flexible spending arrangement (FSA).
	  • Dependent Care Assistance Program (DCAP).
	• Eligibility to participate in the PEBB (SmartHealth) wellness program or receive a wellness incentive.
	• Premium surcharges.
	• Premium payments.
		Submit the *Request for Review/Notice of Appeal* form to:
		Health Care Authority
		PEBB Appeals
		P.O. Box 42699
		Olympia, WA 98504-2699
		PEBB Appeals must receive the form **no later than 30 days** after the date of the denial notice for the decision you are appealing.

An employee (or the dependent of one) of: • A county • A municipality • A political subdivision • A tribal government • A school district • An educational service district • The Washington Health Benefits Exchange • An employee organization representing state civil service employees	A decision by your employer regarding: • Eligibility for and enrollment in medical and dental. • Premium surcharges.	Contact your employer for information on how to appeal its decision or action.
	A decision by your employer, a PEBB insurance carrier, or the PEBB Program regarding: • Eligibility for or enrollment in life insurance. • Eligibility for or enrollment in long-term disability insurance. • Eligibility to participate in the PEBB (SmartHealth) wellness program or receive a PEBB wellness incentive.	Submit the *Request for Review/Notice of Appeal* form to: Health Care Authority PEBB Appeals P.O. Box 42699 Olympia, WA 98504-2699 PEBB Appeals must receive the form **no later than 30 days** after the date of the denial notice for the decision you are appealing.

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PEBB Appeals

If you are ...	And your appeal concerns ...	Follow these instructions:
Seeking a review of a decision by a PEBB health plan, insurance carrier, or benefit administrator	A benefit or claim—for example: • Medical. • Dental. • Life insurance. • Long-term disability insurance. • Flexible spending arrangement (FSA) reimbursement claim. • Dependent Care Assistance Program (DCAP) reimbursement claim. • Auto or home insurance. SmartHealth appeals regarding: • Completion of the wellness incentive program requirements. • A reasonable alternative request.	Contact the PEBB health plan, insurance carrier, or benefit administrator to request information on how to appeal its decision.

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

You must provide us with a copy of a valid power of attorney or a completed *Authorization for Release of Information* form naming your representative and authorizing him or her to access your medical records and 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/pages/forms.aspx**.

Enrollment Summary

How do I enroll?

It's important to submit your forms within the required timelines. Your personnel, payroll, or benefits office must receive the following forms within these timelines after you become eligible for PEBB benefits:

- *Employee Enrollment/Change* or *Employee Enrollment/Change for Medical Only Groups* form: **No later than 31 days**
- *Long Term Disability (LTD) Enrollment/Change Form:* **No later than 31 days**
- *Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form:* **No later than 60 days**

Generally, an employee becomes eligible the first day of employment; ask your personnel, payroll, or benefits office when your eligibility begins.

If you enroll family members on your PEBB coverage, you must provide proof of their eligibility within PEBB's enrollment timelines or the family members will not be enrolled. A list of documents we will accept as proof is on page 39.

If your personnel, payroll, or benefits office doesn't receive your completed form(s) and verification documents for your dependents (if any) within the 31-day window, we will enroll you as a single subscriber in Uniform Medical Plan (UMP) Classic, and Uniform Dental Plan (UDP), basic life insurance, and basic long-term disability (LTD) insurance (if your employer offers these coverages). If enrolled as a single subscriber due to missed timelines, you will owe medical premiums back to your effective date for PEBB benefits. Your dependents (if any) will not be enrolled. You cannot change plans or enroll your eligible dependents until the next annual open enrollment, unless you have a special open enrollment event that allows the change.

For more information on enrollment timelines for the life insurance, long-term disability insurance, flexible spending arrangement (FSA), Dependent Care Assistance Program (DCAP), and the SmartHealth wellness program, see pages 31–36. You can enroll in auto or home insurance at any time.

Which forms do I use?

You will find these forms in the back of this guide:

- If your employer offers PEBB medical, dental, life, and LTD insurance coverage, complete the *Employee Enrollment/Change* form (for medical and dental coverage); *Life and AD&D Enrollment/Change Form* (for life insurance); and *Long-Term Disability (LTD) Enrollment/Change Form* (for long-term disability insurance).
- If your employer offers PEBB medical coverage only, complete the *Employee Enrollment/Change for Medical Only Groups*.

To enroll in other PEBB-sponsored benefits:

- FSA or DCAP—Visit **www.pebb.flex-plan.com**.
- Auto/home insurance—Visit **www.hca.wa.gov/pebb/pages/auto_home.aspx** to find a local office or call Liberty Mutual Insurance Company at 1-800-706-5525.

If you enroll the family members shown in the box below, you must also complete the appropriate forms.

Am I required to enroll in this health coverage?

Employees may waive PEBB medical coverage if they are enrolled in other employer-based group health insurance. If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical coverage.

If your employer offers PEBB dental, basic life, and basic LTD insurance, you must enroll in these coverages for yourself.

See "Waiving Medical Coverage" on page 16 for instructions and timelines for waiving PEBB medical coverage.

Additional required forms

If enrolling a ...	... then complete this form
Registered domestic partner (or a domestic partner's child)	*Declaration of Tax Status*
Dependent child with a disability	*Certification of Dependent With a Disability* (or your medical plan's certification form)
Extended (legal) dependent child	*Extended Dependent Certification*

Find it here

If you need more forms, go to **www.hca.wa.gov/pebb** or contact your personnel, payroll, or benefits office.

For complete details on PEBB enrollment, refer to chapters 182-08 and 182-12 WAC. You can find these in the *PEBB Rules and Policies* page at **www.hca.wa.gov/pebb.**

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Enrollment Summary

Can I enroll on two PEBB accounts?

No. If you and your spouse or registered domestic partner are both eligible for PEBB benefits, 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. You could waive medical coverage for yourself, and enroll as a dependent on your spouse's or registered domestic partner's medical coverage. **However, you must enroll in dental, basic life, and basic LTD insurance under your own account.** See "Waiving Medical Coverage" on page 16.

ID cards

After you enroll, your plan(s) will send you an identification (ID) card to show providers when you receive care. If you have questions about your ID card, contact your plan directly.

(The Uniform Dental Plan does not mail ID cards, but you may download one from the plan's website.)

When does coverage begin?

When newly eligible—Medical, dental, basic life, and basic LTD insurance coverage begins on the first day of the month after an employee becomes eligible for PEBB benefits (generally the first day of employment). If the employee becomes eligible on the first working day of the month, these PEBB benefits begin on that day.

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

When making a change during annual open enrollment or when a special open enrollment event occurs—Coverage will begin as noted in the table below. For annual open enrollment, the appropriate form(s) and proof of your dependent's eligibility must be received no later than the last day of the annual open enrollment.

Annual event	When coverage begins
Open enrollment (November 1-30)	January 1 of the following year
Special open enrollment events	**When coverage begins**
Marriage or establishment of a registered domestic partnership	The first day of the month after the date of the event or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that day.
Birth or adoption	The date of birth (newborn children), adoption, or the date you assume legal obligation for the child's support in anticipation of adoption. **Note:** If the child's date of birth or adoption is before the 16th day of the month, you pay the higher premium for the full month (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th, the higher premium will begin the next month. If you add your eligible spouse or registered domestic partner to your PEBB coverage due to your child's birth or adoption, his or her medical coverage begins the first day of the month in which the birth or adoption occurs. Basic Dependent Life Insurance for newborns (if elected) begins on the 14th day after birth.
Child becomes eligible as a dependent with a disability, or an extended dependent	The first day of the month after eligibility certification.
Other events that create a special open enrollment (see page 14)	The first day of the month after the event date or the date your personnel, payroll, or benefits office receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that day.

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

For a special open enrollment, the completed form(s) and proof of your dependent's eligibility and/or the event must be received **no later than 60 days** after the special open enrollment event. In many instances, the date you turn in your form affects the date that coverage begins; you may want to turn the form in sooner. When the special open enrollment is for birth or adoption, the forms and proof of your dependents' eligibility and/or the event must be received as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the enrollment form must be received no later than 12 months after the date of birth, adoption, or the date you assume legal obligation for total or partial support in anticipation of adoption. See "What is a special open enrollment?" on page 13 for more information and a list of special open enrollment events starting on page 14.

What if I'm entitled to Medicare?

Medicare Parts A and B

When you or your covered dependents become entitled to Medicare, the person entitled to Medicare should contact the nearest Social Security office to ask about the advantages of immediate or deferred enrollment in Medicare Part B.

For employees and their enrolled spouses ages 65 and older, PEBB medical plans provide primary coverage, and Medicare coverage is ordinarily secondary. However, you may choose to refuse the PEBB medical plan in favor of Medicare coverage. **If you want to refuse the PEBB medical plan, you must notify the PEBB Program in writing.** If you refuse the PEBB medical plan, you can reenroll during the annual open enrollment (for coverage effective January 1 of the following year) or if you have a special enrollment event that allows the change. However, you will remain enrolled in PEBB dental, life, and long-term disability coverage.

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

Medicare guidelines direct that registered domestic partners who are ages 65 and older must have Medicare as their primary insurer, if entitled.

Medicare Part B

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

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

Medicare Part D

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

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

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

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

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

How much do the plans cost?

For state agency and higher-education employees, see the "2015 Monthly Premiums" on page 19. There are no employee premiums for dental, basic life and basic long-term disability benefits. School district employees and those who work for a city, tribal government, county, port, water district, hospital, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

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

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

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Some subscribers must also pay a surcharge in addition to their medical plan's monthly premium:

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

For more details on whether these surcharges will apply to you, see "Premium Surcharges" on page 20.

How do I pay for coverage?

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

Why should I pay my monthly premiums with pretax dollars?

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

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

No. If you are a new employee who enrolls in a medical plan, and your employer offers this benefit, your payroll office may automatically have the premiums deducted before calculating taxes. If you do not want to pay your medical premiums with pretax earnings, your personnel, payroll, or benefits office must receive your completed *Premium Payment Plan Election/Change Form* to waive (opt out of) participation in the premium payment plan **no later than 31 days** after you become eligible for PEBB benefits (generally the first day of employment; see WAC 182-12-114). The form is available from your personnel, payroll, or benefits office.

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

You may only change your participation under the state's premium payment plan (enroll, waive enrollment, or change election) during an annual open enrollment or a special open enrollment as described in WAC 182-08-199.

How do I pay the premium surcharges?

If you elect to pay your PEBB medical premiums with pretax earnings, any applicable surcharges will also be deducted pretax. (Premiums and applicable surcharges are automatically deducted from your paycheck before taxes unless you request otherwise.)

If you do not want your PEBB medical premiums or surcharges paid with pretax earnings, you must complete and submit the *Premium Payment Plan Election/Change Form* to your personnel, payroll, or benefits office **no later than 31 days** after you become eligible for PEBB benefits. **Exception:** If you enroll a registered domestic partner and he or she does not qualify as an Internal Revenue Code Section 152 dependent, the $50 monthly premium surcharge (if it applies to you) will be a post-tax deduction from your paycheck.

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

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

- **Social Security**—If your base salary is under the annual maximum, Section 125 participation saves you money now by reducing your Social Security taxes. However, your lifetime Social Security benefit would be calculated using the lower salary. The 2015 annual maximum is $118,500.
- **Unemployment compensation**—Section 125 also reduces the base salary used to calculate unemployment compensation.

To learn more about Section 125, talk to a qualified financial planner or the local Social Security office.

PEBB forms and frequently asked questions and answers are available at **www.hca.wa.gov/pebb.**

Making Changes in Coverage

How do I make changes?

To make changes to your enrollment or health plan elections, your personnel, payroll, or benefits office must receive the appropriate form(s) during the annual open enrollment or when a special open enrollment event occurs, within the PEBB Program's timelines noted below.

What changes can I make during the annual open enrollment?

To make any of the changes below, your personnel, payroll, or benefits office must receive the appropriate form(s) during the annual open enrollment (usually November 1–30). You may also make some of these changes online during open enrollment using *My Account* at **www.hca.wa.gov/pebb**. The enrollment change will become effective January 1 of the following year.

During the annual open enrollment, you can:	By submitting this form:
• Change your medical or dental plans. • Enroll or remove eligible dependents. • Enroll in a medical plan, if you previously waived PEBB medical coverage for other employer-based group medical insurance coverage (see "Waiving Medical Coverage" on page 16). • Waive enrollment in PEBB medical coverage if you have or are enrolling in other employer-based group medical insurance effective January 1 (see "Waiving Medical Coverage" on page 16).	*Employee Enrollment/ Change* form (if you have PEBB medical, dental, life, and long-term disability insurance) OR *Employee Enrollment/ Change for Medical Only Groups* (if you have PEBB medical coverage only)
• Enroll or re-enroll in a medical flexible spending arrangement (PEBB benefits-eligible state agency and higher-education employees only). • Enroll or re-enroll in the Dependent Care Assistance Program (PEBB benefits-eligible state agency and higher-education employees only).	*Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form* OR Enroll at **www.pebb.flex-plan.com**. (Check the enrollment form for submission directions).
Change your election under the state's premium payment plan (see "How do I pay for coverage?" on page 12).	*Premium Payment Plan Election/Change Form*

What is a special open enrollment?

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

To make a change, your personnel, payroll, or benefits office must receive the appropriate *Employee Enrollment/ Change* form **no later than 60 days** after the event that created the special open enrollment. In many instances, the date you turn in your form affects the date that coverage begins; see the table on page 10 for effective dates. However, if adding a newborn or newly adopted child, and adding the child increases your premium, your employer must receive this form no later than 12 months after the birth or adoption.

Premium surcharge reminders:

When you enroll a dependent on your PEBB medical coverage, you must attest on your enrollment form to whether the tobacco use and spousal coverage premium surcharges apply. See the *2015 Premium Surcharge Help Sheet* starting on page 57 for more details.

(continued)

Making Changes in Coverage

If this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical coverage	Enroll after waiving PEBB medical coverage
Marriage or registering a domestic partnership	Yes	Yes	Yes	Yes	Yes
Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption	Yes	Yes	Yes	Yes	Yes
Child becoming eligible as an extended dependent	Yes	No	Yes	No	Yes
Child becoming eligible as a dependent with a disability	Yes	No	Yes	No	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	No	Yes	No	Yes
Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for their employer contribution toward employer-based group health insurance	Yes	Yes	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	Yes	No	Yes	Yes
Subscriber's dependent moving from outside the United States to live within the United States, or from within the United States to live outside of the United States	Yes	Yes	No	Yes	Yes
Subscriber or dependent having a change in residence that affects health plan availability	No	No	Yes	No	No
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	No	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	Yes	Yes
Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP	Yes	No	Yes	No	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	No	Yes	No	No

(continued)

If this event happens ...	These changes may be permitted as a special open enrollment:				
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical coverage	Enroll after waiving PEBB medical coverage
Subscriber's or dependent's current health plan becoming unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA)	No	No	Yes	No	No
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	No	Yes	No	No

For more information, see Policy 45-2A at **www.hca.wa.gov/pebb** under *PEBB Rules and Policies*.

What happens when a dependent loses eligibility?

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

Consequences for not submitting the form within **60 days** after your dependent loses eligibility may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation options described on page 17.
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- The subscriber may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

What if a National Medical Support Notice or court order requires a change?

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

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

- If you have previously waived PEBB medical coverage, you will be enrolled in UMP Classic unless otherwise directed by the NMSN or court order in order to enroll the dependent.
- If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN or court order. The dependent will be removed the last day of the month the NMSN or court order is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

Health plan enrollment will begin the first day of the month following receipt of the NMSN or court order. If the NMSN or court order is received on the first day of the month, the change to health plan enrollment will begin on that day.

Waiving Medical Coverage

How do I waive coverage?

Employees may waive PEBB medical coverage if they are enrolled in other employer-based group medical insurance. **If you waive coverage for yourself, you cannot enroll your eligible dependents in PEBB medical coverage.**

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

To waive medical coverage, your employer must receive your completed *Employee Enrollment/Change* form indicating that you want to waive enrollment in medical coverage **no later than 31 days** after the date you become eligible for PEBB benefits (this is generally the first day of employment), or during an annual or special open enrollment as described on page 13.

Note: If you waive PEBB medical coverage:

- The premium surcharges will not apply to you. (See "Premium Surcharges" on page 20 for more details.)
- You will not be eligible for the $125 SmartHealth wellness incentive.

What if I'm already enrolled in PEBB coverage?

If you are a newly eligible employee who is already enrolled in PEBB coverage as a dependent under your spouse's, registered domestic partner's, or parent's account, you may either choose to:

- **Waive PEBB medical coverage, and stay enrolled in medical under your spouse's, registered domestic partner's, or parent's account.** You must still enroll in PEBB dental, basic life, and basic long-term disability insurance (if your employer offers them) under your own account. To do this, your personnel, payroll, or benefits office must receive your completed *Employee Enrollment/Change form, Life and Accidental Death and Dismemberment (AD&D) Insurance Enrollment/Change Form*, and *Long Term Disability (LTD) Enrollment/Change Form.* In addition, if you are enrolled in dental coverage under your spouse, partner, or parent, he or she must also complete and submit the *Employee Enrollment/Change* or *Retiree Coverage Election/Change* form to remove you from their dental coverage to prevent dual enrollment in dental coverage.

OR

- **Enroll in PEBB medical coverage under your own account.** To do this, complete the forms listed above. In addition, your spouse, domestic partner, or parent will also need to complete and submit the appropriate enrollment/change form(s) to remove you from their account to prevent dual medical and/or dental coverage.

How do I enroll after waiving coverage?

Once you waive PEBB coverage, you may reenroll. Your personnel, payroll, or benefits office must receive your completed *Employee Enrollment/Change* form before the end of the annual open enrollment or **no later than 60 days** after a special open enrollment event that allows for enrollment. In many instances, the date they receive your form affects the date that coverage begins; you may want to turn the form in sooner. The PEBB Program will require you to provide proof of eligibility and proof of the event that creates a special open enrollment.

For more information, see WAC 182-12-128.

What happens if I don't waive PEBB coverage?

If your personnel, payroll, or benefits office does not receive a completed enrollment form indicating your intent to waive medical coverage within the required timelines, we will enroll you as a single subscriber in Uniform Medical Plan (UMP) Classic, and Uniform Dental Plan (UDP), basic life insurance, and basic long-term disability (LTD) insurance (if your employer offers these coverages). If defaulted as a single subscriber, you will owe medical premiums back to your effective date for PEBB benefits. Your dependents (if any) will not be enrolled.

When Coverage Ends

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. To remove a dependent, your personnel, payroll, or benefits office must receive a completed *Employee Enrollment/ Change* form **no later than 60 days** after the date he or she lost eligibility.
- When you or a dependent misses a required enrollment timeline or chooses not to continue enrollment in a PEBB health plan under one of the options for continuing PEBB benefits, then coverage ends on the last day of the month in which you or your dependent loses eligibility under PEBB rules.

The PEBB Program charges a full month's premium for each calendar month of coverage. If an enrollee dies before the end of the month, premium payments are not prorated.

What are my options when coverage ends?

You, your dependents, or both may be able to temporarily continue your PEBB coverage by self-paying the premiums, with no contribution from your employer, after eligibility ends.

Options for continuing coverage vary based on the reason you lost eligibility. The PEBB Program will mail a *PEBB Continuation of Coverage Election Notice* booklet to you or your dependent when employer-paid coverage ends. This booklet further explains the options listed below, and includes enrollment forms to apply for continuation coverage.

You or your eligible family members must submit the appropriate election form to the PEBB Program **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.

There are four possible continuation coverage options you and your eligible family members may qualify for:

1. COBRA
2. PEBB Extension of Coverage
3. Leave Without Pay (LWOP) coverage
4. PEBB retiree coverage

The first three options temporarily extend PEBB health coverage in certain circumstances when you would otherwise lose medical and dental coverage.

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

PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA.

LWOP coverage is an alternative that is available to employees in specific situations (such as a layoff, educational leave, or when called to active duty in the uniformed services, etc.).

PEBB retiree coverage is available only to:

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

The PEBB Program administers all four continuation coverage options. For information about your rights and obligations under PEBB rules and federal law, refer to your *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet (mailed to you after you enroll in PEBB coverage) or the *PEBB Continuation of Coverage Election Notice* booklet for specific details, or call the PEBB Program at 1-800-200-1004.

What happens to my FSA or DCAP funds when coverage ends?

Participation in the FSA typically ends when your employment ends or you go on unpaid leave that is not approved under the Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA). This means you can claim expenses, up to your available funds, incurred during your employment but, generally, you cannot claim any expenses incurred after you leave employment unless you continue your FSA coverage under COBRA. If you are eligible to continue coverage under COBRA or approved Leave Without Pay (see WAC 182-12-133), you may also extend your FSA COBRA coverage to the end of the plan year so you may claim expenses incurred after your employment ends or your unpaid leave begins.

To continue your participation in the FSA under COBRA or Leave Without Pay for the remainder of the calendar year, you must contact Flex-Plan Services **within 60 days** of the event that ends your employment or when your unpaid leave begins. If you elect to continue your FSA coverage under COBRA, your continued contributions will be made on a post-tax basis. Please contact Flex-Plan Services at 1-800-669-3539 or send an email to **customerservice@flex-plan.com** for more information.

(continued)

When Coverage Ends

If you terminate employment and have unspent DCAP funds, you may continue to submit claims for eligible expenses up to your account balance as long as the expenses for care allow you to look for work or work full-time. You cannot incur expenses after December 31 of the plan year but you may submit claims up to March 31 of the following year.

What happens to my HSA when coverage ends?

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

If you set up automatic payroll deductions to your HSA, contact your payroll office to stop them. If you set up direct deposits to your HSA, contact HealthEquity to stop them.

See "Selecting a PEBB Medical Plan" starting on page 21 to learn more about the CDHP/HSA options.

2015 Monthly Premiums

For state agency and higher-education employees

There are no employee premiums for dental, basic life, and basic long-term disability benefits.

School district employees and employees who work for a city, tribal government, county, port, water district, hospital, etc., must contact their personnel, payroll, or benefits office to get their monthly premiums.

PEBB Medical Plans	Employee	Employee & Spouse*	Employee & Child(ren)	Full Family
Group Health Classic	$107	$224	$187	$304
Group Health Consumer-Directed Health Plan (with a health savings account)	26	62	46	82
Group Health Value	75	160	131	216
Kaiser Permanente Classic	125	260	219	354
Kaiser Permanente Consumer-Directed Health Plan (with a health savings account)	35	80	61	106
Uniform Medical Plan Classic, administered by Regence BlueShield	84	178	147	241
UMP Consumer-Directed Health Plan (with a health savings account)	31	72	54	95

* or registered domestic partner

Monthly Premium Surcharges

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

- A monthly $25-per-account surcharge will apply if you or any family member enrolled in PEBB medical coverage uses tobacco products.
- A monthly $50 surcharge will apply if you enroll your spouse or registered domestic partner in PEBB medical coverage and the spouse or domestic partner has chosen not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.

See "Premium Surcharges" on page 20 for more information.

Premium Surcharges

In 2013, the Legislature established two new premium surcharges to go into effect July 1, 2014:

- Tobacco use premium surcharge
- Spouse or registered domestic partner coverage premium surcharge

These surcharges apply to PEBB benefits-eligible subscribers who:

- Are enrolled in a PEBB medical plan.

AND

- Do not have Medicare Part A and Part B as their primary coverage.

Tobacco use premium surcharge

You will pay a monthly $25 surcharge in addition to your medical plan premium if you or a family member enrolled on your PEBB medical coverage has used a tobacco product in the past two months (whether your enrolled family member lives with you or not).

To determine whether the tobacco use surcharge applies to your account, use the *2015 Premium Surcharge Help Sheet* (found on page 61) and respond by completing and submitting the *2015 Employee Enrollment/Change Form* or *2015 Employee Enrollment/Change Form for Medical Only Groups*. If your form responding to whether the tobacco use surcharge applies to you is not **received within 31 days** of becoming eligible for PEBB benefits, you will pay the monthly $25 surcharge.

To report a change

If you or your enrolled family members' tobacco use changes (or you or your family members have used the tobacco cessation resources mentioned in the *2015 Premium Surcharge Help Sheet*), you may report the change one of two ways:

- Go to *My Account* at **www.hca.wa.gov/pebb** to change your attestation.

OR

- Complete and submit a *2015 Premium Surcharge Change Form* (found at **www.hca.wa.gov/pebb**) to your personnel, payroll, or benefits office.

If you submit a change that adds or removes a surcharge, the change will take effect the month after the change is made. If you enter a change on the first day of the month, the change will be made that month.

Spouse or registered domestic partner coverage premium surcharge

You will pay a monthly $50 surcharge in addition to your medical plan premium if you have a spouse or registered domestic partner enrolled on your PEBB medical coverage, and your spouse or registered domestic partner has chosen not to enroll in employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic. (This is regardless of whether you enroll in UMP Classic.) If you do not enroll a spouse or registered domestic partner on your PEBB medical plan, this surcharge does not apply to you.

If you enroll a spouse or registered domestic partner on your PEBB medical plan, use the *2015 Premium Surcharge Help Sheet* (found on page 61) to determine whether the spouse or registered domestic partner coverage surcharge applies to your account. Then respond by completing and submitting the *2015 Employee Enrollment/Change Form* or *2015 Employee Enrollment/Change Form for Medical Only Groups*. If your form responding to whether the spouse or registered domestic partner coverage surcharge applies to you is not **received within 31 days** of becoming eligible for PEBB benefits, you will pay the monthly $50 surcharge. If you enroll a spouse or registered domestic partner on your PEBB medical plan, you must attest each year during the PEBB annual open enrollment.

To report a change

Outside of the PEBB Programs's annual open enrollment, the following events allow the employee to make a new attestation to add or remove the spousal coverage premium surcharge:

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

You may report the change one of two ways:

- Go to *My Account* at **www.hca.wa.gov/pebb** to change your attestation.

OR

- Complete and submit a *2015 Premium Surcharge Change Form* (found at **www.hca.wa.gov/pebb**) to your personnel, payroll, or benefits office.

If you submit a change that adds or removes a surcharge, the change will take effect the month after the change is made. If you enter a change on the first day of the month, the change will be made that month.

For more information on the premium surcharges, visit **www.hca.wa.gov/pebb** and select *Surcharges.*

Selecting a PEBB Medical Plan

How can I compare the plans?

All medical plans cover the same basic health care services, but vary in other ways such as provider networks, premiums, your out-of-pocket costs, and drug formularies.

For example, the consumer-directed health plans (CDHPs) have the lowest monthly premiums, but they also have higher annual deductibles and higher-out-of-pocket maximums.

Group Health and Kaiser Permanente are managed-care plans. These plans require you to select a primary care provider (PCP) within its network to fulfill or coordinate all of your health needs. These plans may not pay for benefits if you see a non-contracted provider.

The Uniform Medical Plan (UMP) is a preferred-provider organization (PPO) administered by Regence BlueShield. This plan is available anywhere in the world. A PPO allows you to self-refer to any approved provider type in most cases. However, 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 the network.

Find it here

See a side-by-side comparison of the medical plans' benefits and costs on pages 26–28.

Use an interactive comparison tool, find links to each plan's website, or view a summary of benefits at **www.hca.wa.gov/pebb.**

See premiums for all PEBB medical plans on page 19.

Remember, if you cover eligible dependents, everyone must enroll in the same medical and dental plans. To choose a plan that best meets your needs, here are some things to consider:

Cost. 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. **If you are employed by a school district, city, county, tribal government, port, water district, hospital, or other employer group, contact your personnel, payroll, or benefits office to find your monthly premium.**

Your costs also include:

- **Deductible.** All medical 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 benefits are exempt from the medical plans' deductibles. This means you do not have to pay your deductible before the plan pays for the service.

  Note: If you enroll in a CDHP, keep in mind:

  - If you cover one or more family members, you must pay the entire family deductible before the plan begins paying benefits.
  - Although the CDHPs don't have a separate prescription-drug deductible, your prescription-drug costs are subject to the CDHP annual deductible.

- **Coinsurance or copays.** PEBB's managed-care plans require you to pay a fixed amount (called a copay) or percentage of an allowed fee (called a coinsurance) when you receive network care. UMP Classic and the CDHPs usually require members to pay coinsurance.

- **Out-of-pocket limit.** The annual out-of-pocket limit is the most you pay in a calendar year. 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 you incur during the year, such as your annual deductible, copays, and coinsurance, count toward your out-of-pocket limit. However, here are a few costs that do not apply toward your 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. 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 22.

Geography. In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on pages 24-25. 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 health-care services.

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Your provider. If you have a long-term relationship with your doctor or health-care provider, you should verify whether he or she is in the plan's network. Contact the provider or plan before you select a plan.

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 also should keep paperwork received from their provider or for qualified health care expenses to verify eligible payments or reimbursements from their health savings account.

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

Note: If you have other comprehensive health coverage, you may not enroll in a consumer-directed health plan with a health savings account. Call HealthEquity at 1-877-873-8823 to ask about certain exceptions.

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

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 are enrolled in Medicare 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 Employees' Beneficiary Association Medical Expense Plan (VEBA MEP) account, unless you convert it to a limited-purpose VEBA MEP.
- 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 flexible spending arrangement (FSA) or health reimbursement arrangement (HRA). This also applies if your spouse has an FSA, even if you are not covering your spouse on your CDHP. This does not apply if the FSA or HRA is a limited purpose account, or for a post-deductible FSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. Check IRS *Publication 969—Health Savings Accounts and Other Tax-Favored Health Plans*, contact your tax advisor, or call HealthEquity (the HSA trustee for Group Health, Kaiser Permanente, and UMP) toll-free at 1-877-873-8823 to verify whether you qualify.

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* 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.

Your employer or the PEBB Program contributes the following amounts to your HSA:

- $58.34 each month for an individual subscriber, up to $700.08 for the 2015 calendar year; or
- $116.67 each month for a subscriber with one or more enrolled family members, up to $1,400.04 for the 2015 calendar year.
- $125 if you qualified for a SmartHealth wellness incentive in 2014 (from the PEBB Program).

The contributions from your employer go into the HSA in monthly installments over the year, and are deposited on the last day of each month. The entire annual amount is **not** deposited in your HSA on January 1.

You can also choose to contribute to your HSA, either through pretax payroll deductions (if available from your employer) or direct deposits to HealthEquity. You may be able to deduct your HSA contributions from your federal income taxes. The IRS has an annual limit for contributions from all sources into an HSA. In 2015, the annual HSA contribution limit is $3,350 (for individuals) and $6,650 (for 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.

It is your responsibility not to exceed the maximum allowable contributions

allowed under Internal Revenue Service rules. Before you make your own contributions, first count the annual contribution from your employer. Also count the $125 SmartHealth wellness incentive if you receive it in January 2015

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 limit 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.

How do I find 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 upon request in Spanish, Tagalog, Chinese, and Navajo from your medical plan.

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 review it online; • Go to **www.hca.wa.gov/pebb** to review it online; or • Call your plan's customer services to request a paper copy at no charge.	You can either: • Go to **www.hca.wa.gov/pebb** to review it online; or • Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge.
You can find the medical plans' websites and customer service phone numbers on page 2.	

2015 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**	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
Kaiser Permanente Classic **Kaiser Permanente Consumer-Directed Health Plan (CDHP)**	Clark Cowlitz Lewis (ZIP Codes 98591, 98593, and 98596) Skamania (ZIP Codes 98639, 98648, and 98671) Wahkiakum (ZIP Codes 98612 and 98647)	
Uniform Medical Plan Classic **UMP Consumer-Directed Health Plan (CDHP)**	Available in all Washington counties and worldwide.	

Oregon	
Group Health Classic **Group Health Consumer-Directed Health Plan (CDHP)** **Group Health Value**	Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
Kaiser Permanente Classic **Kaiser Permanente Consumer-Directed Health Plan (CDHP)**	Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) Clackamas (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97086, 97089, 97222, and 97267-69) Columbia Hood River (ZIP Code 97014) Linn (ZIP Codes 98321-22, 97335, 97348, 97355, 97358, 97360, 97374, 97377, and 97389) Marion (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-12, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392) Multnomah Polk Washington Yamhill
Uniform Medical Plan 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 Value**	Kootenai Latah
Uniform Medical Plan Classic **UMP Consumer-Directed Health Plan (CDHP)**	Available in all Idaho counties and worldwide.

2015 Medical Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans, and extended-network benefits for Group Health's consumer-directed health plan (CDHP). 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	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Medical deductible Applies to out-of-pocket limit	$250/person $750/family	$350/person $1,050/family	$1,400/person $2,800/family*		$250/person $750/family	$1,400/person $2,800/family*	$250/person $750/family	$1,400/person $2,800/family*
Medical out-of-pocket limit[1] (See separate prescription drug out-of-pocket limit for UMP Classic.)	$2,000/person $4,000/family Your deductible, copays, and coinsurance for all covered services apply.		$5,100/person $10,200/family** Your deductible, copays, and coinsurance for all covered services apply.		$2,000/person $4,000/family Your deductible, copays, and coinsurance for most covered services apply.	$4,200/person $8,400/family** Your deductible, copays, and coinsurance for most covered services apply.	$2,000/person $4,000/family Your medical deductible, copays, and coinsurance for most covered medical services apply.	$4,200/person $8,400/family** Your deductible and coinsurance for most covered services apply.
Prescription drug deductible	None	None	Prescription drug costs apply toward medical deductible.		Prescription drug costs apply toward medical deductible.		$100/person $300/family* (Tier 2 and 3 drugs only)	Prescription drug costs apply toward medical deductible.
Prescription drug out-of-pocket limit[1]	Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.				Prescription drug copays apply to the medical out-of-pocket limit.		$2,000/person Your prescription drug deductible, copays, and coinsurance for all covered prescription drugs apply.	Presciption coinsurance applies to the medical out-of-pocket limit.

*Must meet family medical or prescription drug deductible before plan pays benefits.
**Must meet family medical out-of-pocket limit before plan pays 100% for covered benefits.

The information in this document is accurate at the time of printing. Contact the plans or review the certificate of coverage before making decisions.

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Ambulance Air or ground, per trip	20%	20%	10%	30%	15%	15%	20%	20%
Diagnostic tests, laboratory, and x-rays	$0; MRI/ CT/PET scan $30	$0; MRI/ CT/PET scan $40	10%	30%	$10	15%	15%	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	10%	30%	20%	20%	15%	15%
Emergency room (copay waived if admitted)	$250	$300	10%	10%	$75	15%	$75 copay + 15%	15%
Hearing Routine annual exam	$15	$20	10%	30%	$30	$30	$0	15%
Hardware	You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.							
Home health	$0	$0	10%	30%	15%	15%	15%	15%
Hospital services Inpatient	$150/day up to $750 maximum/ admission	$200/day up to $1,000 maximum/ admission	10%	30%	15%	15%	$200/day up to $600 maximum/ year per person + 15% professional fees	15%
Outpatient	$150	$200	10%	30%	15%	15%	15%	15%
Office visit								
Primary care	$15	$20	10%	30%	$20	$20	15%	15%
Urgent care	$15	$20	10%	30%	$40	$40	15%	15%
Specialist	$30	$40	10%	30%	$30	$30	15%	15%
Mental health	$15	$20	10%	30%	$20	$20	15%	15%
Chemotherapy	$15	$20	10%	30%	$0	$0	15%	15%
Radiation	$30	$40	10%	30%	$0	$0	15%	15%
Physical, occupational, and speech therapy (per-visit cost for 60 visits/ year combined)	$15	$20	10%	30%	$30	$30	15%	15%

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

[2] Group Health's CDHP Extended Network includes First Choice Health Network, First Health Network, and its affiliated providers, and any other licensed provider in the U.S.

[3] UMP 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.

[4] Preventive care is not covered in Group Health's CDHP Extended Network except for routine mammography screening. Annual medical deductible and 30% coinsurance applies.

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

(continued)

2015 Medical Benefits Comparison

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan[3]	
	Classic	Value	CDHP	CDHP Extended Network[2]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Prescription drugs								
Retail pharmacy (up to a 30-day supply)								
Value tier	$5	$5	$5	$5	Does not apply	Does not apply	5% (up to $10/ 30-day supply)	15%
Tier 1	$20	$20	$20	$20	$15	$15	10% (up to $25/ 30-day supply)	
Tier 2	$40	$40	$40	$40	$30	$30	30% (up to $75/ 30-day supply)	
Tier 3	50% up to $250	50% up to $250	50% up to $250	50% up to $250	Does not apply	Does not apply	50% (up to $150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs)	
Mail order (up to a 90-day supply)								
Value tier	$10	$10	$10	Does not apply	Does not apply	Does not apply	5% (up to $30/ 90-day supply)	15%
Tier 1	$40	$40	$40	Does not apply	$30	$30	10% (up to $75/ 90-day supply)	
Tier 2	$80	$80	$80	Does not apply	$60	$60	30% (up to $225/ 90-day supply)	
Tier 3	50% up to $750	50% up to $750	50% up to $750	Does not apply	Does not apply	Does not apply	50% (up to $150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs)	
Preventive care	$0	$0	$0	Not covered[4]	$0	$0	$0	$0
See certificate of coverage or check with plan for full list of services.								
Spinal manipulations	$15	$20	10%	30%	$30	$30	15%	15%
Vision care[5]								
Exam (annual)	$15	$20	10%	30%	$20	$20	$0	$0
Glasses and contact lenses	You pay any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. **Exception:** For UMP Classic, you pay any amount over $65 for contact lens fitting fees.							

*Must meet family medical or prescription drug deductible before plan pays benefits.
**Must meet family medical out-of-pocket limit before plan pays 100% for covered benefits.

Selecting a PEBB Dental Plan

You have three dental plans to choose from:

- **DeltaCare (managed-care plan)**
- **Willamette Dental Group Plan (managed-care plan)**
- **Uniform Dental Plan (UDP) (preferred-provider plan)**

How do DeltaCare and Willamette Dental Group plans work?

DeltaCare and Willamette Dental Group are managed-care plans. This means you must select and receive care from a primary care provider in that plan's network or, as needed, receive a referral from your provider to see a specialist. You may change providers within your selected plan's network any time during the year. DeltaCare is administered by Delta Dental of Washington, and its network is **DeltaCare PEBB (Group 3100)**. Willamette Dental Group administers its own dental network.

These plans don't have an annual deductible, so you don't have to keep track of how much you have paid out of pocket before the plan begins covering benefits. And you pay a set amount (called a copay) when you receive dental services. DeltaCare and Willamette Dental Group also do not have 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. With this plan, you can choose any dental provider and can change providers at any time.

UDP is also administered by Delta Dental of Washington, and its network is **Delta Dental PPO (Group 3000)**. When you see a network provider, your out-of-pocket costs 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 (called coinsurance) for dental services after you have met the annual deductible. UDP pays up to the annual maximum of $1,750 for covered benefits for each enrolled family member, including preventive care visits.

Before you select a plan or provider

1. Confirm that a specific provider is within the dental plan's network and is accepting new patients (if choosing a new provider). The provider can tell you if his or her practice is "in network" for your plan.
2. Call the dental plan's customer service (listed in the front of this booklet) or use their online provider directory to confirm whether the provider is in network for your plan.
3. Make sure you correctly identify your dental plan's network. For example, mention PEBB Group 3000 if you want to enroll in UDP, or Group 3100 if you want to enroll in DeltaCare. (Willamette Dental Group does not use a group number.)
4. Confirm the selection you've made on your enrollment form before you submit it. Did you want a preferred-provider or a managed-care plan?

Note: Delta Dental of Washington administers both UDP and DeltaCare, but each plan offers different networks. How much you pay for services depends on the specific provider network for your dental plan.

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 benefits 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	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	
Treatment of gum disease (periodontic services)	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	

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

Group Term Life and AD&D Insurance

Your life insurance benefits include six options to allow you to cover yourself, your spouse or registered domestic partner, and your children. As an employee, your basic life insurance covers you and pays your designated beneficiaries in the event of your death. Your basic life insurance includes Accidental Death and Dismemberment (AD&D) insurance, which provides extra benefits for certain injuries or death resulting from a covered accident.

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

What are my PEBB life and AD&D insurance options?

PEBB offers $25,000 of basic life insurance and $5,000 basic AD&D insurance (called **Basic Life and AD&D Insurance for Employees**) as part of your benefits package, at no cost to you.

PEBB also offers optional life insurance for you to purchase:

- **Supplemental Term Life Insurance for Employees**: You may apply for additional amounts in $10,000 increments from $10,000 to $750,000. Supplemental Term Life Insurance for Employees covers death from any cause.
- **Basic Life Insurance for Dependents**: $2,500 for your spouse or registered domestic partner, and $2,500 for each dependent child. Basic Life Insurance covers death from any cause. You pay $0.62 per family per month, regardless of the number of dependents.
- **Supplemental Term Life Insurance for Spouse or Registered Domestic Partner**: If you enroll your spouse or registered domestic partner in Basic Life Insurance, you may apply for optional amounts of Supplemental Life Insurance in $5,000 increments (up to one-half of the amount of Employee Supplemental Life Insurance you obtain for yourself). Supplemental Life Insurance covers death from any cause.
- **Supplemental AD&D Insurance for Employees**: You may enroll in Supplemental AD&D coverage in multiples of $25,000 ($25,000 minimum) up to $250,000 for accidental death and dismemberment. Supplemental AD&D Insurance does not cover death and dismemberment from other causes. Supplemental AD&D Insurance never requires evidence of insurability.
- **Supplemental AD&D Insurance for Dependents**: If you select Supplemental AD&D Insurance for dependents in addition to your own, your spouse or registered domestic partner will be insured for 50 percent of your benefit if you have no dependent children. If you have children, your spouse or registered domestic partner will be insured for 40 percent and each dependent child for 5 percent of your benefit. If you have no spouse or registered domestic partner, each dependent child will be insured for 10 percent of your benefit. This dependent coverage does not reduce your coverage. Supplemental AD&D Insurance never requires evidence of insurability.

PEBB life insurance benefits have no cash value.

When can I enroll?

You may enroll **no later than 60 days** after becoming eligible for PEBB benefits (generally your first day of employment) for the following coverage, without providing evidence of insurability:

- Supplemental Term Life Insurance for Employees up to $250,000 (if you are under age 60) or up to $100,000 (if you are age 60 or older)
- Basic Life Insurance for Dependents
- Supplemental Term Life Insurance for Spouse or Registered Domestic Partner (up to $50,000) but not more than one-half of the amount of Supplemental Life Insurance for Employees
- Supplemental AD&D Insurance

You must provide evidence of insurability to ReliaStar Life if you:

- Apply more than 60 days after becoming eligible for PEBB benefits.
- Request more than $250,000 (if under age 60) or more than $100,000 (if age 60 or older) in Supplemental Term Life Insurance for Employees.
- Request more than $50,000 in Supplemental Term Life Insurance for your spouse or registered domestic partner.

ReliaStar Life must approve your request before you will have coverage.

How do I enroll?

Complete and submit the *Life and AD&D Insurance Enrollment/Change Form* (found in the back of this booklet) to your employer's personnel, payroll, or benefits office. If applying for Supplemental Term Life Insurance for yourself or Supplemental Term Life Insurance for your spouse or registered domestic partner that requires

(continued)

Group Term Life and AD&D Insurance

evidence of insurability, your employer must also complete the *Life Insurance Evidence of Insurability Form* (found at **www.hca.wa.gov/pebb**). Once your employer has completed their portion of the form, complete your portion and submit the form to ReliaStar Life Insurance Company. (Their address is on the form.)

For questions about enrollment, contact your employer's personnel, payroll, or benefits office. If you need additional information, contact ReliaStar Life Insurance Company at 1-866-689-6990.

PEBB group term life insurance coverage is offered through ReliaStar Life Insurance Company, a member of the Voya™ family of companies (Policy Form #LP00GP). This is a summary of benefits only. To see the certificate of coverage or to get forms, either:

- Go to **www.hca.wa.gov/pebb**.

or

- Contact your employer's personnel, payroll, or benefits office.

Premiums

Supplemental Life Insurance for Employees and Supplemental Spouse Life Insurance

	COST PER $1,000 PER MONTH	
Age	Non-Tobacco User	Tobacco User
Less than 25	$0.029	$0.038
25–29	0.032	0.045
30–34	0.035	0.059
35–39	0.044	0.068
40–44	0.066	0.076
45–49	0.095	0.115
50–54	0.148	0.176
55–59	0.277	0.328
60–64	0.425	0.499
65–69	0.784	0.961
70+	1.170	1.562

Your premium rate changes to the next higher rate as you reach each new age bracket.

Supplemental Accidental Death and Dismemberment Insurance

			Coverage your spouse or registered domestic partner would have		Coverage your children would have	
Employee AD&D benefit	Cost to cover only yourself	Cost to cover you and your dependents	With no children	With children	If you have a spouse or registered domestic partner	If you have no spouse or registered domestic partner
$ 25,000	$0.48	$0.73	$12,500	$10,000	$1,250	$2,500
50,000	0.95	1.45	25,000	20,000	2,500	5,000
75,000	1.43	2.18	37,500	30,000	3,750	7,500
100,000	1.90	2.90	50,000	40,000	5,000	10,000
125,000	2.38	3.63	62,500	50,000	6,250	12,500
150,000	2.85	4.35	75,000	60,000	7,500	15,000
175,000	3.33	5.08	87,500	70,000	8,750	17,500
200,000	3.80	5.80	100,000	80,000	10,000	20,000
225,000	4.28	6.53	112,500	90,000	11,250	22,500
250,000	4.75	7.25	125,000	100,000	12,500	25,000

Rates shown are guaranteed through December 31, 2015.

Long-Term Disability Insurance

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

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

What are my PEBB long-term disability insurance options?

LTD coverage has two parts:

1. **Basic LTD Plan** is provided by PEBB as part of your benefits package, at no cost to you.
2. **Optional LTD Plan** is available for you to purchase.

LTD benefit amounts

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

The LTD benefit for each plan is shown below:

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

Waiting period before benefits become payable

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

Optional LTD Plan: 30, 60, 90, 120, 180, 240, 300, or 360 days (depending on your election), or the period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, whichever is longer.

What is considered a disability?

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

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

Maximum benefit period

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

Age	Maximum benefit period
61 or younger	To age 65, but not less than 42 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

(continued)

Long-Term Disability Insurance

How much does the Optional Plan cost?

Payroll deduction as a percentage of Predisability Earnings

Benefit waiting period	Higher-education retirement plan employees	TRS, PERS, and other retirement plan employees
30 days	1.95%	1.54%
60 days	1.00%	0.82%
90 days	0.55%	0.45%
120 days	0.32%	0.27%
180 days	0.24%	0.21%
240 days	0.23%	0.21%
300 days	0.21%	0.19%
360 days	0.21%	0.18%

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

When can I enroll?

You may enroll in Optional LTD coverage **within 31 days** after becoming eligible for PEBB benefits (generally your first day of employment) without providing evidence of insurability.

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

How do I enroll?

If applying within 31 days of initial eligibility for PEBB benefits, complete and submit the *Long Term Disability (LTD) Enrollment/Change Form* (found in the back of this booklet) to your employer's personnel, payroll, or benefits office.

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

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

PEBB's long-term disability (LTD) insurance coverage is offered through Standard Insurance Company. This is a summary. To see the long term disability plan booklet or to get forms, you can do one of the following:

- Go to **www.hca.wa.gov/pebb**.

or

- Contact your employer's personnel, payroll, or benefits office.

Example #1

If you are a higher-education retirement plan employee with monthly earnings of $1,000, the 60-day benefit waiting period would cost $10 per month.

Earnings:	$	1,000	per month
60-day benefit waiting period:	x	0.01	(1.00% converts to 0.01 when multiplying)
Monthly cost:	$	10.00	

Example #2

If you are a TRS, PERS, or other retirement plan employee with monthly earnings of $1,000, the 60-day benefit waiting period would cost $8.20 per month.

Earnings:	$	1,000	per month
60-day benefit waiting period	x	0.0082	(0.82% converts to 0.0082 when multiplying)
Monthly cost:	$	8.20	

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

FSA and DCAP

What is a flexible spending arrangement?

The PEBB Program offers a medical flexible spending arrangement (FSA) that allows you to set aside money from each paycheck—before taxes—to pay for qualified out-of-pocket health expenses. This reduces your annual taxable income and allows you to pay for certain out-of-pocket health expenses tax-free. This is only offered to PEBB benefits-eligible state and higher-education employees.

You decide how much you want to contribute for the plan year when you enroll. The minimum annual contribution is $240; the maximum is $2,500.

The full amount of your calendar year contribution is available on the first day of the month after Flex-Plan Services receives and approves your enrollment form for expenses incurred that day forward. You may use your FSA to reimburse yourself for out-of-pocket medical, dental, and vision expenses allowed by the Internal Revenue Service (IRS). You may not pay premiums from your account, but you can use it for deductibles, copays, coinsurance, and other qualified expenses. Your and your family members' expenses (those who qualify as dependents under IRS rules) may be reimbursed from your account, even if they are not enrolled on your PEBB coverage.

What is the Dependent Care Assistance Program?

Child care can be one of the single largest expenses for a family. The Dependent Care Assistance Program (DCAP) offers you an opportunity to reduce taxable income by setting aside money from each paycheck—before taxes—to pay for eligible day care expenses. This is only offered to PEBB benefits-eligible state and higher-education employees.

Qualifying dependents must live with you and may include:

- Your dependent 12 years old or younger.
- A dependent age 13 or older may be eligible if he or she cannot physically or mentally care for himself or herself, and regularly spends at least eight hours each day in your household.

DCAP reimburses eligible dependent care expenses that allow you and your spouse (if married) to attend school full time, work, or look for work. If you have a stay-at-home spouse, you cannot enroll in the DCAP.

The DCAP limit is set by the IRS and is a calendar year limit of $5,000 per household (or $2,500 if married and you and your spouse are filing separate tax returns), but not to exceed earned income limits.

How do I enroll?

To set up an FSA or DCAP account, you can enroll at the following times:

- When you become eligible for PEBB benefits. Your personnel, payroll, or benefits office must receive a completed *Flexible Spending Arrangement (FSA) & Dependent Care Assistance Program (DCAP) Enrollment Form* **no later than 31 days** after you become eligible (usually on your first day of employment). See WAC 182-08-197 for details.
- During the PEBB annual open enrollment (usually November 1-30).
- During the plan year if you or an eligible family member has an event that creates a special open enrollment (see "When can I change my election in the FSA or DCAP?" below).

When can I change my election in the FSA or DCAP?

Once you enroll in an FSA or DCAP, you cannot make changes to your election(s) during the plan year unless a special open enrollment event occurs (see WAC 182-08-199 for details). The requested change must correspond to and be consistent with the event. If you have an event and want to change your elections, your personnel, payroll, or benefits office must receive your completed *Flex-Plan Change in Status* form **no later than 60 days** after the date of the event. Your employer will review your special open enrollment event and forward your form to Flex-Plan Services for processing, as appropriate. Flex-Plan Services will not approve requests received more than 60 days after the event. The change to your FSA or DCAP account will begin on the first of the month after the date of the event or the date your personnel, payroll, or benefits office receives your *Flex-Plan Change in Status* form, whichever is later. If that day is the first of the month, the change begins on that day.

For more information about making a change, see the FSA or DCAP enrollment guide at **www.pebb.flex-plan.com**.

Flex-Plan Services, Inc. administers the FSA and DCAP

For more information and forms, go to Flex-Plan's website at **www.pebb.flex-plan.com** or call Flex-Plan Services at 1-800-669-3539.
Send questions via email to **customerservice@flex-plan.com**.

SmartHealth Wellness Program

SmartHealth, the state's voluntary wellness program for eligible PEBB subscribers, focuses on your health and well-being. This program helps you take steps to improve your health by participating in fun and engaging activities and earn a wellness incentive.

If you meet the wellness incentive requirements, you may be eligible for:

- A one-time deposit of $125 into your health savings account in January 2016.

OR

- If enrolled in a Classic or Value medical plan, you could earn a $125 reduction in your annual medical deductible in 2016 when you (the subscriber) receive covered services.

Who is eligible to participate?

PEBB medical plan subscribers who are not enrolled in Medicare Part A and Part B may participate in this wellness program. Eligible subscribers and their spouses or registered domestic partners enrolled in PEBB medical coverage can participate in activities through the new SmartHealth website; however, only the subscriber will earn the $125 incentive.

How can SmartHealth help me?

SmartHealth is centered around an online experience that provides easy-to-use, interactive tools. You can find out where you are on your fitness journey and set goals for where you want to go. Participate in healthier activities while SmartHealth helps track your progress. With SmartHealth, you can participate in activities to improve your fitness, nutrition, and stress management—even your financial health. It starts with taking a well-being assessment to help customize your wellness experience. From there, you can jump straight into activities that interest you.

SmartHealth also rewards you for taking advantage of your health plan benefits—such as checkups and immunizations—at little or no cost to you. It's a good practice that can lead to better health and peace of mind.

How can I earn a wellness incentive?

If you are eligible, you can register at **www.smarthealth.hca.wa.gov** starting January 1, 2015, to participate in the SmartHealth program.

To qualify for a PEBB wellness incentive in 2016, you must complete the program requirements shown below within these timelines:

I am enrolled in PEBB medical coverage effective:	What do I need to do to qualify for the wellness incentive?	When is the deadline to complete these activities?
January 1 – April 1, 2015 with no break in coverage	Complete SmartHealth Well-being Assessment (800 points) Complete SmartHealth wellness activities worth 1,200 points TOTAL: 2,000 points	**June 30, 2015**
January 1 – April 1, 2015 with a break in coverage that results in my regaining eligibility for PEBB medical coverage April 2, 2015 through December 31, 2015	Register on SmartHealth website (1,000 points) Complete SmartHealth Well-being Assessment (800 points) Join a SmartHealth activity (200 points) TOTAL: 2,000 points	**Within 120 days** of effective date of PEBB medical coverage; unless coverage begins October 1 or later, then criteria must be met no later than December 31, 2015)
April 2 – December 1, 2015 with or without a break in coverage	Register on SmartHealth website (1,000 points) Complete SmartHealth Well-being Assessment (800 points) Join a SmartHealth activity (200 points) TOTAL: 2,000 points	**Within 120 days** of effective date of PEBB medical coverage; unless coverage begins October 1 or later, then criteria must be met no later than December 31, 2015)

You must meet the two criteria below **both** when you complete the required activities **and** when the incentive is distributed in 2016:

- You are enrolled in a PEBB medical plan.

AND

- You are not enrolled in Medicare Part A and Part B as your primary coverage.

A PEBB wellness incentive will only be provided if funds are approved by the Legislature for a PEBB wellness program or wellness incentives, or both.

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.
- **Convenient payment options**—including automatic payroll deduction (for employees), electronic funds transfer (EFT), or direct billing at home.
- **A 12-month guarantee** on our competitive rates.
- **Prompt claims service** with access to local representatives.

When can I enroll?

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

How do I enroll?

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

- Visit PEBB's website at **www.hca.wa.gov/pebb/Pages/auto_home.aspx.**
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB member (client #8246).
- Call or visit one of the local offices (see box).

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

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

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

Federal Way 1-800-826-9183
33915 1st Way S., Suite 203

Portland, OR 1-800-248-8320
650 NE Holladay St.

Redmond 1-800-253-5602
15809 Bear Creek Parkway, #120

Spokane 1-800-208-3044
16201 East Indiana Ave.,
Suite 2280

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

Tumwater 1-800-319-6523
300 Deschutes Way SW,
Suite 210

Valid Dependent Verification Documents

Use the list below to determine which verification document(s) to submit with your enrollment 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 produced 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, and you may black out dependents' Social Security numbers)
- The subscriber's and spouse's most recent *1040 Married Filing Separately* federal tax return (black out financial information, and you may black out dependents' Social Security numbers)
- 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, and you may black out dependents' Social Security numbers)
- 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.*

Enrollment Forms

The following forms are available online:

2015 Employee Enrollment/Change

http://www.hca.wa.gov/pebb/Documents/50-400_2015.pdf

2015 Employee Enrollment/Change for Medical Only Groups

http://www.hca.wa.gov/pebb/Documents/52-030_2015.pdf

Life and AD&D Insurance Enrollment/Change Form

http://www.hca.wa.gov/pebb/documents/161989-2014.pdf

Long Term Disability (LTD) Enrollment/Change Form

http://www.standard.com/eforms/7533d_377661.pdf

Washington State Health Care Authority
Public Employees Benefits Board

Do not submit this help sheet with your 2015 enrollment form or *2015 Premium Surcharge Change Form*.

2015 Premium Surcharge Help Sheet

- Use the information below to attest on your 2015 enrollment form or the *2015 Premium Surcharge Change Form* whether the premium surcharges apply.
- The surcharges do not apply to subscribers and any family members enrolled in PEBB dental coverage only.
- The surcharges do not apply to retirees, COBRA, or extension of coverage subscribers enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

What are "tobacco products"?

Tobacco products are defined as any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, chewing tobacco, snuff, and other tobacco products.

Tobacco products do not include:

- E-cigarettes (until their tobacco-related status is determined by the U.S. Food and Drug Administration [FDA]).
- Tobacco cessation aids approved by the FDA, such as:
  1. Over-the-counter nicotine replacement products.
     - All over-the-counter tobacco cessation products for adults age 18 and older.
     - All over-the-counter tobacco cessation products for children under age 18 if recommended by a doctor.

     Examples of over-the-counter nicotine replacement products include:
     - Skin patches–generic (nicotine film), private label, or brand-name (Habitrol or Nicoderm).
     - Chewing gum (also called nicotine gum)–generic (nicotine polacrilex or Thrive), private label, or brand-name (Nicorette).
     - Lozenges–generic (nicotine polacrilex), private label, or brand-name (Nicorette or Commit).
  2. Prescription nicotine replacement products.
     - Nasal spray or oral inhaler–brand name (Nicotrol)
     - Products not containing nicotine, such as pills–generic (buproprion hydrochloride) or brand name (Chantix or Zyban)

What is "tobacco use"?

Tobacco use is defined as any use of tobacco products within the past two months. It does not include the religious or ceremonial use of tobacco.

The surcharge **will not** apply if you and all family members ages 18 and older who use tobacco products are enrolled in your PEBB medical plan's tobacco cessation program, or if children ages 17 and younger who use tobacco products access information and resources at **teen.smokefree.gov**.

Does this mean tobacco use within the past two months from today?

Tobacco products used within the two months before the date you complete this form count as "tobacco use."

What if tobacco use changes?

When **all** enrolled family members have not used tobacco products for two months, or have used the tobacco cessation resources noted above, you may change your attestation online using *My Account* at **www.hca.wa.gov/pebb** or submit a *2015 Premium Surcharge Change Form* to remove the surcharge for future months.

(continues on next page)

Spouse or registered domestic partner coverage premium surcharge

Will the spouse or registered domestic partner coverage premium surcharge apply to me?

If you have a spouse or registered domestic partner on your 2015 PEBB medical plan, answer "YES" or "NO" to the following questions. **Check the corresponding boxes on your 2015 enrollment form or *2015 Premium Surcharge Change Form***. If you don't have a spouse or registered domestic partner on your PEBB medical plan, you don't need to complete this questionnaire—this surcharge doesn't apply to you.

	Questions	YES	NO
1	Are you covering your spouse or registered domestic partner in Public Employees Benefits Board (PEBB) medical coverage under your account in 2015?		
2	Will your spouse or registered domestic partner be eligible for medical coverage through his or her employer in 2015? (If your spouse or registered domestic partner will not be employed in 2015, answer "NO.")		
3	Will your spouse's or registered domestic partner's employer offer at least one medical plan that serves your spouse's or registered domestic partner's county of residence in 2015?		
4	Has your spouse or registered domestic partner chosen not to enroll in his or her employer's medical coverage in 2015?		
5	Will the coverage offered by your spouse's or registered domestic partner's employer in 2015 NOT be through the PEBB Program? Answer "YES" if your spouse's or registered domestic partner's employer **does not** offer PEBB coverage. Answer "NO" if your spouse's or registered domestic partner's employer **does** offer PEBB coverage.		
6	Will your spouse's or registered domestic partner's share of the medical premium through his or her employer be less than $89.31 per month in 2015?		

▶ **If you answered "YES" to ALL of these questions, you may have to pay the surcharge.**

To find out whether you do:

1. Your spouse or registered domestic partner should ask his or her employer for a *2015 Summary of Benefits and Coverage (SBC)* for **all** medical plans that:
   - Serve the county of residence for your spouse or registered domestic partner.
   - Have a monthly premium of less than $89.31 per month for the employee.
2. Use the *2015 Summary of Benefits and Coverage (SBC)* information to answer the questions in the *2015 Spousal Plan Calculator* online tool at **www.hca.wa.gov/pebb**.

   Or, you can download a paper version of the *2015 Spousal Plan Calculator* from the website and submit it with your 2015 enrollment form or your *2015 Premium Surcharge Change Form*.

   If you don't have access to the internet, you may request a paper *2015 Spousal Plan Calculator* from your employer (if an employee). Retirees, COBRA, and Leave Without Pay subscribers may call the PEBB Program at 1-800-200-1004 to request a paper copy.

If using the online *2015 Spousal Plan Calculator*:

- Provide all the information requested by the form.
- Click the Compute button.
- You will be provided with the "YES" or "NO" response to the question "Does the spouse or registered domestic partner coverage surcharge apply to you?" Enter this response on your 2015 enrollment form or *2015 Premium Surcharge Change Form*.

If using a paper *2015 Spousal Plan Calculator*:

- Provide all the information requested by the form.
- Check "Employer or PEBB Program to determine."
- Include a copy of the *2015 Spousal Plan Calculator* when you submit your 2015 enrollment form or *2015 Premium Surcharge Change Form*.
- Your employer or the PEBB Program will determine whether your spouse's or registered domestic partner's employer-based group medical insurance is comparable to UMP Classic.

▶ **If you answered "NO" to ANY of these questions, you will not have to pay the surcharge if you check "NO" on your 2015 enrollment form or *2015 Premium Surcharge Change Form.***

Washington State
Health Care Authority
Public Employees Benefits Board

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HCA 50-100 (12/14)