

Your PEBB benefits for

# 2021



**Quick start guide**  
Page 5



**2021 Monthly premiums**  
Page 30



**Eligibility**  
Pages 8–12



**Medical plans by county**  
Page 29



**Medical benefits comparison**  
Pages 31–40



**Enrollment forms**  
At the end of the guide

# Employee Enrollment Guide



# Who to contact for help

## Contact the health plans for help with:

- Benefit questions
- ID cards
- Claims
- Checking to see if a health care provider is in the plan's network
- Choosing a health care provider
- Making sure your prescriptions are covered

## Contact your payroll or benefits office for help with:

- Eligibility for coverage and enrollment questions or changes
- Accessing paper forms
- Premium surcharges questions
- Updating your contact information (name, address, phone, etc.)
- Enrolling or removing dependents
- Payroll deduction information (including pretax or post-tax contributions)
- Appeals (See page 63.)

## Medical plans

### Kaiser Permanente NW Classic or CDHP<sup>1</sup>

[my.kp.org/wapebb](http://my.kp.org/wapebb)

Portland area: 503-813-2000

All other areas: 1-800-813-2000

TTY: 711

### Kaiser Permanente WA Classic, CDHP, SoundChoice, or Value

[kp.org/wa/pebb](http://kp.org/wa/pebb)

1-866-648-1928 TTY: 711

1-800-833-6388

### Uniform Medical Plan (UMP) Classic, Select, or CDHP

Administered by Regence BlueShield and Washington State Rx Services

Medical services:

[ump.regence.com/pebb](http://ump.regence.com/pebb)

1-888-849-3681 TRS: 711

Prescription drugs:

[ump.regence.com/pebb/benefits/prescriptions](http://ump.regence.com/pebb/benefits/prescriptions)

1-888-361-1611 TRS: 711

### UMP Plus—Puget Sound High Value Network

[pugetsoundhighvaluenetwork.org](http://pugetsoundhighvaluenetwork.org)

1-855-776-9503 TRS: 711

### UMP Plus—UW Medicine Accountable Care Network

[pebb.uwmedicine.org](http://pebb.uwmedicine.org)

1-855-520-9500 TRS: 711

## Dental plans

### DeltaCare, administered by Delta Dental of Washington

[deltadentalwa.com/pebb](http://deltadentalwa.com/pebb)

1-800-650-1583

TTY: 1-800-833-6384

### Uniform Dental Plan, administered by Delta Dental of Washington

[deltadentalwa.com/pebb](http://deltadentalwa.com/pebb)

1-800-537-3406

TTY: 1-800-833-6384

### Willamette Dental of Washington, Inc.

[willamettedental.com/wapebb](http://willamettedental.com/wapebb)

1-855-4DENTAL (433-6825)

TTY: 711

## Auto and home insurance

### Liberty Mutual Insurance Company

[hca.wa.gov/employee-retiree-benefits/employees/auto-and-home-insurance](http://hca.wa.gov/employee-retiree-benefits/employees/auto-and-home-insurance)

1-800-706-5525

## Health savings account

### HealthEquity

[learn.healthequity.com/pebb](http://learn.healthequity.com/pebb)

1-844-351-6853 TRS: 711

## Life and accidental death and dismemberment (AD&D) insurance

### Metropolitan Life Insurance Company (MetLife)

Enrollment and management:

[mybenefits.metlife.com/wapebb](http://mybenefits.metlife.com/wapebb)

Info, docs, and more:

[metlife.com/wshca](http://metlife.com/wshca)

1-866-548-7139

## Long-term disability (LTD) Insurance

### Standard Insurance Company

1-800-368-2860

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

### Navia Benefit Solutions

[pebb.naviabenefits.com](http://pebb.naviabenefits.com)

425-452-3500

1-800-669-3539

## Voluntary wellness program

### SmartHealth

[hca.wa.gov/pebb-smarthealth](http://hca.wa.gov/pebb-smarthealth)

1-855-750-8866

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

The *PEBB Employee Enrollment Guide* will provide you with information you need to sign up for, use, or change your PEBB benefits. Please keep this book for later reference. An online version of this guide is available on the Health Care Authority website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

Newly eligible employees have 31 days to enroll in PEBB benefits. In addition, the annual open enrollment in the fall provides an opportunity for employees to make changes to their account.

See page 56 for information on special open enrollments.































For information about enrolling in PEBB Continuation Coverage (COBRA or Unpaid Leave), or PEBB retiree insurance coverage, visit the HCA website at [hca.wa.gov/erb](https://hca.wa.gov/erb).

## **COVID-19 update on hiring**

Due to the COVID-19 pandemic, employees who are hired (or return to work) at a state agency in jobs that respond to the state of emergency may be able to get PEBB coverage sooner than normal. To learn more about this exception to the timelines listed in this document, visit HCA's website at [hca.wa.gov/coronavirus](https://hca.wa.gov/coronavirus).

# Contents

---

 Who to contact for help .....	2
 Welcome.....	3
 Quick start guide .....	5
 Enrollment checklist.....	7
 Subscriber eligibility .....	8
 Dependent eligibility .....	10
 How to enroll.....	13
 Medicare and PEBB.....	16
 Waiving medical coverage .....	17
 Paying for benefits .....	19
 Premium surcharges.....	21
 Choosing your benefits.....	23
 Selecting a medical plan.....	24
 Consumer-directed health plans with a health savings account.....	26
 Behavioral health coverage .....	28
 2021 Medical plans available by county .....	29
 2021 Monthly premiums .....	30
 2021 Medical benefits comparison.....	31
 Selecting a dental account.....	41
 Dental benefits comparison.....	42
 Life and AD&D insurance.....	43
 Long-term disability insurance .....	47
 Medical FSA and DCAP .....	49
 SmartHealth.....	51
 Auto and home insurance .....	52
 After you enroll.....	53
 Changing your coverage .....	55
Special open enrollment.....	56
 When coverage ends .....	59
 Appeals .....	63
 Enrollment forms .....	64
2021 PEBB Employee Enrollment/Change	
2021 PEBB Employee Enrollment Change for Medical Only Groups	
Long-term Disability (LTD) Enrollment/Change Form	
Premium Surcharge Attestation Help Sheet	

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact your payroll or benefits office.



Use this *Quick start guide* for an overview of the enrollment process. Watch for references to page numbers where you'll find more information. Look for the **Good to know!** boxes throughout this guide for quick tips, definitions, and where to find more information.

## 1. Find out if you're eligible

To be eligible for PEBB benefits, you must meet the eligibility criteria described in PEBB Program rules. Your employing agency will determine if you are eligible for PEBB benefits based on your specific work circumstances. See "Subscriber eligibility" on page 8 for more information.

## 2. Learn about your benefits

A list of the benefits available to eligible employees is on page 7.

You may be able to waive PEBB medical coverage if you have other coverage. See "Waiving medical coverage" on page 17.

You will pay a premium for medical coverage. Premiums for dental coverage, basic life insurance, basic accidental death and dismemberment insurance (AD&D), and basic long-term disability (LTD) insurance, if offered, are paid by your employer. You will also pay monthly premiums for any supplemental coverage you are eligible for and elect. See "Paying for benefits" on page 19.

## 3. Get ready to enroll your eligible dependents

Are you enrolling a spouse, state-registered domestic partner, or children on your account? Enroll your dependents in the same plans that you choose for yourself. See "Dependent eligibility" on page 10 for eligibility rules and information.

### Information needed to enroll eligible dependents

For your spouse, state-registered domestic partner, or any children, you will need to provide their:

- Name
- Date of birth
- Social Security number
- Verification documents. Make sure you have the right documents on hand to prove their eligibility. These verification documents are listed on page 11. You may need to submit additional forms, see page 13.)

## 4. Choose your health plans

### Health plans available to you

A list of medical plans and premiums is on page 30. Check "2021 Medical plans available by county," beginning on page 29, to see what plans are available to you. To enroll in a Kaiser Permanente plan you must either live or work in one of the counties where it is offered. For UMP Plus, you must live in one of the counties where it is offered. Dental plans (if your employer offers them) are on page 41.

### Compare health plan benefits and premiums

The "2021 Medical benefits comparison" starts on page 31. The "Dental benefits comparison" is on page 42. These charts give you some basic cost information to compare plans.

### Virtual benefits fair

This online benefits fair is available 24/7 to help you learn more about your benefits. Visit plan booths to watch informative videos and access additional resources. Visit the virtual benefits fair through HCA's website at [hca.wa.gov/vbf-pebb](https://hca.wa.gov/vbf-pebb).

## 5. Enroll

### Complete these forms

The following forms and proof of your dependents' eligibility, if enrolling them under your coverage, must be received by your payroll or benefits office **no later than 31 days** after you become eligible for PEBB benefits:

- PEBB Employee Enrollment/Change form (if your employer offers the full benefits package)
- PEBB Employee Enrollment/Change for Medical Only Groups form (if your employer offers PEBB medical coverage only)
- PEBB Long-Term Disability Enrollment/Change form
- The PEBB MetLife Employee Enrollment/Change form for life and AD&D insurance must be received by MetLife no later than 31 days after you become eligible for PEBB benefits.

(continued)

### **Attest to the premium surcharges**

There are two premium surcharges that may apply to you. When you enroll in medical coverage, you must attest as to whether you or any enrolled dependents age 13 or older use tobacco products. If you are enrolling a spouse or state-registered domestic partner on your medical coverage, you must also attest as to whether they could have enrolled in an employer-based group medical insurance plan.

If you do not attest, or if your attestation shows the surcharge applies to you, you will be charged these premium surcharges. See “Premium surcharges” on page 21 for details and how to attest.

## **6. Consider these additional benefits**

You can buy supplemental life insurance, supplemental AD&D insurance, and supplemental LTD insurance. See pages 43 through 48 for more information about these important benefits and how to enroll, if your employer offers these benefits.

You may be eligible to enroll in a Medical Flexible Spending Arrangement (FSA) or the Dependent Care Assistance Program (DCAP). These are pretax accounts used to pay for certain expenses. See page 49 for more information and how to enroll.

### **Consider supplemental insurance for your dependents**

You may also choose to cover your dependents with supplemental life and AD&D insurance if your employer offers these benefits. See pages 43 through 48 for more information.

## **7. What's next**

The health plans you chose will send you welcome packets. See “After you enroll” on page 53.

# Enrollment checklist



- Check your eligibility and deadlines
- Learn about your benefits
- Check plans available to you
- Review benefits comparison charts
- Visit the virtual benefits fair
- Choose your benefits
- Choose to enroll in or waive medical coverage
- Submit enrollment forms, verification documents to prove dependents' eligibility, and any additional documents needed
- Attest to premium surcharges
- Consider supplemental coverage
- Consider Medical FSA and DCAP
- Sign up for email delivery after you're enrolled

## Your 2021 PEBB benefits

- Medical insurance (You pay a portion of the total premium.)
- Health savings account (HSA) for those who enroll in a consumer directed health plan (CDHP)
- SmartHealth (voluntary wellness program)
- Auto and home insurance

## Your employer may also offer

- Dental insurance
- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance
- Basic long-term disability (LTD) insurance
- Supplemental life insurance
- Supplemental AD&D insurance
- Supplemental LTD insurance
- Medical Flexible Spending Arrangement (FSA)
- Dependent Care Assistance Program (DCAP)

## *Good to know!*

### **Sign up for email**

Get the latest news and updates from the PEBB Program by going paperless. When you receive general information and newsletters by email it's faster for you and helps reduce the toll on the environment.

After you are enrolled, go to PEBB My Account at [hca.wa.gov/my-account](https://hca.wa.gov/my-account) to sign up. University of Washington employees sign up in Workday.



# Subscriber eligibility

## Who is eligible for PEBB benefits?

This guide provides a general summary of employee eligibility for PEBB benefits. In this booklet, employees are also called “subscribers.”

Your employer will determine if you are eligible for the employer contribution toward PEBB benefits based on your specific employment circumstances (see Washington Administrative Code [WAC] 182-12-114 and 182-12-131). Please contact your payroll or benefits office to find out if you are eligible. All eligibility determinations are based on rules in Chapters 182-08 and 182-12 WAC on the PEBB *Rules and policy* webpage at [hca.wa.gov/pebb-rules](http://hca.wa.gov/pebb-rules). If discrepancies arise between WACs and this guide, the WACs take precedence. If you disagree with the eligibility determination, see “Appeals” on page 63.

### Employees from an employer group

If you are an employee from an employer group that receives PEBB benefits through a contract with the Health Care Authority (such as a county, municipality, political subdivision, tribal government, or educational service district), contact your payroll or benefits office for eligibility criteria.

### Employees

You are eligible for PEBB benefits upon employment if your employer anticipates you will work an average of at least 80 hours per month and for at least eight hours each month for more than six consecutive months.

If your employer determines you are not eligible, but later revises the hours you are anticipated to work or the duration (length) of your employment such that you would meet the criteria described above, you become eligible for PEBB benefits on the first day of the month after the revision.

If your employer determines you are not eligible, but based on your work pattern you later meet the criteria described above, you become eligible for PEBB benefits on the first day of the month after the six-month averaging period.

## Good to know!

### Stacking hours

**You may also “stack” or combine hours worked in more than one position to establish and keep eligibility, as long as the work is within one state agency in which you:**

- Work two or more positions at the same time (concurrent stacking) or
- Move from one position to another (consecutive stacking) or
- Combine hours from a seasonal position and a non-seasonal position.

**You must notify your employer if you believe you are eligible for benefits based on stacking (see WAC 182-12-114 (1)(c)).**

### Higher-education faculty

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

If you are a faculty member you are eligible for PEBB benefits upon employment if your employer anticipates you will work half-time or more for the entire instructional year or equivalent nine-month period.

If your employer doesn’t anticipate that this will happen, then you are eligible for PEBB benefits at the beginning of the second consecutive quarter or semester of employment in which you are anticipated to work (or have actually worked) half-time or more. (Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty members who work less than half-time during the summer quarter/semester.)

If you receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), and meet the criteria listed above, you become eligible for PEBB benefits when the revision is made.

You may become eligible or remain eligible for PEBB benefits by working as faculty for more than one higher-education institution. If this happens, you must notify all employing agencies that you may be eligible for PEBB benefits through stacking. As a faculty member you become eligible for PEBB benefits through stacking when you meet the criteria listed above.

You may continue any combination of medical or dental, and may also continue life insurance and AD&D insurance when you are between periods of eligibility by enrolling in and self-paying for PEBB Continuation Coverage (Unpaid Leave). You can do so for a maximum of 12 months. See

WAC 182-12-142 for continuation coverage information. The PEBB Program must receive your election to self-pay benefits **no later than 60 days** from the date your PEBB health plan coverage ends, or from the postmark date on the election notice we sent, whichever is later.

### Seasonal employees

“Seasonal employee” means a state employee hired to work during a recurring, annual season with a duration of three months or more, and who is anticipated to return each season to perform similar work.

If you are a seasonal employee you are eligible for PEBB benefits upon employment if you are anticipated to work an average of at least 80 hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season. (A season means any recurring, annual period of work at a specific time of year that lasts 3 to 11 consecutive months.)

If your employer changes your anticipated work hours or duration (length) of employment such that you meet the eligibility criteria above, you become eligible for PEBB benefits when the change is made.

As a seasonal employee, if you are found ineligible for benefits, but you later work an average of at least 80 hours per month and work for at least eight hours in each month for more than six consecutive months, you become eligible for PEBB benefits the first of the month following the six-month averaging period.

If you work in more than one position or job within one state agency, you may “stack” or combine hours worked to establish and maintain eligibility. You must notify your employer if you believe you are eligible through stacking. See WAC 182-12-114 (2)(c) for details.

If you are a seasonal employee who works a season of **nine months or more:**

- You are eligible for the employer contribution toward PEBB benefits in any month of the season in which you are in pay status for eight or more hours during that month, and through the off-season after each season worked.
- You are eligible for a period that may not exceed a total of 12 consecutive calendar months for the combined season and off season.

If you are a seasonal employee who works a season of **less than nine months:**

- You are eligible for the employer contribution toward PEBB benefits in any month of the season in which you are in a pay status eight or more hours during that month.
- You are not eligible for the employer contribution toward PEBB benefits during the off-season.
- You may continue any combination of medical or dental, and may also continue life insurance and AD&D insurance when you are in between periods of eligibility by enrolling in and self-paying for PEBB Continuation Coverage (Unpaid Leave) for a maximum

of 12 months. See WAC 182-12-142 for continuation coverage information. The PEBB Program must receive your election to self-pay benefits **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the election notice we sent, whichever is later.

### Elected and full-time appointed officials

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

### Justices and judges

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

## What if I’m eligible for PEBB benefits both as an employee and as a dependent?

You cannot enroll in medical or dental coverage under two PEBB accounts. If you are an eligible employee and are also eligible as a dependent under your spouse’s, state-registered domestic partner’s, or parent’s account, see “Waiving medical coverage” on page 17 for options available to you.



# Dependent eligibility

You may enroll the following dependents:

- Your legal spouse
- Your state-registered domestic partner, as defined in WAC 182-12-109 and RCW 26.60.020(1). This includes substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Strict requirements apply to these partnerships, including that one partner is age 62 or older and you live in the same residence.
- Your children as defined in WAC 182-12-260(3) through the last day of the month in which they turn age 26.

## How are children defined?

For our purposes, children are defined as described in WAC 182-12-260(3). This definition includes:

- Children based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated.
- Children of your spouse, based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated.
- Children you are legally required to support ahead of adoption.
- Children of your state-registered domestic partner, based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated.
- Children named in a court order or divorce decree for whom you are legally required to provide support or health care coverage.
- Extended dependent children who meet specified eligibility criteria. See “Extended dependents” below.
- Children of any age with a disability. See “Children with disabilities” on this page.

## Extended dependents

Children may also include extended dependents (such as a grandchild, niece, nephew, or other child) for whom you, your spouse, or your state-registered domestic partner are legal custodians or legal guardians. The legal responsibility for them is shown by a valid court order and the child’s official residence with the custodian or guardian.

An extended dependent child does not include foster children unless you, your spouse, or your state-registered domestic partner are legally required to provide support ahead of adoption.

## Children with disabilities

Eligible children also include children of any age with a developmental or physical disability that renders them incapable of self-sustaining employment and chiefly dependent upon the employee for support and ongoing

care. Their condition must have occurred before they turned age 26. You must provide proof of the disability and dependency for a child age 26 or older to enroll on your PEBB health plan coverage or for an enrolled child turning age 26 to continue their enrollment. Newly eligible employees must submit the certification form within the 31-day enrollment period.

The PEBB Program, with input from your medical plan (if the child is enrolled in PEBB medical coverage), will verify the disability and dependency of a child with a disability beginning at age 26. The first verification lasts for two years. After that, we will occasionally review their eligibility, but not more than once a year. These verifications may require renewed proof from you. If the PEBB Program does not receive your verification within the time allowed, the child will no longer be covered.

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

You must notify the PEBB Program in writing when your child with a disability is no longer eligible. The PEBB Program must receive notice within 60 days of the last day of the month your child loses eligibility for health plan coverage.

## Proving dependent eligibility

Verifying (proving) dependent eligibility helps us make sure we cover only people who qualify for health plan coverage. You provide this proof by submitting official documents listed below. We will not enroll a dependent if we cannot verify their eligibility. We reserve the right to review a dependent’s eligibility at any time.

A few exceptions apply to the dependent verification process:

- Extended dependent children are reviewed through a separate process.
- Previous dependent verification data verified by the School Employees Benefits Board (SEBB) Program may be used when a subscriber moves from SEBB Program coverage to PEBB Program coverage and is requesting to enroll an eligible dependent who has been previously verified under the SEBB Program.

Submit the documents with your enrollment forms within the PEBB Program enrollment timelines. You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and notarized. These documents must be approved (verified).

## Documents to enroll a spouse

Provide a copy of (choose one):

- The most recent year's federal tax return filed jointly that lists the spouse (black out financial information)
- The most recent year's federal tax returns for you and your spouse if filed separately (black out financial information)
- A marriage certificate and evidence that the marriage is still valid. For example, a utility bill or bank statement dated within the past six months showing both your and your spouse's names (black out financial information)
- Petition for dissolution or invalidity of marriage
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

## Documents to enroll a state-registered domestic partner or partner of a legal union

Provide a copy of (choose one):

- A certificate/card of state-registered domestic partnership or legal union and evidence that the partnership is still valid. For example, a utility bill or bank statement dated within the past six months showing both your and your state-registered domestic partner's names (black out financial information)
- Petition for invalidity (annulment) of a state-registered domestic partnership or legal union
- Petition for dissolution of a state-registered domestic partnership or legal union
- Legal separation notice of a state-registered domestic partnership or legal union
- Valid J-1 or J-2 visa issued by the U.S. government

If enrolling a state-registered domestic partner, also attach a completed *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under Internal Revenue Code (IRC) Section 152, as modified by IRC Section 105(b).

If enrolling a partner of a legal union, proof of Washington state residency for both the subscriber and the partner is required in addition to dependent verification documents described above. Additional dependent verification documents will be required within one year of the partner's enrollment for them to remain enrolled. More information can be found in PEBB Program Administrative Policy 33-1 on the HCA website at [hca.wa.gov/pebb-rules](https://hca.wa.gov/pebb-rules).

## Documents to enroll children

Provide a copy of (choose one):

- The most recent year's federal tax return that includes the child as a dependent (black out financial information). You can submit one copy of your tax return as a verification document for all family members listed who require verification.
- Birth certificate (or hospital certificate with the child's

footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse or state-registered domestic partner. If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or state-registered domestic partner in order to enroll the child, even if not enrolling them in PEBB insurance coverage.

- Certificate or decree of adoption showing the name of the parent who is the subscriber, the subscriber's spouse, or state-registered domestic partner
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-2 visa issued by the U.S. government

See "Additional required forms" on page 13 for information regarding requirements for an extended dependent, state-registered domestic partner or their eligible children, or child with a disability.

## What happens when I am required to provide health plan coverage for a child?

When a National Medical Support Notice (NMSN) requires you to provide health plan coverage for your dependent child, you may enroll the child and request changes to their health plan coverage as directed by the NMSN. You must submit the appropriate *2021 PEBB Employee Enrollment/Change* form and a copy of the NMSN to your payroll and benefits office.

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

The following options are allowed:

- The child will be enrolled under the subscriber's PEBB health plan coverage as directed by the NMSN.
- If you have previously waived PEBB medical coverage, you will be enrolled in medical coverage as directed by the NMSN in order to enroll the child.
- The subscriber's selected health plan will be changed if directed by the NMSN.
- If the child is already enrolled under another PEBB subscriber, the child will be removed from the other health plan coverage and enrolled as directed by the NMSN.
- If the subscriber is eligible for and elects COBRA or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.
- When an NMSN requires someone else to provide health plan coverage for your enrolled dependent child, and that health plan coverage is in fact provided, you may remove the child from your coverage. The child will be removed prospectively.

## What happens when my dependent loses eligibility?

You must remove an ineligible dependent **no later than 60 days** after the date they no longer meet PEBB Program eligibility. Your payroll or benefits office must receive the appropriate *PEBB Employee Enrollment/Change* form to remove a dependent from your account **within 60 days** of the last day of the month they no longer meet PEBB eligibility criteria. If a dependent child with a disability is no longer eligible, written notice must be provided to the PEBB Program. Your dependent will be removed from coverage on the last day of the month they no longer meet the eligibility criteria.

Consequences for not submitting the form within 60 days are explained in WAC 182-12-262 (2)(a). The consequences may include (but are not limited to):

- The dependent may lose eligibility to continue PEBB medical or dental coverage under one of the continuation options described in WAC 182-12-270 and on page 59.
- You may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility.
- You may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.
- You may be responsible for premiums paid by the state for a dependent's health plan coverage after the dependent lost eligibility.

See "When coverage ends" on page 59.

## What happens if I die, or my dependent dies?

See "When coverage ends" on page 59.

### *Good to know!*

#### **You have appeals rights**

If you disagree with a specific eligibility decision or denial, you can appeal. See "Appeals" on page 63.



## When do I enroll?

You must enroll **within 31 days** of becoming eligible for PEBB benefits. If you do not enroll, you will be automatically enrolled as a single subscriber. See “Am I required to enroll? What happens if I don’t waive or enroll?” on page 14. You may also have the option to waive your PEBB medical, see “Waiving medical coverage” on page 17.

## How do I enroll?

Use the *PEBB Employee Enrollment/Change* forms in the back of this guide to enroll in PEBB health plan coverage. Your payroll or benefits office must receive any forms **no later than 31 days** after you become eligible for PEBB benefits. University of Washington employees must enroll through Workday. See the “Quick start guide” on page 5 and “Am I required to enroll? What happens if I don’t waive or enroll?” on page 14.

Your payroll or benefits office must also receive proof of your dependent’s eligibility **no later than 31 days** after you become eligible for PEBB benefits. If the documents are not received in time, your dependents will not be enrolled and you will not be able to enroll them until open enrollment or a special open enrollment event. A list of documents we will accept as proof is on page 11.

If you are eligible and your employer offers these benefits, you will automatically be enrolled in basic life, basic accidental death and dismemberment (AD&D), and basic long-term disability (LTD) insurance.

To enroll in supplemental life, supplemental AD&D, or supplemental LTD insurance, see pages 43 through 48.

To enroll in a Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP), see page 49.

## Which forms do I use?

The following forms must be received by your payroll or benefits office, or contracted vendor **no later than 31 days** after you become eligible for PEBB benefits.

If your employer offers PEBB medical, dental, life, AD&D, and LTD insurance, complete these:

- *2021 PEBB Employee Enrollment/Change* form
- *2021 PEBB Long-Term Disability (LTD) Enrollment/Change* form

The following form for life and AD&D insurance must be received by MetLife **no later than 31 days** after you become eligible for PEBB benefits. If you miss the deadline or request supplemental life insurance coverage over the guaranteed issue coverage amount, evidence of insurability will be required to enroll. Evidence of insurability is not required for supplemental AD&D insurance.

- *2021 PEBB MetLife Enrollment/Change* form. If you have questions about enrollment in life insurance, contact MetLife at 1-866-548-7139.

If your employer offers PEBB medical only, complete:

- *2021 PEBB Employee Enrollment/Change for Medical Only Groups* form

To enroll in other PEBB-sponsored benefits:

- Medical FSA or DCAP (state agency and higher-education employees only): Visit the Navia website at [pebb.naviabenefits.com](https://pebb.naviabenefits.com) to enroll **no later than 31 days** after you become eligible for PEBB benefits. University of Washington employees must enroll through Workday.
- Auto/home insurance: See page 52 of this guide, visit HCA’s website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee) under *Additional benefits* to find a local office, or call Liberty Mutual Insurance Company at 1-800-706-5525.

## Additional required forms

If you are enrolling one of the dependents described below, you must also submit the applicable forms with your election or change form.

*PEBB Declaration of Tax Status:* You must submit this form when enrolling an extended dependent, state-registered domestic partner, or their eligible children, regardless of tax status.

*PEBB Certification of a Child with a Disability:* After turning age 26, your child may be eligible for enrollment under your PEBB Program health plans if your child’s disability occurred before age 26 and they are incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

*PEBB Extended Dependent Certification:* To be considered for enrollment in PEBB health plan coverage as an extended dependent, all of the following conditions must be met:

- The extended dependent must not be your child through birth, adoption, marriage, or a state-registered domestic partnership.
- You, your spouse, or your state-registered domestic partner are the legal guardian or have legal custody of the child.
- The child’s official residence is with the guardian or custodian.
- You have provided a valid court order showing that you, your spouse, or your state-registered domestic partner have legal custody or guardianship.
- The child is not a foster child unless you, your spouse, or your state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

## Good to know!

### Find your form

Forms are available on HCA's website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee) under the *Forms & publications* tab.

## Am I required to enroll? What happens if I don't waive or enroll?

If your employer determines that you are eligible for PEBB benefits, you are required to enroll in or waive PEBB medical within PEBB Program timelines. If you do not enroll or waive medical, you will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic for medical coverage. Other plans you will be automatically enrolled in include Uniform Dental Plan, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance (if your employer offers these benefits).

**You will be charged a monthly \$105 premium for your medical coverage as well as a \$25 tobacco use premium surcharge.** You can change your tobacco use attestation anytime by submitting a *PEBB Premium Surcharge Attestation Change* form to your payroll or benefits office or on PEBB My Account at [hca.wa.gov/my-account](https://hca.wa.gov/my-account). See "Premium surcharges" on page 21.

You cannot change plans until the next annual open enrollment, unless you have a special open enrollment event that allows the change.

Your dependents will not be enrolled. You cannot enroll your eligible dependents until the next annual open enrollment, unless you have a special open enrollment event that allows the change.

If you are enrolled on your spouse's, state-registered domestic partner's, or parent's PEBB health plan coverage, you will be removed from that coverage.

You may waive enrollment in PEBB medical coverage if you are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. You must actively indicate your intention to waive by submitting the appropriate *2021 PEBB Employee Enrollment/Change* form to your payroll or benefits office. See "Waiving medical coverage" on page 17 for instructions and timelines.

## Can I enroll in two PEBB accounts?

No. You cannot enroll in medical or dental coverage under two PEBB accounts. Medical and dental coverage is limited to a single enrollment per individual.

However, if you are an eligible employee and are also eligible as a dependent under your spouse's, state-registered domestic partner's, or parent's account, you may choose one of these options:

- Waive PEBB medical under your own account and, instead, remain enrolled in PEBB medical under your spouse's, state-registered domestic partner's, or parent's account. You must be removed from their dental account. You must enroll in PEBB dental coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance (if your employer offers them) under your own account. See "Waiving medical coverage" on page 17.
- Enroll in PEBB medical (as well as PEBB dental, basic life insurance, basic AD&D insurance, and basic LTD, if you are eligible) under your own account. You must be removed from the other medical and dental accounts.

## Can I enroll in PEBB benefits and also have SEBB insurance coverage as a dependent?

Yes. If you are enrolled in PEBB Program benefits, and your spouse, state-registered domestic partner, or parent is enrolled in School Employees Benefits Board (SEBB) Program benefits, you can be enrolled in both programs. Your primary coverage would be through the PEBB Program and your secondary coverage would be through the SEBB Program, which is also administered by the Health Care Authority. There is no added benefit if enrolling in dental in both plans.

## Good to know!

### Medicare and PEBB

If you or any of your dependents are enrolled in Medicare or may soon be, read more about how Medicare and PEBB benefits work together on page 16.

## How does being enrolled in both PEBB and SEBB affect the premium surcharge?

If you are enrolled in the PEBB Program covering yourself as well as your spouse or state-registered domestic partner as a dependent, and your spouse is enrolled in the School Employees Benefits Board (SEBB) Program and covers you as a dependent in medical coverage, or vice versa, you and your spouse would not incur the \$50 spouse or state-registered domestic partner coverage premium surcharge, as long as you attest that it does not apply to you.

However, if your spouse or state-registered domestic partner waives their SEBB medical coverage and enrolls on your account, you will be charged the \$50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium. Alternately, if you waive enrollment in PEBB medical and your spouse or state-registered domestic partner enrolls you as a dependent on their SEBB medical coverage, they

will be charged the \$50 spouse or state-registered domestic partner coverage premium surcharge in addition to their monthly medical premium. See “Premium surcharges” on page 21.

### **Weigh the options of dual enrollment**

Having one person enrolled in both the PEBB and SEBB programs is currently allowed, but it may not give your family an advantage — especially financially. Whether it works to your advantage depends on your specific health care circumstances. Research both PEBB and SEBB benefits to compare. Be sure to consider the premiums, deductibles, copays, coinsurance, and premium surcharges if you’re thinking about dual enrolling. Neither program will pay more than the allowed amount for care. If you aren’t sure how a plan you’re considering would share costs with another plan, contact the plan and ask about coordination of benefits. You can also read your plan’s certificate of coverage, available at [hca.wa.gov/erb](https://hca.wa.gov/erb).

Another thing to consider is that the Washington State Legislature recently passed a law that limits dual enrollment between the PEBB and SEBB programs starting with the 2022 plan year.

### ***Good to know***

#### **Protect your income**

If your employer offers them, consider buying supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance. See how on pages 43 through 48.



# Medicare and PEBB

For employees and their enrolled spouses age 65 and older, PEBB medical plans provide primary coverage, and Medicare coverage is usually secondary.

## When you retire

If you retire and are eligible for PEBB retiree insurance coverage (see “When coverage ends” on page 59), you and any enrolled dependents must enroll and stay enrolled in Medicare Part A and Part B, if eligible, to remain enrolled in a PEBB retiree health plan. Medicare will become the primary insurer, and PEBB medical becomes secondary.

## Waiving PEBB medical

You may choose to waive your enrollment in PEBB medical and have Medicare as your primary coverage. However, you will remain enrolled in PEBB dental coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance if your employer offers these benefits. See “Waiving medical coverage” on page 17.

If you waive PEBB medical, you can enroll during the PEBB Program’s annual open enrollment (for coverage effective January 1 of the following year). The exception is if you have a special open enrollment event that allows you to enroll in PEBB medical after having waived enrollment. See “What changes can I make during a special open enrollment?” on page 56.

## Deferring Medicare Parts A and B

When you or your covered dependents become eligible for Medicare Part A and Part B, either by age or by disability, the member eligible for Medicare should contact the nearest Social Security office to ask about the advantages of immediate or deferred enrollment in Medicare Part B. Find contact information for your local office on the Social Security Administration’s website at [ssa.gov/agency/contact](https://www.ssa.gov/agency/contact).

In most cases, employees and their spouses covered under a PEBB medical plan can defer Medicare Part B enrollment without a late enrollment penalty. They can sign up for Medicare Part B during a special enrollment period when the employee terminates employment or retires. If you are receiving a monthly Social Security benefit, you cannot defer Medicare Part A. Contact your nearest Social Security office or call 1-800-772-1213 for information on deferring or reinstating Medicare.

If the eligibility is due to a disability, contact a local Social Security office or call 1-800-772-1213 regarding deferred enrollment.

## Deciding on Medicare Part D

Medicare Part D is available to people enrolled in Medicare Part A or Part B. It is a voluntary program that offers prescription drug benefits through private plans. These

plans provide at least a standard level of coverage set by Medicare.

All PEBB medical plans available to employees provide creditable prescription drug coverage. Creditable coverage is as good as or better than Medicare Part D coverage. When you become enrolled in Medicare Part A or Part B, you can keep your PEBB insurance coverage and not pay a Medicare Part D late enrollment penalty if you decide to enroll in a Medicare Part D plan later. To avoid a premium penalty, you cannot be without creditable prescription drug coverage for more than two full months. If you enroll in a Medicare Part D plan, your PEBB medical plan may not coordinate prescription drug benefits with that plan.

## If you lose or terminate PEBB medical coverage

To avoid paying a higher premium, you should enroll in a Medicare Part D plan within two months after your PEBB medical coverage ends, unless you have other creditable drug coverage. If you don’t enroll within the two-month deadline, you may have to wait for coverage and your Medicare Part D plan’s monthly premium may increase by 1 percent or more for every month you don’t have creditable coverage.

If you enroll or terminate (cancel) enrollment in Medicare Part D, you may need a “notice of creditable coverage” to prove to Medicare or the prescription drug plan that you have had continuous prescription drug coverage to re-enroll at a later date without penalties. You can call the PEBB Program at 1-800-200-1004 to request a notice of creditable coverage.

## Be aware of enrollment deadlines

Be sure you understand the Medicare enrollment timelines, especially if you will be leaving employment within a few months of you or your covered dependent becoming eligible for Medicare.

### *Good to know!*

#### **Questions about Medicare**

Visit the Centers for Medicare & Medicaid Services website at [medicare.gov](https://www.medicare.gov) or call at 1-800-633-4227.

# Waiving medical coverage



## What does waiving mean?

If you are eligible for the employer contribution toward PEBB benefits, you can waive your enrollment in PEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. If you waive PEBB medical coverage, you must enroll in PEBB dental coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance if your employer offers them.

## If you waive enrollment in medical coverage

- You cannot enroll your eligible dependents in PEBB medical coverage, but you can enroll them in PEBB dental coverage if your employer offers it.
- The premium surcharges will not apply to you.
- You are eligible to participate in the SmartHealth wellness program, but you cannot qualify for the wellness incentives.
- You can enroll in supplemental life insurance, supplemental AD&D insurance, supplemental LTD insurance, the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) if your employer offers them.

## How do I waive medical coverage?

To waive enrollment in PEBB medical coverage, your employer must receive the appropriate *2021 PEBB Employee Enrollment/Change* form indicating this choice **no later than 31 days** after you become eligible for PEBB benefits, or during an annual open enrollment or special open enrollment (as described on pages 56 through 58).

## What if I'm already enrolled in PEBB health plan coverage?

If you are a newly eligible employee who is already enrolled in health plan coverage as a dependent under your spouse's, state-registered domestic partner's, or parent's PEBB account, you may choose one of these two options:

- Waive PEBB medical and stay enrolled in medical under your spouse's, state-registered domestic partner's, or parent's PEBB account. You must enroll in PEBB dental coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance (if your employer offers them) under your own account. Your spouse, state-registered domestic partner, or parent must submit the appropriate *2021 PEBB Employee Enrollment/Change* form and

remove you from their dental coverage to prevent dual enrollment in PEBB dental coverage.

- Enroll in PEBB health plan coverage under your own account. To do this, complete the appropriate *2021 PEBB Employee Enrollment/Change* form. Your payroll or benefits office must receive this form **no later than 31 days** after the date you become eligible for PEBB benefits. Your spouse, state-registered domestic partner, or parent will need to submit the required enrollment/change form(s) and remove you from their PEBB account to prevent dual enrollment in PEBB health plan coverage.

## Good to know!

### What is coinsurance?

Learn the definitions of terms such as deductible, coinsurance, copayment, and out-of-pocket on page 25.

## How do I enroll later if I've waived medical coverage?

If you waive PEBB medical coverage, you can enroll only during the next annual open enrollment (for coverage effective January 1 the following year). The exception is if you have a special open enrollment event that allows you to enroll in medical coverage, such as losing eligibility for other coverage, getting married, or having a child. See "What changes can I make during a special open enrollment?" on page 56.

## What happens if I don't enroll in or waive medical coverage?

If you are eligible for the employer contribution toward PEBB benefits but do not either enroll in or waive PEBB medical coverage within PEBB Program timelines, you will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic for medical coverage. Other plans you will be automatically enrolled in include Uniform Dental Plan, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance (if your employer offers these benefits).

**You will be charged a monthly \$105 premium for your medical coverage as well as a \$25 tobacco use premium surcharge.**

(continued)

You can change your tobacco use attestation anytime through PEBB My Account at [hca.wa.gov/my-account](https://hca.wa.gov/my-account) or by submitting a *PEBB Premium Surcharge Attestation Change* form to your payroll or benefits office. See “Premium surcharges” on page 21.

If you are enrolled on your spouse’s, state-registered domestic partner’s, or parent’s PEBB health plan coverage, you will be removed from that coverage.

If you are automatically enrolled, you cannot change plans or enroll your eligible dependents until the next PEBB Program annual open enrollment, unless you have a special open enrollment event that allows the change.

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

You cannot waive your enrollment in employee medical to stay enrolled in PEBB retiree insurance coverage, even if you are enrolled in Medicare. PEBB retiree insurance coverage will be deferred if you become newly eligible for PEBB benefits as an employee.

# Paying for benefits



## What does my employer pay?

If you are eligible for PEBB benefits, your employer will pay the premiums for dental coverage (if your employer offers it) for you and your dependents.

Your employer also pays the premiums for basic life insurance, basic AD&D insurance, and basic LTD insurance (if your employer offers it). You pay nothing for these basic benefits.

**Exception:** Employees who work for a city, tribal government, county, port, water district, hospital, educational service district, etc., must contact their payroll or benefits office to get their monthly premiums, as information described above may be different.

## What do I pay?

### Monthly premiums

You pay a monthly medical premium for yourself and any enrolled dependents on your account. Your medical premiums pay for a full calendar month of coverage. Your premiums cannot be prorated for any reason, including when a member dies before the end of the month.

### Premium surcharges

In addition to your monthly medical premium, you may be charged a \$25-per-account tobacco use premium surcharge and/or a \$50 spouse or state-registered domestic partner coverage premium surcharge. See “Premium surcharges” on page 21 for details on whether the premium surcharges apply to you.

### Out-of-pocket costs

You are responsible for paying any out-of-pocket costs for deductibles, coinsurance, or copayments for services under the medical, dental, and vision plans you choose. See “2021 Medical benefits comparison” on pages 31 through 40 for a side-by-side comparison of many common benefits and costs for services for each plan.

You can also buy supplemental life and supplemental AD&D insurance for yourself and your eligible dependents, and supplemental LTD insurance for yourself. See more about these benefits on pages 43 through 48.

### *Good to know!*

#### **Protect your income**

If your employer offers them, consider buying supplemental life, supplemental accidental death and dismemberment (AD&D), and supplemental long-term disability (LTD) insurance. See how on pages 43 through 48.

## How much will my monthly premiums be?

For state agency and higher-education employees, see the “2021 Monthly premiums” on page 30. There are no employee premiums for dental coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance.

**Exception:** Employees who work for a city, tribal government, county, port, water district, hospital, educational service district, etc., must contact their payroll or benefits office to get their monthly premiums.

## Payroll deductions and taxes

If you are an eligible state agency or higher-education institution employee, monthly medical premiums and applicable premium surcharges are deducted from your paychecks before taxes are taken out under the premium payment plan, unless you request otherwise. If you are not a state agency or higher-education employee, ask your payroll or benefits office if they offer a pretax deduction benefit under their own Section 125 plan.

**Exception:** If you enroll a dependent who does not qualify as an IRC Section 125 dependent (i.e., state-registered domestic partner), your monthly medical premiums and applicable premium surcharges for these dependents will be deducted from your paycheck post-tax. However, you will be able to make premium payments for your own insurance coverage with pretax payroll deductions.

### *Good to know!*

#### **Additional benefits you may like**

Medical Flexible Spending Arrangements (FSA) and Dependent Care Assistance Program (DCAP) are benefits that may suit your financial needs. See page 49.

## Why would I pay my monthly premiums with pretax dollars?

Paying your premiums pretax allows you to keep more money in your paycheck because the premium, applicable premium surcharges, and/or contributions are deducted before taxes are calculated. This reduces your taxable income, which lowers your taxes.

*(continued)*

## Would it benefit me not to have a pretax deduction?

Deducting your premiums pretax may affect the following benefits:

**Social Security:** If your base salary is less than the annual federal taxable maximum (find it on the Social Security Administration's website at [ssa.gov/OACT/COLA/cbb.html](https://ssa.gov/OACT/COLA/cbb.html)), paying your premiums pretax reduces your Social Security taxes now. However, your lifetime Social Security earnings would be calculated using the lower salary, which lowers your Social Security benefit when you retire.

**Unemployment compensation:** Paying your premiums pretax also reduces the base salary used to calculate unemployment compensation.

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

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

Yes. You may opt out or opt in to the state's premium payment plan during the PEBB Program's annual open enrollment or if you have an applicable special open enrollment event as described in WAC 182-08-199. See "What changes can I make during a special open enrollment?" on page 56.

### *Good to know!*

#### **Changing from pretax to post-tax**

If you do not want your PEBB medical premiums or applicable premium surcharges paid with pretax earnings, you must complete and submit the *PEBB Premium Payment Plan Election/Change* form to your employer's payroll or benefits office.

# Premium surcharges



Two premium surcharges may apply if you are enrolled in a PEBB medical plan:

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

If you do not attest (respond) to these surcharges within the PEBB Program's timelines explained below, or if your attestation shows the surcharge applies to you, you will be charged the surcharge in addition to your monthly medical premium.

For more information on the premium surcharges, visit the *Surcharges* webpage at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

## Tobacco use premium surcharge

You will be charged a \$25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you or any dependents (age 13 or older) enrolled on your PEBB medical coverage have used a tobacco product in the past two months.

The surcharge will not apply if:

- You and all enrolled dependents age 18 and older who use tobacco products are enrolled in a tobacco cessation program through your medical plan, or
- Enrolled dependents age 13 to 17 who use tobacco products have accessed information and resources on the Smokefree Teen website at [teen.smokefree.gov](https://teen.smokefree.gov).

You do not have to attest for enrolled dependents age 12 and younger. You do not need to attest when the dependent turns age 13, unless the dependent uses, or starts using, tobacco products.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, read about your options in PEBB Program Administrative Policy 91-1 on the PEBB *Rules and policies* webpage at [hca.wa.gov/pebb-rules](https://hca.wa.gov/pebb-rules).

## How to attest to this surcharge

To find out if the tobacco use surcharge applies to your account, use the *PEBB Premium Surcharge Attestation Help Sheet* at the back of this guide.

You must attest when you enroll. Submit the *PEBB Employee Enrollment/Change* form to your payroll or benefits office. You can find the form at the end of this guide, and on the public employee webpages at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee) under *Forms & publications*. Exception: University of Washington employees must use Workday.

## How to report a change in tobacco use

You can report a change in tobacco use anytime if:

- Any enrolled dependent age 13 and older starts using tobacco products.

- You or your enrolled dependent have not used tobacco products within the past two months.
- You or your enrolled dependent who is 18 years or older and uses tobacco products enrolls in the free tobacco cessation program through your PEBB Program medical plan.
- Your enrolled dependent who is 13 to 17 years old and uses tobacco products accesses the tobacco cessation resources on the Smokefree Teen website at [teen.smokefree.gov](https://teen.smokefree.gov).

You may report the change in tobacco product use anytime in one of two ways:

- Go to PEBB My Account on at [hca.wa.gov/my-account](https://hca.wa.gov/my-account) to change your attestation. **Exception:** University of Washington employees must use Workday.
- Submit a *PEBB Premium Surcharge Attestation Change* form (found on the public employee webpages at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee)) to your payroll or benefits office.

If the change you report means that the surcharge applies to you, the surcharge is effective the first day of the month after you report the change in tobacco use. If that day is the first of the month, then the surcharge begins on that day.

If the change in tobacco use means the surcharge no longer applies to you, the surcharge will be removed from your account the first day of the month after we receive your new attestation. If that day is the first of the month, then the change to your account begins on that day.

## Good to know!

### If you don't attest, you will be charged

You will be charged a \$25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you do not attest for all dependents you enroll (age 13 or older), or if your attestation shows the surcharge applies to you.

You will be charged a \$50 monthly surcharge if you enroll a spouse or state-registered domestic partner and do not attest or if your attestation shows the surcharge applies to you.

(continued)

## Spouse or state-registered domestic partner coverage premium surcharge

If you do not enroll a spouse or state-registered domestic partner on your PEBB medical coverage, this premium surcharge does not apply to you and you do not need to attest.

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

- That person chose not to enroll in another employer-based group medical insurance that is comparable to PEBB's Uniform Medical Plan (UMP) Classic.
- You do not attest by the required deadline.
- Your attestation response results in incurring the premium surcharge.

### How to attest to this surcharge

If you enroll a spouse or state-registered domestic partner on your PEBB medical coverage, use the *PEBB Premium Surcharge Attestation Help Sheet* at the back of this guide to find out if this premium surcharge applies to you. Then, attest on your enrollment form and submit the form to your payroll or benefits office. **Exception:** UW Employees must use Workday.

If you enroll a spouse or state-registered domestic partner on your PEBB medical coverage but do not respond to the surcharge, or if the attestation results in you incurring the surcharge, you will be charged the \$50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium.

### To report a change to this surcharge

Outside of annual open enrollment, you can only report a change to this surcharge **within 60 days** of a change in your spouse's or state-registered domestic partner's employer-based group medical insurance.

To change your attestation, submit the *PEBB Premium Surcharge Attestation Change* form (on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee)) to your payroll or benefits office. In most cases, you must provide proof of the qualifying event. **Exception:** UW employees must use Workday.

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

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

## Good to know!

### Premium surcharges and dependents

When you enroll dependents (age 13 and older) on your PEBB medical coverage, you must attest on your enrollment form as to whether the tobacco use premium surcharge applies for each dependent you enroll.

If enrolling a spouse or state-registered domestic partner, you must attest as to whether the spouse or state-registered domestic partner coverage premium surcharge applies.

See the *PEBB Premium Surcharge Attestation Help Sheet* at the back of this guide for details.

# Choosing your benefits



The PEBB Program and our benefit plan carriers have a variety of tools to help you choose the plans that are right for you and decide which additional benefits you may want to enroll in.

## Benefits comparison charts

You'll find benefits comparison charts for health plans in this guide and on the public employee webpages on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee). These charts will help you compare the costs and availability of the most widely used features of plans. See "2021 Medical benefits comparison" on page 31 and "Dental benefits comparison" on page 42.

## Certificates of coverage

The certificates of coverage (COCs), also called benefits booklets, are produced by the health plans to provide detailed information about plan benefits and what is and is not covered. You can find the COCs for all PEBB health plans on the *Medical plan and benefits* tab on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

## Summary of Benefits and Coverage

Summaries of Benefits and Coverage (SBCs) are required under the federal Affordable Care Act to help members understand plan benefits and medical terms. SBCs help you compare things like:

- Whether there are services a plan doesn't cover.
- What isn't included in a plan's out-of-pocket limit.
- Whether you need a referral to see a specialist.

The PEBB Program and medical plans provide an SBC, or explain how to get one, at different times throughout the year (like when you apply for coverage, renew your plan, or request an SBC). SBCs are available upon request in your preferred language.

You can get SBCs on the *Medical plans and benefits* webpage at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee), or from the medical plans' websites. You can also call the plan's customer service or the PEBB Program at 1-800-200-1004 to request a paper copy at no charge. Medical plan websites

and customer service phone numbers are listed at the front of this guide.

SBCs do not replace medical benefits comparisons or the plans' certificates of coverage.

## Virtual benefits fair

The virtual benefits fair is a convenient way to learn about your benefit options through an online experience that's available anytime, day or night. Use your computer, tablet, or smartphone to visit and explore at your own pace.

The virtual benefits fair includes an exhibit hall where each insurance carrier and plan administrator has a booth that displays information about their plan options. You can get information about medical and dental plans, as well as life insurance, accidental death and dismemberment insurance, long-term disability insurance, Medical Flexible Spending Arrangement (FSA), Dependent Care Assistance Program (DCAP), and SmartHealth, our voluntary wellness program. You'll get links to videos, downloadable content and other information to help you choose the right plans for you and your dependents. Visit the virtual benefits fair on the HCA website at [hca.wa.gov/vbf-pebb](https://hca.wa.gov/vbf-pebb).

## Next step

On the following pages, "Selecting a medical plan" will provide more information you need to know. Also see "Selecting a dental plan" on page 41.



# Selecting a medical plan

When choosing your medical plan, be sure to consider how it could influence your overall care. This is especially important if you have a high-risk pregnancy, are currently undergoing treatment, have a chronic condition (such as diabetes, heart disease, depression, or cancer), or are taking a high-cost medication. If you cover eligible dependents, they must enroll in the same medical and dental plans. You should also consider plan eligibility and availability.

## Eligibility

Not everyone qualifies to enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA). See “Consumer-directed health plans with a health savings account” on page 26.

## Availability

To enroll in a Kaiser Permanente plan you must either live or work in one of the counties where it is offered. For a UMP Plus plan, you must live in one of the counties where it is offered.

See “2021 Medical plans available by county” on page 29. Be sure to contact the medical plans you’re interested in to ask about provider availability in your county.

If you move out of your plan’s service area, you may need to change your plan. You must report your new address and any request to change your medical plan to your payroll or benefits office **no later than 60 days** after you move.

## Good to know!

### Only one account

PEBB medical and dental coverage is limited to a single enrollment per individual. See page 14.

## What types of plans are available?

The PEBB Program offers several types of medical plans.

### Value-based plans

Value-based plans aim to provide high-quality care at a lower cost. Providers have committed to follow evidence-based treatment practices, coordinate care with other providers in your network, and meet specific criteria about the quality of care they provide. This means your providers are dedicated to ensuring you get the right care at the right time, which usually results in lower out-of-pocket costs for you. The plans listed on the right in bold are value-based plans.

## Managed-care plans

Managed-care plans may require you to select a primary care provider within the medical plan’s network to fulfill or coordinate all of your health care needs. You can change providers at any time, for any reason within the contracted network. Some outpatient specialty services are available in network participating medical offices without a referral. This type of plan may not pay benefits if you see a non-contracted provider for non-emergency services. The following PEBB medical plans are managed-care plans (value-based plans are in bold).

- **Kaiser Permanente NW Classic<sup>1</sup>**
- **Kaiser Permanente WA Classic**
- **Kaiser Permanente WA SoundChoice**
- **Kaiser Permanente WA Value**

## Preferred provider organization (PPO) plans

PPOs allow you to self-refer to any approved provider type in most cases, but usually provide a higher level of coverage if the provider contracts with the plan. The following PEBB medical plans are PPO plans (value-based plans are in bold).

- UMP Classic, administered by Regence BlueShield
- UMP Select, administered by Regence BlueShield
- **UMP Plus–Puget Sound High Value Network**, administered by Regence BlueShield (not available if any member is enrolled in Medicare)
- **UMP Plus–UW Medicine Accountable Care Network**, administered by Regence BlueShield (not available if any member is enrolled in Medicare)

## Consumer-directed health plans (CDHP)

A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax free, have a lower monthly premium than most plans, a higher deductible and a higher out-of-pocket limit. Also see “Consumer-directed health plans with a health savings account” on page 26 to find out if you qualify to enroll. The following PEBB medical plans are CDHPs (value-based plans are in bold).

- **Kaiser Permanente NW<sup>\*</sup> CDHP**
- **Kaiser Permanente WA CDHP**
- UMP CDHP, administered by Regence BlueShield

## How can I compare the medical plans?

All PEBB medical plans cover the same basic health care services. They vary in other ways, such as provider networks, premiums, out-of-pocket costs, and drug formularies. The PEBB Program has a variety of tools and

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

resources to help you choose the plan that's right for you. See "Choosing your benefits" on page 23.

## Medical plan differences to consider

When choosing your PEBB medical plan, here are some things to keep in mind.

### Your providers

If you want to see specific providers, contact the PEBB medical plan (not the provider) to see who is in the plan's network before you join. Plan contact information is listed at the beginning of this guide. For links to the plans' provider searches, visit the *Find a provider* webpage at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

### Your current care

Discuss with your current providers and care specialists how switching to a new medical plan may impact your care. You'll want to learn how a new plan could affect your or your dependent's ability to continue care with the same medical team, at the same facilities, and with the same prescription medications.

### Network adequacy

All health carriers in Washington State are required to maintain provider networks that provide members reasonable access to covered services. Check the plans' provider directories to see how many providers are accepting new patients and what the average wait time is for an appointment.

### Mental health and substance abuse treatment

Carriers must provide additional information on their websites to consumers on the ability to ensure timely access to mental health and substance abuse care. For more information, see page 28 or Engrossed Substitute House Bill 1099 (Brennen's Law) on the Washington State Legislature's website at [leg.wa.gov](https://leg.wa.gov).

### Coordination with your other benefits

All PEBB medical plans coordinate benefit payments with other group plans, Apple Health (Medicaid), and Medicare. This is called coordination of benefits. It ensures the highest level of reimbursement for services when a person is covered by more than one plan. Payment will not exceed the benefit amount.

If you are also covered by another health plan, call the medical plans directly to ask how they will coordinate benefits. This is especially important for those coordinating benefits between the PEBB and SEBB programs, and those also enrolled in Apple Health (Medicaid).

PEBB medical and dental coverage is limited to a single enrollment per individual.

### Premiums

A premium is the monthly amount the employee or employer pays to the plan to cover the cost of insurance. The premium does not cover copays, coinsurance, or deductibles. Premium amounts vary by medical plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits. Generally, plans with higher premiums may have lower annual deductibles, copays, or coinsurance costs. Plans with lower premiums may have higher deductibles, coinsurance, copays, and more limited networks. It is important to consider all of these when choosing a plan. Premiums for all PEBB medical plans are listed on page 30.

### Deductibles

Most medical plans require you to pay a certain amount of plan costs, such as fees for office visits, before the plan pays for covered services. This is known as the deductible. Medical plans may also have a separate annual deductible for specific prescription drugs. Covered preventive care services are exempt from the medical plan deductible. This means you do not have to pay your deductible before the plan pays for the covered preventive service.

### Coinsurance or copays

When you receive care, some plans require you to pay a fixed amount, called a copay. Other plans require you to pay a percentage of an allowed fee, called coinsurance. These amounts vary by plan and are based on the type of care received.

### Out-of-pocket limit

The annual out-of-pocket limit is the most you pay in a calendar year for covered benefits. Some plans have a separate out-of-pocket limit for prescription drugs. Once you have reached the out-of-pocket limit, the plan pays 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges (such as your annual deductible, copays, and coinsurance) may count toward your out-of-pocket limit. Others, such as your monthly premiums, do not count toward your out-of-pocket limit. See the plan's certificate of coverage for details.

### Referral procedures

Some plans allow you to self-refer to network providers for specialty care. Others require you to have a referral from your primary care provider. After you join a medical plan, you may change your provider, although the rules vary by plan.

### Paperwork

In general, PEBB medical plans don't require you to file claims. However, Uniform Medical Plan (UMP) members may need to file a claim if they receive services from an out-of-network provider. CDHP members also should keep paperwork from providers and for qualified health care expenses to verify eligible payments from their health savings account.



# Consumer-directed health plans with a health savings account

A consumer-directed health plan (CDHP) combines a high-deductible health plan and a health savings account (HSA). This type of plan generally has lower premiums with higher out-of-pocket costs than other types of medical plans.

When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (like deductibles, copays, and coinsurance), including some that your health plans may not cover. For details, see *Publication 969—Health Savings Accounts and Other Tax Favored Health Plans* on the IRS website at [irs.gov](https://www.irs.gov).

The HSA is administered by HealthEquity, Inc.

## Who is not eligible for a CDHP?

You cannot enroll in a CDHP with an HSA if:

- You are enrolled in Medicare Part A or Part B or Apple Health (Medicaid).
- You are also enrolled in another health plan that is not an IRS-qualified high-deductible health plan, unless it is limited coverage like dental, vision, or disability coverage.
- You, your spouse, or state-registered domestic partner is enrolled in a Voluntary Employee Beneficiary Association Medical Expense Plan (VEBA MEP). However, you may enroll if you convert it to limited health reimbursement account (HRA) coverage.
- You have a TRICARE plan.
- You are enrolled in a Medical Flexible Spending Arrangement (FSA). This also applies if your spouse has a Medical FSA, even if you are not covering your spouse on your CDHP. It does not apply if your spouse's Medical FSA or HSA is a limited-purpose account or a post-deductible Medical FSA. If you try to enroll in both, you will be enrolled only in the CDHP with an HSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. To verify whether you qualify, check *The HealthEquity Complete HSA Guidebook* on the HealthEquity website at [healthequity.com/pebb](https://www.healthequity.com/pebb) under Documents; *Publication 969—Health Savings Accounts and Other Tax-Favored Health Plans* on the IRS website at [irs.gov](https://www.irs.gov); contact your tax advisor; or call HealthEquity toll-free at 1-877-873-8823 (TRS: 711).

## Employer contributions

You must establish an HSA with HealthEquity to receive any employer contributions. If you are eligible, the Health Care Authority, on behalf of your employer, will contribute the following amounts to your HSA:

- \$58.34 each month for an individual subscriber, up to \$700.08 for 2021; or
- \$116.67 each month for a subscriber with one or more enrolled dependents, up to \$1,400.04 for 2021.

The entire annual amount is not deposited to your HSA in January. Contributions from your employer are deposited into your HSA in installments on the last day of each month.

If you qualify for the SmartHealth wellness incentive, \$125 will be deposited in your HSA at the end of January the following year.

## Your contributions

You can choose to contribute to your HSA in either of these ways:

- Contact your payroll or benefits office to set up pretax payroll deductions (if available from your employer).
- Contact HealthEquity to set up direct deposits to your HSA.

The IRS has an annual limit for HSA contributions from all sources. In 2021, the limit is \$3,600 (for subscriber only) and \$7,200 (for you and one or more dependents). If you are age 55 or older, you may contribute an additional amount up to \$1,000 annually.

To make sure you do not go beyond the limit, take into account your employer's contributions, your contributions, and the SmartHealth wellness incentive in January (if you qualify for it).

## Other features of the CDHP with an HSA

If you cover dependents, you must pay the entire family deductible before the CDHP begins paying benefits.

Your prescription drug costs count toward the annual deductible and out-of-pocket maximum if you enroll in Kaiser Permanente NW CDHP<sup>1</sup>, Kaiser Permanente WA CDHP, or UMP CDHP.

Your HSA balance can grow over the years, earn interest, be invested, and build savings that you can use to pay for health care as needed and/or pay for Medicare Part B premiums.

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

## Can I enroll in a CDHP plan and Medicare Part A or Part B?

If you enroll in Medicare Part A or Part B and are enrolled in a CDHP with an HSA, you should change medical plans, or you could be subject to IRS tax penalties.

The PEBB Program should receive your medical plan change request 30 days before the Medicare enrollment date, but must receive your request to change plans **no later than 60 days** after the Medicare enrollment date.

## Are there special considerations if I enroll in a CDHP mid-year?

Yes. Enrolling in a CDHP and opening an HSA mid-year may limit the amount you (or your employer) can contribute in the first year. If you have any questions about this, talk to your tax advisor.

## How do I designate or update beneficiaries for my HSA?

You will designate beneficiaries when you enroll in the HSA. To review and update your HSA beneficiary information, use HealthEquity's online member portal at [learn.healthequity.com/pebb/hsa](https://learn.healthequity.com/pebb/hsa). You can also download and print the *Beneficiary Designation Form*, or contact HealthEquity at 1-844-351-6853 to request a copy.

## What happens to my HSA when I leave the CDHP?

If you later choose a medical plan that is not a CDHP, you won't forfeit any unspent funds in your HSA. You can spend your HSA funds on qualified medical expenses in the future. However, you, your employer, the PEBB Program, and other individuals can no longer contribute to your HSA. If you set up automatic payroll deductions to your HSA, contact your payroll office to stop them. If you set up direct deposits to your HSA, contact HealthEquity to stop them.

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



# Behavioral health coverage

## Ensuring timely access to care

Your mental health affects your physical health. If you or a loved one need access to services for mental health and substance use disorders, you can use this guide to research each plan's network and timely access to services for substance use, mental health, and recovery care.

All health carriers in Washington State must maintain provider networks that provide enrollees reasonable access to covered services. To find a provider for mental health, physical health, or substance use, you can start by checking your plans' provider directory. If you need more information, you can call the plan's customer service number. The plan will know what providers are accepting new patients. Wait times may vary, depending on whether you are seeking emergent, urgent, or routine care. Ask your plan about wait times when considering your plan enrollment and make sure to specify how quickly you need care when scheduling appointments.

All carriers must provide information on their websites for mental health and substance abuse treatment providers' ability to ensure timely access to care. For more information, see Engrossed Substitute House Bill 1099 (Brennen's Law) on the Washington State Legislature's website at [leg.wa.gov](http://leg.wa.gov).

If you are having trouble receiving services from your plan, including the ability to schedule an appointment, you can file a complaint on the Office of the Insurance Commissioner website at [insurance.wa.gov/file-complaint-or-check-your-complaint-status](http://insurance.wa.gov/file-complaint-or-check-your-complaint-status), or by calling 1-800-562-6900.

## Compare coverage by plan

When you need information about what mental health and substance use disorders are covered, you can read the PEBB medical plans' Certificates of Coverage, which are on the *Medical plans and benefits* webpage at [hca.wa.gov/pebb-employee](http://hca.wa.gov/pebb-employee).

Key words to look for in these documents are: inpatient and outpatient coverage, mental health, chemical dependency, residential treatment facility, and substance use disorder. The "2021 Medical benefits comparison" beginning on page 31 includes a high-level summary of coverage by plan.

## Crisis information

If you or a family member is experiencing a mental health or substance abuse crisis:

### For immediate help

Call 911 or go to the nearest emergency care facility for a life-threatening emergency.

### For suicide prevention

Contact the National Suicide Prevention Lifeline at 1-800-273-8255 (TTY: 1-800-799-4889)

### For additional support

Refer to the HCA website at [hca.wa.gov/mental-health-crisis-lines](http://hca.wa.gov/mental-health-crisis-lines) for county-based crisis support assistance options.

### Washington Recovery Help Line

Call 1-866-789-1511 anytime, day or night. This anonymous and confidential help line provides crisis intervention and referral services for individuals in Washington State experiencing substance use disorder, problem gambling, and/or a mental health challenge. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day, seven days a week. In addition, they can suggest local treatment resources for substance use, problem gambling, and mental health, as well as other community services.

# 2021 Medical plans available by county



Washington		
Kaiser Permanente NW Classic <sup>1</sup>	Clark	
Kaiser Permanente NW Consumer-Directed Health Plan (CDHP)*	Cowlitz	
Kaiser Permanente WA Classic	Benton	Pierce
Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)	Columbia	Skagit
Kaiser Permanente WA Value	Franklin	Snohomish
	Island	Spokane
	King	Thurston
	Kitsap	Walla Walla
	Kittitas	Whatcom
	Lewis	Whitman
	Mason	Yakima
Kaiser Permanente WA SoundChoice	King	Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.
	Kitsap	
	Pierce	
	Snohomish	
	Spokane	
	Thurston	
Uniform Medical Plan (UMP) Classic	Available in all Washington counties and worldwide.	
UMP Select		
UMP Consumer-Directed Health Plan (CDHP)		
UMP Plus – Puget Sound High Value Network	Chelan	Pierce
	Douglas	Snohomish
	King	Thurston
	Kitsap	Yakima
UMP Plus – UW Medicine Accountable Care Network	King	Snohomish
	Kitsap	Spokane
	Pierce	Thurston
	Skagit	
Oregon		
Kaiser Permanente NW Classic*	Benton (ZIP codes: 97330, 97331, 97333, 97339, 97370, and 97456)	Linn (ZIP codes: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389, and 97446)
Kaiser Permanente WA Consumer-Directed Health Plan (CDHP)	Clackamas	Marion
	Columbia	Multnomah
	Hood River (ZIP code: 97014)	Polk
	Lane	Washington
		Yamhill
Uniform Medical Plan (UMP) Classic	Available in all Oregon counties and worldwide	
UMP Select		
UMP Consumer-Directed Health Plan (CDHP)		
Idaho		
UMP Classic	Available in all Idaho counties and worldwide.	
UMP Select		
UMP Consumer-Directed Health Plan (CDHP)		

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

# \$ 2021 Monthly premiums

## For state agency and higher-education employees

There are no employee premiums for dental coverage, basic life insurance, basic accidental death and dismemberment insurance, and basic long-term disability insurance. Employees who work for an educational service district, city, tribal government, county, port, water district, hospital, etc., must contact their payroll or benefits office to get their monthly premiums.

Effective January 1, 2021

Plan	Employee	Employee & spouse <sup>1</sup>	Employee & children	Employee, spouse <sup>1</sup> & children
<b>Kaiser Permanente NW Classic<sup>2</sup></b>	\$159	\$328	\$278	\$447
<b>Kaiser Permanente NW CDHP<sup>2</sup></b>	\$25	\$60	\$44	\$79
<b>Kaiser Permanente WA Classic</b>	\$189	\$388	\$331	\$530
<b>Kaiser Permanente WA CDHP</b>	\$26	\$62	\$46	\$82
<b>Kaiser Permanente WA SoundChoice</b>	\$55	\$120	\$96	\$161
<b>Kaiser Permanente WA Value</b>	\$112	\$234	\$196	\$318
<b>UMP Classic</b>	\$105	\$220	\$184	\$299
<b>UMP Select</b>	\$37	\$84	\$65	\$112
<b>UMP CDHP</b>	\$25	\$60	\$44	\$79
<b>UMP Plus—PSHVN</b>	\$72	\$154	\$126	\$208
<b>UMP Plus—UW Medicine ACN</b>	\$72	\$154	\$126	\$208

## Medical premium surcharges

Two premium surcharges may apply in addition to your monthly medical premium. You will be charged for them if the conditions described below apply, or if you do not attest to the surcharges.

- A monthly \$25-per-account medical premium surcharge will apply if you or any dependent (age 13 and older) enrolled in PEBB medical coverage uses tobacco products.
- A monthly \$50 medical premium surcharge will apply if you enroll a spouse or state-registered domestic partner in PEBB medical coverage, and they have chosen not to enroll in another employer-based group medical plan that is comparable to PEBB's UMP Classic.

For more guidance on whether these premium surcharges apply to you, see the *2021 PEBB Premium Surcharge Attestation Help Sheet* under *Forms & publications* on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

<sup>1</sup> Or a state-registered domestic partner

<sup>2</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

# 2021 Medical benefits comparison



The chart below briefly compares the medical deductibles and per-visit out-of-pocket costs of some in-network benefits for PEBB medical plans. Copays and coinsurance may apply; 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. If anything in these charts conflicts with the plan's certificate of coverage (COC), the COC takes precedence and prevails. All dental plans include a non-duplication of benefits clause, which applies when you have dental coverage under more than one account.

## Annual costs

(You pay)

Plan	Medical deductible Applies to medical out-of-pocket limit	Medical out-of-pocket limit <sup>1</sup> (See separate prescription drug out-of-pocket limit for some plans.)
<b>Kaiser Foundation Health Plan of the Northwest</b>		
<b>Kaiser Permanente NW Classic<sup>2</sup></b>	\$300/person \$900/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for most covered services apply.
<b>Kaiser Permanente NW CDHP<sup>2</sup></b>	\$1,400/person \$2,800/family <sup>3</sup>	\$5,100/person • \$10,200/family Your deductible, copays, and coinsurance for most covered services apply.
<b>Kaiser Foundation Health Plan of Washington</b>		
<b>Kaiser Permanente WA Classic</b>	\$175/person \$525/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for all covered services apply.
<b>Kaiser Permanente WA CDHP</b>	\$1,400/person \$2,800/family <sup>3</sup>	\$5,100/person • \$10,200/family Your deductible, copays, and coinsurance for all covered services apply.
<b>Kaiser Permanente WA SoundChoice</b>	\$125/person \$375/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for all covered services apply.
<b>Kaiser Permanente WA Value</b>	\$250/person \$750/family	\$3,000/person • \$6,000/family Your deductible, copays, and coinsurance for all covered services apply.
<b>Uniform Medical Plan (UMP)<sup>4</sup></b>		
<b>UMP Classic</b>	\$250/person \$750/family	\$2,000/person • \$4,000/family Your deductible, copays, and coinsurance for most covered medical services apply.
<b>UMP Select</b>	\$750/person \$2,250 family	\$3,500/person • \$7,000 family Your deductible, copays, and coinsurance for most covered medical services apply.
<b>UMP CDHP</b>	\$1,400/person \$2,800/family <sup>3</sup>	\$4,200/person • \$8,400/family (\$7,000 per person in a family) <sup>5</sup> Your deductible and coinsurance for most covered services apply.
<b>UMP Plus—PSHVN</b>	\$125/person	\$2,000/person • \$4,000/family
<b>UMP Plus—UW Medicine ACN</b>	\$375/family	Your deductible, copays, and coinsurance for most covered medical services apply.

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

<sup>2</sup> Kaiser Foundation Health Plan of the Northwest, (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>3</sup> Must meet family combined deductible (medical and prescription drug) before plan pays benefits.

<sup>4</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

<sup>5</sup> Out-of-pocket expenses for a single member under a family account are not to exceed \$7,000

# Annual costs

(You pay)

Plans	Prescription drug deductible	Prescription drug out-of-pocket limit <sup>1</sup>
<b>Kaiser Foundation Health Plan of the Northwest</b>		
<b>Kaiser Permanente NW Classic<sup>2</sup></b>	None	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
<b>Kaiser Permanente NW CDHP<sup>2</sup></b>	Prescription drug costs combined with medical deductible.	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
<b>Kaiser Foundation Health Plan of Washington</b>		
<b>Kaiser Permanente WA Classic</b>	\$100/person • \$300/family Does not apply to Value and Tier 1 drugs	\$2,000/person • \$8,000/family Your prescription drug deductible, copayments, and coinsurance for all covered prescription drugs apply.
<b>Kaiser Permanente WA CDHP</b>	Prescription drug costs are combined with medical deductible.	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
<b>Kaiser Permanente WA SoundChoice</b>	\$100/person • \$300/family Does not apply to Value and Tier 1 drugs	\$2,000/person • \$8,000/family Your prescription drug deductible, copayments, and coinsurance for all covered prescription drugs apply.
<b>Kaiser Permanente WA Value</b>	\$100/person • \$300/family Does not apply to Value and Tier 1 drugs	\$2,000/person • \$8,000/family Your prescription drug deductible, copayments, and coinsurance for all covered prescription drugs apply.
<b>Uniform Medical Plan (UMP)<sup>3</sup></b>		
<b>UMP Classic</b>	\$100/person • \$300/family Tier 2 and specialty drugs except covered insulins only	\$2,000/person • \$4,000/family Your prescription drug deductible copayments, and coinsurance for all covered prescription drugs apply.
<b>UMP Select</b>	\$250/person • \$750/family Tier 2 and specialty drugs except covered insulins only	\$2,000/person • \$4,000/family Your prescription drug deductible and coinsurance for all covered prescription drugs apply.
<b>UMP CDHP</b>	Prescription drug costs are combined with medical deductible	Prescription drug copays and coinsurance are combined with the medical out-of-pocket limit.
<b>UMP Plus—PSHVN</b> <b>UMP Plus—UW</b> <b>Medicine ACN</b>	None	\$2,000/person • \$4,000/family Your coinsurance for all covered prescription drugs applies.

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

<sup>2</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW), offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>3</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

# Prescription drug benefits

Retail pharmacy prescription drugs (up to a 30-day supply)  
(You pay)

Plans	Value Tier (specific high-value prescription drugs used to treat certain chronic conditions)	Tier 1 (Generics)	Tier 2 (Preferred brand; high-cost generic drugs, specialty drugs)	Tier 3 (non-preferred brand-name drugs and non-preferred generic drugs)	Tier 4 (specialty and certain high cost generic drugs)	Tier 5 (Non-preferred)
<b>Kaiser Foundation Health Plan of the Northwest</b> (office visits and prescription drugs are not subject to the deductible)						
<b>Kaiser Permanente NW Classic<sup>1</sup></b>	N/A	\$15 (not subject to deductible)	\$40 (not subject to deductible)	\$75 (not subject to deductible)	50% up to \$150 (not subject to deductible)	N/A
<b>Kaiser Permanente NW CDHP<sup>1</sup></b>	N/A	\$15 (after deductible); \$0 for some preventive medications	\$40 (after deductible)	\$75 (after deductible)	50% up to \$150 (after deductible)	N/A
<b>Kaiser Foundation Health Plan of Washington</b>						
<b>Kaiser Permanente WA Classic</b>	\$5	\$20	\$40	50% up to \$250	N/A	N/A
<b>Kaiser Permanente WA CDHP</b>	\$0 for some preventive medications	\$20 (after deductible)	\$40 (after deductible)	50% up to \$250 (after deductible)	N/A	N/A
<b>Kaiser Permanente WA SoundChoice</b>	\$5	\$15	\$60	50%	\$150	50% up to \$400
<b>Kaiser Permanente WA Value</b>	\$5	\$25	\$50	50%	\$150	50% up to \$400
<b>Uniform Medical Plan (UMP)<sup>2</sup></b>						
<b>UMP Classic</b>	5% up to \$10	10% up to \$25	30% up to \$75	N/A	N/A	N/A
<b>UMP Select</b>	5% up to \$10	10% up to \$25	30% up to \$75	N/A	N/A	N/A
<b>UMP CDHP</b>	15% (after deductible)	15% (after deductible)	15% (after deductible)	N/A	N/A	N/A
<b>UMP Plus—PSHVN</b>	5% up to \$10	10% up to \$25	30% up to \$75	N/A	N/A	N/A
<b>UMP Plus—UW Medicine ACN</b>	5% up to \$10	10% up to \$25	30% up to \$75	N/A	N/A	N/A

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

# Prescription drug benefits

Mail order (up to a 90-day supply unless otherwise noted)

Plans	Value tier	Tier 1	Tier 2	Tier 3	Tier 4
<b>Kaiser Foundation Health Plan of the Northwest</b>					
<b>Kaiser Permanente NW Classic</b> <sup>1</sup>	N/A	\$30 (not subject to deductible)	\$80 (not subject to deductible)	\$150 (not subject to deductible)	50% to \$750 (not subject to deductible)
<b>Kaiser Permanente NW CDHP</b> <sup>1</sup>	N/A	\$30; (after deductible); \$0 for some preventive medications	\$80 (after deductible)	\$150 (after deductible)	50% to \$750 (after deductible)
<b>Kaiser Foundation Health Plan of Washington</b>					
<b>Kaiser Permanente WA Classic</b>	\$10	\$40	\$80	50% up to \$750	N/A
<b>Kaiser Permanente WA CDHP</b>	\$0 for some preventive medications	\$40 (after deductible)	\$80 (after deductible)	50% up to \$750 (after deductible)	N/A
<b>Kaiser Permanente WA SoundChoice</b>	\$10	\$30	\$120	50%	N/A
<b>Kaiser Permanente WA Value</b>	\$10	\$50	\$100	50%	N/A
<b>Uniform Medical Plan (UMP)<sup>2</sup></b>					
<b>UMP Classic</b>	5% up to \$30	10% up to \$75	30% up to \$225	N/A	N/A
<b>UMP Select</b>	5% up to \$30	10% up to \$75	30% up to \$225	N/A	N/A
<b>UMP CDHP</b>	15% (after deductible)	15% (after deductible)	15% (after deductible)	N/A	N/A
<b>UMP Plus—PSHVN</b>	5% up to \$30	10% up to \$75	30% up to \$225	N/A	N/A
<b>UMP Plus—UW Medicine ACN</b>	5% up to \$30	10% up to \$75	30% up to \$225	N/A	N/A

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

# Hospital care

Plans	Inpatient (residential treatment centers, psychiatric hospitals)	Outpatient (hospital affiliated clinics, outpatient facilities, etc.)	Home health
<b>Kaiser Foundation Health Plan of the Northwest</b>			
<b>Kaiser Permanente NW Classic</b> <sup>1</sup>	15%	15%	15%
<b>Kaiser Permanente NW CDHP</b> <sup>1</sup>	15%	15%	15%
<b>Kaiser Foundation Health Plan of Washington</b>			
<b>Kaiser Permanente WA Classic</b>	\$150/day up to \$750 maximum/admission	\$150	\$0
<b>Kaiser Permanente WA CDHP</b>	10%	10%	10%
<b>Kaiser Permanente WA SoundChoice</b>	\$500/admission	15%	15%
<b>Kaiser Permanente WA Value</b>	\$250/day up to \$1,250 maximum/admission	\$200	\$0
<b>Uniform Medical Plan (UMP)<sup>2</sup></b>			
<b>UMP Classic</b>	\$200/day up to \$600 maximum/year per person + 15% professional services	15%	15%
<b>UMP Select</b>	\$200/day up to \$600 maximum/year per person + 20% professional services	20%	20%
<b>UMP CDHP</b>	15% professional services	15%	15%
<b>UMP Plus—PSHVN</b>	\$200/day up to \$600 maximum/year per person + 15% professional services	15%	15%
<b>UMP Plus—UW Medicine ACN</b>	\$200/day up to \$600 maximum/year per person + 15% professional services	15%	15%

(continued)

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

# Hearing

Plans	Routine annual hearing exam	Hardware
Kaiser Foundation Health Plan of the Northwest		
Kaiser Permanente NW Classic <sup>1</sup>	\$35 (not subject to deductible)	One hearing aid per ear covered in full during any consecutive 60 months. <sup>2</sup>
Kaiser Permanente NW CDHP <sup>1</sup>	\$30	
Kaiser Foundation Health Plan of Washington		
Kaiser Permanente WA Classic	Primary care \$15 Specialist \$30	One hearing aid per ear covered in full during any consecutive 60 month period. <sup>2</sup>
Kaiser Permanente WA CDHP	10%	
Kaiser Permanente WA SoundChoice	Primary care \$0 Specialist 15%	
Kaiser Permanente WA Value	Primary care \$30 Specialist \$50	
Uniform Medical Plan (UMP) <sup>3</sup>		
UMP Classic	\$0	One hearing aid per ear covered in full, up to the plan’s allowed amount, once every five calendar years.
UMP Select	\$0	One hearing aid per ear covered in full, up to the plan’s allowed amount, once every five calendar years.
UMP CDHP	15%	One hearing aid per ear covered in full, up to the plan’s allowed amount after deductible is met, once every five calendar years.
UMP Plus—PSHVN	\$0	One hearing aid per ear covered in full, up to the plan’s allowed amount, once every five calendar years.
UMP Plus—UW Medicine ACN	\$0	One hearing aid per ear covered in full, up to the plan’s allowed amount, once every five calendar years.

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon

<sup>2</sup> Kaiser Permanente plans pay up to the allowed amount and in-network providers do not charge for any amount over the allowed amount (known as balance billing). Non-network providers will not be covered. For CDHP, deductible must be met.

<sup>3</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

## Office visits

Plans	Primary care	Urgent care	Specialist	Mental health (independent provider offices, medical groups, freestanding clinics)	Chemo-therapy (does not include chemotherapy treatment)	Radiation (does not include radiation treatment)	Virtual or
<b>Kaiser Foundation Health Plan of the Northwest</b>							
<b>Kaiser Permanente NW Classic<sup>1</sup></b>	\$25; \$0 ages 0-17 (not subject to deductible)	\$45 (not subject to deductible)	\$35 (not subject to deductible)	\$25; \$0 ages 0-17 (not subject to deductible)	\$0	\$0	\$0 (not subject to deductible)
<b>Kaiser Permanente NW CDHP<sup>1</sup></b>	\$20	\$40	\$30	\$20	\$0	\$0	\$0
<b>Kaiser Foundation Health Plan of Washington</b>							
<b>Kaiser Permanente WA Classic</b>	\$15	\$15	\$30	\$15	\$30	\$30	\$0 (not subject to deductible)
<b>Kaiser Permanente WA CDHP</b>	10%	10%	10%	10%	10%	10%	\$0 (after deductible)
<b>Kaiser Permanente WA SoundChoice</b>	\$0 (not subject to deductible)	15%	15%	\$0 (not subject to deductible)	15%	15%	\$0 (not subject to deductible)
<b>Kaiser Permanente WA Value</b>	\$30	\$30	\$50	\$30	\$50	\$50	\$0 (not subject to deductible)
<b>Uniform Medical Plan (UMP)<sup>2</sup></b>							
<b>UMP Classic</b>	15%	15%	15%	15%	15%	15%	Varies, see COC
<b>UMP Select</b>	20%	20%	20%	20%	20%	20%	Varies, see COC
<b>UMP CDHP</b>	15%	15%	15%	15%	15%	15%	Varies, see COC
<b>UMP Plus—PSHVN</b>	\$0	15%	15%	15%	15%	15%	Varies, see COC
<b>UMP Plus—UW Medicine ACN</b>	\$0	15%	15%	15%	15%	15%	Varies, see COC

(continued)

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

## Other services and equipment

Plans	Ambulance Air or ground, per trip	Diagnostic tests, laboratory, and x-rays	Durable medical equipment, supplies, and prosthetics	Emergency room (Copay waived if admitted)	Preventive care See certificate of coverage or check with plan for full list of services.
<b>Kaiser Foundation Health Plan of the Northwest</b>					
<b>Kaiser Permanente NW Classic<sup>1</sup></b>	15%	\$10 (not subject to deductible)	20%	15%	\$0
<b>Kaiser Permanente NW CDHP<sup>1</sup></b>	15%	15%	20%	15%	\$0
<b>Kaiser Foundation Health Plan of Washington</b>					
<b>Kaiser Permanente WA Classic</b>	20% (not subject to deductible)	\$0 \$30 for MRI/ CT/PET scan	20%	\$250	\$0
<b>Kaiser Permanente WA CDHP</b>	10%	10%	10%	10%	\$0
<b>Kaiser Permanente WA SoundChoice</b>	20% (not subject to deductible)	15%	15%	\$75 + 15%	\$0
<b>Kaiser Permanente WA Value</b>	20% (not subject to deductible)	\$0 \$50 for MRI/ CT/PET scan	20%	\$300	\$0
<b>Uniform Medical Plan (UMP)<sup>2</sup></b>					
<b>UMP Classic</b>	20%	15%	15%	\$75 + 15%	\$0
<b>UMP Select</b>	20%	20%	20%	\$75 + 20%	\$0
<b>UMP CDHP</b>	20%	15%	15%	15%	\$0
<b>UMP Plus—PSHVN</b>	20%	15%	15%	\$75 + 15%	\$0
<b>UMP Plus—UW Medicine ACN</b>	20%	15%	15%	\$75 + 15%	\$0

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

## Therapy and alternative medicine

Plans	Physical, occupational, and speech therapy (per-visit cost for 60 visits/year combined)	Chiropractic Maximum amount   visits per year	Acupuncture Maximum visits per year	Massage therapy Maximum visits per year
<b>Kaiser Foundation Health Plan of the Northwest</b> (office visits are not subject to the deductible)				
<b>Kaiser Permanente NW Classic</b> <sup>1</sup>	\$35 (not subject to deductible)	\$35   12	\$35 no limit with physician referral	Physician referred only
<b>Kaiser Permanente NW CDHP</b> <sup>1</sup>	\$30	\$30   12	\$30 no limit with physician referral	Physician referred only
<b>Kaiser Foundation Health Plan of Washington</b>				
<b>Kaiser Permanente WA Classic</b>	\$30	\$15   10	20%   12	15% (60 visits/per year combined with physical, occupational, speech therapy)
<b>Kaiser Permanente WA CDHP</b>	10%	10%   10	10%   12	10% (60 visits/per year combined with physical, occupational, speech therapy)
<b>Kaiser Permanente WA SoundChoice</b>	15%	\$0   10	20%   12	15% 16
<b>Kaiser Permanente WA Value</b>	\$50	\$30   10	20%   12	\$50 (60 visits/per year combined with physical, occupational, speech therapy)
<b>Uniform Medical Plan (UMP)</b> <sup>2</sup>				
<b>UMP Classic</b>	15%	15%   10	15%   16	15%   16
<b>UMP Select</b>	20%	20%   10	20%   16	20%   16
<b>UMP CDHP</b>	15%	15%   10	15%   16	15%   16
<b>UMP Plus—PSHVN</b>	15%	15%   10	15%   16	15%   16
<b>UMP Plus—UW Medicine ACN</b>	15%	15%   10	15%   16	15%   16

(continued)

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

## Vision care

Plans	Annual vision exam	Glasses and contact lenses	Pediatric vision care (up to age 19) Exam (annual)	Pediatric vision care Glasses and contact lenses (up to age 19)
Kaiser Foundation Health Plan of the Northwest				
Kaiser Permanente NW Classic <sup>1</sup>	\$25 (not subject to deductible)	You pay any amount over \$150 every two calendar years for frames, lenses, and contacts combined.	\$0	\$0 frames and lenses 50% for a one-year supply of contact lenses in lieu of glasses
Kaiser Permanente NW CDHP <sup>1</sup>	\$20		\$0	
Kaiser Foundation Health Plan of Washington				
Kaiser Permanente WA Classic	\$15	You pay any amount over \$150 every 24 months for frames, lenses, and contacts combined.	\$0	\$0 frames and lenses 50% for a one-year supply of contact lenses in lieu of glasses
Kaiser Permanente WA CDHP	10%		\$0	
Kaiser Permanente WA SoundChoice	15%		\$0	
Kaiser Permanente WA Value	\$30		\$0	
Uniform Medical Plan (UMP) <sup>2</sup>				
UMP Classic UMP Select UMP CDHP UMP Plus—PSHVN UMP Plus—UW Medicine ACN	You pay \$0 for routine vision exam; \$30 copay for contact lens exam and fitting fee	\$0 up to the allowed amount for one pair of standard lenses and frames once every two calendar years; or, the plan pays up to \$150 for elective contact lenses in lieu of frames and lenses once every two calendar years. You pay a \$30 fitting fee for contact lenses.	\$0	\$0 up to the allowed amount for one pair of standard lenses and frames once every calendar year; or, you pay \$0 of the allowed amount for elective contact lenses or necessary contact lenses in lieu of frames and lenses once every calendar year when you see a VSP Choice network provider. You pay \$0 fitting fee for contact lenses.

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

<sup>1</sup> Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

<sup>2</sup> UMP Classic and UMP CDHP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services, plus any amount the provider charges over the allowed amount (known as balance billing). UMP Plus members will pay 50% coinsurance for out-of-network providers and any amount the out-of-network provider charges over the plan's allowed amount.

# Selecting a dental account



You and any enrolled dependents must enroll in the same PEBB dental plan. If you do not select a dental plan you will be automatically enrolled in Uniform Dental Plan.

There are three PEBB Program dental plans to choose from — two managed care plans and one preferred-provider plan. Make sure you check with the plan to see if the dental provider you want is in the plan's network. The "Dental benefits comparison" is on the next page.

## Check with the plan to see if your dental provider is in the plan's network

Make sure you correctly identify your dental plan's network and group number (see table below). This is especially important because DeltaCare and UDP are both administered by Delta Dental of Washington and are sometimes confused. You can call the dental plan's customer service number (listed in the beginning of this guide), or use the dental plan network's online directory. Carefully review your selection before enrolling.

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

DeltaCare and Willamette Dental Group are managed-care plans. You must choose and receive care from a primary dental provider (PCD) in that plan's network. Your primary care dental provider must give you a referral to see a specialist. You may change network providers at any time.

If you seek services from a dental provider not in the plan's network, these plans will not pay your claims.

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

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

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

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

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

When you see a network preferred provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network. Under UDP, you pay a percentage of the plan's allowed amount (coinsurance) for dental services after you have met the annual deductible. UDP pays up to an annual maximum of \$1,750 for covered benefits for each enrolled dependent, including preventive visits.

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

## Dental plan options

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

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



# Dental benefits comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the plan directly. A PPO refers to a preferred-provider organization (network). Managed-care plans have a closed network. If anything in these charts conflicts with the plan's certificate of coverage (COC), the COC takes precedence and prevails. All dental plans include a non-duplication of benefits clause, which applies when you have dental coverage under more than one plan.

Annual costs	Uniform Dental Plan <sup>1</sup> (Group 3000 Delta Dental PPO)	DeltaCare <sup>2</sup> (Group 3100)	Willamette Dental Group <sup>2</sup> (Group WA82)
<b>Deductible</b>	You pay \$50/person, \$150/family	None	None
<b>Plan maximum (See specific benefit maximums below)</b>	You pay amounts over \$1,750	No general plan maximum	No general plan maximum

Benefits	Uniform Dental Plan <sup>1</sup> (Group 3000 Delta Dental PPO) You pay after deductible:	DeltaCare <sup>2</sup> (Group 3100) You pay:	Willamette Dental Group <sup>2</sup> (Group WA82) You pay:
<b>Dentures</b>	50% PPO and out of state; 60% non-PPO	\$140 for complete upper or lower	\$140 for complete upper or lower
<b>Endodontics</b> (root canals)	20% PPO and out of state; 30% non-PPO	\$100 to \$150	\$100 to \$150
<b>Nonsurgical TMJ</b>	30% of costs until plan has paid \$500 for PPO, out of state, or non-PPO; then any amount over \$500 in member's lifetime	30% of costs, then any amount after plan has paid \$1,000 per year, then any amount over \$5,000 in member's lifetime	30% of costs, then any amount after plan has paid \$1,000 per year, then any amount over \$5,000 in member's lifetime
<b>Oral surgery</b>	20% PPO and out of state; 30% non-PPO	\$10 to \$50 to extract a tooth	\$10 to \$50 to extract a tooth
<b>Orthodontia</b>	50% of costs until plan has paid \$1,750 for PPO, out of state, or non-PPO; then any amount over \$1,750 in member's lifetime (deductible doesn't apply)	Up to \$1,500 copay per case	Up to \$1,500 copay per case
<b>Orthognathic surgery</b>	30% of costs until plan has paid \$5,000 for PPO, out of state, or non-PPO; then any amount over \$5,000 in member's lifetime	30% of costs until plan has paid \$5,000; then any amount over \$5,000 in member's lifetime	30% of costs until plan has paid \$5,000; then any amount over \$5,000 in member's lifetime
<b>Periodontic services</b> (treatment of gum disease)	20% PPO and out of state; 30% non-PPO	\$15 to \$100	\$15 to \$100
<b>Preventive/diagnostic</b> (deductible doesn't apply)	\$0 PPO; 10% out of state; 20% non-PPO	\$0	\$0
<b>Restorative fillings</b>	20% PPO and out of state; 30% non-PPO	\$10 to \$50	\$10 to \$50
<b>Restorative crowns</b>	50% PPO and out of state; 60% non-PPO	\$100 to \$175	\$100 to \$175

<sup>1</sup> Preferred-provider plan (PPO)

<sup>2</sup> Managed-care plans

# Life and AD&D insurance



The PEBB Program provides basic life insurance and basic accidental death and dismemberment (AD&D) insurance at no cost to PEBB benefits-eligible state and higher-education employees, as well as employees who work for an educational service district (who are not represented), a tribal government, or an employer group that offers both PEBB medical and dental coverage. If your employer offers this benefit, you will automatically be enrolled in basic life and AD&D insurance, even if you waive medical coverage.

You can enroll in supplemental life and supplemental AD&D insurance for yourself and your eligible dependents.

These benefits are not available to employees who are only offered medical benefits.

Life and AD&D insurance is provided through Metropolitan Life Insurance Company (MetLife), plan number 164995. The information below is a summary of benefits only. If anything conflicts with the certificate of coverage (COC), the COC takes precedence and prevails. To see the COC, visit *Forms & publications* on HCA's website [hca.wa.gov/pebb-employee](http://hca.wa.gov/pebb-employee) or contact MetLife at 1-866-548-7139.

## What is (employer-paid) basic life insurance?

As an employee, you are automatically enrolled in basic life insurance, which covers you and pays your designated beneficiaries in the event of your death. This benefit is paid for by your employer, and you do not have to provide evidence of insurability (proof of good health).

Basic life insurance coverage is \$35,000 for death from any cause.

## What is (employee-paid) supplemental life insurance?

The following are the kinds of supplemental life insurance you can buy.

### Supplemental life insurance for employees

You may enroll in supplemental life insurance for yourself in increments of \$10,000 up to \$1,000,000. You can enroll up to \$500,000 of coverage without evidence of insurability if elected **no later than 31 days** after becoming eligible for the employer contribution toward PEBB benefits. Evidence of insurability is always required for coverage above \$500,000, up to the maximum of \$1,000,000.

### Supplemental life insurance for spouse or state-registered domestic partner

If you are enrolled in supplemental life insurance, you may enroll in supplemental life insurance for your spouse or state-registered domestic partner in increments of \$5,000 up to \$500,000, not to exceed one-half the supplemental amount you get for yourself as an employee. You can enroll in up to \$100,000 of coverage without evidence of insurability if elected **no later than 31 days** after becoming eligible for the employer contribution toward PEBB benefits. Evidence of insurability is always required for coverage above \$100,000, up to the maximum of \$500,000.

### Supplemental life insurance for children

If you enroll in supplemental life insurance for yourself, you may enroll in coverage for your children in \$5,000 increments up to \$20,000. One premium covers all your enrolled children. Evidence of insurability is not required for children when enrolled **within the 31-day** window of eligibility. Any increases in coverage or late enrollment require evidence of insurability.

## Evidence of insurability

MetLife must approve your evidence of insurability if you apply for:

- Any amount of supplemental life insurance for yourself, spouse, state-registered domestic partner, or children **after 31 days** of becoming eligible for PEBB benefits.
- More than \$500,000 in supplemental employee life insurance **within 31 days** of becoming eligible for PEBB benefits.
- More than \$100,000 in supplemental spouse or state-registered domestic partner life insurance **within 31 days** of becoming eligible for PEBB benefits.

(continued)

## What does supplemental life insurance cost?

The table below shows the monthly cost per \$1,000 of coverage, based on your (the employee's) age as of December 31, 2020, and tobacco use by the insured person.

## Supplemental life insurance monthly rates for employees, spouse or state-registered domestic partner, and children

Age	Monthly cost per \$1,000	
	Non-tobacco user	Tobacco user
Less than 25	\$0.028	\$0.037
25–29	\$0.031	\$0.043
30–34	\$0.034	\$0.057
35–39	\$0.043	\$0.066
40–44	\$0.064	\$0.073
45–49	\$0.092	\$0.111
50–54	\$0.143	\$0.170
55–59	\$0.268	\$0.317
60–64	\$0.411	\$0.482
65–69	\$0.758	\$0.929
70+	\$1.131	\$1.510
Cost for your children	\$0.124	N/A

### Good to know!

#### Example of supplemental life insurance

To cover yourself, the monthly rate at age 40 to 44 for a non-tobacco user is \$0.064 per \$1,000 coverage. For \$10,000 of supplemental life insurance coverage, the monthly cost is \$0.64.

\$10,000 coverage: 10  
40–44 age rate:  $\times 0.064$   
Monthly cost: \$ 0.64

## When can I enroll in supplemental life insurance?

You may enroll in supplemental life insurance or supplemental dependent life insurance at any time. The guaranteed issue amounts are available for supplemental life insurance and dependent life insurance (without submitting evidence of insurability) when your enrollment is no later than:

- **31 days** after the date you become eligible for PEBB benefits.

- **60 days** after the date of marriage or state-registered domestic partnership.
- **60 days** after the birth or adoption of a child. A newly born child must be at least 14 days old before supplemental dependent life insurance coverage is effective.

Once you have enrolled one child in dependent life insurance, each succeeding child will automatically be covered for the same amount on the date that child becomes eligible as defined in MetLife's certificate of coverage. If you apply for or change your employee or spouse or state-registered domestic partner supplemental life insurance coverage after the deadline, you must provide evidence of insurability to MetLife for approval, regardless of the coverage amount requested.

Requests submitted within the above deadlines for coverage over the guaranteed issue amount will require evidence of insurability only for the amount over the guaranteed issue. If the additional amount is denied, the employee or family member will be enrolled in the guaranteed issue amount.

## How do I enroll in supplemental life insurance?

Enroll online using the MetLife MyBenefits portal at [mybenefits.metlife.com/wapebb](https://mybenefits.metlife.com/wapebb).

## How do I create an online account with MetLife?

1. Visit MetLife's MyBenefits portal at [mybenefits.metlife.com/wapebb](https://mybenefits.metlife.com/wapebb). A *Welcome to MyBenefits* screen will appear.
2. You should see *PEBB Benefits — State of Washington* in the *Account Sign in* box.
3. Select the *Register now* button.
4. Complete the registration form and verification process.
5. Select *Go to Accounts* in the registration confirmation pop-up.

If you have questions about enrollment or the MetLife website, or need paper forms, please contact MetLife at 1-866-548-7139, Monday through Friday, 5 a.m. to 8 p.m. Pacific Time (except for major holidays).

## How do I designate beneficiaries for my life insurance?

You must name a beneficiary for your life insurance. To name or update beneficiaries for life insurance, use MetLife's MyBenefits portal at [mybenefits.metlife.com/wapebb](https://mybenefits.metlife.com/wapebb). You can also call MetLife at 1-866-548-7139 to request a *Group Term Life Insurance Beneficiary Designation* form or download the form under *Forms & publications* on HCA's website [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

## Can I waive life and AD&D insurance?

If you are eligible for SEBB benefits, you cannot waive basic life and AD&D insurance. However, you have two options if you object to this coverage:

- You can name a charity as your beneficiary.
- On your enrollment form, you can leave the beneficiary information blank. Tell your family and anyone who might be handling your estate not to file a claim on your death. If you choose not to identify a beneficiary, the benefit amount will be turned over to the state as abandoned property.

## If I leave employment, can I continue life insurance coverage?

If you're eligible for portability or conversion due to termination or other reasons, MetLife will send you information and an application. When porting or converting your employee life insurance coverage, your coverage will become an individual policy that is not tied to the PEBB Program.

### Portability Provision

Under the Portability Provision, you can apply to continue all or part of your active employee basic life, supplemental life, and dependent life insurance.

You must be actively enrolled and apply **within 60 days** from when your coverage ended to have the opportunity to continue your coverage through portability.

Dependent child and spouse or state-registered domestic partner life insurance may be continued, even if you choose not to continue your life insurance.

To continue life insurance under the Portability Provision, you must apply to MetLife **within 60 days** after the date your PEBB Program life insurance ends, including when you move to PEBB retiree term life insurance. Any amount of life insurance not ported may be converted.

### Conversion Provision

You may apply to convert your basic life, supplemental life, spouse or state-registered domestic partner, or dependent child life insurance to an individual policy. The amount of the individual policy will be equal to (or, if you choose, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting.

You have **60 days** to apply for conversion coverage after your PEBB employee life insurance ends.

Contact MetLife directly at 1-866-548-7139 with any questions.

## Is there an accelerated benefit in PEBB Program life insurance coverage?

Yes, our basic and supplemental life insurance plans have an accelerated benefits option. If a subscriber becomes terminally ill and is expected to die within 24 months, they can request to receive a portion of their life insurance benefit before their death.

Subscribers may receive up to 80 percent of their basic life benefit amount, not to exceed \$28,000.

Subscribers may receive up to 80 percent of their combined basic life and supplemental life benefit amount, not to exceed \$500,000.

This option is also available for spouse or state-registered domestic partner dependent life insurance.

*(continued)*

## What is (employer-paid) basic AD&D insurance?

You will be automatically enrolled in basic accidental death and dismemberment (AD&D) insurance, which provides benefits for certain injuries or death resulting from a covered accident. This benefit is paid for by your employer.

Basic AD&D coverage is \$5,000.

## What is (employee-paid) supplemental AD&D insurance?

The following are the types of supplemental AD&D insurance you can buy.

### Supplemental AD&D insurance for employees

You may enroll in supplemental AD&D coverage in increments of \$10,000 up to \$250,000. Supplemental AD&D insurance does not cover death and dismemberment from nonaccidental causes and never requires evidence of insurability.

### Supplemental AD&D insurance for your spouse or state-registered domestic partner

If you enroll in supplemental AD&D insurance for yourself, you can choose to cover your spouse or state-registered domestic partner with AD&D coverage in increments of \$10,000 up to \$250,000. Evidence of insurability is not required.

### Supplemental AD&D insurance for children

If you enroll in supplemental AD&D insurance for yourself, supplemental AD&D coverage is available for your children in \$5,000 increments up to \$25,000. One premium covers all your enrolled children. Evidence of insurability is not required.

## What does supplemental AD&D insurance cost?

The table below shows the monthly cost per \$1,000 of coverage.

### Supplemental AD&D insurance monthly rates

Insured	Monthly cost per \$1,000
Employee	\$0.019
Spouse or state-registered domestic partner	\$0.019
All dependent children	\$0.016

## Good to know!

### Example of supplemental AD&D insurance

To cover yourself, the monthly rate is \$0.019 per \$1,000 coverage. For \$10,000 of supplemental AD&D insurance coverage, the monthly cost is \$0.19.

\$10,000 coverage:	10
Monthly rate:	$\times 0.019$
Monthly cost:	\$ 0.19

## When can I enroll in supplemental AD&D insurance?

You can enroll in supplemental AD&D anytime.

Supplemental AD&D insurance never requires evidence of insurability.

## How do I enroll in supplemental AD&D insurance?

Enroll online using MetLife's MyBenefits portal at [mybenefits.metlife.com/wapebb](https://mybenefits.metlife.com/wapebb). If you have any questions about enrollment or need to request a form, please contact MetLife at 1-866-548-7139.

## How do I designate beneficiaries for my AD&D insurance?

To name or update beneficiaries for AD&D insurance, use MetLife's MyBenefits portal at [mybenefits.metlife.com/wapebb](https://mybenefits.metlife.com/wapebb). You can also call MetLife at 1-866-548-7139 to request a *Group Term Life Insurance Beneficiary Designation* form or download the form under *Forms & publications* on HCA's website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).

# Long-term disability insurance



Long-term disability (LTD) insurance protects a portion of your salary if you are unable to work due to serious injury or illness. When you enroll in LTD coverage, it pays a percentage of your monthly earnings to you if you become disabled.

The PEBB Program offers basic (employer-paid) LTD insurance at no cost to PEBB benefits-eligible state and higher-education employees, employees of an educational service district (who are not represented), tribal government, or employer group that offers both PEBB medical and dental coverage. If eligible, you will automatically be enrolled in basic LTD insurance coverage, even if you waive PEBB medical coverage. You may also enroll in (employee-paid) supplemental LTD insurance.

**Exceptions:** Supplemental LTD insurance is not available to seasonal employees who work a season that is less than nine months or port commissioners.

These benefits are provided through Standard Insurance Company. The information below is a summary. If anything conflicts with the LTD plan booklet, the LTD plan booklet takes precedence and prevails. To see the LTD plan booklet or to get a form, go to the *Additional benefits* webpages on HCA's website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee) or contact your payroll or benefits office.

## What is (employer-paid) basic LTD insurance?

The PEBB Program's basic LTD insurance provides you with a monthly payment ranging between \$50 a month and \$240 a month in the event of a disability. The amount you receive is based on 60 percent of the first \$400 of your predisability earnings, reduced by any deductible income, but in any case it will not exceed \$240 a month. You may want to consider buying supplemental LTD insurance (see below) if you would like to protect more of your income.

## Waiting period before benefits become payable for basic LTD

Benefits start after the benefit-waiting period, which is the longer of:

- 90 days.
- The period of sick leave (excluding shared leave) for which you are eligible under your employer's sick leave, paid time off (PTO), or other salaried continuation plan (excluding vacation leave).
- The period of Washington Paid Family and Medical Leave for which you are receiving benefits.

Benefits continue during your disability up to the maximum benefit period. The maximum benefit period is determined by your age when your disability begins. See "What is the maximum benefit period?" on the next page.

## Terms and conditions apply

LTD insurance has limitations, including a 12-month exclusion period and a preexisting condition exclusion. Please read your certificate of coverage carefully to understand this benefit.

## What is considered a disability?

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

After the first 24 months, disability as a result of sickness, injury, or pregnancy means being unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably able through education, training, or experience. During this period, you are considered partially disabled if you are working but unable to earn more than 60 percent of your indexed predisability earnings in that occupation and in all other occupations for which you are reasonably suited.

## What is (employee-paid) supplemental LTD insurance?

If you are eligible for basic LTD, you may buy supplemental LTD to ensure that you protect more of your income in the event you become disabled and cannot work.

Supplemental LTD provides you with a monthly payment ranging between \$50 a month and \$6,000 a month in the event of a disability. The amount you receive is based on 60 percent of the first \$10,000 of your insured earnings, reduced by any deductible income.

Supplemental LTD benefits start and continue in the same manner as basic LTD.

## What does supplemental LTD insurance cost?

Your monthly supplemental LTD premium is a percentage of your insured earnings (your monthly gross pay before you became disabled). To calculate your premium, select your desired benefit waiting period and multiply your monthly base pay (up to \$10,000) by the percentage shown in the table on the next page.

(continued)

## Supplemental LTD rates

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

## Waiting period before benefits become payable for supplemental LTD

Benefits start after the benefit-waiting period, which is the longer of:

- 90, 120, 180, 240, 300, or 360 days (depending on your election)
- The period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave plan, and/or
- The period of Washington Paid Family and Medical Leave for which you are receiving benefits

## What is the maximum benefit period?

For both basic and supplemental LTD insurance, the "maximum benefit period" means the benefit duration, which is based on your age when the disability begins.

Age	Maximum benefit period
61 or younger	To age 65 or to SSNRA <sup>1</sup> or 42 months, whichever is longer
62	To SSNRA <sup>1</sup> or 42 months, whichever is longer
63	To SSNRA <sup>1</sup> or 36 months, whichever is longer
64	To SSNRA <sup>1</sup> or 30 months, whichever is longer
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

<sup>1</sup> SSNRA is Social Security normal retirement age

## When can I enroll in supplemental LTD insurance?

You may enroll in supplemental LTD coverage **no later than 31 days** after becoming eligible for PEBB benefits without providing evidence of insurability.

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

## How do I enroll in supplemental LTD insurance?

If you are newly eligible and **within 31 days** of becoming eligible for PEBB Program benefits, submit the *PEBB Long Term Disability (LTD) Enrollment/Change* form (found in the back of this booklet) to your payroll or benefits office.

If you apply for supplemental LTD coverage **after 31 days**, or decrease the waiting period, submit the *PEBB Long Term Disability (LTD) Enrollment/Change* form and the *PEBB Long Term Disability (LTD) Evidence of Insurability* form (found on HCA's website at [hca.wa.gov/pebb-employee](http://hca.wa.gov/pebb-employee)) and submit it to The Standard Insurance Company.

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

## Good to know!

### Examples of supplemental LTD insurance

#### Example 1

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

**Earnings:** \$1,000 per month

**90-day benefit waiting period:** x 0.0072 (0.72% converts to 0.0072 when multiplying)

**Monthly cost:** \$ 7.20

#### Example 2

If you are a TRS, PERS, or other retirement plan employee with monthly earnings of \$1,000, the 90-day benefit waiting period would cost \$6 per month.

**Earnings:** \$ 1,000 per month

**90-day benefit waiting period:** x 0.006 (0.6% converts to 0.006 when multiplying)

**Monthly cost:** \$6



Both the Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) are available to public employees eligible for PEBB benefits who work at state agencies, higher-education institutions, and community and technical colleges, as described in Washington Administrative Code (WAC) 182-12-116. See the *Additional benefits* webpage on HCA's website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee) to learn more.

The Medical FSA and DCAP are administered by Navia Benefit Solutions, Inc. For details and forms, visit the Navia website at [pebb.naviabenefits.com](https://pebb.naviabenefits.com) or call 1-800-669-3539. Email questions to [customerservice@naviabenefits.com](mailto:customerservice@naviabenefits.com).

## What is a Medical Flexible Spending Arrangement (FSA)?

A Medical FSA allows you to set aside money from your paycheck on a pretax basis to pay for qualifying out-of-pocket health care costs for you and your qualified tax dependents. You can set aside as little as \$240 or as much as \$2,750 per calendar year.

You cannot enroll in both a Medical FSA and a PEBB consumer-directed health plan (CDHP) with a health savings account (HSA). If you try to enroll in both, you will be enrolled in the CDHP with an HSA.

## How does the Medical FSA work?

Your Medical FSA helps you pay for deductibles, copays, coinsurance, and many other expenses. You can use your Medical FSA for your health care expenses or those of your spouse or qualified tax dependent, even if they are not enrolled in your PEBB medical or dental plan.

To figure out how much you may want to contribute, estimate your out-of-pocket medical expenses for the calendar year and enroll in a Medical FSA for that amount. The more accurate you are in estimating your expenses, the better this benefit will work for you. The full amount you elect to set aside for your Medical FSA is available on the first day your benefits become effective.

The amount you set as your annual election cannot be changed unless a special open enrollment event (also called a qualifying event) occurs during the plan year. Common special open enrollment events include birth, death, adoption, marriage, and divorce. Your change in election amount must be consistent with the qualifying event.

Your election amount is deducted from your pay, divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted pretax, which reduces your taxable income, so you don't pay federal taxes on your elected Medical FSA dollars.

## \$250 Medical FSA contribution for represented employees

The collective bargaining agreement negotiated in September 2018 states that represented employees whose rate of pay on November 1, 2020 results in an annual salary of \$50,004 or less will receive a Medical FSA contribution of \$250 in January 2021. This money is an employer-paid benefit; it will not come out of your paycheck. Other eligibility criteria apply. If you have questions, please contact your payroll or benefits office.

### How do I get the contribution for represented employees?

If you are eligible for this contribution, you will receive it automatically from your employer. No action is required on your part.

- If you do not enroll in a Medical FSA for 2021, Navia Benefit Solutions will open an account in your name and send you a welcome letter with a debit card loaded with \$250. Use the debit card for eligible health care expenses by March 15, 2022. If you do not want the funds, you do not have to spend them. They will be forfeited.
- If you enroll in a Medical FSA for the 2021 plan year, the \$250 contribution will be added to your account with Navia Benefit Solutions in January 2021.

You will not receive this benefit if you enroll in a CDHP with an HSA for 2021. This limitation is an Internal Revenue Service rule. You will also forfeit this benefit if you waive PEBB medical coverage for 2021, unless you waive to enroll as a dependent on someone else's PEBB medical plan (that is not a CDHP). If you cannot receive the \$250 for one of these reasons, the collective bargaining agreement does not allow the \$250 to be distributed or used in any other way. You will forfeit this benefit.

## What is the Dependent Care Assistance Program (DCAP)?

The DCAP allows you to set aside money from your paycheck on a pretax basis to help pay for qualifying child care or elder care expenses while you and your spouse attend school full-time, work, or look for work.

A qualifying dependent must live with you and must be 12 years old or younger. A dependent age 13 or older qualifies only if they are physically or mentally incapable of self-care and regularly spend at least eight hours each day in your household. The care must be provided during the hours the parent(s) work, look for work, or attend school.

You can set aside as much as \$5,000 annually (for a single person or married couple filing joint income tax return) or \$2,500 annually (for a married person filing a separate income tax return).

The total amount of your contribution cannot be more than either your earned income or your spouse's earned income, whichever is less. Earned income means wages, salaries, tips, and other employee compensation, as well as net earnings from self-employment.

## How does DCAP work?

The DCAP helps you pay for eligible expenses including elder day care, babysitting, day care, preschool, and registration fees.

Estimate your child or elder care expenses for the calendar year and enroll in the DCAP for that amount.

Your election amount is deducted from your pay, and divided by the number of paychecks you will receive in the calendar year. Your election amount will be deducted from your paychecks pretax (which reduces your taxable income).

## When can I enroll in Medical FSA and DCAP?

You may enroll in the Medical FSA and the DCAP at the following times:

- During the PEBB Program's **annual open enrollment**
- **No later than 31 days** after the date you become eligible for PEBB benefits
- **No later than 60 days** after you or an eligible dependent experience a qualifying event that creates a special open enrollment

## How do I enroll in the Medical FSA and DCAP?

Before you enroll, make sure to review the PEBB Medical FSA or DCAP enrollment guides on the Navia website at [pebb.naviabenefits.com](https://pebb.naviabenefits.com). You can also call Navia Benefit Solutions at 1-800-669-3539 if you have questions.

To enroll in these benefits, download and print the *Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) Enrollment* form on the Navia member portal at [pebb.naviabenefits.com](https://pebb.naviabenefits.com). If you are enrolling anytime other than open enrollment, you must return the form to your payroll or benefits office **no later than 31 days** after you become eligible for PEBB benefits. **Exception:** University of Washington employees must enroll through Workday.

If you enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA) you cannot also enroll in a Medical FSA in the same plan year. You are eligible to enroll in DCAP.

## When can I change my Medical FSA or DCAP election?

Once you enroll in a Medical FSA or DCAP, you can change your election only if you have a qualifying life event that creates a special open enrollment. Your election change must be consistent with the qualifying event. For example, you cannot reduce your annual election if you get married; you can only increase it.

If you have a qualifying event and want to change your elections, your payroll or benefits office must receive your *Navia Benefit Solutions PEBB Change of Status* form and proof of the qualifying event that created the special open enrollment **no later than 60 days** after the date of the event. **Exception:** University of Washington employees must submit the change through Workday.

For more information, see the *Medical FSA Enrollment Guide* or *DCAP Enrollment Guide* on the Navia website at [pebb.naviabenefits.com](https://pebb.naviabenefits.com).

SmartHealth is included in your benefits and is a voluntary wellness program that supports you on your journey toward living well.

Participate in activities to help support your whole person well-being, including managing stress, building resiliency, and adapting to change. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentives.

## Who is eligible?

You (the subscriber) and your spouse or state-registered domestic partner enrolled in PEBB medical coverage can participate in SmartHealth. However, only subscribers enrolled in PEBB medical coverage can qualify for the SmartHealth wellness incentives.

Are you waiving PEBB medical coverage? You can still access SmartHealth, but you won't be eligible to qualify for the SmartHealth wellness incentives.

## What are the wellness incentives?

Subscribers can qualify for two wellness incentives:

- A \$25 Amazon.com gift card. (Please note this is a taxable benefit.)
- Either a \$125 reduction in the subscriber's 2022 PEBB medical deductible, or a one-time deposit of \$125 into the subscriber's health savings account (if enrolled in a PEBB consumer-directed health plan in 2022). The 2021 incentive is distributed by January 31, 2022 if you qualify.

## How do I qualify for the wellness incentives?

### To qualify for the \$25 Amazon.com gift card wellness incentive:

- Take the SmartHealth well-being assessment.
- Claim the \$25 Amazon.com gift card by December 31, 2021.

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

### To qualify for the \$125 wellness incentive:

- Take the SmartHealth well-being assessment.
- Earn 2,000 total points within the deadline requirement.
- To receive the \$125 wellness incentive in 2022, the subscriber must still be enrolled in a PEBB medical plan in 2022.

SmartHealth will work with a subscriber who cannot complete a wellness incentive requirement in order to provide an alternative requirement that will allow the

subscriber to qualify for the wellness incentive or waive the requirement.

If a subscriber qualifies for the \$125 wellness incentive in 2021, then becomes a retiree or continuation coverage subscriber enrolled in Medicare Part A and Part B as their primary coverage and is enrolled in a PEBB medical plan after January 1, 2022, they will still receive the SmartHealth incentive in 2022.

## How do I get started?

1. Visit [smarthealth.hca.wa.gov](https://smarthealth.hca.wa.gov) and click *Get Started*.
2. Take the SmartHealth well-being assessment. After completing the assessment, you earn the \$25 Amazon.com gift card. The gift card is taxable. If you don't have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the assessment by phone.

- It only takes 15 minutes.
- This is the first step to qualify for the wellness incentive.
- Learn your top strengths and areas to improve.

3. Join and track activities to earn at least 2,000 points by your deadline to qualify for a \$125 wellness incentive (distributed by January 31, 2022).

## What is my deadline to qualify for the wellness incentive?

Your deadline to qualify for and claim the \$25 Amazon.com gift card wellness incentive is December 31, 2021.

Your deadline to qualify for the \$125 wellness incentive depends on the date your PEBB medical coverage becomes effective:

- If you are already enrolled in PEBB medical or are a new subscriber and your PEBB medical effective date is January through September 2021: Deadline is November 30, 2021.
- If your PEBB medical effective date is October through December 2021: Deadline is December 31, 2021.

## What if I don't have internet access?

Contact SmartHealth Customer Service to participate in SmartHealth by phone.

## SmartHealth contacts

Find out more on the HCA website at [hca.wa.gov/pebb-smarthealth](https://hca.wa.gov/pebb-smarthealth). Visit the SmartHealth portal at [smarthealth.hca.wa.gov](https://smarthealth.hca.wa.gov) to track activities.

If you have questions, call SmartHealth Customer Service, 7 a.m. to 7 p.m., Monday through Friday, at 1-855-750-8866.



# Auto and home insurance

As a PEBB member, you may receive a discount of up to 12 percent off Liberty Mutual's auto insurance rates and up to 5 percent off Liberty Mutual's home insurance rates.

In addition to the discounts, Liberty Mutual offers:

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

## When can I enroll?

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

## How do I enroll?

To request a quote for auto or home insurance, contact Liberty Mutual one of these ways:

- Look for auto/home insurance under *Additional benefits* on the HCA's website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a Washington State PEBB Program member (client #8246).
- Call or visit one of the local offices (listed on the right.)

If you are already a Liberty Mutual policyholder and would like to take advantage of this group discount, call one of the local offices to find out how they can convert your policy at your next renewal (have your current policy handy).

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

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

### Portland

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

### Bellevue

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

### Spokane

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

### Tukwila

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

### Olympia

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



## What to expect next

You should receive a welcome packet or letter from your health plans.

If you have questions that you can't find on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee) or in this guide, contact your payroll or benefits office.

### *Good to know!*

#### **Special open enrollment**

See “What changes can I make during a special open enrollment?” on page 56. When a special open enrollment event occurs, coverage will begin as noted in the table beginning on that page.

## When do my benefits begin?

If you are newly eligible, your medical and dental coverage, basic life insurance, basic AD&D insurance, and basic LTD insurance begin on the first day of the month after you become eligible. If you become eligible on the first working day of the month, PEBB benefits begin on that day. Contact your payroll or benefits office with questions about eligibility and when your benefits begin.

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

If you are newly eligible and elect enrollment in the Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP), benefits begin the first day of the month after you become eligible. If you become eligible on the first working day of the month, Medical FSA and DCAP begin that day.

If you elect supplemental life insurance, supplemental AD&D insurance, or supplemental LTD insurance, insurance begins the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

## When do my benefits begin if I am regaining eligibility?

Your medical and dental coverage will begin the first day of the month that you are in pay status for eight or more hours if you are in one of these groups:

- Returning from unpaid leave that did not last more than 29 months after losing the employer contribution
- A faculty member who was eligible for the employer contribution and lost it and now is returning to work within 12 months of losing the employer contribution
- A seasonal worker who was eligible for the employer contribution and lost it and now is returning to work within 12 months of losing the employer contribution

If you continued your supplemental life insurance or supplemental AD&D insurance while on leave, your coverage will start the first day of the month that you are in pay status for eight hours or more. If you were eligible and chose to continue your supplemental LTD insurance or you were not eligible to continue your LTD insurance, it will begin the first day of the month you are in pay status for eight hours or more. If you were eligible to continue your supplemental life, supplemental AD&D, or supplemental LTD insurance and chose not to, your insurance begins the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

## When coverage begins

### **PEBB Program annual open enrollment**

January 1 of the following year

### **Newly eligible**

The first of the month following eligibility

### **Marriage or registering a domestic partnership**

The first of the month after the event or the date your payroll or benefits office receives your completed enrollment form with proof of your dependent's eligibility, whichever is later. If that day is the first of the month, coverage begins on that day. You can submit the proof of eligibility later than the enrollment form, as long as it is within 60 days of the event.

### **Birth, adoption, or assumed legal obligation for total or partial support in anticipation of adoption**

The date of birth (for a newly born child), the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier (for a newly adopted child).

(continued)

If you enroll yourself in order to enroll a newly born or newly adopted child, medical coverage begins the first day of the month in which the event occurs.

If you enroll your eligible spouse or state-registered domestic partner in your PEBB health plan coverage due to your child's birth or adoption, their medical coverage begins the first day of the month in which the birth or adoption occurs.

If the child's date of birth or adoption is before the 16th day of the month, you pay the higher premium for that full month (if adding the child increases the premium). If the child's date of birth or adoption is on or after the 16th day of the month, the higher premium will begin the next month.

A newly born child must be at least 14 days old before supplemental dependent life insurance and AD&D insurance coverage purchased by the employee becomes effective.

You can submit the proof of eligibility later than the enrollment form, as long as it is within 60 days of the event period.

#### **Child becomes eligible as an extended dependent**

The first day of the month following eligibility certification

#### **Other events that create a special open enrollment**

The first of the month after the date of the event or the date your payroll or benefits office receives your enrollment form (and proof of the event that created the special open enrollment) with any other required documents, whichever is later. If that day is the first of the month, the coverage begins on that day. You can submit the proof of eligibility

later than the enrollment form, as long as it is within 60 days of the event.

### ***Good to know!***

#### **ID cards**

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

The Uniform Dental Plan does not mail ID cards, but you may download one from the UDP website at [deltadentalwa.com/pebb](https://deltadentalwa.com/pebb).

# Changing your coverage



## How do I make changes in my health plan coverage?

Submit the required forms to your payroll or benefits office during the annual open enrollment period or within the PEBB Program's timelines when a special open enrollment event occurs. **Exception:** UW employees must enroll through Workday. Enrollment changes are effective January 1 of the following year.

## What changes can I make anytime?

You can make these changes outside of annual open enrollment without a special open enrollment event.

- Change your name or address. Use the appropriate *PEBB Employee Enrollment/Change* form. UW employees use Workday.
- Apply for or cancel coverage, change coverage amounts, and update beneficiary information for supplemental life, and supplemental accidental death and dismemberment (AD&D) insurance. Evidence of insurability may be required. See "Life and AD&D Insurance" on page 43.
- Apply for, terminate, or change auto or home insurance coverage. See "Auto and Home Insurance" on page 52.

- Remove dependents from coverage due to loss of eligibility (this is required). Your payroll or benefits office must receive the appropriate *PEBB Employee Enrollment/Change* form **within 60 days** of the last day of the month the dependent loses eligibility for PEBB health plan coverage. You may also need to provide proof of the event before the dependent can be removed. UW employees use Workday.
- Enroll in or cancel supplemental long-term disability insurance, or change the waiting period. Use the *Long-Term Disability Enrollment/Change* form. Evidence of insurability may be required.
- Make changes to your tobacco use premium surcharge attestation. Use the *PEBB Premium Surcharge Attestation Change* form or log in to PEBB My Account at [hca.wa.gov/my-account](https://hca.wa.gov/my-account).
- Start, stop, or change your contribution to your health savings account (HSA). Use the *PEBB Employee Authorization for Payroll Deduction to Health Savings Account* form under *Forms & publications* on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee).
- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available on the HealthEquity website at [learn.healthequity.com/pebb](https://learn.healthequity.com/pebb).

(continued)

## Changes you can make during annual open enrollment

During the annual open enrollment, you can:	Submit this form:
<ul style="list-style-type: none"> <li>• Change your medical or dental plan</li> <li>• Enroll or remove eligible dependents</li> <li>• Enroll in a medical plan, if you previously waived PEBB medical</li> <li>• Waive enrollment in PEBB medical coverage. See "Waiving medical coverage" on page 17.</li> </ul>	<i>PEBB Employee Enrollment/Change</i> form (if you have PEBB medical, dental, life, AD&D, and long-term disability insurance) OR <i>PEBB Employee Enrollment/Change for Medical Only Groups</i> (if you have PEBB medical only)
<ul style="list-style-type: none"> <li>• Enroll or re-enroll in a Medical Flexible Spending Arrangement (FSA) (PEBB benefits-eligible state agency and higher-education employees only)</li> <li>• Enroll or re-enroll in a Dependent Care Assistance Program (DCAP) (PEBB benefits-eligible state agency and higher-education employees only)</li> </ul> <p>Your participation in the Medical FSA and DCAP does not automatically continue from plan year to plan year. If you wish to participate, you must enroll in this benefit annually.</p>	<i>PEBB Medical Flexible Spending Arrangement and Dependent Care Assistance Program Enrollment Form</i> OR Enroll on Navia's website at <a href="https://pebb.naviabenefits.com">pebb.naviabenefits.com</a> . (Check the enrollment form for submission directions.) <b>Exception:</b> University of Washington employees must use Workday.
Enroll or opt out of participation under the premium payment plan. See "Paying for benefits" on page 19.	<i>PEBB Premium Payment Plan Election/Change</i> form
Attest to the spouse or state-registered domestic partner coverage premium surcharge	Use PEBB My Account or a <i>PEBB Employee Enrollment/Change</i> form

## What is a special open enrollment?

Certain events let you make account changes (like changing plans or enrolling a dependent) outside of annual open enrollment. We call these special open enrollment events.

The change in enrollment must be allowable under the Internal Revenue Code and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependents, or both. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits or regaining eligibility for PEBB benefits.

The changes shown below through page 58 may be allowed as a special open enrollment.

In addition, employees can make changes to supplemental life and AD&D insurance, and employees eligible to participate in the salary reduction plan may also be able to enroll in or revoke their election (or make a new election) under the Medical Flexible Spending Arrangements (FSA), Dependent Care Assistance Program (DCAP), or the premium payment plan during a special open enrollment.

## What changes can I make during annual open enrollment?

To make any of the changes described in the table below, your payroll or benefits office must receive the

required form(s) during the PEBB Program's annual open enrollment. You may also make some of these changes online during open enrollment using PEBB My Account at [hca.wa.gov/my-account](https://hca.wa.gov/my-account).

## How do I make changes during a special open enrollment?

You must provide evidence of the event that created the special open enrollment (for example, a marriage or birth certificate) along with the *PEBB Employee Enrollment/Change* form (and other required forms) to your payroll or benefits office **no later than 60 days** after the event. In many instances, the date your form is received affects the effective date of the change in enrollment. **Exception:** University of Washington employees must use Workday.

You may want to submit your request sooner to avoid a delay in the enrollment or change. When the special open enrollment is for birth or adoption, submit the required forms and proof of your dependent's eligibility and/or the event as soon as possible to ensure timely payment of claims. If adding the child increases the premium, your employer must receive the enrollment form and proof of your dependent's eligibility and/or the event **no later than 60 days** after the date of birth, adoption, or the date you assume legal obligation for support in anticipation of adoption.

## Changes you can make with a special open enrollment

If this event happens	These changes may be permitted as a special open enrollment					Submit these documents (List is not inclusive)
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical	
Marriage or registering a domestic partnership	Yes <sup>1</sup>	Yes <sup>2</sup>	Yes	Yes <sup>3</sup>	Yes	Marriage certificate; certificate of state-registered domestic partnership or legal union  Also provide evidence the marriage/partnership is still valid (e.g., a utility bill dated within the past six months showing both names).
Birth or adoption, including assuming a legal obligation for support in anticipation of adoption	Yes	Yes	Yes	Yes <sup>3</sup>	Yes	Birth certificate (or hospital certificate with child's footprints); certificate or decree of adoption; placement letter from adoption agency  All valid documents for proof of this event must show the name of the parent who is the subscriber, subscriber's spouse, or the subscriber's state-registered domestic partner.

If this event happens	These changes may be permitted as a special open enrollment					Submit these documents (List is not inclusive)
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical	
Child becomes eligible as an extended dependent through legal custody or legal guardianship	Yes	No	Yes	No	Yes	Valid court order showing legal custody, guardianship, or temporary guardianship, signed by a judge or officer of the court AND signed <i>PEBB Extended Dependent Certification</i> form
Employee or a dependent loses other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA)	Yes	No	Yes	No	Yes	Certificate of creditable coverage; letter of termination of coverage from health plan or payroll or benefits office; or COBRA election notice
Employee has a change in employment status that affects their eligibility for their employer contribution toward their employer-based group health plan	Yes	Yes	Yes	Yes <sup>3</sup>	Yes	Employee hire letter from employer that contains information about benefits eligibility; employment contract; termination letter; letter of resignation; statement of insurance; certificate of coverage
Employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.	Yes	Yes	Yes	Yes <sup>3</sup>	Yes	Employee hire letter from their employer that contains information about benefits eligibility; employment contract; termination letter; letter of resignation; statement of insurance; certificate of coverage
Employee or a dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment	Yes	Yes	No	Yes <sup>3</sup>	Yes	Certificate of credible coverage; letter of enrollment or termination of coverage from the health plan; letter of enrollment or termination of coverage from the employer's payroll or benefits office; proof of waiver
Employee's dependent moves from another country to live in the United States, or from within the U. S. to live outside of the United States and that change in residence resulted in the dependent losing their health insurance	Yes	Yes	No	No	Yes	Visa or passport with date of entry; proof of former and current residence (e.g., utility bill); letter or document showing coverage was lost (e.g., certificate of credible coverage)
A court order requires the employee or any other individual to provide a health plan for an eligible child of the employee	Yes	Yes	Yes	No	Yes	Valid court order
Employee or a dependent has a change in residence that affects health plan availability	No	No	Yes	No	No	Proof of former and current residence (e.g., utility bill); certificate of credible coverage

(continued)

If this event happens	These changes may be permitted as a special open enrollment					Submit these documents (List is not inclusive)
	Add dependent	Remove dependent	Change PEBB medical and/or dental plan	Waive PEBB medical	Enroll after waiving PEBB medical	
Employee or a dependent enrolls in or loses eligibility for Apple Health (Medicaid) or a state Children's Health Insurance Program (CHIP)	Yes	Yes	Yes	No	Yes	Enrollment or termination letter from Medicaid or CHIP reflecting the date the subscriber or subscriber's dependent enrolled in Medicaid or CHIP or the date at which the subscriber or subscriber's dependent lost eligibility for Medicaid or CHIP
Employee or a dependent becomes eligible for a state premium assistance subsidy for PEBB medical plan coverage from Medicaid or a state CHIP	Yes	No	Yes	No	Yes	Eligibility letter from Medicaid or CHIP
Employee or a dependent enrolls in or loses eligibility for Medicare. If waiving PEBB medical, only allowed if enrolling in Medicare. If enrolling after waiving PEBB medical, only allowed if lost eligibility for Medicare.	No	No	Yes	Yes	Yes	Medicare benefit verification letter; copy of Medicare card; notice of denial of Medicare coverage; Social Security denial letter; Medicare entitlement or cessation of disability form
Employee's or a dependent's current medical plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA)	No	No	Yes	No	No	Cancellation letter from the health plan; coverage confirmation in a new health plan; Medicare entitlement letter; copy of current tax return claiming you as a dependent
Employee or a dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the employee or their dependent (requires approval by the PEBB Program)	No	No	Yes, if approved by the PEBB Program	No	No	Submit request for a plan change to: Health Care Authority PEBB Program PO Box 42684 Olympia, WA 98504-5502
Employee or a dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan	No	No	No	Yes	Yes	Certificate of credible coverage; proof of enrollment or termination of coverage from TRICARE.

<sup>1</sup> Employee may add only the new spouse, state-registered domestic partner, or children of the spouse or partner. Existing dependents may not be added.

<sup>2</sup> Employee may remove a dependent from PEBB health plan coverage only if the dependent enrolls in the new spouse's or state registered domestic partner's plan.

<sup>3</sup> Waiving for this event is allowed only if the employee enrolls in medical under the new spouse or state-registered domestic partner's employer-based group health plan.

For more information about the changes you can make during these events, see PEBB Program Administrative Policy Addendum 45-2A on the HCA website at [hca.wa.gov/pebb-rules](https://hca.wa.gov/pebb-rules).

# When coverage ends



Your PEBB insurance coverage ends as described below:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends.
- When your employment relationship is terminated, coverage ends on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
  - On the date specified in your letter of resignation; or
  - On the date specified in any contract or hire letter, or on the effective date of an employer-initiated termination notice.

Your dependents' insurance coverage will end if you fail to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program.

## What happens if I or my dependent loses eligibility?

In the event you lose eligibility, your employer will notify you and give you the opportunity to appeal the decision. You can find information on how to appeal on page 63.

If your dependent loses eligibility, you must remove the ineligible dependent from your account. Your payroll or benefits office must receive the appropriate *2021 PEBB Employee Enrollment/Change* form **within 60 days** of the last day of the month your dependent is no longer eligible.

The PEBB Program collects premiums for the entire last calendar month of coverage and will not prorate them for any reason.

## What are my options when coverage ends?

If applicable, you may be eligible to enroll on your spouse's, state-registered domestic partner's or parent's PEBB insurance coverage as a dependent.

You, your dependents, or both may be able to temporarily continue your PEBB insurance coverage by self-paying the premiums and applicable premium surcharges on a post-tax basis. This is called PEBB Continuation Coverage. Your employer will make no contribution toward the premiums.

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

- PEBB Continuation Coverage (COBRA)
- PEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

The first two options temporarily extend PEBB health plan coverage when your or your dependent's PEBB health plan coverage ends due to a qualifying event. If you qualify

for both PEBB Continuation Coverage options, you may choose to enroll in only one of the options.

## How does PEBB Continuation Coverage work?

The PEBB Program will mail a *PEBB Continuation Coverage Election Notice* booklet to you or your dependent at the address we have on file when your employer-paid coverage ends. This booklet explains the continuation coverage options and includes enrollment forms to apply.

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

The PEBB Program administers all PEBB Continuation Coverage options. For information about your rights and obligations under PEBB Program rules and federal law, refer to the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* (mailed to you after you enroll in PEBB insurance coverage), the *PEBB Continuation Coverage Election Notice* under *Forms & publications* on the HCA website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee), or the *PEBB Retiree Enrollment Guide*. You can also call the PEBB Program at 1-800-200-1004.

## PEBB Continuation Coverage (COBRA)

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

## PEBB Continuation Coverage (Unpaid Leave)

PEBB Continuation Coverage (Unpaid Leave) is an alternative created by the PEBB Program with wider eligibility criteria and qualifying event types, such as a layoff, approved leave of absence, educational leave, or when called to active duty in the uniformed services. This option allows you to continue life insurance and, in some instances, LTD insurance. If you do not elect this coverage, your dependents do not have independent election right to PEBB Continuation Coverage (Unpaid Leave).

## PEBB retiree insurance coverage

PEBB retiree insurance coverage is available only to:

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

When you plan to terminate your employment and want to enroll in PEBB retiree insurance coverage, contact the PEBB Program about 90 days prior to terminating employment at 1-800-200-1004 to ask general PEBB retiree insurance questions. This phone line is only for retiring employees and continuation coverage members. Employees should contact their payroll or benefits office with questions about the PEBB Program or their account-related questions.

You can also request a *PEBB Retiree Enrollment Guide* or download it from HCA's website at [hca.wa.gov/pebb-retirees](http://hca.wa.gov/pebb-retirees). You have **60 days** from the date your employer-paid PEBB coverage, COBRA coverage, or continuation coverage ends for the PEBB Program to receive your application for retiree insurance coverage. Once your form is received, PEBB Program staff will review your form for eligibility and contact you if they need additional information.

When you become eligible for Medicare Part A and Part B, you must enroll and maintain enrollment in Medicare Part A and Part B to enroll or remain enrolled in a PEBB retiree health plan. Be sure you understand the Medicare enrollment timelines, especially if you are leaving employment within a few months of becoming eligible for Medicare or are in your Medicare Initial Enrollment Period (IEP) and want to enroll in PEBB retiree insurance coverage.

## What happens to my Medical Flexible Spending Arrangement (FSA) when coverage ends?

When your PEBB insurance coverage ends or you go on unpaid leave that is not approved under the Family and Medical Leave Act (FMLA), the Washington Paid Family and Medical Leave program, or military leave, you are no longer eligible to contribute to your Medical FSA.

Eligibility ends on the last day of the month of loss of coverage or unapproved leave. You will be able to claim only expenses incurred while employed, up to your remaining benefit, unless you are eligible to continue your Medical FSA under PEBB Continuation Coverage (COBRA) or PEBB Continuation Coverage (Unpaid Leave), through Navia Benefit Solutions. Claims may be submitted up to

your account balance and must be submitted to Navia Benefit Solutions by March 31 of the following plan year.

### *Good to know!*

#### **For more information on when Medical FSA and DCAP coverage ends**

See the *PEBB Medical FSA Enrollment Guide* on the Navia member portal at [pebb.naviabenefits.com](http://pebb.naviabenefits.com). You can also contact Navia Benefit Solutions at 1-800-669-3539 or send an email to [customerservice@naviabenefits.com](mailto:customerservice@naviabenefits.com).

## What happens to my DCAP funds when coverage ends?

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

## What happens to my HSA when coverage ends?

If you enroll in a CDHP with a health savings account (HSA), then later switch to another type of plan, leave employment, or retire, any unspent funds in your HSA will remain available to you, unless you close your account. There is a fee for account balances below a certain threshold. Contact HealthEquity for information about fees.

You can use your HSA funds on qualified medical expenses, or you can leave them for the future. However, you, your employer, the PEBB Program, and others may no longer contribute to your HSA.

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

See "Consumer-directed health plans with a health savings account" on page 26.

## What happens to my life and AD&D insurance when coverage ends?

If your PEBB employee life insurance ends, you may have an opportunity to continue all or part of your coverage through a portability or conversion option. If you are eligible for these options, MetLife will send you information and an application. Accidental death and dismemberment (AD&D) insurance is not eligible for portability or conversion. For more information, see “Life and AD&D insurance” on page 43 or contact MetLife at 1-866-548-7139.

## If I die, are my surviving dependents eligible?

If you die, your dependents will lose their eligibility for the employer contribution toward PEBB Program benefits. Your dependent (a spouse, state-registered domestic partner or dependent children) may be eligible to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage as a survivor. To do so, they must meet the procedural and eligibility requirements described in WAC 182-12-180 or 182-12-265.

The PEBB Program must **receive** all required forms **no later than 60 days** after the date of the employee’s death or the date the survivor’s PEBB insurance coverage ends, whichever is later.

If your surviving spouse, state-registered domestic partner, or dependent children do not meet the eligibility requirements described in WAC 182-12-180 or 182-12-265, they may be eligible to continue health plan enrollment in PEBB Continuation Coverage (COBRA) as described in WAC 182-12-146. See “What are my options when coverage ends?” on page 59.

## What happens when a dependent dies?

If your covered dependent dies, you must submit the appropriate *PEBB Employee Enrollment/Change* form to your payroll or benefits office to remove the deceased dependent from your coverage **no later than 60 days** after the event.

By submitting this form, your premium may be reduced to reflect the change in coverage. For example, if the deceased person was the only dependent on your account, then the premium withheld from your paycheck will be lower when they are removed.

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

If you have supplemental life insurance or supplemental AD&D insurance for your dependent, or are unsure if you elected supplemental life or AD&D insurance for the dependent, contact MetLife at 1-866-548-7139. Also consider updating any beneficiary designations for benefits such as your life or AD&D insurance, Department of Retirement Systems administered pension benefits, or other administered deferred compensation program accounts.



# Appeals

## How do I appeal a decision made by a health plan?

If you are seeking a review of a decision by a PEBB medical or dental plan or insurance carrier, contact the plan or insurance carrier to request information on how to appeal its decision. For example, you would contact your medical plan to appeal a denial of a medical claim. Contact information is listed at the beginning of this guide.

## How do I appeal a decision from my employer or the PEBB Program?

If you or your dependent disagree with a specific decision or denial, you or your dependent may file an appeal. You can find guidance on filing an appeal in WAC 182-16 and on HCA's website at [hca.wa.gov/pebb-appeals](http://hca.wa.gov/pebb-appeals) or see "Instructions and deadlines" beginning on this page.

## How do I appeal a decision made by a PEBB Appeals presiding officer?

You can appeal the PEBB Appeals Unit's presiding officer's initial order by filing a written request for review or by making an oral request for review.

Information detailing your right to request review is included in the PEBB Appeals Unit's presiding officer's initial order. Once your request for review is received by the Appeals Unit, a final order will generally be mailed within 20 days.

Mail your written request to:

Health Care Authority  
PEBB Appeals  
PO Box 45504  
Olympia, WA  
98504-5504

By fax: 360-763-4709

Request a review by calling 1-800-351-6827.

### Deadline for requesting an appeal

The PEBB Appeals Unit must **receive** your request for review **no later than 21 calendar days** after the service date of the initial order.

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

You must provide the PEBB Program with an *Authorization for Release of Information* form or a copy of a valid power of attorney naming your representative and authorizing

them to access your medical records and/or PEBB Program account information and exercise your rights under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule. The form is available on HCA's website at [hca.wa.gov/pebb-appeals](http://hca.wa.gov/pebb-appeals). If you have questions, please call the PEBB Appeals Unit at 1-800-351-6827.

## Instructions and deadlines

### If your situation is

You are a current or former state agency or higher-education employee (or their dependent) and you disagree with a decision made by your employer and are requesting your employer's review about your premium surcharges or eligibility for or enrollment in:

- Medical coverage
- Dental coverage
- Life insurance
- Accidental death and dismemberment (AD&D) insurance
- Long-term disability (LTD) insurance
- Medical Flexible Spending Arrangement (FSA)
- Dependent Care Assistance Program (DCAP)

**Instructions:** Complete Sections 1 through 3 of the *PEBB Employee Request for Review/Notice of Appeal* form (available under *Forms & publications* on HCA's website at [hca.wa.gov/pebb-employee](http://hca.wa.gov/pebb-employee)) and submit it to your payroll or benefits office.

**Deadline:** Your employer must **receive** the form **no later than 30 calendar days** after the date on the initial denial notice or decision you are appealing.

### If your situation is

You are a current or former state agency or higher-education employee (or their dependent) and you disagree with a review decision made by your employer or agree further review is needed because your employer believes that there was an error but did not grant you the relief you requested, and you are now requesting the PEBB Appeals Unit review of your employer's decision.

**Instructions:** Complete Section 7 of the *PEBB Employee Request for Review/Notice of Appeal* form (available under *Forms & publications* on HCA's website at [hca.wa.gov/pebb-employee](http://hca.wa.gov/pebb-employee)) and submit it to the PEBB Appeals Unit as directed on the form.

**Deadline:** The PEBB Appeals Unit must **receive** the form **no later than 30 calendar days** after the employer's review decision date in Section 4 of the form.

### If your situation is

You are a current or former state agency or higher-education employee (or their dependent) and you disagree with a decision from the PEBB Program about:

- Eligibility and enrollment in:
  - Premium payment plan
  - Medical FSA
  - DCAP
  - Life insurance
  - AD&D insurance
- Eligibility to participate in SmartHealth or receive a wellness incentive
- Eligibility and enrollment for a dependent, an extended dependent, or dependent child with a disability
- Premium surcharges
- Premium payments

**Instructions:** Follow the appeal instructions on the decision letter you received from the PEBB Program.

### If your situation is

You are a current or former employer group employee (or their dependent) of:

- A county
- A municipality
- A political subdivision of the state
- A tribal government
- An educational service district
- The Washington Health Benefit Exchange
- An employee organization representing state civil service employees

... and you disagree with a decision made by your employer about:

- Premium surcharges
- Eligibility for or enrollment in:
  - Medical coverage
  - Dental coverage

**Instructions:** Contact your employer for information on how to appeal the decision or action.

### If your situation is

You are a current or former employer group employee (or their dependent) of:

- A county
- A municipality
- A political subdivision of the state
- A tribal government
- An educational service district
- The Washington Health Benefit Exchange
- An employee organization representing state civil service employees

... and you disagree with a decision made by your employer, a PEBB insurance carrier, or the PEBB Program about:

- Eligibility for or enrollment in:
  - Life insurance
  - AD&D insurance
  - Long-term disability insurance
- Eligibility and enrollment for a dependent, extended dependent, or a dependent child with a disability
- Eligibility to participate in SmartHealth or receive a wellness incentive

**Instructions:** Complete Sections 1 through 3 of the *2021 PEBB Employee Request for Review/Notice of Appeal* form (available under *Forms & publications* on HCA's website at [hca.wa.gov/pebb-employee](https://hca.wa.gov/pebb-employee)) or submit a letter to the PEBB Appeals Unit as described in the denial letter from the PEBB Program.

**Deadline:** The PEBB Appeals Unit must **receive** this form **no later than 30 calendar days** after the date of the initial denial notice or decision you are appealing.

### If your situation is

You are a current or former state agency or higher-education employee (or their dependent), or employer group employee (or their dependent) and you are seeking a review of a decision made by a PEBB medical or dental plan or insurance carrier about:

- A benefit or claim
- Completion of SmartHealth requirements or a request for a reasonable alternative to a SmartHealth requirement
- Life insurance premium payments

**Instructions:** Contact the medical or dental plan or insurance carrier to request information on how to appeal the decision.



# Enrollment Forms

---

These forms referenced in this book are available online:

**2021 PEBB Employee Enrollment/Change**

<https://www.hca.wa.gov/assets/pebb/50-0400-public-employee-enrollment-change-form-2021.pdf>

**2021 PEBB Employee Enrollment Change for Medical Only Groups**

<https://www.hca.wa.gov/assets/pebb/52-0030-public-employee-enrollment-change-form-medical-only-2021.pdf>

**Long-term Disability (LTD) Enrollment/Change Form**

[http://www.standard.com/eforms/7533\\_377661.pdf](http://www.standard.com/eforms/7533_377661.pdf)

**Premium Surcharge Attestation Help Sheet**

<https://www.hca.wa.gov/assets/pebb/50-0226-pebb-premium-surcharge-attestation-help-sheet-2021.pdf>