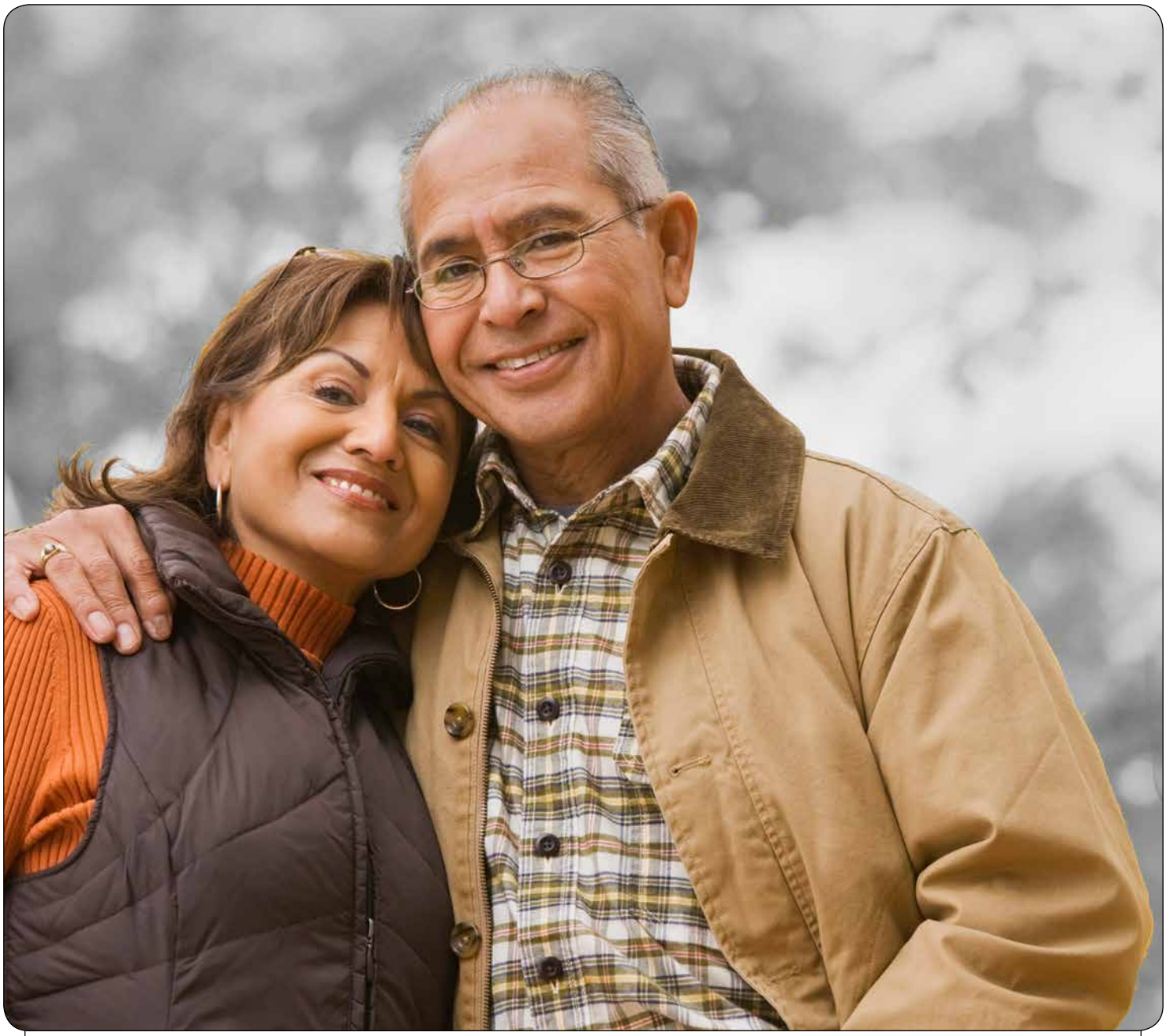
Washington State Health Care Authority
Public Employees Benefits Board

Your PEBB Benefits for 2013

Retiree Enrollment Guide



Monthly Rates Pages 12-13
Eligibility Summary Pages 14-15
Notice of Creditable Prescription Drug Coverage Page 20
Benefits Comparison Pages 34-37
Enrollment Forms Back cover

HCA 51-205 (6/13)

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

Important requirements to remember:

- **You have 60 days after the date your employer or continuous COBRA coverage ends to enroll in or defer (postpone) PEBB retiree coverage.** If you don't complete and submit the *Retiree Coverage Election Form* within the required timeframe, you could lose your right to enroll.
- If entitled, you and/or your dependent(s) must enroll and maintain enrollment in both Medicare Part A and Part B to qualify for PEBB retiree coverage. If you don't, you and/or your dependent(s) will no longer be eligible for enrollment in PEBB retiree coverage.
- We will not enroll you until we receive your first premium payment unless you choose to have your premiums deducted from your monthly pension check.
- If you are a retiree and not entitled to Medicare, or enrolling a domestic partner you must provide documents that verify your dependent's eligibility for PEBB retiree coverage or the dependent will not be enrolled.

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

Call the PEBB Program at 360-725-0440 or toll-free at 1-800-200-1004 Monday through Friday, 8 a.m. to 5 p.m.
For personal assistance, visit our office at 626 8th Avenue SE, Olympia, WA, 98501.
To send a fax dial 360-725-0771.
Go to **www.hca.wa.gov/pebb** for forms, publications, and information updates.

Mail first premium payments to:

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

Write to the PEBB Program at:

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

For automatic bank account withdrawals of your monthly premium:

An *Electronic Debit Service Agreement* form is provided in the back of this booklet.

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

Contact the Plans

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

Medical Plans	Website addresses	Customer service phone numbers	TTY Customer service phone numbers (deaf, hard of hearing, or speech impaired)
Group Health Classic, Medicare, or Value Group Health Options, Inc. (CDHP)	www.ghc.org/pebb	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente Classic, CDHP, or Senior Advantage	www.my.kaiserpermanente.org/nw/wapebb	503-813-2000 or 1-800-813-2000 Medicare members: 1-877-221-8221	1-800-735-2900
Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield	www.ump.hca.wa.gov	1-888-849-3681	711

Medicare Supplement Plan	Website address	Customer service phone number	TTY Customer service phone number (deaf, hard of hearing, or speech impaired)
Medicare Supplement Plan F, administered by Premera Blue Cross	www.premera.com	1-800-817-3049	1-800-842-5357

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

Health Savings Account Trustee	Website address	Customer service phone number	TTY Customer service phone number (deaf, hard of hearing, or speech impaired)
HealthEquity, Inc.	**www.healthequity.com/pebb**	1-877-873-8823	711

VEBA Voluntary Employee Beneficiary Association Trust	Website address	Customer service phone number	TTY Customer service phone number (deaf, hard of hearing, or speech impaired)
Meritain Health	**www.veba.org**	1-888-828-4953	711

Life Insurance	ReliaStar Life Insurance Company	1-866-689-6990	
Long-Term Care Insurance	John Hancock Life Insurance Company (U.S.A.)	**www.hca.wa.gov/pebb/pages/ltc.aspx**	1-800-399-7271
Auto and Home Insurance	Liberty Mutual Insurance Company	**www.hca.wa.gov/pebb/pages/auto_home.aspx**	1-800-706-5525

Welcome to Retirement!

The Public Employees Benefits Board (PEBB) Program, administered by the Health Care Authority, is pleased to be able to offer its members choice, access, value, and stability. PEBB purchases and coordinates health insurance benefits for eligible public employees and retirees, but we each have a part to play in making choices that can lead to quality health care.

Look inside to find...

- Basic information about your medical and dental coverage, life, long-term care, and auto and home insurance options to help you make decisions.
- Information on who can enroll.
- Enrollment requirements.
- Plans available in your county.
- Monthly premiums.

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

The contents of this document are accurate at the time of printing. Please call the PEBB Program at 1-800-200-1004 or visit **www.hca.wa.gov/pebb** for updates to laws or rules or to find more information. If you have questions not answered in this booklet, please contact one of our benefits representatives Monday through Friday between 8 a.m. and 5 p.m.

Where to find laws and rules

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

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 or make a change, go to **www.hca.wa.gov/pebb** and select *My Account* in the left navigation panel.

Already signed up? If you signed up to receive PEBB mailings at your work email address, remember to change to a personal email address when you retire.

Table of Contents

Glossary of Health Coverage and Medical Terms **7**

2013 PEBB Retiree Monthly Rates **12**

Eligibility Summary **14**
- Who's eligible for PEBB coverage? 14
- Can I cover my family members? 15
- If I die, are my surviving dependents eligible? 15
- Eligibility for dependents of emergency service employees 15

PEBB Appeals **16**
- How can I appeal a decision? 16

Enrollment **17**
- How do I enroll? 17
- Can I enroll on two PEBB accounts? 17
- How long does the enrollment process take? 17
- When does coverage begin? 18
- What if I'm entitled to Medicare? 19
- CDHPs and Medicare don't mix 19
- How much do the plans cost? 19
- How do I pay for coverage? 19
- What happens if I miss a premium payment? 20
- How do I choose a medical or dental plan? 20
- PEBB prescription-drug coverage is creditable 20

Making Changes in Coverage **21**
- How do I add or remove dependents? 21
- What changes can I make during the annual open enrollment? 21
- What is a special open enrollment? 21
- What events allow me to add dependents? 22
- What events allow me to change health plans? 22

Deferring Your Coverage **24**
- Deferral rights for retirees 24
- Deferral rights for surviving dependents of employees or retirees 24
- Deferral rights for surviving dependents of emergency services personnel 25
- How do I enroll after deferring PEBB coverage? 25
- How do I enroll after deferring PEBB coverage for Medicaid? 25

When Coverage Ends **26**
- How do I cancel coverage? 26
- When does PEBB coverage end? 26
- What are my options when coverage ends? 26

How the Medical Plans Work **27**
- What do I need to know about the consumer-directed health plans? 27
- What do I need to know about the Medicare Advantage and Medicare Supplement plans? 28
- How can I compare the plans? 29

How to Find the Summaries of Benefits and Coverage **31**

2013 Medical Plans Available by County **32**

2013 Medical Benefits Comparison **34**

2013 Medicare Plan Benefits Comparison **36**

Outline of Medicare Supplement Coverage **38**

How the Dental Plans Work **42**
- Is a managed-care dental plan right for me? 42

Dental Benefits Comparison **43**

Life Insurance **45**

Long-Term Care Insurance **46**

Auto and Home Insurance **47**

Valid Dependent Verification Documents **48**

Completing the Retiree Forms **49**
- New enrollment 49
- Changing enrollment 49

Enrollment Forms ..... **(from the back cover)**
- *2013 Retiree Coverage Election Form (form A)*
- *Premera Blue Cross Group Medicare Supplement Enrollment Application (form B)*
- *Medicare Advantage Plan Election Form (form C)*
- *Electronic Debit Service Agreement*

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- See page 10 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

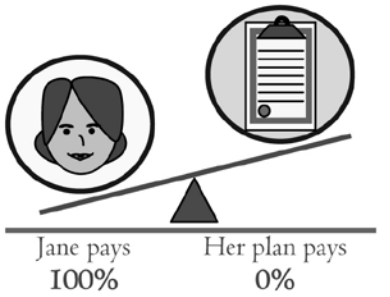
Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 10 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 10 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an **emergency medical condition**.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

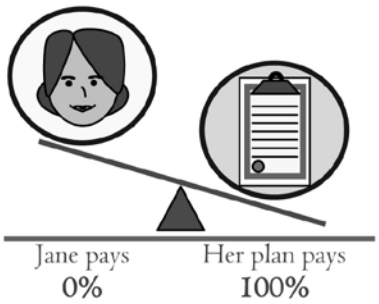
Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 10 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

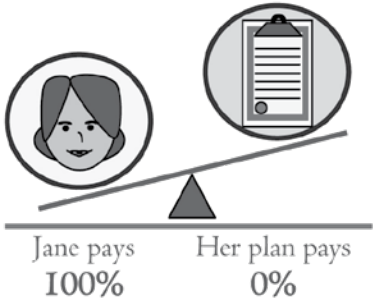
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

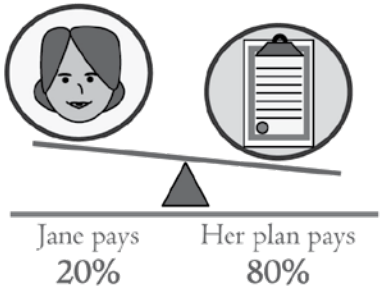
December 31st
End of Coverage Period



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

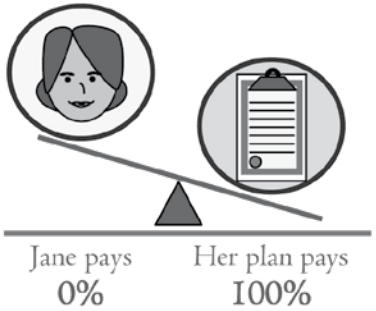
Office visit costs: $125
Jane pays: $125
Her plan pays: $0



Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

2013 PEBB Retiree Monthly Rates

Effective January 1, 2013

Special Requirements

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

Medical Plans

Members **not** eligible for Medicare (or enrolled in Part A only):	Group Health Classic	Group Health Value	Group Health CDHP	Kaiser Permanente Classic	Kaiser Permanente CDHP	UMP Classic	UMP CDHP
Subscriber Only	$ 584.66	$ 535.22	$ 513.77	$ 567.06	$ 498.95	$ 545.83	$ 499.95
Subscriber & Spouse*	1,163.14	1,064.26	1,018.40	1,127.94	988.26	1,085.48	990.26
Subscriber & Child(ren)	1,018.52	932.00	906.83	987.72	880.52	950.57	882.27
Full Family	1,597.00	1,461.04	1,353.13	1,548.60	1,311.50	1,490.22	1,314.25

Members enrolled in Part A & Part B of Medicare:	Group Health Medicare Plan	Group Health Classic	Group Health Value	Kaiser Permanente Classic	UMP Classic
Subscriber Only	$135.60	N/A‡	N/A‡	$ 151.67	$ 219.24
Subscriber & Spouse* (1 Medicare eligible)	N/A‡	$ 714.08	$ 664.64	712.55	758.89
Subscriber & Spouse* (2 Medicare eligible)	265.02	N/A‡	N/A‡	297.16	432.30
Subscriber & Child(ren) (1 Medicare eligible)	N/A‡	569.46	532.38	572.33	623.98
Subscriber & Child(ren) (2 Medicare eligible)	265.02	N/A‡	N/A‡	297.16	432.30
Full Family (1 Medicare eligible)	N/A‡	1,147.94	1,061.42	1,133.21	1,163.63
Full Family (2 Medicare eligible)	N/A‡	698.88	661.80	717.82	837.04
Full Family (3 Medicare eligible)	394.44	N/A‡	N/A‡	442.65	645.36

*** or state-registered domestic partner**

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

Medicare Supplement Plan F, administered by Premera Blue Cross		
	Plan F (Age 65 or older, eligible by age)	Plan F (Under age 65, eligible by disability)
Subscriber Only	$ 109.10	$ 206.11
Subscriber & Spouse* (1 Medicare eligible)**	648.75	745.76
Subscriber & Spouse* (2 Medicare eligible – 1 retired, 1 disabled)	309.03	309.03
Subscriber & Spouse* (2 Medicare eligible)	212.02	406.04
Subscriber & Child(ren) (1 Medicare eligible)**	513.84	610.85
Full Family (1 Medicare eligible)**	1,053.49	1,150.50
Full Family (2 Medicare eligible – 1 retired, 1 disabled)**	713.77	713.77
Full Family (2 Medicare eligible)**	616.76	810.78

*or state-registered domestic partner

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

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

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Uniform Dental Plan, administered by Washington Dental Service	Willamette Dental Group Plan
Subscriber Only	$ 39.53	$ 46.34	$ 40.20
Subscriber & Spouse*	79.06	92.68	80.40
Subscriber & Child(ren)	79.06	92.68	80.40
Full Family	118.59	139.02	120.60

*or state-registered domestic partner

Retiree Life Insurance Self-Pay Rate – $6.57 per month

Eligibility Summary

Who's eligible for PEBB coverage?

The information provided in this guide is a general summary of PEBB retiree eligibility. The PEBB Program will determine your eligibility at the time of your application based on eligibility in PEBB rules. You can find the PEBB retiree eligibility in WAC 182-12-171. A link is available in the *PEBB Rules and Policies* page of the PEBB website.

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

- State agency
- State higher-education institution
- K-12 school district or educational service district
- PEBB-participating employer group

You may be eligible to enroll in PEBB retiree insurance if you are an elected or full-time appointed state official (as defined under WAC 182-12-114(4)) who voluntarily or involuntarily leaves public office.

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

The procedural requirements include:

- You must submit a *Retiree Coverage Election Form* (form A) to enroll or defer enrollment in retiree insurance coverage **no later than 60 days** after your employer-paid or COBRA coverage ends.
- If you or a dependent you wish to enroll is entitled to Medicare and your retirement date is after July 1, 1991, enrolling in and maintaining enrollment in Medicare Part A and Part B is required.

The eligibility requirements, in general, are:

- You must be a vested member and meet the eligibility criteria to retire from a Washington State-sponsored retirement plan when your employer-paid or COBRA coverage ends (unless you are an elected or appointed state official as defined under WAC 182-12-114(4)). The following are Washington State-sponsored retirement plans:
  - Public Employees Retirement System (PERS) 1, 2, or 3
  - Public Safety Employees Retirement System (PSERS)
  - Teachers Retirement System (TRS) 1, 2, or 3
  - Washington Higher Education Retirement Plan (for example, TIAA-CREF)
  - School Employees Retirement System (SERS) 2 and 3
  - Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
  - Washington State Patrol Retirement System (WSPRS) 1 or 2
  - State Judges/Judicial Retirement System
  - Civil Service Retirement System and Federal Employees' Retirement System are considered a Washington State-sponsored retirement system for Washington State University Extension employees covered under PEBB insurance at the time of retirement or disability.
- You must immediately begin to receive a monthly retirement plan payment, with the following exceptions:
  - If you receive a lump sum payment instead of a monthly retirement plan payment, you are only eligible if the Department of Retirement Systems offered you the choice between a lump sum equivalent payment and an ongoing monthly payment.
  - If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3 and you meet the retirement plan's eligibility criteria when your employer-paid or COBRA coverage ends, you do not have to receive a monthly retirement plan payment.
  - If you are an employee retiring under a Washington higher-education retirement plan (such as TIAA-CREF) and you meet your retirement plan's eligibility criteria or you are at least age 55 with 10 years of state service, you do not have to receive a monthly retirement plan payment.

- If you are an employee retiring from a PEBB-participating employer group and your employer does not participate in a Washington State-sponsored retirement system, you do not have to receive a monthly retirement plan payment. However, you do have to meet the same age and years of service as if you had been employed as a member of either PERS Plan 1 or PERS Plan 2 for the same period of employment.
- If you are an elected or full-time appointed official of the legislative or executive branches of state government (as defined under WAC 182-12-114(4)), you do not have to meet the age and years of service requirement or receive a monthly retirement plan payment from a state-sponsored retirement system.

Can I cover my family members?

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

- Your lawful spouse.
- Your state-registered domestic partner.
- Your children, 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 state-registered domestic partner, or children specified in a court order or divorce decree.

In addition, children include extended dependents in your spouse's, or your state-registered domestic partner's legal custody or legal guardianship. An extended dependent may be your grandchild, niece, nephew, or other child for whom you, your spouse, or 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 include:

- Children up to age 26.
- Children of any age with a disability who are incapable of self-support, provided the disability, mental illness, intellectual or other developmental disability occurred before age 26. You must provide evidence of the disability and evidence the condition occurred before age 26. The PEBB Program will verify the disability and dependency of a child with a disability periodically beginning at age 26.

If adding an extended dependent or a dependent with a disability age 26 or older, you must complete the *Extended Dependent Certification* form or *Certification of Dependent with a Disability* form, respectively, 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. You must notify the PEBB Program in writing **no later than 60 days** after your dependent is no longer eligible.

The PEBB Program will not enroll a dependent if the PEBB Program cannot verify the dependent's eligibility. You can find a list of documents you must provide to verify your dependent's eligibility on page 48.

If I die, are my surviving dependents eligible?

The surviving dependents of an eligible employee or an eligible retiree may be eligible to enroll in PEBB retiree insurance if they meet both the procedural requirements and the eligibility requirements outlined in WAC 182-12-265.

Eligibility for dependents of emergency service employees

If you are a surviving dependent of an emergency service employee who was killed in the line of duty, you may be eligible to enroll in PEBB retiree insurance if you meet both the procedural and eligibility requirements outlined in WAC 182-12-250.

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 will find guidance on filing an appeal in chapter 182-16 WAC and at **www.hca.wa.gov/pebb** or call the PEBB Appeals Manager at 1-800-351-6827.

If you are...	You must...
Seeking a review of an eligibility, enrollment, or premium payment decision or action taken by the PEBB Program	Submit your appeal to the PEBB Appeals Manager **no later than 60 days** from the date of the PEBB Program's denial of the decision or action you are appealing. Send appeals to: **Health Care Authority** **PEBB Appeals** **P.O. Box 42684** **Olympia, WA 98504-2684**
Seeking a review of a decision or action by a health plan or insurance carrier about a claim or benefit (such as a dispute about a course of treatment or billing)	Contact the health plan or insurance carrier to request information on how to appeal its decision or action.

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

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

How do I enroll?

To enroll in PEBB retiree coverage, you have **60 days** after your employer-paid or COBRA coverage ends to:

- Submit your completed *Retiree Coverage Election Form* (form A) and any other required enrollment form (form B or C) found in the back of this guide to the PEBB Program. Be sure to include the certification forms required to enroll a domestic partner, same-sex spouse, an extended dependent, or a dependent with a disability if this applies to you. The forms can be found at **www.hca.wa.gov/pebb**.
- Submit the form(s) by fax, mail, or hand deliver to PEBB.
- Submit form A even if you decide to defer your enrollment. See "Deferring Your Coverage" on page 24 for more information.

You may also enroll your eligible dependents. If you are not on Medicare and want to enroll your dependent(s), you must provide proof of eligibility with your *Retiree Coverage Election Form*. Any subscriber enrolling a state-registered domestic partner must also submit proof of eligibility. See page 48 for a list of documents the PEBB Program will accept as proof.

You must send your first payment when you enroll, unless you choose to have your premiums deducted from your monthly pension check. Make your check for the premium payable to the Health Care Authority.

If you don't send us your completed form(s) and full premium payment (unless enrolled in pension deduction) or your request to defer coverage within 60 days after your employer-paid or COBRA coverage ends, you will lose your future right to enroll in PEBB coverage unless you regain eligibility.

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

Can I enroll on two PEBB accounts?

If you and your spouse or state-registered domestic partner are both eligible for PEBB coverage, you need to decide which of you will cover yourselves and any eligible children on your medical or dental plans. An enrolled family member may be enrolled in only one medical or dental plan. You could defer the medical coverage for yourself (see "Deferring Your Coverage" on page 24) and enroll as a dependent on your spouse's or domestic partner's medical coverage.

How long does the enrollment process take?

If you are retiring as a **state employee or a higher-education institution employee,** here's what you can expect after you send your form(s) to us:

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

If you are a K-12 retiree and meet PEBB eligibility and enrollment requirements, your coverage begins the first of the month after your school district or COBRA coverage ends.

continued

When does coverage begin?

When newly eligible—Medical, dental, and term life insurance coverage will begin on the first day of the month after employer-paid or COBRA coverage ends, as long as the appropriate forms are returned **no later than 60 days** after this coverage ends.

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. You must submit the appropriate form(s) either during the annual open enrollment or **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 in your form sooner. See "What is a special open enrollment?" on page 21 for more information.

Annual event	When coverage begins
Open enrollment	January 1 of the following year
Special open enrollment events	**When coverage begins**
Marriage or establishment of a state-registered domestic partnership	The first day of the month after the date of the event or the date the PEBB Program receives your completed enrollment form, whichever is later.
Birth or adoption	The date of birth (newborn children) 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 state-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
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	The first day of the month after the event date or the date the PEBB Program receives your completed enrollment form, whichever is later. **Note:** To be eligible for enrollment, dependents who lose other medical coverage must enroll in a PEBB plan **no later than 60 days** after their other coverage ends. The PEBB Program may require you to provide proof your dependent lost other health coverage.

What if I'm entitled to Medicare?

When you or your covered dependents become entitled to Medicare, the person entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B to remain eligible for PEBB retiree coverage. The entitlement to Medicare qualifies as a special open enrollment event, allowing you to change your health plans. Once you or your covered dependent(s) enrolls in Medicare Part A and Part B, you must send us a copy of either the Medicare card(s) or a letter from the Social Security Administration that shows the effective date of Medicare Part A and Part B coverage. Medicare will become the primary insurer, and the PEBB medical plan becomes secondary. Mail a copy of the Medicare card or letter to:

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

We will update your account to reduce your premium to the lower Medicare rate, if applicable, and notify your health plan of your Medicare enrollment.

CDHPs and Medicare don't mix

If you are enrolled in a consumer-directed health plan with a health savings account (HSA) when you or your covered dependent(s) become entitled to Medicare, you must take action **no later than 60 days** after enrolling in Medicare Part A and Part B.

If a covered family member becomes entitled to Medicare Part A or Part B, the subscriber must either:

- Remove the family member from PEBB coverage **no later than 60 days** after enrolling in Medicare Part A and Part B.

or

- Choose a new health plan. Your annual deductible and annual out-of-pocket maximum will restart with your new plan. You can keep the HSA, but no longer contribute to it. Contact Health Equity, the HSA trustee, about any balance requirements and account fees. If you are enrolled in Medicaid, you can't enroll a CDHP. Other restrictions apply.

How much do the plans cost?

Please see the retiree rates (premiums) on pages 12-13. 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.

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

How do I pay for coverage?

You can help ensure that your premium payments are made on time and avoid disruptions in your coverage by using pension deduction or automatic bank account withdrawals. Here are your payment options:

- **Pension deduction** – Your premium is taken from your end-of-the-month pension check. For example, if your coverage takes effect January 1, your January 31 check will show your premium deduction for January.
- **Automatic bank account withdrawals** – You must complete and return an *Electronic Debit Service Agreement* form to the HCA. You can find the form in the back of this booklet. You must continue to pay your premium invoices until you receive a letter from the HCA with your electronic debit start date. Approval takes six to eight weeks.
- **A personal check or money order** – Please send your payment with your election form to:
  Health Care Authority
  P.O. Box 42695
  Olympia, WA 98504-2695
  Make your check payable to Health Care Authority.
- **Voluntary Employees' Beneficiary Association (VEBA) Trust account** – You must contact VEBA to request reimbursement for your premiums. VEBA cannot pay your monthly premiums directly to the PEBB Program. You must also notify VEBA when your premiums change. VEBA will not reimburse you for retiree term life insurance. The administrator for VEBA is Meritain Health. Please call VEBA toll-free at 1-888-828-4953 for information, or visit **www.veba.org.**

continued

Note: If you enroll in a consumer-directed health plan, you must elect limited VEBA plan coverage; call VEBA for details on how to do this.

What happens if I miss a premium payment?

You must pay the premiums for your PEBB coverage when due. If you pay late or do not pay in full, we will cancel your coverage at the end of the month in which we received the last full premium payment. If your insurance coverage is cancelled, coverage for your covered dependents also will be cancelled. You cannot enroll again in PEBB coverage unless you regain eligibility.

How do I choose a medical or dental plan?

Follow these steps:

1. Check "2013 Medical Plans Available by County" on pages 32-33 to see which plans are in your county of residence.
2. Read about the different types of medical and dental plans PEBB offers. Highlights of the medical plans begin on page 34. You can find other details to consider when choosing a medical plan under "How can I compare the plans?" on page 29. The dental plan descriptions are on pages 42-43.
3. Call the plans directly with any questions about specific benefits, what prescription drugs they cover, or about specific health care providers. The plan phone numbers and websites are listed on page 3 of this guide.
4. Compare the premiums on pages 12-13.
5. Check the provider directory on your medical or dental plan's website to find out if your provider participates with the plan you choose. Then call your provider to confirm his or her participation. If you are choosing a new provider, make sure he or she is accepting new patients.
6. Choose your plan. You may enroll in dental coverage if you also enroll in medical coverage. When you enroll in dental coverage, your dependents also must enroll in dental. You and your enrolled dependents must maintain retiree dental coverage for at least two years. However, you do not have to stay enrolled in the same dental plan every year.

If you cancel or defer enrollment in medical coverage, you also must cancel/defer dental coverage.

PEBB prescription-drug coverage is creditable

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

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

If you do enroll in Medicare Part D, the only PEBB medical plan that coordinates benefits with Medicare Part D is Premera Blue Cross Medicare Supplement Plan F.

If you are enrolled in any other PEBB medical plan, you cannot enroll in Medicare Part D and keep your PEBB coverage.

How do I add or remove dependents?

To add a dependent, you must submit a *Retiree Coverage Election Form* indicating the dependent's enrollment to the PEBB Program within the required time limits. If adding a dependent with a disability or an extended dependent, you must also submit the appropiate dependent certification form.

If you are a retiree not on Medicare and want to add a newly eligible dependent to your coverage, you must provide a copy of the required documents as evidence of the dependent's eligibility within PEBB's enrollment time limits or the dependent will not be enrolled. Any subscriber enrolling a state-registered domestic partner must also submit proof of eligibility. See page 48 for a list of documents the PEBB Program will accept as proof.

Subscribers may add or remove eligible dependents during the PEBB annual open enrollment or, in some circumstances, a special open enrollment event. See "What is a special open enrollment?" for details. To make a change, you must submit the appropriate form(s) before the end of the annual open enrollment or **no later than 60 days** after the special open enrollment event.

Although subscribers are required to remove dependents when they are no longer eligible, retiree subscribers may remove an eligible dependent from coverage any time during the year. Unless otherwise approved by the PEBB Program, the dependent will be removed from coverage prospectively.

Exception: If you want to enroll a newborn or child whom you have adopted (or assumed a legal obligation for total or partial support in anticipation of adoption), you should notify the PEBB Program by submitting a *Retiree Coverage Election Form* as soon as possible to ensure timely payment of claims. If adding the child increases your premium, you must submit the *Retiree Coverage Election Form* no later than 12 months after the date of birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

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

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

What changes can I make during the annual open enrollment?

During the PEBB annual open enrollment you can:

- Change medical or dental plans.
- Enroll or remove eligible dependents from your coverage.
- Enroll in a health plan if you previously deferred PEBB retiree coverage for other coverage (see "Deferring Your Coverage" on page 24).
- Defer enrollment in PEBB retiree health coverage if you have or are enrolling in other coverage effective no later than January 1 of the following year. (See "Deferring Your Coverage" on page 24 for specific health coverage you can defer PEBB retiree coverage for.)

You must submit the appropriate form(s) to the PEBB Program before the end of the annual open enrollment (usually November 30). The enrollment change will become effective January 1 of the following year.

What is a special open enrollment?

A retiree subscriber may change his or her enrollment outside of the annual open enrollment when an event creates a special open enrollment. However, the change in enrollment must correspond to the event that creates the special open enrollment for either the subscriber or the subscriber's dependent (or both).

continued

To make an enrollment change, the subscriber must submit the appropriate form(s) to the PEBB Program **no later than 60 days** after the event that created the special open enrollment. In addition to the appropriate forms, the PEBB Program may require the subscriber to provide evidence of eligibility or evidence of the event that created the special open enrollment. In most cases, enrollment will start the first day of the month after we receive the enrollment form.

What events allow me to add dependents?

Any one of the following events may create a special open enrollment to enroll a dependent:

1. Subscriber acquires a new dependent due to:
   a. Marriage or registering a domestic partnership.
   b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
   d. A child becoming eligible as a dependent with a disability.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
3. Subscriber or a dependent has a change in employment status that affects the subscriber's or the dependent's eligibility for the employer contribution toward group health coverage.
4. Subscriber or subscriber's dependent has a change in enrollment under another employer plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
5. Subscriber's dependent moves from outside the United States to live within the United States.
6. A court order or National Medical Support Notice requires the subscriber or any other person to provide insurance coverage for an eligible dependent of the subscriber. (A former spouse or former state-registered domestic partner is not an eligible dependent.)
7. Subscriber or a subscriber's dependent becomes eligible for, or loses eligibility for, state premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

What events allow me to change health plans?

Any one of the following events may create a special open enrollment for a subscriber to change his or her health plan:

1. Subscriber acquires a new dependent due to:
   a. Marriage or registering a domestic partnership
   b. Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption
   c. A child becoming eligible as an extended dependent through legal custody or legal guardianship
   d. A child becoming eligible as a dependent with a disability.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
3. Subscriber or a subscriber's dependent has a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward group health coverage.
4. Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location, the subscriber must select a new health plan. If the subscriber does not select

a new health plan, the PEBB Program may change the subscriber's health plan as described in WAC 182-08-196.

5. A court order or National Medical Support Notice requires the subscriber, or any other person to provide insurance coverage for an eligible dependent of the subscriber. (A former spouse or former state-registered domestic partner is not an eligible dependent.)
6. Subscriber or a subscriber's dependent becomes eligible for, or loses eligibility for, state premium assistance through Medicaid or a state children's health insurance program (CHIP).
7. Subscriber or subscriber's dependent becomes entitled to Medicare, or enrolls in or cancels a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or dependent's entitlement to Medicare, the subscriber must select a new health plan as described in WAC 182-08-196.
8. Subscriber's or a subscriber's dependent's current health plan becomes unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA). The PEBB Program may require evidence that the subscriber or dependent is no longer eligible for an HSA.
9. Subscriber or subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the dependent for a specific condition or ongoing course of treatment. The subscriber may not change his or her health plan election if the subscriber's or an enrolled dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
    a. Active cancer treatment, such as chemotherapy or radiation therapy for up to 90 days or until medically stable.
    b. Transplant within the last 12 months.
    c. Scheduled surgery within the next 60 days (elective procedures within the next 60 days do not qualify for continuity of care).
    d. Recent major surgery still within the post operative period of up to eight weeks.
    e. Third trimester of pregnancy.

Note: If you change medical plans midyear, your annual deductible and annual out-of-pocket maximum will restart with your new plan.

Deferral rights for retirees

You may defer (postpone) your enrollment in PEBB retiree medical and dental coverage under the circumstances listed below. If you defer enrollment in a PEBB retiree medical plan, you may not enroll in a PEBB dental plan. Except as stated below, if you defer enrollment in a PEBB health plan, you also defer enrollment for your dependents.

- If you are continuously enrolled in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if you are continuously enrolled in a comprehensive, employer-sponsored medical plan including COBRA as an employee or the dependent of an employee.
- Beginning January 1, 2001, if you are continuously enrolled in medical coverage as a retiree or a dependent in a federal retiree plan, such as TRICARE.
- Beginning January 1, 2006, if you are continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, your Medicaid coverage must include coverage for medical and hospital benefits. Your eligible dependents who are not eligible for creditable coverage under Medicaid may continue PEBB coverage.

To defer medical (or medical and dental) coverage, you must submit a *Retiree Coverage Election Form* to the PEBB Program:

- If you are an employee who is retiring, you must submit the form **no later than 60 days** after your employer-paid or COBRA coverage ends.
- If you are enrolled as a retiree, you must submit the form before you defer coverage.

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

Deferral rights for surviving dependents of employees or retirees

A surviving dependent of an employee, a retiree, or a school district or educational service district employee who is eligible for PEBB retiree coverage under WAC 182-12-265 may defer enrollment under the circumstances listed below. If a surviving dependent defers enrollment in a PEBB retiree medical plan, he or she may not enroll in a PEBB dental plan.

- If a surviving dependent is continuously enrolled in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if a surviving dependent is continuously covered under another comprehensive, employer-sponsored medical plan as an employee or the dependent of an employee, including COBRA.
- Beginning January 1, 2001, if a surviving dependent is continuously enrolled in medical coverage as a retiree or the dependent in a federal retirement plan, such as TRICARE.
- Beginning January 1, 2006, if a surviving dependent is continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the surviving dependent's Medicaid coverage must include coverage for medical and hospital benefits. A surviving dependent's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB coverage.

To defer medical (or medical and dental) coverage, a surviving dependent must submit a *Retiree Coverage Election Form* to the PEBB Program:

- In the event of an employee or retiree's death, a surviving dependent must submit the form **no later than 60 days** after the death.
- If a surviving dependent enrolls in PEBB retiree coverage as a surviving dependent and is eligible to defer coverage in the future, he or she must submit the form before deferring coverage.

Deferral rights for surviving dependents of emergency services personnel

A surviving dependent of emergency services personnel killed in the line of duty who is eligible for PEBB retiree coverage under WAC 182-12-250 may defer enrollment under the circumstance listed below. If a surviving dependent defers enrollment in a PEBB retiree medical plan, he or she may not enroll in a PEBB dental plan.

- Surviving dependent is continuously enrolled in comprehensive employer-sponsored medical plan including COBRA. The surviving dependent must submit a *Retiree Coverage Election Form* to the PEBB Program **no later than 180 days** after the later of:
  - The death of the emergency service employee.
  - The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
  - The last day the surviving dependent was covered under a health plan through the emergency service employee's employer.
  - The last day the surviving dependent was covered under COBRA coverage from the emergency service employee's employer as described in WAC 182-12-250.

How do I enroll after deferring PEBB coverage?

If a retiree or surviving dependent deferred enrollment in PEBB retiree coverage, he or she may reenroll under the following circumstances, as long as he or she has had continuous enrollment in other coverage defined earlier in this section.

- During any PEBB annual open enrollment.
- **No later than 60 days** after the date other coverage ends. Enrollment will begin the first day of the month after other coverage ends.

Although a retiree or survivor has 60 days to enroll, the retiree or survivor must pay PEBB premiums back to when other coverage ended.

To enroll, submit a *Retiree Coverage Election Form* and proof of continuous enrollment in other medical coverage to the PEBB Program. Proof must list when the coverage began and ended.

If a retiree or surviving dependent deferred enrollment in PEBB coverage for federal retiree coverage, he or she has a one-time opportunity to enroll in PEBB medical and dental coverage.

How do I enroll after deferring PEBB coverage for Medicaid?

Retirees or surviving dependents who defer PEBB retiree coverage while continually enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage may enroll in PEBB coverage if they lose their Medicaid coverage:

- During any PEBB annual open enrollment.
- **No later than 60 days** after the date Medicaid coverage ends, or no later than the end of the calendar year when the retiree or survivor's Medicaid coverage ends, if he or she was also eligible under subsidized Medicare Part D.

Retirees who defer enrollment may enroll in a PEBB health plan if the retiree receives formal notice that the Department of Social and Health Services has determined it is more cost-effective to enroll the retiree or the retiree's eligible dependent(s) in PEBB medical than a medical assistance program.

How do I cancel coverage?

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

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

In most cases, plan enrollment will end at the end of the month in which we receive your written request. If you are enrolled in a Medicare Advantage plan, you must also send a completed *PEBB Medicare Advantage Plan Disenrollment Form* (form D) to us. We will send form D to your plan, which will remove you from coverage on the first of the month after the plan receives the form.

If you cancel your PEBB retiree coverage, you cannot enroll again later unless you regain eligibility for PEBB coverage, for example, by returning to state service.

When does PEBB coverage end?

Health plan enrollment ends on the earliest of the following dates:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends.
- When you or your dependent declines the opportunity, is ineligible for, or chooses not to continue enrollment in a PEBB medical 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.
- Coverage for you and your enrolled dependents ends on the last day of the month for which you last paid the full premium. PEBB charges a full month's premium for each calendar month of coverage. The HCA will not prorate a premium if an enrollee dies or cancels his or her coverage before the end of the month.
- If an enrollee or newborn eligible for benefits under "Obstetric and Newborn Care" is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB coverage ends, and the enrollee is not immediately covered by other health care coverage, contact the PEBB Program to determine whether the enrollee qualifies for an extended benefit.

What are my options when coverage ends?

You, your dependents, or both may temporarily continue your PEBB coverage by self-paying the premiums after your eligibility ends. Options for continuing coverage vary based on the reason you lost eligibility. See below for continuation options.

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

Your dependents lose eligibility when you die; however, they may continue PEBB retiree coverage even if they were not covered at the time of your death. Your spouse or state-registered domestic partner may continue coverage indefinitely as long as he or she pays the premiums. Your other dependents may continue coverage until they are no longer eligible under PEBB rules.

If your spouse is no longer eligible due to divorce, he or she may continue coverage for **up to 36 months** under COBRA.

If your state-registered domestic partnership ends, PEBB will offer your domestic partner and his or her children an extension of coverage for **up to 36 months**.

If your dependent child is no longer eligible under PEBB rules, he or she may continue under COBRA for **up to 36 months**.

For information about your rights and obligations under PEBB rules and federal law, review the *Continuation of Coverage Election Notice* booklet.

PEBB retirees may choose a managed-care plan, Medicare supplement plan, Medicare Advantage plan, consumer-directed health plan, or a preferred-provider plan. Your options are based on what plans are available in your county and whether you are enrolled in Medicare Part A and Part B.

Medicare options:

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

Non-Medicare options:

Managed-care plans

- Group Health Classic
- Group Health Value
- Kaiser Permanente Classic

Consumer-directed health plans (CDHPs)

- Group Health Options, Inc. (CDHP)
- Kaiser Permanente CDHP
- Uniform Medical Plan (UMP) CDHP, administered by Regence BlueShield

Preferred-provider plan:

- UMP Classic

Generally, a classic plan has a higher premium than a value plan, but the classic plan's annual deductible and your costs at the point of service are lower.

A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax-free. The CDHP has a lower monthly premium, a higher deductible, and a higher out-of-pocket maximum. All of your medical coinsurances and copays count toward your out-of-pocket maximum. **You cannot enroll in this plan if you are enrolled in Medicare. You cannot enroll your spouse or a dependent who is enrolled in Medicare.**

While UMP Classic allows you to see any covered provider type, your costs may be lower if you see a provider in the plan's network.

PEBB retirees enrolled in Medicare Part A and Part B who select Group Health or Kaiser Permanente must enroll in their plan's Medicare Advantage plan if one is available in their county.

All PEBB plans (except Premera Blue Cross Medicare Supplement Plan F) coordinate benefit payments with other group plans, Medicaid, and Medicare. This is called coordination of benefits (COB). This coordination ensures benefit costs are more fairly distributed when a person is covered by more than one plan.

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

PEBB plans will not coordinate benefits with any individual health plan. This means how your PEBB plan pays for benefits will not change for a particular service or treatment, even if you or a dependent have an individual medical or dental policy covering that service or treatment.

You can compare some of the medical plans' benefits in this booklet (see pages 34-41) and at **www.hca.wa.gov/pebb**.

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

When you enroll in a CDHP, you are automatically enrolled in a tax-free health savings account (HSA) which 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 plan may not cover. See IRS Publication 969—*Health Savings Accounts and Other Tax-favored Health Plans* for details.

An HSA is set up with a qualified trustee to pay for or reimburse your costs for qualified medical services and expenses. HealthEquity, Inc., is the qualified trustee for the Group Health, Kaiser Permanente, and UMP CDHPs.

When you enroll in a CDHP, the PEBB Program contributes the following amounts to your HSA:

- $58.34 each month for an individual subscriber, up to $700.08 for the 2013 calendar year; or
- $116.67 each month for a subscriber with one or more enrolled family members, up to $1,400.04 for the 2013 calendar year.

The contribution from the PEBB Program goes into the HSA in monthly installments over the year, and is 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 through 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, which is $3,250 for individual subscribers and $6,450 for families in 2013. Members ages 55 and older may contribute up to $1,000 more annually (in addition to the limits above).

To ensure you do not go beyond the maximum allowable limit, make sure to calculate the PEBB Program's contribution amount for the year, plus any additional amount you contribute.

Some other features of the CDHP/HSA:

- Your prescription-drug costs count toward the annual deductible and out-of-pocket maximum.
- 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.

See "How can I compare the plans?" on page 29 for more details on the CDHPs.

You cannot enroll in a CDHP/HSA if:

- You or your spouse or state-registered domestic partner is enrolled in Medicare or Medicaid.
- You are enrolled in another comprehensive medical health plan—for example, on a spouse's or domestic partner's plan.
- You or your spouse or state-registered domestic partner is enrolled in VEBA, unless you convert it to a limited VEBA.
- You have received Veterans' Administration benefits (including prescription drugs) in the three months before you enroll in a CDHP/HSA, or have TRICARE coverage.
- You enrolled in a flexible spending account (FSA) or a 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. See IRS Publication 969 for details.

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

Medicare Advantage plans are available from Group Health and Kaiser Permanente, but are not available in every county. When these medical plans offer a Medicare Advantage plan in your county, and you are enrolled in Medicare Part A and Part B, you must enroll in the Medicare Advantage plan.

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

Group Health also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Group Health Medicare Advantage plan. The Group Health Original Medicare plan's benefits differ from the Medicare Advantage plan, but Group Health Original Medicare still coordinates with Medicare Part A and Part B.

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

The PEBB Program does not offer the high-deductible Plan F shown in the *Outline of Medicare Supplement Coverage* that begins on page 38.

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

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

How can I compare the plans?

All medical plans, with the exception of Premera Blue Cross Medicare Supplement Plan F, cover the same basic health care services, although benefit enhancements, limitations, premiums, annual deductibles, annual out-of-pocket maximums, copays, and coinsurance may vary.

If you cover eligible dependents, **they must be covered under the same medical and dental plans you choose** (unless you select Medicare Supplement Plan F and your dependents are not eligible for Medicare).

As you review the plans consider:

Geography. In most cases, you must live in the plan's service area to join the plan. See "2013 Medical Plans Available by County" on pages 32-33. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.

Cost. As a retiree, you pay the premium for your medical or medical/dental coverage. Keep in mind, a higher premium cost doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits (except Medicare Supplement Plan F).

Special medical needs. If you or a dependent needs certain medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. **Note:** Each plan has a different formulary, which is a list of approved prescription drugs the plan will cover.

Medicare. If you or your covered dependents are entitled to Medicare, you must enroll in Medicare Part A and Part B to keep your PEBB retiree coverage. You also cannot enroll in a consumer-directed health plan if you or a covered dependent is enrolled in Medicare.

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

Deductible. All medical plans, except Group Health Medicare Advantage and Kaiser Permanente Senior Advantage, 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.

Some of your out-of-pocket costs do not apply to the plans' annual deductible. The plans can tell you which benefits' costs apply to the annual deductible.

All the CDHPs have lower premiums and a higher annual deductible than other medical plans available to retirees not enrolled in Medicare. Keep in mind:

- If you cover one or more family members, you must pay the entire family deductible before the CDHP 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.
- The CDHPs' annual deductible applies toward the annual out-of-pocket maximum.

continued

Out-of-pocket maximum. This is the maximum amount you pay in one calendar year. Once you have paid this amount, most plans pay 100 percent of allowed charges for a majority of covered services for the remainder of the calendar year. The out-of-pocket maximum varies by plan.

For all plans except the consumer-directed health plans, the amounts you pay for prescription drugs, deductibles, and some copays and coinsurance do not apply toward your out-of-pocket maximum. The plans can tell you which benefits' costs apply to the out-of-pocket maximum.

If you enroll in a CDHP and cover one or more family members, you must pay the entire family out-of-pocket maximum before the plan pays 100 percent for covered benefits.

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.

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 before you join by calling the provider and plan directly.

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. Members enrolled in a consumer-directed health plan also should keep paperwork received from their provider or from qualified medical expense purchases to verify payments or reimbursements from their health savings account.

Coordination with your other benefits. If you are also covered through your spouse's or domestic partner's comprehensive group health coverage, call the medical and dental plans directly to ask how they will coordinate benefits. Coordinating your PEBB plan's benefits with your other plan's benefits may save you money. **Note:** If you have other comprehensive health coverage, you may not enroll in a consumer-directed health plan with a health savings account. Call Health Equity 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 3.

Find health plan locations

Not all types of plans are available in every county. See pages 32-33 to find the plans in your area.

How to Find the Summaries of Benefits and Coverage

For 2013, the federal Patient Protection and Affordable Care Act requires the PEBB Program and health 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.

If you want to request an SBC from your current PEBB medical plan	If you want to request an SBC from another PEBB medical plan
You can either: • Go to your plan's website to view it online; OR • Call your plan's customer services to request a paper copy at no charge.	You can either: • Go to the plan's website to view it online; OR • Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge.
You can find the medical plans' websites and customer service phone numbers on page 3.	

2013 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 Options, Inc. (consumer-directed health plan)** **Group Health Value** *These plans not available to Medicare members.*	• Benton • Columbia • Franklin • Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Kittitas	• Lewis • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) • Mason • Pierce • San Juan • Skagit • Snohomish • Spokane	• Stevens (ZIP Codes 99013, 99034, 99040, 99110, 99148, and 99173) • Thurston • Walla Walla • Whatcom • Whitman • Yakima
Group Health Medicare Advantage	• Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) • Island • King • Kitsap • Lewis	• Mason (ZIP Codes 98312, 98524, 98528, 98541, 98546, 98548, 98555, 98560, 98584, 98588, and 98592)	• Pierce • San Juan • Skagit • Snohomish • Spokane • Thurston • Whatcom
Group Health Original Medicare	• Benton • Columbia • Franklin • Kittitas • Lincoln (ZIP Codes 99008, 99029, 99032, and 99122)	• Mason* • Stevens (ZIP Codes 99013, 99034, 99040, 99110, 99148, and 99173) • Walla Walla • Whitman	• Yakima **Original Medicare is available in ZIP Codes where Medicare Advantage is not available.*
Kaiser Permanente Classic **Kaiser Permanente consumer-directed health plan** *These plans not available to Medicare members.*	• Clark • Cowlitz • Lewis (ZIP Codes 98591, 98593, and 98596)	• Skamania (ZIP Codes 98639, 98648, and 98671)	• Wahkiakum (ZIP Codes 98612 and 98647)
Kaiser Permanente Senior Advantage	• Clark • Cowlitz	• Lewis (ZIP Codes 98591, 98593, and 98596)	• Skamania • Wahkiakum (ZIP Codes 98612 and 98647)
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in all Washington counties and nationwide.		
UMP Classic **UMP consumer-directed health plan** **UMP Medicare**	Available in all Washington counties and worldwide.		

Oregon	
Group Health Classic **Group Health Options, Inc. (consumer-directed health plan)** **Group Health Original Medicare** **Group Health Value**	• Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
Kaiser Permanente Classic **Kaiser Permanente consumer-directed health plan** *These plans not available to Medicare members.*	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, and 97267-69) • Columbia • Hood River (ZIP Code 97014) • Linn (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389) • Marion (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-12, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392) • Multnomah • Polk • Washington • Yamhill
Kaiser Permanente Senior Advantage	• Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas • Columbia • Hood River • Linn (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389) • Marion • Multnomah • Polk • Washington • Yamhill
Medicare Supplement Plan F, administered by Premera Blue Cross	Available in all Oregon counties and nationwide.
UMP Classic **UMP consumer-directed health plan** **UMP Medicare**	Available in all Oregon counties and worldwide.

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

2013 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	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
Deductible	$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*
Out-of-pocket maximum	$2,000/ person $4,000/family	$2,000/person $4,000/family	$5,100/person $10,200/family**		$2,000/ person $4,000/family	$4,200/person $8,400/ family**	$2,000/person $4,000/family	$4,200/person $8,400/ family**
Prescription drug deductible	Does not apply	Does not apply	Included in deductible		Does not apply	Included in deductible	$100/person $300/family (Tier 2 and 3 drugs)	Included in deductible

*Must meet family deductible before plan pays benefits.
**Must meet family out-of-pocket maximum before plan pays 100% for covered benefits.

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan	
	Classic	Value	CDHP	CDHP Extended Network[1]	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%	30%	$75	15%	$75 copay + 15%	15%
Hearing Routine annual exam	$15	$20	10%	30%	$20	$20	$0	15%
Hardware	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%

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

Benefits	Group Health				Kaiser Permanente		Uniform Medical Plan	
	Classic	Value	CDHP	CDHP Extended Network[1]	Classic	CDHP	Classic	CDHP
	You pay				You pay		You pay	
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%
Prescription drugs Retail pharmacy (up to a 30-day supply)								15%*
Value tier	$5	$5	$5	$5	Does not apply	Does not apply	5% (up to $10/ 30-day supply)	
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%* (no dollar limit; no coverage for specialty drugs)	
Mail order (up to a 90-day supply)								15%*
Value tier	$10	$10	$10	Does not apply	Does not apply	Does not apply	5% (up to $30/ 90-day supply)	
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%* (specialty drugs up to $150; no limit for non-specialty)	
Preventive care	$0	$0	$0	30%	$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 Exam (annual)	$15	$20	10%	30%	$20	$20	$0	$0
Glasses and contact lenses	Any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.							

[1] *Group Health's CDHP Extended Network includes First Choice Health Network, First Health Network, and any licensed provider.*

UMP members who see an out-of-network provider will pay 40% of the allowed amount plus the amount the provider charged that was more than the allowed amount.

*May also be subject to an ancillary charge if drug has an available generic equivalent.

2013 Medicare Plan Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. Group Health and Kaiser Permanente offer Medicare Advantage plans, but not in all areas. If you are in an area where a Medicare Advantage plan is not available, your plan will enroll you in its Medicare coordination plan.

Annual Costs	**Group Health Medicare Plan**		**Kaiser Permanente Senior Advantage**	**UMP Classic**
	Medicare Advantage	**Original Medicare** (Coordinates with Medicare)		**Medicare**
	You pay		**You pay**	**You pay**
Deductible	$0	$250/person $750/family	$0	$250/person $750/family
Out-of-pocket maximum	$2,500/person	$2,000/person	$1,500/person $3,000/family	$2,500/individual $5,000/family
Prescription drug deductible	Does not apply	Does not apply	Does not apply	$100/person $300/family

Benefits	**Group Health Medicare Plan**		**Kaiser Permanente Senior Advantage**	**UMP Classic**
	Medicare Advantage	**Original Medicare** (Coordinates with Medicare)		**Medicare**
	You pay		**You pay**	**You pay**
Ambulance Air or ground, per trip	$150	20%	$50	20%
Diagnostic tests, laboratory, and x-rays	$0	$0 MRI/CT/PET scan $30	$0	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	$0	15%
Emergency room (copay waived if admitted)	$65	$150	$50	$75 copay + 15%
Hearing Routine annual exam	$20	$15	$30	$0
Hardware	Any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.			
Hospital services Inpatient	$200/day for first 5 days, up to $1,000 maximum/ admission	$150/day, up to $750 maximum/ admission	$500/admission	$200/day up to $600/admission + 15% professional fees
Outpatient	$200	$150	$50	15%

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (Coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Office visit				
Primary care	$20	$15	$30	15%
Urgent care	$20	$15	$35	15%
Specialist	$20	$30	$30	15%
Mental health	$20	$15	$30	15%
Chemotherapy	$0	$15	$0	15%
Radiation	$0	$30	$0	15%
Physical, occupational, and speech therapy	$20	$15 (Per-visit cost for 60 visits/ year combined)	$30	15%
Prescription drugs				
Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies				
Value tier	Does not apply	$5	Does not apply	5% (up to $10/ 30-day supply)
Tier 1	$20	$20	$20	10% (up to $25/ 30-day supply)
Tier 2	$40	$40	$40	30% (up to $75/ 30-day supply)
Tier 3	50% up to $250	50% up to $250	Does not apply	50%*
Mail order (up to a 90-day supply)				
Value tier	Does not apply	$10	Does not apply	5% (up to $30/ 90-day supply)
Tier 1	$40	$40	$40	10% (up to $75/ 90-day supply)
Tier 2	$80	$80	$80	30% (up to $225/ 90-day supply)
Tier 3	50% up to $750	50% up to $750	Does not apply	50%* (specialty drugs up to $150; no limit for non-specialty)
Preventive care	$0	$0	$0	$0
	See certificate of coverage or check with plan for full list of services.			
Spinal manipulations	$20	$15	$30	15%
Vision care				
Exam (annual)	$20	$15	$30	$0
Glasses and contact lenses	Any amount over $150 every 24 months (or two calendar years for UMP Classic) for frames, lenses, contacts, and fitting fees combined.			

*May also be subject to an ancillary charge if drug has an available generic equivalent.

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

Outline of Medicare Supplement Coverage
Washington State Health Care Authority

PREMERA BLUE CROSS

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

Basic Benefits included in all plans:

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

Plan A	Plan B	Plan C	Plan D	Plan F & Plan F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Basic benefits, including 100% Part B coinsurance	Hospitalization & preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization & preventive care paid at 100%; other basic benefits paid at 75%	Basic benefits, including 100% Part B coinsurance	Basic including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of pocket limit $4,660 paid at 100% after limit reached	Out of pocket limit $2,320 paid at 100% after limit reached		

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Washington State Health Care Authority

SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2013)

Eligible By Reason Of Age Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan F $109.10	Plan F $212.02	Plan F $205.85	Plan F $411.70

Eligible By Reason Of Disability Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan F $206.11	Plan F $406.04	Plan F $349.93	Plan F $699.86

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

SUBSCRIPTION CHARGE INFORMATION

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

DISCLOSURES

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

READ YOUR CERTIFICATE VERY CAREFULLY

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

RIGHT TO RETURN CERTIFICATE

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

CERTIFICATE REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A Deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after: (while using 60 lifetime reserve days)	All but $578 a day	$578 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

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

PLAN F (continued):

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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $140 of Medicare approved amounts*	$0	$140 (Part B Deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $140 of Medicare approved amounts*	$0	$140 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

MEDICARE (PARTS A & B)

HOME HEALTH CARE - Medicare approved services			
Medically Necessary Skilled Care Services and Medical Supplies	100%	$0	$0
Durable Medical Equipment			
First $140 of Medicare approved amounts*	$0	$140 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

How the Dental Plans Work

You have three dental plans to choose from:

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

Uniform Dental Plan (UDP) is a preferred-provider plan administered by Washington Dental Service (WDS). This plan provides members with the freedom to choose any dentist, but members receive a higher level of coverage when they receive treatment from dentists who participate in the WDS Delta Dental PPO plan (Group 3000). If you select a dentist who is not in the Delta Dental PPO network you are responsible for having your dentist complete and sign a claim form.

You can verify that your dentist participates in the Delta Dental PPO network by calling UDP at 1-800-537-3406 or using the search tool online at **www.deltadentalwa.com/pebb.**

Note: UDP does not mail ID cards but you may download one online.

DeltaCare is also administered by Washington Dental Service (WDS). Under this managed-care plan, you select a primary care dentist from the DeltaCare PEBB network. You must confirm that your dentist is in the DeltaCare PEBB network (Group 3100) that serves PEBB members, and you must receive care from your selected dentist. This is important, as you could be responsible for all costs if you receive care from a provider who is not in the DeltaCare PEBB network.

You can search for network providers at **www.deltadentalwa.com/pebb** using the *Find a Dentist* tool or verify a dentist's participation by calling DeltaCare at 1-800-650-1583.

Willamette Dental Group Plan, underwritten by Willamette Dental of Washington, Inc, is also a managed-care dental plan. You must receive your care from a Willamette Dental Group provider.

Willamette Dental Group has over 50 offices located throughout Washington, Oregon, and Idaho. You can find a list of Willamette Dental Group providers and offices at **www.WillametteDental.com/WApebb** or by calling 1-855-433-6825.

Because dentist and clinic participation with the dental plans can change, please contact the dental plans to verify dentists and clinic locations.

Is a managed-care dental plan right for me?

The table on the next page briefly compares the benefits and costs of the UDP and the managed-care dental plans. Before enrolling in a managed-care dental plan, it is important to consider the following:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB member.)
- Am I willing to travel for services if I select a dentist in another service area?
- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out if their plan will cover your continuous dental treatment.

Are UDP and DeltaCare the same as Delta Dental?

Washington Dental Service (WDS) is a member of the nationwide Delta Dental Plans Association. WDS administers several dental plans, including the Uniform Dental Plan (UDP, Group 3000) and DeltaCare (Group 3100). If you choose UDP or DeltaCare, be sure that you choose a WDS member dentist who participates in your plan's network. Each plan has its own provider network.

Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the dental plans directly.

Annual Costs	Uniform Dental Plan (preferred-provider organization)	• DeltaCare • Willamette Dental Group Plan (managed-care dental plans)
	You pay	You pay
Annual deductible	$50/person, $150/family	$0
Annual maximum	Amounts over $1,750; orthodontia, nonsurgical TMJ, and orthognathic surgery have specific coverage maximums	No general plan maximum; nonsurgical TMJ and orthognathic surgery have specific coverage maximums

Benefits	Uniform Dental Plan (preferred-provider organization)	• DeltaCare • Willamette Dental Group Plan (managed-care dental plans)
	You pay	You pay
Dentures	50% PPO and out of state; 60% non-PPO	$140 for complete upper or lower
Endodontics (root canals)	20% PPO and out of state; 30% non-PPO	$100 to $150
Nonsurgical TMJ	30% of costs up to $500 for PPO, out of state, or non-PPO; then any amount over $500 in member's lifetime	DeltaCare: 30% of costs up to $1,000 per year; then any amount over $5,000 in member's lifetime Willamette Dental Group Plan: 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 up to $1,750 for PPO, out of state, or non-PPO; then any amount over $1,750 in member's lifetime	Up to $1,500 per case
Orthognathic surgery	30% of costs up to $5,000 for PPO, out of state, or non-PPO; then any amount over $5,000 in member's lifetime	30% of costs up to $5,000; then any amount over $5,000 in member's lifetime
Periodontic services	20% PPO and out of state; 30% non-PPO	$15 to $100
Preventive/diagnostic	$0 PPO; 10% out of state; 20% non-PPO	$0
Restorative crowns	50% PPO and out of state; 60% non-PPO	$100 to $175
Restorative fillings	20% PPO and out of state; 30% non-PPO	$10 to $50

Life Insurance

Eligibility

Eligibility is the same as for medical and dental plans, **except retiree term life insurance is only available to those who**:

- Meet the PEBB Program's retiree eligibility requirements and had life insurance through the PEBB Program as an employee; **or**
- Are a retiree of an eligible employer group, K-12 school district, or educational service district who had life insurance through the PEBB Program as an active employee; **and**
- Are not on a waiver of premium due to disability.

Your dependents are not eligible for retiree term life insurance.

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

Amount of insurance

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

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

This insurance has no cash value.

Premium cost

The cost is $6.57 per month, regardless of age. Rates are guaranteed until December 31, 2013.

Enrollment

Complete the *Retiree Coverage Election Form* and return it to the PEBB Program no later than **60 days** after your employer-paid coverage ends. There are no plans for future open enrollment periods for this life insurance coverage.

Effective date

If you enroll when eligible and pay premiums on time, insurance becomes effective on your retirement date.

No exclusions

This plan covers death from any cause.

Disability

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

Beneficiary

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

(1) Spouse/state-registered domestic partner
(2) Children
(3) Parents
(4) Estate

If you are married and wish to name someone other than your spouse/state-registered domestic partner as beneficiary, or if you have special estate planning needs, you should seek legal and tax advice before completing your beneficiary designation.

Claim filing

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

Insurance certificate

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

Long-Term Care Insurance

The PEBB Program sponsors a voluntary group long-term care insurance plan for:

- Employees who are eligible for PEBB benefits.
- Retirees who are eligible for PEBB benefits.
- Spouses and state-registered domestic partners (including surviving spouses of eligible employees).
- Parents and parents-in-law (under issue age 80 on the coverage effective date) of eligible employees.

John Hancock Life Insurance Company (U.S.A.) is the underwriter for the group long-term care insurance plan (licensed in all states except New York; permitted in New York to service existing insureds and clients).

Family members must be issue age 18 or older to apply for coverage. All applicants must reside in the U.S. (50 states and District of Columbia) on the date they apply and the coverage effective date. This does not apply to employees and their spouses or state-registered domestic partners temporarily residing outside of the U.S. applying with their U.S. residence address. (All certificates will be mailed to a U.S. address.)

Why should I apply for long-term care insurance?

The need for long-term care can occur at any point during your life due to illness, accident, or the effects of aging.

Long-term care insurance covers services at home, in a nursing home setting, and other types of facilities. The mix of care settings and levels of care varies with different policies.

Who helps coordinate what type of care is needed?

John Hancock's care coordinators are registered nurses or licensed social workers who are knowledgeable in long-term care. They will work with you and your family to find the care that is right for you and help you use your long-term care benefits wisely. However, you are not required to follow their recommendations.

What are some features of the long-term care insurance plan?

- **Premiums are based on your age at time of enrollment**—Your age when your coverage becomes effective determines your monthly premium rate. The younger you are when you enroll, the lower your cost will be.
- **Inflation protection feature**—This allows you to increase your coverage periodically, so that it helps keep pace with inflation. You can choose to accept or decline each inflation addition offer, allowing you to determine how much coverage you need.
- **Easy premium payment methods**—You have the option to pay premiums through direct billing or automatic bank withdrawal.
- **Full portability of coverage**—Even if you leave your job and are no longer eligible for PEBB benefits, you can continue your coverage at group rates.

How do I apply?

A retiree, his or her spouse or state-registered domestic partner, parent, parent-in-law, or surviving spouse may apply for long-term care insurance at any time by providing proof of good health. Proof of good health and approval for coverage by the carrier are required to enroll in long-term care insurance.

To request an enrollment kit from John Hancock Life Insurance Company (U.S.A.), you can either:

- Visit PEBB's group long-term care website at **http://pebbltc.jhancock.com** (user name: **pebbltc** password: **jhancock)**, or
- Call John Hancock Life Insurance Company (U.S.A) at 1-800-399-7271.

This is only a brief summary of some of the features of the PEBB group long-term care insurance plan. Some plan features vary by state. More details about plan provisions and exclusions are available from John Hancock.

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?

For PEBB members, this means a group discount of up to 12% off Liberty Mutual's auto and home insurance rates. In addition to the discount, Liberty Mutual also offers:

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

When can I enroll?

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

How do I enroll?

To request a quote for auto or home insurance, you can contact Liberty Mutual one of three ways (be sure to 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. Discounts and savings are available where state laws and regulations allow, and may vary by state. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify.

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

Federal Way	**1-800-826-9183** 930 S. 336th St., Suite C
Portland, OR	**1-800-248-8320** One Liberty Centre
Redmond	**1-800-253-5602** 15809 Bear Creek Parkway #120
Spokane	**1-800-208-3044** 11707 East Sprague Ave., Suite 205
Tukwila	**1-800-922-7013** 14900 Interurban Ave. S., Suite 142
Tumwater	**1-800-319-6523** 300 Deschutes Way SW, Suite 210

Valid Dependent Verification Documents

For retirees not on Medicare and any subscriber enrolling a state-registered domestic partner:

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.

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 dependents' Social Security numbers)
- The subscriber's and spouse's most recent 1040 Married Filing Separately federal tax return (black out financial information and 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 state-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*
- Proof of financial interdependency (for example, a bank statement—black out financial information) and certificate/card of state-registered domestic partnership*
- 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 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 state-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 or state-registered domestic partnership, then only the marriage certificate or certificate/card of state-registered domestic partnership is required.

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

Completing the Retiree Forms

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

New enrollment

Step 1: Check the "2013 Medical Plans Available by County" section in this guide to find the plans available to you.

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

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

Mail your forms

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

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

Note: If you or any covered dependents haven't sent us a copy of your Medicare card(s), please send it along with your form(s).

If you are not enrolled in Medicare, or to enroll a domestic partner, you must also provide documents that prove eligibility of any dependents you wish to enroll.

If you have questions about the enrollment process, please call us at **1-800-200-1004**.

If sending payment with your form(s), please enclose your check or money order payable to Health Care Authority and mail to:

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

Changing enrollment

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

Step 2: If you are changing medical plans, check the "2013 Medical Plans Available by County" section in this guide to find the plans available to you.

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

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

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

If you're adding a state-registered domestic partner, same-sex spouse, or a domestic partner's or same-sex spouse's child to your coverage, you must also complete and submit the *Declaration of Tax Status* form. You can download this form from our website or call the PEBB Program to request one.

Form A Use form A only to enroll in or make changes to these plans
Group Health Classic, Medicare Plan (Original Medicare), or Value
Group Health Options, Inc. (CDHP)
Kaiser Permanente Classic or CDHP
Uniform Medical Plan Classic or UMP CDHP
Forms A and C Use forms A and C to enroll in or make changes to these plans
Group Health Medicare Advantage
Kaiser Permanente Senior Advantage
Forms A and B Use forms A and B to enroll in or make changes to this plan
Medicare Supplement Plan F, administered by Premera Blue Cross

Completing the Retiree Forms

The following forms are available online:

2013 Retiree Coverage Election Form (Form A)

http://www.hca.wa.gov/pebb/documents/51-403F-2013.pdf

Premera Blue Cross Medicare Supplement Enrollment Application (Form B)

http://www.hca.wa.gov/pebb/documents/premeraB.pdf

2013 Medicare Advantage Plan Election Form (Form C)

http://www.hca.wa.gov/pebb/documents/51-576-2013.pdf

Electronic Debit Service Agreement

http://www.hca.wa.gov/pebb/documents/42-450-2013.pdf