

Your PEBB benefits for

2022

Employee Enrollment Guide



Quick start guide

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Enrollment forms

At the end of the guide

Washington State
Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD





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 (Also see page 59.)

Medical plans

Kaiser Permanente NW¹ Classic or CDHP

my.kp.org/wapebb
1-800-813-2000 (TRS: 711)

Kaiser Permanente WA Classic, CDHP, SoundChoice, or Value

kp.org/wa/pebb
1-866-648-1928
(TRS: 711 or 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
1-888-849-3681 (TRS:711)

Prescription drugs:

ump.regence.com/pebb/benefits/prescriptions
1-888-361-1611 (TRS: 711)

UMP Plus–Puget Sound High Value Network

pugetsoundhighvaluenetwork.org
1-855-776-9503

UMP Plus–UW Medicine Accountable Care Network

pebb.uwmedicine.org
1 888-402-4237 (TRS: 711)

Dental plans

DeltaCare

Administered by Delta Dental of Washington
deltadentalwa.com/pebb
1-800-650-1583 (TTY: 1-800-833-6384)

Uniform Dental Plan

Administered by Delta Dental of Washington
deltadentalwa.com/pebb
1-800-537-3406 (TTY: 1-800-833-6384)

Willamette Dental Group

willamettedental.com/wapebb
1-855-433-6825 (TRS: 711)

Auto and home insurance

Liberty Mutual Insurance Company

hca.wa.gov/employee-retiree-benefits/employees/auto-and-home-insurance
1-800-706-5525

Medical Flexible Spending Arrangement (FSA), Limited Purpose FSA, and Dependent Care Assistance Program (DCAP)

Navia Benefit Solutions

pebb.naviabenefits.com
1-800-669-3539 or 425-452-3500

Health savings account (HSA) for consumer-directed health plans (CDHP)

HealthEquity

learn.healthequity.com/pebb
1-844-351-6853 (TRS: 711)

Life and AD&D insurance

Metropolitan Life Insurance Company (MetLife)

Enrollment and management:

mybenefits.metlife.com/wapebb

Info, docs, and more:

metlife.com/wshca
1-866-548-7139

Long-term disability (LTD) insurance

Standard Insurance Company

standard.com/mybenefits/wash-state-hca-pebb
1-800-368-2860

Voluntary wellness program

SmartHealth

Track activities:

smarthealth.hca.wa.gov

Eligibility and deadlines:

hca.wa.gov/pebb-smarthealth
1-855-750-8866

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.

¹ 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 guide for reference. An online version is available on the PEBB webpage at 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 you to change your plans, add or remove dependents, and make other changes. You can also make changes during a special open enrollment if you have a qualifying life event. See “Changing your coverage” on page 51.

For information about options for continuing insurance coverage once your or a dependent’s eligibility for PEBB benefits has ended, see “When coverage ends,” on page 56.

The PEBB Program is managed by the Washington State Health Care Authority (HCA).































Good to know!

PEBB My Account is changing

In spring 2022, PEBB My Account will be updated to a more user-friendly and user-directed application. With the improved PEBB My Account, you will enroll in and view benefit elections, make changes, upload forms and documents, attest to premium surcharges, request changes due to special open enrollments, and other functions. Watch for announcements on the HCA website at hca.wa.gov/pebb-employee for how to sign up for and use the updated PEBB My Account.



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Use this 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 additional information.

1. Find out if you're eligible

To be eligible for PEBB benefits, you must meet the 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 "Employee 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 will pay a monthly premium for medical coverage, which includes vision. Your employer pays part of the premium for medical, and all of the premiums for dental coverage, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and employer-paid long-term disability (LTD) insurance, if your employer offers them.

You will pay monthly premiums for any supplemental (employee-paid) coverage you are enrolled in. See "Paying for benefits" on page 18.

You may be able to waive PEBB enrollment if you have other group coverage. See "Waiving enrollment" on page 16.

Good to know!

You will be automatically enrolled in employee-paid LTD insurance

Starting January 1, 2022, all current and newly eligible employees will be automatically enrolled in or transitioned to an employee-paid long-term disability (LTD) plan that covers 60 percent of your predisability earnings, with a 90-day benefit waiting period. You can reduce to a lower-cost 50-percent coverage level or decline the coverage at any time. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer. See "Long-term disability insurance" on page 42 for more details.

3. Get ready to enroll your eligible dependents

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

To enroll your spouse, state-registered domestic partner, or 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 documents are listed on page 11. You may need to submit additional forms. See "Additional required forms for dependents" on page 13.

4. Choose your health plans

Health plans available to you

For information on the plans available to you, see "Selecting a medical plan," on page 23 and "Selecting a dental plan," on page 37.

Check "2022 Medical plans available by county," on page 28, 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 availability is based on the network the dentist participates in, rather than where you live or work.

Compare health plan benefits and costs

A list of medical plans and premiums is on page 31.

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

The "2022 PEBB Medical benefits comparison" starts on page 32. The "Dental benefits comparison" is on page 36. These charts give you some basic cost information about deductibles and cost-shares so you can compare plans.

Learn more

If you need more details, refer to other sections of this guide. See "Contents" on page 4. You can also find information on the HCA website at hca.wa.gov/pebb-employee.

The virtual benefits fair is available online 24/7 to help you learn more about your benefits. Visit plan booths to watch informative videos and find more resources. The virtual benefits fair is available on HCA's website at hca.wa.gov/vbf-pebb.

5. Enroll

Your payroll or benefits office must receive one of the following forms and proof of your dependents' eligibility, if enrolling them, **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)

6. Attest to the premium surcharges

There are two premium surcharges that may apply to you. When you enroll in medical coverage, you must attest (respond) 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 whether they could have enrolled in another employer-based group medical insurance plan.

If you do not attest, or if your attestations show the surcharges apply to you, you will be charged these premium surcharges in addition to your monthly medical premium. See “Premium surcharges” on page 20 for details and how to attest.

7. Learn about additional benefits

Additional benefits include (if your employer offers them):

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

Automatic enrollments

You will be automatically enrolled in basic life insurance, basic AD&D insurance, and employer-paid LTD insurance, as well as employee-paid LTD insurance, unless you decline the coverage. You will be automatically enrolled in the state’s premium payment plan.

About employee-paid LTD coverage

Starting January 1, 2022, all current and newly eligible employees will be automatically enrolled in or transitioned to an employee-paid LTD plan that covers 60 percent of your insured income, with a 90-day benefit waiting period.

During open enrollment 2021, you can use PEBB My Account to reduce to a lower-cost 50-percent coverage level or decline the coverage. Pierce County, UW, and WSU employees use Workday.

At any other time, use the *2022 Long Term Disability Insurance Enrollment and Change* form to reduce or decline coverage. The form is available on HCA’s LTD webpage at hca.wa.gov/ltd.

If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer. See page 42 for more information.

Consider supplemental life and AD&D insurance

You can enroll yourself and your dependents in supplemental (employee-paid) life and AD&D insurance. See “Life and AD&D insurance” on page 39.

Consider two FSAs and DCAP

You may be eligible to enroll in a Medical Flexible Spending Arrangement (FSA), Limited Purpose FSA, or the Dependent Care Assistance Program (DCAP). These are pretax accounts used to pay for certain expenses. See page 45 for more information and how to enroll.

8. What’s next

The health plans you choose will send you welcome packets. See “After you enroll” on page 49.

Good to know!

Tax-saving programs

To enroll in the Medical Flexible Spending Arrangement (FSA), Limited Purpose FSA, and Dependent Care Assistance Program (DCAP), download and print the forms from Navia’s website at pebb.naviabenefits.com or call 1-800-669-3539. UW and WSU employees use Workday.

Good to know!

Automatic enrollments

You will be automatically enrolled in the following, if you are eligible and your employer offers them.

- Basic (employer-paid) life insurance
- Basic (employer-paid) accidental death and dismemberment (AD&D) insurance
- Employer-paid long-term disability (LTD) insurance
- Employee-paid LTD insurance at the 60-percent coverage level with a 90-day benefit waiting period, unless you reduce to a lower-cost coverage level or decline the coverage. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer. See details on page 42.
- The state’s premium payment plan (see “Payroll deductions and taxes” on page 18).

Enrollment checklist



- Check your eligibility and deadlines, page 8
- Learn about your benefits, page 22-24
- Consider medical plans available to you, page 28
- Review benefits comparison charts, page 32-38
- Visit the virtual benefits fair, page 22
- Learn about waiving enrollment, page 16
- Choose your health plans, page 32-38
- Submit enrollment forms, verification documents to prove dependents' eligibility, and any additional documents needed, page 13
- Attest to premium surcharges, page 20
- Consider supplemental (employee-paid) life and AD&D insurance, page 39
- Consider Medical FSA, Limited Purpose FSA, and DCAP, page 45
- Sign up for email delivery after you're enrolled, see box to right

All PEBB employers offer these benefits for 2022

- Medical insurance (which includes vision)
- 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
- Employer-paid long-term disability (LTD) insurance
- Supplemental life insurance
- Supplemental AD&D insurance
- Employee-paid LTD insurance
- Medical FSA
- Limited Purpose FSA
- Dependent Care Assistance Program (DCAP)

Good to know!

Get your news by 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 to sign up for email delivery. Pierce County, Washington State University, and University of Washington employees sign up in Workday.



Employee eligibility

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

Your employer will determine if you are eligible for the employer contribution toward PEBB benefits based on your specific work circumstances (see Washington Administrative Code [WAC] 182-12-114 and 182-12-131) and notify you. Please contact your payroll or benefits office if you have questions about eligibility or when coverage will begin. All eligibility determinations are based on rules in Chapters 182-08 and 182-12 WAC on the PEBB Rules and policies webpage at hca.wa.gov/pebb-rules. If discrepancies arise between WACs and this guide, the WACs take precedence. If you disagree with an eligibility determination, see “Appeals” on page 59.

Employees from an employer group

If you are an employee who works for a city, county, port, tribal government, water district, hospital, etc., or you are a non-represented educational service district employee, 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 day the revision is made.

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 for employees

You may “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 faculty, 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 faculty 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 revision 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 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

Justices 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.

Eligibility as both a subscriber and 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 enrollment" on page 16 for options available to you.

Eligibility in both PEBB and SEBB

Effective January 1, 2022, if you are eligible for enrollment in both the PEBB and School Employees Benefits Board (SEBB) Programs, you are limited to a single enrollment in medical, dental, and vision plans (SEBB Program) or medical and dental plans (PEBB Program). If you do not take action to resolve the dual enrollment, the PEBB Program or the SEBB Program will automatically enroll or disenroll you as described in WAC 182-12-123(6).



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, except as described below.

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 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 of a Child with a Disability* 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 periodically 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 PEBB 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. HCA may audit dependent eligibility determinations.

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 in English with your enrollment forms within the PEBB Program enrollment timelines. Documents written in another language must include a translated copy prepared by a professional translator and notarized. These documents must be approved.

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 certificate¹ and evidence that the marriage is still valid (do not have to live together). For example, a utility bill, life insurance beneficiary document, or bank statement dated within the last six months showing both your and your spouse's names (black out financial information)
- A recently filed (within the last six months) petition for dissolution, petition for legal separation (marriage), or petition to invalidate (annul) marriage
- 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 partnership² or legal union and evidence that the partnership is still valid (do not have to live together). For example, a utility bill, life insurance beneficiary document, or bank statement dated within the last six months showing both your and your state-registered domestic partner's names (black out financial information)
- A recently filed (within the last six months) petition for dissolution of a state-registered domestic partnership, or petition to invalidate (annul) state-registered domestic partnership

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.

¹ If within six months of marriage, only the certificate is required.

² If within six months of state-registration, only the certificate/card is required

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, if a birth certificate is unavailable, a hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner. 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 a 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 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

(Continued)

health plan coverage and enrolled as directed by the NMSN. If the child is enrolled in both a School Employees Benefits Board (SEBB) medical plan and a PEBB medical plan as a dependent, the child will be enrolled according to 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 when they no longer meet PEBB Program eligibility criteria. 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 coverage options described in WAC 182-12-270 and on page 56.
- You may be billed for claims paid by the health plan for services that occurred 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 56.

What happens if I die, or my dependent dies?

See "When coverage ends" on page 56.

Good to know!

You have appeals rights

If you disagree with a specific eligibility decision or denial, you can appeal. See "Appeals" on page 9.



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 the next page. You may also have the option to waive your enrollment. See “Waiving enrollment” on page 16.

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. Pierce County, Washington State University, and University of Washington employees must enroll through Workday. See the “Quick start guide” on page 5.

Your payroll or benefits office must also receive all required forms and dependent verification documents **no later than 31 days** after you become eligible for PEBB benefits. A list of documents we will accept as proof is on page 11.

If the documents are not received in time, your dependents will not be enrolled, and you will not be able to enroll them until the next annual open enrollment or a special open enrollment event that allows enrolling a dependent.

If you are eligible and your employer offers these benefits, you will be automatically enrolled in basic life, basic accidental death and dismemberment (AD&D), and employer-paid long-term disability (LTD) insurance. You will also be automatically enrolled in employee-paid LTD insurance, unless you decline this coverage. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer. See page 42 for more information.

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, submit the *PEBB Employee Enrollment/Change* form.
- If your employer offers PEBB medical only, submit the *PEBB Employee Enrollment/Change for Medical Only Groups* form.

For other PEBB-sponsored benefits:

- Reduce, increase, decline, or enroll in employee-paid LTD insurance (see page 42).
- Enroll in and name your beneficiaries for basic life and basic AD&D insurance online at mybenefits.metlife.com/wapebb. If you cannot enroll online, submit the *PEBB MetLife Employee Enrollment/Change* form to MetLife.

- To enroll in supplemental life and AD&D at mybenefits.metlife.com/wapebb. If you cannot enroll online, submit the *PEBB MetLife Employee Enrollment/Change* form to MetLife. If you miss the deadline to enroll in 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.
- To enroll in Medical FSA, Limited Purpose FSA, or DCAP (state agency and higher-education employees only) during open enrollment, or to get the enrollment form at other times, visit the Navia website at pebb.naviabenefits.com. Washington State University and University of Washington employees must enroll through Workday.
- For auto/home insurance, see page 48 of this guide, visit HCA’s website at 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 for dependents

When enrolling one of the dependents described below, in addition to submitting an enrollment form, also submit the following applicable forms with your election or change form.

PEBB Declaration of Tax Status: Submit this form when enrolling an extended dependent, state-registered domestic partner, or their eligible children, regardless of tax status, or for any other dependent you are enrolling who does not qualify as your dependent for federal tax purposes.

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.

(Continued)

- The child is not a foster child, unless you, your spouse, or your state-registered domestic partner has assumed a legal obligation for support ahead of adoption.

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 enrollment within PEBB Program timelines. You may waive enrollment in PEBB medical coverage if you are enrolled in another employer-based group medical insurance, a TRICARE plan, or Medicare. If you waive enrollment in PEBB medical, you will be enrolled in PEBB dental. **Exception:** You may waive enrollment in PEBB medical to enroll in SEBB medical only if you are enrolled in SEBB dental and vision. By doing so, you also waive enrollment in PEBB dental. You must indicate your intent to enroll or waive enrollment by submitting an enrollment form to your payroll or benefits office. See "Waiving enrollment" on page 16 for instructions and timelines.

Good to know!

Find your form

Forms are available on the HCA website at hca.wa.gov/pebb-employee under *Forms & publications*.

If you do not enroll or waive enrollment:

- You will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic for medical coverage, Uniform Dental Plan, basic life insurance, basic AD&D insurance, and employer-paid LTD insurance (if your employer offers these benefits).
- You will also be automatically enrolled in employee-paid LTD insurance (if your employer offers it). See page 42 for details.
- You will be charged a monthly \$110 premium for your medical coverage and a \$25 tobacco use premium surcharge. You can change your tobacco use attestation anytime. See "Premium surcharges" on page 20.
- Your dependents will not be enrolled.
- You cannot change plans or add 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.
- Effective January 1, 2022, if you are eligible for enrollment in both the PEBB and SEBB Programs, you are limited to a single enrollment in medical, dental, and vision (SEBB Program) or medical and dental (PEBB Program). If you do not take action to resolve the dual

enrollment, the PEBB Program or the SEBB Program will automatically enroll or disenroll you as described in WAC 182-12-123(6).

Can I enroll on two PEBB accounts?

No. Medical and dental coverage is limited to a single PEBB 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 PEBB account, you may choose one of these options:

- Waive PEBB medical under your own account and, instead, stay 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, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and employer-paid long-term disability (LTD) insurance (if your employer offers them) under your own account. You will also be automatically enrolled in employee-paid LTD insurance (if your employer offers this), unless you decline the coverage. See "Waiving enrollment" on page 16.
- Enroll in PEBB medical, as well as PEBB dental, basic life insurance, basic AD&D insurance, and employer-paid LTD (if your employer offers them), under your own account. You will also be automatically enrolled in employee-paid LTD insurance (if your employer offers this), unless you decline the coverage. You must be removed from the other medical and dental accounts.

Can I enroll in both PEBB and SEBB health plan coverage?

No, you cannot. You may waive your PEBB medical to enroll in SEBB medical only if you are also enrolled in SEBB dental and vision. In doing so, you waive your enrollment in PEBB dental.

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 the next page.



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 56), you and any enrolled dependents must enroll and stay enrolled in Medicare Part A and Part B, if eligible, to enroll or remain enrolled in a PEBB retiree health plan. Medicare will become the primary insurer, and PEBB medical becomes secondary.

Waiving PEBB medical or removing your Medicare-eligible dependent

You may choose to waive your enrollment in PEBB medical and have Medicare as your primary medical coverage. However, you will remain enrolled in PEBB dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and employer-paid long-term disability (LTD) insurance, if your employer offers these benefits. You will remain enrolled in employer-paid LTD insurance (if your employer offers this), unless you decline it. See “Waiving enrollment” on page 16.

You may also choose to remove a dependent who enrolls in Medicare Part A and Part B as a special open enrollment event. See “What changes can I make during a special open enrollment?” on page 53.

If you waive PEBB medical for yourself or remove your dependent, you or your dependent can enroll only during the next annual open enrollment (for coverage effective January 1 of the following year) or if you or your dependent have a special open enrollment event that allows you or your dependent to enroll. See “What changes can I make during a special open enrollment?” on page 53.

Deferring Medicare

When you or your covered dependent becomes eligible for Medicare Part A and Part B, either by age or by disability, the member eligible for Medicare should contact the Social Security Administration to ask about the advantages of immediate or deferred enrollment in Medicare. Find contact information for your local office on the Social Security Administration’s website at ssa.gov/agency/contact.

In most cases, employees and their spouses covered under a PEBB medical plan can enroll in Medicare Part B without a late enrollment penalty after employment ends. If you are eligible for premium-free Medicare Part A, you can enroll in Medicare Part A anytime after you’re first eligible for Medicare. If you are receiving a monthly Social Security benefit, you cannot defer Medicare Part A. You can sign up for Medicare Part B during a special enrollment period when you terminate employment or retire.

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 enroll 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 prescription 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 of the national base beneficiary premium 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 reenroll later 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 your 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 or call 1-800-633-4227.

Waiving enrollment

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 still enroll in PEBB dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, employer-paid long-term disability (LTD) insurance and employee-paid LTD insurance (unless you choose to decline it), if your employer offers them.

Exception: You may waive your enrollment in a PEBB medical plan to enroll in a SEBB medical plan only if you are also enrolled in SEBB dental and vision plans. In doing so, you waive your enrollment in PEBB dental. You cannot enroll in both SEBB and PEBB health plans.

If you waive enrollment in medical

- You cannot enroll your eligible dependents in PEBB medical, but you can enroll them in PEBB dental, 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 incentive.
- You can enroll in supplemental life insurance and supplemental AD&D insurance, the Medical Flexible Spending Arrangement (FSA), Limited Purpose FSA, and the Dependent Care Assistance Program (DCAP) if your employer offers them.
- You will be automatically enrolled in employee-paid LTD insurance, unless you decline the coverage, if your employer offers it. See page 40 for more information.

How do I waive medical?

To waive PEBB medical, your employer must receive the appropriate *2022 PEBB Employee Enrollment/Change* form indicating this choice **no later than 31 days** after you become eligible for PEBB benefits. You can also waive medical during an annual open enrollment or special open enrollment, as described on pages 52 through 55. You may waive your enrollment in a PEBB medical plan to enroll in a SEBB medical plan only if you are also enrolled in SEBB dental and vision plans. In doing so, you waive your enrollment in PEBB dental. You cannot enroll in both SEBB and PEBB health plans.

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

You cannot be enrolled in two PEBB accounts. 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 the following 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, basic life insurance, basic AD&D insurance, and employer-paid LTD insurance, if your employer offers them, under your own account. You will be automatically enrolled in employee-paid LTD insurance, if your employer offers it, although you can reduce to a lower-cost coverage level or decline the coverage at any time. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer. Your spouse, state-registered domestic partner, or parent must submit the appropriate *2022 PEBB Employee Enrollment/Change* form and remove you from their dental to prevent two enrollments in PEBB dental coverage.
- Enroll in PEBB health plan coverage under your own account. To do this, complete the appropriate *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 forms and remove you from their PEBB account to prevent two enrollments in PEBB health plan coverage.

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

If you waive PEBB enrollment, you can enroll only during the next annual open enrollment (for coverage effective January 1 the following year) or if you have a special open enrollment event that allows it. See "What changes can I make during a special open enrollment?" on page 53.

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 enrollment within PEBB Program timelines, you will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Classic, Uniform Dental Plan, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and employer-paid long-term disability (LTD) insurance, if your employer offers these benefits.

You will also be automatically enrolled in employee-paid LTD insurance, if your employer offers it, unless you decline the coverage. See page 42 for more information.

You will be charged a monthly \$110 premium for your medical coverage as well as a \$25 tobacco use premium surcharge. See page 20.

You can change your tobacco use attestation anytime through PEBB My Account at 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 20.

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 health 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.

Can I waive PEBB and enroll in SEBB?

You may waive your PEBB medical to enroll in SEBB medical only if you are also enrolled in SEBB dental and vision. In doing so, you waive your enrollment in PEBB dental.

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. The PEBB Program will defer PEBB retiree insurance coverage if you become newly eligible for PEBB benefits as an employee.

Good to know!

What is coinsurance?

Learn the definitions of terms such as deductible, coinsurance, copayment, and out-of-pocket on page 24.

Paying for benefits

What does my employer pay?

If you are eligible for PEBB benefits, your employer pays a portion of the medical premium and all of 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 employer-paid long-term disability (LTD) insurance (if your employer offers them). You pay nothing for these benefits.

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 medical premium and life insurance premium cannot be prorated for any reason, including when a member dies before the end of the month. LTD premiums may only be prorated the month an employee enrolls if they are required to submit evidence of insurability.

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 20 for details.

Out-of-pocket costs

You are responsible for paying any out-of-pocket costs for deductibles, coinsurance, or copayments for services under the medical and dental plans you choose. See the medical and dental benefits comparisons on pages 32 through 38 for side-by-side comparisons of many common benefits and costs for services for each plan.

Supplemental and employee-paid insurance

You can buy supplemental life and supplemental AD&D insurance for yourself and your eligible dependents. You will be automatically enrolled in employee-paid LTD insurance, although you can reduce to a lower-cost coverage level or decline the coverage at any time. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer. See more about these benefits on pages 39 through 44.

How much will my monthly medical premiums be?

For state agency and higher-education employees, see the “2022 Monthly premiums” on page 31. There are no employee premiums for dental coverage, basic life insurance, basic AD&D insurance, and employer-paid LTD insurance.

Exception: If you are an employee who works for a city, county, port, tribal government, water district, hospital, etc., or a non-represented educational service district employee,

contact your payroll or benefits office to get your monthly premiums. Your payment information may be different from what’s described here.

Payroll deductions and taxes

If you are an eligible state agency or higher-education institution employee, your monthly medical premiums and applicable premium surcharges are deducted from your paychecks before taxes, under the state’s 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 (e.g., a 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. Please submit the *Declaration of Tax Status* form if you enroll a dependent who does not qualify as an IRC Section 125 dependent.

Good to know!

Additional benefits you may like

Medical Flexible Spending Arrangements (FSA) or Limited Purpose FSA, and Dependent Care Assistance Program (DCAP), are benefits that may suit your financial needs. See page 45.

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.

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), 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 or tax specialist, or visit your local Social Security office.

Can I change my mind about having my medical premiums 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 a special open enrollment event that allows the change as described in WAC 182-08-199. See "What changes can I make during a special open enrollment?" on page 3.

Good to know!

Changing your pretax payments

If you do not want your PEBB medical premiums or applicable premium surcharges paid with pretax earnings, you must submit the *PEBB Premium Payment Plan Election/Change* form to your 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.

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.

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 would 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.

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 appropriate *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 under *Forms & publications*. Pierce County, Washington State University, and 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 age 18 or older and uses tobacco products enrolls in the free tobacco cessation program through your PEBB Program medical plan.
- Your enrolled dependent who is age 13 to 17 and uses tobacco products accesses the tobacco cessation resources on the Smokefree Teen website at teen.smokefree.gov.

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

- Go to PEBB My Account at hca.wa.gov/my-account to change your attestation. Pierce County, Washington State University, and University of Washington employees must use Workday.
- Submit a *PEBB Premium Surcharge Attestation Change Form* to your payroll or benefits office. The form is under *Forms & publications* on the HCA website at hca.wa.gov/pebb-employee.

If the change in tobacco use you report means that the surcharge applies to you, the surcharge is effective the first day of the month following the status change. 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 monthly tobacco use premium surcharge if you do not attest for all dependents age 13 or older you enroll, 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.

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 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. Pierce County, Washington State University, and University of Washington 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* to your payroll or benefits office. The form is found under *Forms & publications* on the HCA website at hca.wa.gov/pebb-employee. In most cases, you must provide proof of the qualifying event. Pierce County, Washington State University, and University of Washington employees must use Workday.

If you submit a change that results in incurring the premium surcharge, the change is effective the first day 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 at hca.wa.gov/pebb-employee. These charts will help you compare the costs and availability of the most widely used features of plans. See "2022 Medical benefits comparison" on page 32 and "Dental benefits comparison" on page 38.

Certificate of coverage

The health plans produce certificates of coverage (COCs), also called benefits booklets, 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 webpage at 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 SBCs, or explain how to get one, at different times throughout the year (like when you apply for coverage or renew your plan). 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, 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 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.

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 15.

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.

At the virtual benefits fair, 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 (AD&D) insurance, long-term disability insurance, Medical Flexible Spending Arrangement (FSA), Limited Purpose 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.

Next step

On the following pages, "Selecting a medical plan" will provide more information to consider in making your choices. Also see "Selecting a dental plan" on page 37.

Good to know!

Online, 24/7

The virtual benefits fair is designed to help answer your questions about plans and benefits. Visit on the HCA website at hca.wa.gov/vbf-pebb.

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 page 25.

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 “2022 Medical plans available by county” on page 28. 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 “Eligibility as both a subscriber and a dependent” on page 9.

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 NW¹ Classic**
- **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 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 to members enrolled in Medicare)
- **UMP Plus–UW Medicine Accountable Care Network**, administered by Regence BlueShield (not available to members 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. If you enroll in a CDHP, you can also enroll in a Limited Purpose FSA, which allows you to set aside pretax money to pay for dental and vision expenses. See “FSAs and DCAP” on page 45 to find out more about the Limited Purpose FSA.

The following PEBB medical plans are CDHPs (value-based plans are in bold).

- **Kaiser Permanente NW¹ CDHP**
- **Kaiser Permanente WA CDHP**
- UMP CDHP, administered by Regence BlueShield

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

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 resources to help you choose the plan that's right for you. See "Choosing your benefits" on page 22.

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.

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 ask about the average wait time 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 27.

Coordination with your other benefits

All PEBB medical plans coordinate benefit payments with other group plans, 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 also enrolled in Medicaid.

PEBB medical and dental coverage is limited to a single enrollment per individual. Also, you cannot enroll in health plans under both the PEBB and SEBB programs. Starting January 1, 2022, if you are enrolled in both PEBB and SEBB health plans, the PEBB Program or the SEBB Program will enroll or disenroll you as described in WAC 182-12-123(6).

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. Premiums for all PEBB medical plans are listed on page 31.

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, if you have a Uniform Medical Plan (UMP) plan, you may need to file a claim if you receive services from an out-of-network provider. If you have a CDHP, you should keep paperwork from providers and for qualified health care expenses to verify eligible payments from your health savings account.

CDHPs with an HSA



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 compatible with a Limited Purpose Flexible Spending Arrangement (FSA) and the Dependent Care Assistance Program (DCAP). Read more about these benefits on page 45.

The HSA is administered by HealthEquity, Inc.

Some subscribers are not eligible

You cannot enroll in a CDHP with an HSA if:

- You are enrolled in Medicare Part A or Part B or Medicaid.
- You are enrolled in another health plan that is not an IRS-qualified high-deductible health plan (HDHP), unless it is limited coverage like dental, vision, or disability coverage. You can enroll in a Limited Purpose FSA for dental or vision expenses, described on page 43, and remain eligible for a CDHP with an HSA.
- 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. The Limited Purpose FSA is compatible with an HSA.
- You are claimed as a dependent on someone else's tax return.

Other exclusions apply. To confirm whether you qualify, check *The Complete HSA Guidebook on the HealthEquity* website at [healthequity.com/pebb](https://www.healthequity.com/pebb) under *Documents*; read the *IRS 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

After your HSA is automatically established through HealthEquity, you can start to receive employer contributions. If you are eligible, the Health Care Authority will contribute the following amounts to your HSA:

- \$58.34 each month for an individual subscriber, up to \$700.08 annually for 2022; or
- \$116.67 each month for a subscriber with one or more enrolled dependents, up to \$1,400.04 annually for 2022.

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 two 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 2022, the limit is \$3,650 (for subscriber only) and \$7,300 (for you and one or more enrolled 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.

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.

Can I enroll in a CDHP 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 recommends sending your medical plan change request 30 days before the Medicare enrollment date but must receive it **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 name or update beneficiaries for my HSA?

You will name 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. 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 a 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. 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 2019-20 Engrossed Substitute House Bill

1099 (Brennen's Law) on the Washington State Legislature's website at 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, 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.

Key words to look for in these documents include inpatient and outpatient coverage, mental health, chemical dependency, residential treatment facility, and substance use disorder. The "2022 Medical benefits comparison" beginning on page 32 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

The HCA website at hca.wa.gov/mental-health-crisis-lines includes 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.



2022 Medical plans available by county

In most cases, you must live in the medical plan's service area to join the plan. Be sure to call the medical plan(s) you are interested in to ask about provider availability in your county. If you move out of your medical plan's service area, you may need to change plans. You must report your new address to your payroll or benefits office no later than 60 days after your move.

Available

Unavailable

98541 Available in listed ZIP code(s) only

	Kaiser Permanente NW ¹		Kaiser Permanente WA				Uniform Medical Plan				
	Classic	CDHP	Classic	CDHP	Value	SoundChoice	Classic	Select	CDHP	UMP Plus - Puget Sound High Value Network	UMP Plus - UW Medicine Accountable Care Network
Washington											
Adams											
Asotin											
Benton											
Chelan											
Clallam											
Clark											
Columbia											
Cowlitz											
Douglas											
Ferry											
Franklin											
Garfield											
Grant											
Grays Harbor											
Island											
Jefferson											
King											
Kitsap											
Kittitas											

1. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

	Kaiser Permanente NW ¹		Kaiser Permanente WA				Uniform Medical Plan				
	Classic	CDHP	Classic	CDHP	Value	SoundChoice	Classic	Select	CDHP	UMP Plus - Puget Sound High Value Network	UMP Plus - UW Medicine Accountable Care Network
Klickitat	⊘				⊘			⊘			⊘
Lewis	⊘		⊘	⊘	⊘	⊘		⊘			⊘
Lincoln	⊘				⊘			⊘			⊘
Mason	⊘		⊘	⊘	⊘	⊘		⊘			⊘
Okanogan	⊘				⊘			⊘			⊘
Pacific	⊘				⊘			⊘			⊘
Pend Oreille	⊘				⊘			⊘			⊘
Pierce	⊘				⊘			⊘			⊘
San Juan	⊘				⊘			⊘			⊘
Skagit	⊘		⊘	⊘	⊘	⊘		⊘		⊘	⊘
Skamania	⊘				⊘			⊘			⊘
Snohomish	⊘				⊘			⊘			⊘
Spokane	⊘				⊘			⊘		⊘	⊘
Stevens	⊘				⊘			⊘			⊘
Thurston	⊘				⊘			⊘		⊘	⊘
Wahkiakum	⊘				⊘			⊘			⊘
Walla Walla	⊘		⊘	⊘	⊘	⊘		⊘			⊘
Whatcom	⊘		⊘	⊘	⊘	⊘		⊘			⊘
Whitman	⊘		⊘	⊘	⊘	⊘		⊘			⊘
Yakima	⊘		⊘	⊘	⊘	⊘		⊘		⊘	⊘

1. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

	Kaiser Permanente NW ¹		Kaiser Permanente WA				Uniform Medical Plan				
	Classic	CDHP	Classic	CDHP	Value	SoundChoice	Classic	Select	CDHP	UMP Plus - Puget Sound High Value Network	UMP Plus - UW Medicine Accountable Care Network

Oregon

Benton	97330, 97331, 97333, 97339, 97370, 97456			⊘				⊘			⊘
Clackamas	✔			⊘				⊘			⊘
Columbia	✔			⊘				⊘			⊘
Hood River	97014			⊘				⊘			⊘
Lane	✔			⊘				⊘			⊘
Linn	97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389, 97446			⊘				⊘			⊘
Marion	✔			⊘				⊘			⊘
Multnomah	✔			⊘				⊘			⊘
Polk	✔			⊘				⊘			⊘
Washington	✔			⊘				⊘			⊘
Yamhill	✔			⊘				⊘			⊘

Idaho

All counties	⊘			⊘				⊘			⊘
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1. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.

2022 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 employee-paid long-term disability insurance. Employees who work for an educational service district, city, county, port, tribal government, water district, hospital, etc., need to contact their payroll or benefits office to get their monthly premiums.

Effective January 1, 2022	Managed Care Plans						Preferred Provider Organization (PPO) Plans				
	Kaiser Foundation Health Plan of the Northwest ¹		Kaiser Foundation Health Plan of Washington				Uniform Medical Plan (administered by Regence BlueShield)				
	Classic	CDHP	Classic	SoundChoice	Value	CDHP	Classic	Plus	Select	CDHP	
Monthly premiums											
Subscriber	\$159	\$26	\$204	\$50	\$113	\$24	\$110	\$78	\$39	\$24	
Subscriber & spouse ²	\$328	\$62	\$418	\$110	\$236	\$58	\$230	\$166	\$88	\$58	
Subscriber & children	\$278	\$46	\$357	\$88	\$198	\$42	\$193	\$137	\$68	\$42	
Subscriber, spouse, ¹ & children	\$447	\$82	\$571	\$148	\$321	\$76	\$313	\$225	\$117	\$76	

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 when required.

- 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 *2022 PEBB Premium Surcharge Attestation Help Sheet* under *Forms & publications* on the HCA website at hca.wa.gov/pebb-employee.

1. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
 2. Or a state-registered domestic partner.



2022 Medical benefits comparison

2022 PEBB medical benefits comparison

Use the following charts to briefly compare the deductibles, out-of-pocket limits, per-visit out-of-pocket costs, and prescription drug costs for PEBB medical plans. Most coinsurance does not apply until after you have paid your annual deductible unless noted that the deductible is waived. Under some plans, copays apply regardless of meeting your deductible, unless enrolled in a consumer-directed health plan (CDHP) with a health savings account. You must pay the deductible first for most covered services before copays or coinsurance apply to a CDHP. Benefits and visit limits listed as per year are based on calendar years (January 1 through December 31). 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.

What you pay	Managed Care and Exclusive Provider Organization (EPO) Plans					
	Kaiser Foundation Health Plan of the Northwest		Kaiser Foundation Health Plan of Washington			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Annual costs						
Medical deductible	\$300/person \$900/family	\$1,400/person \$2,800/family	\$175/person \$525/family	\$125/person \$375/family	\$250/person \$750/family	\$1,400/person \$2,800/family
Medical out-of-pocket limit	\$2,000/person \$4,000/family	\$5,100/person \$10,200/family	\$2,000/person; \$4,000/family		\$3,000/person \$6,000/family	\$5,100/person \$10,200/family
Prescription drug deductible	None	Combined with medical deductible	\$100/person; \$300/family (does not apply to Value or Tier 1 drugs)			Combined with medical deductible (does not apply to preventive drugs)
Prescription drug out-of-pocket limit	Combined with medical limit		\$2,000/person; \$8,000/family			Combined with medical limit
Emergency services						
Ambulance (air or ground/trip)	15%		20% (deductible waived)			10%
Emergency room			\$250	\$75 + 15%	\$300	
Hearing services						
Hearing aids	\$0 one per ear every 60 months		\$0 one per ear any consecutive 60 months			\$0 one per ear any consecutive 60 months
Routine annual hearing exam	\$35	\$30	\$15 (primary care) \$30 (specialist)	\$0 (primary care) 15% (specialist)	\$30 (primary care) \$50 (specialist)	10%

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

What you pay	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan (administered by Regence BlueShield)			
	Classic	Plus	Select	CDHP
Annual costs				
Medical deductible	\$250/person \$750/family	\$125/person \$375/family	\$750/person \$2,250/family	\$1,400/person \$2,800/family
Medical out-of-pocket limit	\$2,000/person \$4,000/family		\$3,500/person \$7,000/family	\$4,200/person \$8,400/family; not to exceed \$7,000/member
Prescription drug deductible	\$100/person; \$300/family (for Tier 2 and specialty, except insulins)	None	\$250/person; \$750/family (for Tier 2 and specialty, except insulins)	Combined with medical deductible
Prescription drug out-of-pocket limit	\$2,000/person; \$4,000/family			Combined with medical limit; not to exceed \$7,000/member
Emergency services				
Ambulance (air or ground/trip)			20%	
Emergency room	\$75 + 15%		\$75 + 20%	15%
Hearing services				
Hearing aids	\$0 (one per ear every 5 years)			
Routine annual hearing exam		\$0		15%

What you pay	Managed Care and Exclusive Provider Organization (EPO) Plans					
	Kaiser Foundation Health Plan of the Northwest		Kaiser Foundation Health Plan of Washington			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Hospital care						
Inpatient	15%		\$150/day up to \$750/admission	\$500/admission	\$250/day up to \$1,250/admission	10%
Outpatient			\$150	15%	\$200	
Office visits						
Behavioral health	\$25 ¹	\$20 ¹	\$15	\$0	\$30	10%
Preventive care (deductible waived)	\$0		\$0			
Primary care	\$25 ¹	\$20 ¹	\$15	\$0	\$30	10%
Specialist	\$35	\$30	\$30	15%	\$50	
Telemedicine/virtual care	\$0		\$0			
Urgent care	\$45	\$40	\$15 (primary care) \$30 (specialist)	15%	\$30 (primary care) \$50 (specialist)	10%
Therapies (max number of visits/year)						
Acupuncture	\$35 (Self-referred: 12 visits/year; Physician-referred: no limit)	\$30 (Self-referred: 12 visits/year; Physician-referred: no limit)	\$15 (12 visits/year)	\$0 (12 visits/year)	\$30 (12 visits/year)	10% (12 visits/year)
Chiropractic/spinal manipulations	\$35 (60 combined visits/year)	\$30 (60 combined visits/year)	\$15 (10 visits/year)	\$0 (10 visits/year)	\$30 (10 visits/year)	10% (10 visits/year)
Massage therapy	\$25 (Self-referred: 12 visits/year)		\$30 (60 combined therapy visits/year)	15% (16 separate visits/year)	\$50 (60 combined therapy visits/year)	10% (60 combined therapy visits/year)
Physical, occupational, speech, and neurodevelopmental therapy	\$35 (60 combined visits/year)	\$30 (60 combined visits/year)		15% (60 combined visits/year)		
Vision care						
Glasses and contact lenses	Any amount over \$150 every 2 years		Any amount over \$150 every 24 months			
Routine annual eye exam	\$25	\$20	\$15 (\$30 specialty)	\$0 (15% specialty)	\$30 (\$50 specialty)	10%

1. \$0 ages 17 and under.

What you pay	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan (administered by Regence BlueShield)			
	Classic	Plus	Select	CDHP
Hospital care				
Inpatient	\$200/day up to \$600 15% professional services (0% for behavioral health)		\$200/day, up to \$600 20% professional services (0% for behavioral health)	15%
Outpatient	15%		20%	15%
Office visits				
Behavioral health	15%		20%	15%
Preventive care (deductible waived)	\$0			
Primary care	15%	\$0	20%	15%
Specialist	15%		20%	15%
Telemedicine/virtual care	Varies, see certificate of coverage			
Urgent care	15%		20%	15%
Therapies (max number of visits/year)				
Acupuncture	\$15 (24 visits/year)			\$15 after deductible (24 visits/year)
Chiropractic/spinal manipulations	\$15 (24 visits/year)			\$15 after deductible (24 visits/year)
Massage therapy	\$15 (24 visits/year)			\$15 after deductible (24 visits/year)
Physical, occupational, speech, and neurodevelopmental therapy	15% (60 combined visits/year)		20% (60 combined visits/year)	15% (60 combined visits/year)
Vision care				
Glasses and contact lenses	\$0 up to the allowed amount for one pair of standard lenses and frames once every 2 years; or any amount over \$150 for elective contact lenses instead of frames and lenses once every 2 years (\$30 fitting fee for contact lenses)			
Routine annual eye exam	\$0			

Prescription drug benefits

Amounts in the following tables show what you pay for prescription drugs. Under the prescription drug benefit, most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.

Note: All plans cover legally-required preventive prescription drugs at 100 percent of allowed amount with no deductible.

Drug tiers	Kaiser Foundation Health Plan of the Northwest			
	Retail (up to 30-day supply)		Mail-order (up to 90-day supply)	
	Classic	CDHP	Classic	CDHP
Generic	\$15		\$30	
Preferred brand-name	\$40		\$80	
Non-preferred brand-name	\$75		\$150	
Specialty	50% up to \$150		Not covered	

Drug tiers	Kaiser Foundation Health Plan of Washington							
	Retail (up to 30-day supply)				Mail-order (up to 90-day supply)			
	Classic	SoundChoice	Value	CDHP	Classic	SoundChoice	Value	CDHP
Value	\$5			Not covered	\$10			Not covered
Preferred generic	\$20	\$15	\$25	\$20	\$40	\$30	\$50	\$40
Preferred brand-name	\$40	\$60	\$50	\$40	\$80	\$120	\$100	\$80
Non-preferred generic and brand-name	50% up to \$250	50%		50% up to \$250	50% up to \$750	50%		50% up to \$750
Preferred specialty	\$150			Not covered	Not covered			
Non-preferred specialty	Not covered	50% up to \$400						

Drug tiers	Uniform Medical Plan							
	Retail and mail order (up to 30-day supply)				Retail and mail order (up to 90-day supply)			
	Classic	Plus	Select	CDHP	Classic	Plus	Select	CDHP
Value	5% up to \$10 ¹			15%; Insulins 5% up to \$10 ¹	5% up to \$30 ¹			15%; Insulins 5% up to \$30 ¹
Tier 1 (Primarily low-cost generic)	10% up to \$25 ¹			15%; Insulins 10% up to \$25 ¹	10% up to \$75 ¹			15%; Insulins 10% up to \$75 ¹
Tier 2 (Preferred brand-name drugs and high-cost generic)	30% up to \$75			15%; Insulins 30% up to \$75 ¹	30% up to \$225			15%; Insulins 30% up to \$225 ¹

¹ Deductible is waived.

Selecting a dental plan

If you are eligible for PEBB Program benefits, dental coverage is included for you and your eligible dependents. Your employer pays the premium. 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. 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

Carefully review your selection before enrolling. Make sure you check with the plan (not your dentist) to see if the dental provider you want is in the plan’s network. Also check that you correctly identify your dental plan’s network and group number (see table below). This is especially important because DeltaCare and Uniform Dental Plan 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.

How do the DeltaCare and Willamette Dental Group plans work?

DeltaCare and Willamette Dental Group are managed-care plans. You choose and receive care from a primary care dental provider (PCD) in that plan’s network. Your PCD 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



2022 Dental benefits comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage (COC) 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 conflict with the plan's COC, the COC takes precedence and prevails. All dental plans include a nonduplication of benefits clause, which applies when you have dental coverage under more than one account.

Cost of Benefits	Managed Care Plans		Preferred Provider Organization (PPO)	
	DeltaCare (Group 3100) You pay	Willamette Dental Group ¹ (Group WA82) You pay	Uniform Dental Plan (Group 3000 Delta Dental PPO) You pay after deductible	
			PPO and out-of-state	Non-PPO
Annual Costs				
Deductible	None		You pay \$50/person, \$150/family	
Annual maximum	None		You pay amounts over \$1,750	
Services				
Crowns	\$100 to \$175		50%	
Dentures	\$140 for complete upper or lower		50%	60%
Fillings	\$10 to \$50		20%	
Nonsurgical TMJ	30% of costs, then any amount after plan has paid \$1,000 per year, then any amount over \$5,000 in member's lifetime	Any amount after plan has paid \$1,000 per year, then any amount over \$5,000 in member's lifetime	30% of costs until plan has paid \$500, then any amount over \$500 in member's lifetime	
Oral surgery	\$10 to \$50 to extract a tooth		20%	30%
Orthodontia	Up to \$1,500 copay per case		50% of costs until plan has paid \$1,750, then any amount over \$1,750 in member's lifetime (deductible doesn't apply)	
Orthognathic surgery	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	
Periodontic services (treatment of gum disease)	\$15 to \$100		20%	30%
Preventive services	\$0		\$0 (deductible doesn't apply)	
Root canals (endodontics)	\$100 to \$150		20%	

¹ Underwritten by Willamette Dental of Washington, Inc. Managed care plan.

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 employees of state agencies and higher-education institutions, as well as:

- Non-represented employees of educational service districts
- Employees of tribal government
- Employer groups that offer both PEBB medical and dental coverage

If your employer offers this benefit, you will be automatically enrolled in basic life and basic AD&D insurance, even if you waive medical coverage. You can also enroll in supplemental life insurance 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 only a summary of benefits. If anything conflicts with the certificate of coverage (COC), the COC prevails. To see the COC, visit *Forms & publications* on HCA's website at hca.wa.gov/pebb-employee or call 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?

You can buy the following kinds of supplemental life insurance.

For employees

You may enroll in supplemental life insurance for yourself in increments of \$10,000 up to \$1 million. You can enroll in 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 million.

For spouse or state-registered domestic partner

If you enroll yourself in supplemental life insurance, you may enroll 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 them 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.

For children

If you enroll in supplemental life insurance for yourself, you may enroll your children in \$5,000 increments up to \$20,000 without evidence of insurability. One premium covers all your enrolled children.

Evidence of insurability

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

- 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.
- Any amount of supplemental life insurance for yourself, your spouse, or your state-registered domestic partner **after 31 days** of becoming eligible for PEBB benefits.

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, 2021, and tobacco use by the insured person.

Supplemental life insurance monthly rates

Age of employee	Monthly cost per \$1,000	
	Non-tobacco user	Tobacco user
Less than 25	\$0.030	\$0.039
25–29	\$0.033	\$0.046
30–34	\$0.036	\$0.060
35–39	\$0.045	\$0.069
40–44	\$0.067	\$0.077
45–49	\$0.097	\$0.117
50–54	\$0.151	\$0.179
55–59	\$0.282	\$0.334
60–64	\$0.432	\$0.508
65–69	\$0.798	\$0.978
70+	\$1.190	\$1.589
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 \$0.067 per \$1,000 coverage. For \$10,000 of supplemental life insurance coverage, the monthly cost is \$0.67.

\$10,000 coverage:	10
40–44 age rate:	$\times 0.067$
Monthly cost:	\$0.67

When can I enroll in supplemental life insurance?

You may enroll in supplemental life insurance for yourself or your dependents at any time. The guaranteed issue amounts are available 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 (described in "What is (employee-paid) supplemental life insurance?" on the previous page) 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 MetLife's MyBenefits portal at mybenefits.metlife.com/wapebb no later than **31 days** after you become eligible for PEBB benefits. If you have any questions about enrollment or need a paper form, please call MetLife at 1-866-548-7139.

How do I create an online account with MetLife?

1. Visit MetLife's MyBenefits portal at 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 call MetLife at 1-866-548-7139, Monday through Friday, 5 a.m. to 8 p.m. (Pacific), except for major holidays.

Good to know!

Designate beneficiaries for your life and AD&D insurance

You must name a beneficiary for your life and AD&D insurance, even if you do not enroll in supplemental coverage. To name or update beneficiaries, use MetLife's MyBenefits portal at 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.

Can I waive basic life and AD&D insurance?

If you are eligible for PEBB 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 basic life, supplemental life, and supplemental 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 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 if 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, supplemental dependent life insurance to an individual policy. The amount of the individual policy will be equal to (or, if you choose, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting.

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

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?

You can buy the following types of 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.

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 in increments of \$10,000 up to \$250,000. Evidence of insurability is not required.

For children

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

Supplemental AD&D insurance monthly rates Monthly cost per \$1,000 of coverage

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:	<u>x 0.019</u>
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. If you have any questions about enrollment or need to request a form, please call MetLife at 1-866-548-7139.



Long-term disability insurance

Long-term disability (LTD) insurance pays a portion of your monthly salary if you are unable to work due to serious injury or illness. The PEBB Program offers two kinds of LTD insurance: employer-paid and employee-paid (if your employer offers it). **Exceptions:** Employee-paid LTD insurance is not available to port commissioners or seasonal employees who work a season that is less than nine months.

These benefits are provided through Standard Insurance Company at competitive group rates. The information below is only a summary of benefits. 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 LTD webpage on HCA's website at hca.wa.gov/ltd or contact your payroll or benefits office.

What is employer-paid LTD insurance?

Employer-paid LTD insurance offers coverage at no cost to employees who are eligible for the employer contribution toward PEBB benefits. In the event of a disability, employer-paid LTD insurance provides you a monthly benefit, with a minimum of \$100 or 10 percent of the LTD benefit before deductible income, whichever is greater. **The maximum monthly benefit is \$240 a month.** The amount you receive is based on 60 percent of the first \$400 of your predisability earnings.

Good to know!

You will be automatically enrolled in employee-paid LTD

Current and new employees will be automatically enrolled in an employee-paid LTD plan that covers 60 percent of your predisability earnings (up to \$16,667 a month), with a 90-day benefit waiting period, starting January 1, 2022.

You can reduce to a lower-cost 50-percent coverage level or decline the coverage at any time. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer.

What is employee-paid LTD insurance?

If you are eligible for employer-paid LTD, you will also be automatically enrolled in employee-paid LTD insurance that covers 60 percent of your predisability earnings (up to \$16,667). If you are already enrolled in employee-paid (formerly called supplemental) LTD insurance for 2021, you will continue to be covered at the 60-percent coverage level and be transitioned to a 90-day benefit waiting period, unless you already have that.

You can reduce your employee-paid LTD to a lower-cost 50-percent coverage level or decline the coverage at any time. If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability and be approved by the insurer.

In the event of a disability, employee-paid LTD provides you a monthly benefit with a minimum of \$100 a month or 10 percent of the LTD benefit before deductible income, whichever is greater. The maximum benefit is \$10,000 a month for the 60-percent coverage level, or \$8,333 for the 50-percent coverage level. The amount you receive is based on either 60 percent or 50 percent (depending on the coverage level you choose) of your predisability earnings (up to \$16,667), reduced by any deductible income.

What does employee-paid LTD insurance cost?

Your monthly employee-paid LTD premium is based on the employee retiree plan you have, your desired coverage level (either 60 percent or 50 percent) and your monthly predisability earnings (base pay). To find your premium easily, use the premium calculator on Standard's website at standard.com/calculator-wapebb.

Monthly employee-paid LTD rates

To calculate your premium, multiply your monthly predisability earnings (up to \$16,667) for the coverage level you choose by the rate shown below.

Higher-education employees retirement plans		TRS, PERS, and other retirement plans	
60%	50%	60%	50%
0.0059	0.0035	0.0047	0.0028

Examples of employee-paid premiums

Your exact premium depends on your retirement plan, monthly predisability earnings, and the coverage level you choose. Here are some examples.

Examples of monthly predisability earnings	Higher-education employees retirement plans		TRS, PERS, and other retirement plans	
	60%	50%	60%	50%
\$3,000	\$17.70	\$10.50	\$14.10	\$8.40
\$4,000	\$23.60	\$14.00	\$18.80	\$11.20
\$5,000	\$29.50	\$17.50	\$23.50	\$14.00
\$6,000	\$35.40	\$21.00	\$28.20	\$16.80
\$7,000	\$41.30	\$24.50	\$32.90	\$19.60
\$8,000	\$47.20	\$28.00	\$37.60	\$22.40
\$9,000	\$53.10	\$31.50	\$42.30	\$25.20
\$10,000	\$59.00	\$35.00	\$47.00	\$28.00
\$11,000- \$16,667	\$64.90- \$98.34	\$38.50- \$58.33	\$51.70- \$78.33	\$30.80- \$46.67

When will I be automatically enrolled in employee-paid LTD insurance?

For current employees

Starting January 1, 2022, if you are an eligible employee, you will be automatically enrolled in or transitioned to an employee-paid LTD plan that covers 60 percent of your predisability earnings (up to \$16,667) with a 90-day benefit waiting period. You will not need to provide evidence of insurability.

For newly eligible employees

You will be automatically enrolled in an employee-paid LTD plan that covers 60 percent of your predisability earnings (up to \$16,667) with a 90-day benefit waiting period. It will start when your other PEBB benefits start. **Exception:** The starting date may be different for faculty hired on a quarter/semester to quarter/semester basis, or an employee regaining eligibility. You will not need to provide evidence of insurability.

If you decline employee-paid LTD **within the 31-day** newly eligible period, you are not required to pay premiums. If you decline employee-paid LTD after the 31-day newly eligible period, the date of the change in coverage will be the first day of the month following the date the employer receives the required election, and premiums will be assessed until the coverage has ended.

How do I reduce or decline my employee-paid LTD insurance?

You can reduce or decline employee-paid LTD insurance at any time.

During annual open enrollment, you can use PEBB My Account to reduce your employee-paid LTD insurance for 2022 to a lower-cost 50-percent coverage level or decline the coverage. Pierce County, UW, and WSU employees use Workday.

At any other time, you can reduce or decline your employee-paid LTD insurance using the *Long Term Disability Insurance Enrollment and Change* form, available on HCA's LTD webpage at hca.wa.gov/ltd. A request to reduce or decline the employee-paid LTD insurance will take effect the first day of the month following the date the employing agency receives the required form.

If you later decide to enroll in or increase coverage, you will have to provide evidence of insurability. An increase in coverage takes effect the day the evidence of insurability is approved.

Benefit waiting period for employer-paid and employee-paid LTD

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

- 90 days;
- The entire period of sick leave (excluding shared leave) for which you are eligible;
- The “fractionated period” of paid time off (PTO) for which you are eligible, if your employer has a PTO plan, as those terms are defined in the policy;
- The entire period of other non-vacation salaried continuation leave for which you are eligible; or
- The end of Washington Paid Family and Medical Leave for which you receive benefits.

Benefits continue during your disability up to the maximum benefit period. See “What is the maximum benefit period?” on the next page.

What is the maximum benefit period?

For both employer-paid and employee-paid LTD insurance, the maximum benefit period means the benefit duration, which is based on your age when the disability begins.

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

Terms and conditions apply

LTD insurance has limitations, including a pre-existing 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.

Questions?

For help with enrollment and premium payments,

please contact your benefits or payroll office.

For help with plan details, please call Standard Insurance Company at 1-800-368-2860.

¹ 1 Social Security normal retirement age

The PEBB Program has several benefits that allow you to set aside money on a pretax basis to pay for your out-of-pocket health care expenses and dependent care costs:

- Medical Flexible Spending Arrangement (FSA)
- Limited Purpose FSA (for those enrolled in CDHPs)
- Dependent Care Assistance Program (DCAP)

All three 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. You may enroll in the DCAP and either a Medical FSA or Limited Purpose FSA. You may choose different amounts for each. See the *Additional benefits* webpage on HCA's website at hca.wa.gov/pebb-employee to learn more.

These benefits are administered by Navia Benefit Solutions, Inc. For details and forms, visit the Navia website at pebb.naviabenefits.com or call 1-800-669-3539. Email questions to customerservice@naviabenefits.com.

What is a flexible spending arrangement (FSA)?

The Medical FSA and Limited Purpose FSA allow 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 \$120 or as much as \$2,750 per calendar year.

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. For the Limited Purpose FSA, estimate your dental and vision expenses. The more accurate you are in estimating your expenses, the better this will work for you.

The full amount you elect to set aside for your Medical FSA or Limited Purpose FSA is available on the first day your benefits become effective — except for orthodontia. Unlike other qualified expenses, orthodontia costs are reimbursed only after you have paid the provider.

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 or Limited Purpose FSA dollars.

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

What is carryover?

Both the Medical FSA and the Limited Purpose FSA allow you to carry over leftover funds. (This is a change for the Medical FSA effective January 1, 2022.) If you have at least \$120 left in your Medical FSA or Limited Purpose FSA

account on December 31, 2022, or have enrolled in an FSA for the next year for at least \$120, you can carry over up to \$550 of unused funds to the next plan year without affecting annual maximums. Eligible funds will be rolled over in late January 2023. Any amount over \$550 will be forfeited.

Under the former grace period system, employees had extra time to spend their funds, but after that date, any remaining money was forfeited to the Health Care Authority. Carryover helps reduce the amount of money employees will forfeit by allowing them to keep it for future years.

You cannot enroll in the Medical FSA and the Limited Purpose FSA in the same year.

Medical FSA

Your Medical FSA helps you pay for deductibles, copays, coinsurance, and many other expenses. You can use this benefit 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.

You cannot enroll in both a Medical FSA and a consumer-directed health plan (CDHP) with a health savings account (HSA).

Limited Purpose FSA

Your Limited Purpose FSA funds can be spent only on dental and vision expenses. It reimburses these expenses for you and your qualified tax dependents. This benefit is intended for subscribers enrolled in a CDHP with an HSA and allows enrollees to save their HSA funds for medical expenses. Your Limited Purpose FSA is compatible with your HSA, so you can spend funds from both accounts in the same plan year.

\$250 Medical FSA contribution for represented employees

The most recent collective bargaining agreement states that represented employees whose rate of pay on November 1, 2021 results in an annual salary of \$50,004 or less will receive a Medical FSA contribution of \$250 in January 2022. 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?

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 2022, 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.
- If you enroll in a Medical FSA for 2022, the \$250 contribution will be added to your account with Navia Benefit Solutions in January 2022.

You will not receive this benefit if you enroll in a CDHP with an HSA for 2022. This limitation is an Internal Revenue

Service rule. You will also forfeit this benefit if you waive PEBB medical coverage for 2022, 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)/caretaker(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 each 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, 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.

You must incur all expenses by December 31, 2022. DCAP does not offer the carryover feature. Submit all claims for DCAP expenses to Navia Benefit Solutions for reimbursement by March 31, 2023. Money left in your account after that date will be forfeited to the Health Care Authority.

Good to know!

Re-enroll in Medical FSA, Limited Purpose FSA, and DCAP

Your participation in the Medical FSA, Limited Purpose FSA, and DCAP does not automatically continue from plan year to plan year. If you wish to participate, you must enroll in these benefits annually.

When can I enroll?

You may enroll in a Medical FSA, Limited Purpose FSA, and 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

Before you enroll, make sure to review the following on the HCA website at pebb.naviabenefits.com:

- *PEBB Medical FSA Enrollment Guide*
- *PEBB Limited Purpose FSA Enrollment Guide*
- *PEBB DCAP Enrollment Guide*

How do I enroll?

Before you enroll, make sure to read the Medical FSA, Limited Purpose FSA, or DCAP enrollment guides on the Navia website at pebb.naviabenefits.com. You can also call Navia Benefit Solutions at 1-800-669-3539 if you have questions.

To enroll in these benefits anytime other than open enrollment, download and print the *Midyear Enrollment Form for Medical Flexible Spending Arrangement (FSA), Limited Purpose FSA, and Dependent Care Assistance Program (DCAP)* on the Navia member portal at pebb.naviabenefits.com. You must return the form to your payroll or benefits office **no later than 31 days** after you become eligible for PEBB benefits. Washington State University and 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. However, you can enroll in the Limited Purpose FSA and DCAP in the same year.

When can I change my election?

Once you enroll in a Medical FSA, Limited Purpose FSA, or DCAP, you can change your election only if you have a qualifying event that creates a special open enrollment. Your election change must be consistent with the qualifying event. For example, if you get married, you cannot reduce your annual election; 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 *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. Washington State University and University of Washington employees must submit the change through Workday.

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 support your whole person well-being, such as managing stress, building resiliency, and adapting to change. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentive each year.

Who is eligible?

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

- **Employees enrolled in PEBB medical coverage**
If you waive PEBB medical coverage, you can still access SmartHealth, but you cannot qualify for the SmartHealth wellness incentive.
- **Retirees not enrolled in Medicare Part A and Part B**
If you are a retiree deferring PEBB retiree insurance coverage, you will not have access to SmartHealth and will not qualify for the SmartHealth wellness incentive.
- **PEBB Continuation Coverage (Unpaid Leave) subscribers**
- **PEBB Continuation Coverage (COBRA) subscribers not enrolled in Medicare Part A and Part B**

What is the wellness incentive?

Each year, subscribers can qualify for a \$125 wellness incentive. How you receive the incentive depends on the type of medical plan you enroll in.

- **For consumer-directed health plans (CDHPs):** A one-time deposit of \$125 goes into the subscriber's health savings account (HSA).
- **For all other PEBB medical plans:** Subscribers get a \$125 reduction in their PEBB medical plan deductible.

When do I get the wellness incentive?

If a subscriber qualifies for the \$125 wellness incentive in 2022, then they will receive the SmartHealth incentive by the end of January 2023 if they are enrolled in PEBB medical as their primary coverage on January 1, 2023. If they are enrolled in Medicare Part A and Part B as their primary coverage on January 1, 2023, they will not receive the incentive even if they earned it the prior year.

How do I qualify for the wellness incentive each year?

Complete all three steps within the deadlines described below to qualify each year.

1. Sign in to SmartHealth at smarthealth.hca.wa.gov.
2. Complete the SmartHealth well-being assessment. It takes about 15 minutes and is worth 800 points.
3. Join and track more activities to earn at least 2,000 total points before your deadline.

When is my deadline?

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 a PEBB medical plan, your deadline is November 30, 2022.
- If you are a new subscriber with a PEBB medical coverage effective date of January through September 2022, your deadline is November 30, 2022.
- If you are a new subscriber with a PEBB medical coverage effective date of October through December 2022, your deadline is December 31, 2022.

What if I can't complete the activities?

Any subscriber for whom it is medically inadvisable or, due to a medical condition, unreasonably difficult to attempt to satisfy the requirement for a PEBB Wellness Incentive Program can request an alternative requirement that will allow them to qualify for the PEBB Wellness Incentive or waive the requirement.

To request an alternative requirement, call SmartHealth customer service at 1-855-750-8866. To learn more, including how to appeal if your request is denied, see the SmartHealth Reasonable Alternative Standard FAQs on HCA's website at hca.wa.gov/pebb-smarthealth.

What if I don't have internet access?

Call SmartHealth Customer Service 1-855-750-8866, Monday through Friday, 7 a.m. to 7 p.m. (Pacific) to learn more.

Who can I contact for more help?

For technical questions about using SmartHealth, contact SmartHealth Customer Service:

- Call 1-855-750-8866, 7 a.m. to 7 p.m. (Pacific), Monday through Friday
- Email support@limeade.com

To learn more about SmartHealth, go the HCA website at hca.wa.gov/pebb-smarthealth.



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.
- 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):

In Washington State

Bellevue

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

Olympia

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

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

In Oregon

Portland

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

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 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 50. When a special open enrollment event occurs, coverage will begin as noted in the table that begins 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, employer-paid LTD insurance, and employee-paid LTD insurance (unless you decline this 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.

Supplemental life and AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

If you request an increase in employee-paid LTD coverage level, it is effective the day the evidence of insurability is approved. A decrease in coverage takes effect the first of the following month.

If you elect enrollment in the Medical Flexible Spending Arrangement (FSA), Limited Purpose 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, Limited Purpose FSA, and DCAP begin that day. See exception for faculty, below.

Contact your payroll or benefits office with questions about eligibility and when your benefits begin.

Faculty

For faculty hired on a quarter-to-quarter or semester-to-semester basis, medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, and employee-paid LTD insurance (unless you elect to decline this 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.

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:

- An employee returning from unpaid leave that did not last more than 29 months after 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. Medical and dental coverage will begin the first day of the month in which the quarter or semester begins for faculty who were eligible for the employer contribution and lost it and now are returning to work in a faculty position no later than the 12th month after the month in which they lost eligibility for the employer contribution toward PEBB benefits and are anticipated to work half-time or more for the quarter or semester.

If you continued your supplemental life insurance or supplemental AD&D insurance while on leave, your coverage would start the first day of the month that you are in pay status for eight hours or more or the first day of the month in which the quarter or semester begins that faculty returns to work half time or more. If you were eligible and chose to continue your employee-paid LTD insurance or you were not eligible to continue your employee-paid LTD insurance, it will begin the first day of the month you are in pay status for eight hours or more or the first day of the month in which the quarter or semester begins for faculty who return to a faculty position as described above. If you were eligible to continue your supplemental life, supplemental AD&D, or employee-paid 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.

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.

When coverage begins

If you enroll or make changes during annual open enrollment

January 1 of the following year

If you are newly eligible

Generally, the first day of the month following the date you become eligible. If you become eligible on the first working day of the month, PEBB benefits begin on that day.

If you get married or register a domestic partnership

The first of the month after the date of 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 date.

If you have a birth, adoption, or assume legal obligation for support in anticipation of adoption

- **For a newly born child:** the date of birth
- **For a newly adopted child:** the date of placement, or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.

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 adding the child increases the premium, and 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 the child's date of birth or adoption is on or after the 16th, 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.

If a child becomes eligible as an extended dependent

The first day of the month following the event date or eligibility certification, whichever is later.

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, 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.

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. Pierce County, Washington State University, and University of Washington employees must make changes through Workday.

Annual open enrollment changes are effective January 1 of the following year. For special open enrollments, the effective date depends on the change requested and the date it is received.

Changes you can make anytime

- Change your name or address by notifying your payroll or benefits office. Use the appropriate PEBB Employee Enrollment/Change form. Pierce County, Washington State University, and University of Washington employees use Workday.
- Apply for, cancel, change coverage amounts, and update beneficiary information for basic and supplemental life insurance, as well as basic and supplemental accidental death and dismemberment (AD&D) insurance. Evidence of insurability may be required. See "Life and AD&D Insurance" on page 39.
- Apply for, cancel, or change auto or home insurance coverage. See "Auto and Home Insurance" on page 48.
- 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. Pierce County, Washington State University, and University of Washington employees use Workday.
- Reduce or increase coverage level, decline coverage, or enroll in employee-paid long-term disability insurance. During annual open enrollment, you can do this on PEBB My Account. Pierce County, University of Washington, and Washington State University use Workday. At any other time, use the *Long Term Disability Enrollment and Change* form. To enroll in or increase coverage, you will have to provide evidence of insurability.
- Make changes to your tobacco use premium surcharge attestation. You can do this on PEBB My Account at hca.wa.gov/my-account or use the *PEBB Premium Surcharge Attestation Change* form found under *Forms & publications* on HCA's website at hca.wa.gov/pebb-employee.
- 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 HCA's website at hca.wa.gov/pebb-employee.
- Change your HSA beneficiary information. Use the *Health Savings Account Beneficiary Designation* form available on HealthEquity's website at learn.healthequity.com/pebb.

Changes you can 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 forms during the PEBB Program’s annual open enrollment. You may also make some of these changes online using PEBB My Account at hca.wa.gov/my-account during open enrollment. Enrollment changes will be effective January 1 of the following year.

During annual open enrollment, you can:	Use this:
<ul style="list-style-type: none"> Change your medical or dental plan. Enroll or remove eligible dependents. Enroll in a medical plan if you previously waived PEBB medical. Waive PEBB medical coverage. See “Waiving enrollment” on page 16. 	<ul style="list-style-type: none"> PEBB My Account (except for enrolling a new dependent) PEBB Employee Enrollment/Change form (if you have PEBB medical, dental, life, AD&D, and long-term disability insurance) <p>OR</p> <ul style="list-style-type: none"> PEBB Employee Enrollment/Change for Medical Only Groups (if you have PEBB medical only)
<ul style="list-style-type: none"> Enroll or re-enroll in a Medical FSA or Limited Purpose FSA (PEBB benefits-eligible state agency and higher-education employees only) Enroll or re-enroll in DCAP (PEBB benefits-eligible state agency and higher-education employees only) 	<p>Navia’s website at pebb.naviabenefits.com. Washington State University and University of Washington employees must use Workday.</p>
<p>Enroll in or opt out of participation under the premium payment plan. See “Paying for benefits” on page 18.</p>	<p>PEBB Premium Payment Plan Election/Change form</p>
<p>Attest to the spouse or state-registered domestic partner coverage premium surcharge</p>	<ul style="list-style-type: none"> PEBB My Account PEBB Premium Surcharge Attestation Change form
<p>Reduce, decline, or enroll in employee-paid LTD coverage</p>	<ul style="list-style-type: none"> During open enrollment, use PEBB My Account After open enrollment, use Long Term Disability Enrollment and Change form.

What is a special open enrollment?

Certain qualifying 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 or regaining eligibility for PEBB benefits.

The changes shown on page 53 through 55 may be allowed as a special open enrollment. In addition, employees can make changes to supplemental life and supplemental AD&D insurance during a special open enrollment.

What changes can I make during a special open enrollment?

Beginning on the next page, see the table of situations that create a special open enrollment, what changes are allowed, and what documents you may need.

How do I make changes during a special open enrollment?

You must provide proof 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. Pierce County, Washington State University, and University of Washington employees 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 payroll or benefits office 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.

Good to know!


Learn more

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.

Changes you can make with a special open enrollment

The icons listed here will indicate which changes may be available in your situation. Lighter icons indicate that the change is not permitted for that situation.

 Add dependent

 Remove dependent

 Change PEBB medical and/or dental plan

 Waive PEBB medical

 Enroll after waiving PEBB medical

Marriage or registration of a state-registered domestic partnership



Submit these documents:

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 with the past six months showing both names).

If the subscriber is newly married and is adding their spouse up to six months after the date of marriage, only a marriage certificate is required. Or, if the subscriber is in a new state-registered domestic partnership and is adding their state registered domestic partner up to six months after the date of registration, only a certificate of state-registered domestic partnership or legal union is required.

For a state-registered domestic partner, also submit *PEBB Declaration of Tax Status* form.

Please note: Employee may add only the new spouse, state-registered domestic partner, or children of the spouse or partner. Existing dependents may not be added.

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.

Employee may change their plan only if the new state-registered domestic partner or the child acquired through the state registered domestic partnership is also a newly eligible tax dependent.

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.

Birth, adoption, or assuming a legal obligation for support in anticipation of adoption



Submit these documents:

Birth certificate (or, if a birth certificate is unavailable, a 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, the subscriber's spouse, or the subscriber's state-registered domestic partner; and a *PEBB Declaration of Tax Status* form if enrolling a child of a state-registered domestic partner.

Please note: 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.

Child becomes eligible as an extended dependent through legal custody or guardianship



Submit these documents:

Valid court order showing legal custody, guardianship, or temporary guardianship, signed by a judge or officer of the court; a signed *PEBB Extended Dependent Certification* form, and a *PEBB Declaration of Tax Status* 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)



Submit these documents:

Certificate of creditable coverage; letter of termination of coverage from health plan or payroll or benefits office; COBRA election notice

Add dependent

Remove dependent

Change PEBB medical and/or dental plan

Waive PEBB medical

Enroll after waiving PEBB medical

Employee has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan



Submit these documents:

Employee hire letter from employer that contains information about benefits eligibility; employment contract; termination letter; letter of resignation; statement of insurance; certificate of coverage

Please note: 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.

Employee’s dependent has a change in 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.



Submit these Documents:

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

Please note: 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.

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



Submit these documents:

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

Please note: 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.

Employee’s dependent moves from another country to live in the United States, or from within the U.S. to another country, and that change in residence resulted in the dependent losing their health insurance



Submit these documents:

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)

Employee or a dependent has a change in residence that affects health plan availability



Submit these documents:

Proof of former and current residence (e.g., utility bill); certificate of credible coverage

A court order requires the employee or any other individual to provide insurance coverage for an eligible child of the employee



Submit these documents:

Valid court order

Employee or dependent enrolls in or loses eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP)



Submit these documents:

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 dependent becomes eligible for a state premium assistance subsidy for PEBB medical plan from Medicaid or CHIP



Submit these documents:

Eligibility letter from Medicaid or CHIP

Employee or 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.



Submit these documents:

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 dependent's current medical plan becomes unavailable because the employee or dependent is no longer eligible for a health savings account (HSA)



Submit these documents:

Cancellation letter from the health plan; coverage confirmation in a new health plan; Medicare entitlement letter; copy of current tax return claiming employee as a dependent

Employee or 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)



Changing PEBB medical and/or dental plans can only be approved by the PEBB Program.

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



Submit these documents:

Certificate of credible coverage; proof of enrollment or termination of coverage from TRICARE

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



When coverage ends

Your PEBB insurance coverage ends as described below.

- The last day of the month you or a dependent lose eligibility for PEBB benefits.
- The last day of the month your 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 by the due date in written requests from the PEBB Program.

What happens if I or my dependent lose eligibility?

If 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 59.

If your dependent loses eligibility, you must remove the ineligible dependent from your account. Your payroll or benefits office must receive the appropriate *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?

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. Your employer will make no contribution toward the premiums. This is called PEBB Continuation Coverage. There are three options you and your eligible dependents may qualify for when employee coverage ends:

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

COBRA and Unpaid Leave temporarily extend PEBB health plan coverage when your or your dependent's PEBB health plan coverage ends due to a qualifying event. You can enroll in only one of these options at a time.

How does PEBB Continuation Coverage work?

The PEBB Program will mail a *PEBB Continuation Coverage Election Notice* to you or your dependent at the address we have on file when your employer-paid coverage ends. The

notice 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 we do not receive the form 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 soon after you enroll in PEBB insurance coverage), the *PEBB Continuation Coverage Election Notice* (mailed to you when your PEBB benefits are terminated), or the *PEBB Retiree Enrollment Guide*. You can find these under *Forms & publications* on the HCA website at hca.wa.gov/pebb-employee.

PEBB Continuation Coverage (COBRA)

PEBB Continuation Coverage (COBRA) is for current and former employees and their dependents who are qualified beneficiaries under federal COBRA Continuation Coverage law. COBRA eligibility is defined in federal law and governed by federal rules. PEBB Continuation Coverage (COBRA) also includes coverage for some members who are not qualified beneficiaries under federal COBRA Continuation Coverage. Your dependents may have independent election rights to PEBB Continuation Coverage (COBRA).

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 cases, LTD insurance. If you do not elect this coverage, your dependents do not have independent election rights 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).
- 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, download a *PEBB Retiree Enrollment Guide* on HCA's website at hca.wa.gov/pebb-retirees. You can also request it by calling the PEBB Program at 1-800-200-1004. We also offer an online tutorial that walks you through filling out the retiree Form A at your own pace. If you need help with the form, the tutorial is available on HCA's website at hca.wa.gov/pebb-retirees.

We suggest you request or review this information about three months before your employment is terminated if you want to enroll in PEBB retiree insurance coverage. 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.

If you would like to enroll in a Medicare Advantage Prescription Drug plan, submit the required forms to the PEBB Program no later than the last day of the month prior to the month your employer-paid PEBB coverage, COBRA, or continuation coverage ends.

Once we receive your form, PEBB Program staff will review it for eligibility and contact you if they need more information. Your opportunity to enroll in PEBB retiree insurance coverage may be affected if the 60-day deadline is not met.

When you become eligible for Medicare Part A and Part B, you must enroll and stay enrolled in Medicare Part A and Part B to enroll or stay enrolled in PEBB retiree insurance coverage. 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. See "Medicare and SEBB" on page 15.

For general eligibility and enrollment questions, you can also call the PEBB program at 1-800-200-1004 (TRS: 711) or send us a secure message at hca.wa.gov/fuze-questions. This phone line and FUZE are only for retiring employees and continuation coverage members. You must set up a secure login to use the FUZE feature. This helps protect your privacy and sensitive health information. Employees should contact their payroll or benefits office with questions about the PEBB Program or their account-related questions.

What happens to my Medical FSA or Limited Purpose 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 Flexible Spending Arrangement (FSA) or Limited Purpose 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 or Limited Purpose 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 FSA and DCAP coverage ends

See the *PEBB Medical FSA Enrollment Guide*, *PEBB Limited Purpose FSA Enrollment Guide*, and *PEBB Dependent Care Assistance Program Guide* on the Navia member portal at pebb.naviabenefits.com. You can also call Navia Benefit Solutions at 1-800-669-3539 or send an email to 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, call HealthEquity to stop them.

See “Consumer-directed health plans with an HSA” on page 25.

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

When 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 39 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 children) may be eligible to enroll in or defer (postpone or pause) 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 child does 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 56.

What happens when a dependent dies?

If your covered dependent dies, 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.

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 if you are unsure, call 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.

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 made by 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 have 30 days to request an appeal. You can find guidance on filing an appeal in WAC 182-16 and on the HCA website at hca.wa.gov/pebb-appeals or see “Appeal instructions and deadlines” beginning at the bottom of this page.

How do I request a review of an initial order?

You can file a written request or make an oral request for review.

Information detailing your right to request review is included in the 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

Send a fax to: 360-763-4709.

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

Deadline for requesting a review of the initial order

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?

Send the PEBB Program 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 the PEBB Appeals webpage at hca.wa.gov/pebb-appeals. If you have questions, please call the PEBB Appeals Unit at 1-800-351-6827.

Appeal 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)
- Limited Purpose FSA
- Dependent Care Assistance Program (DCAP)

Instructions: Complete Sections 1 through 3 of the *PEBB Employee Request for Review/Notice of Appeal* form (available on the PEBB Appeals webpage at hca.wa.gov/pebb-appeals) 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 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 on the PEBB Appeals webpage at hca.wa.gov/pebb-appeals) 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 your employer’s written review decision date in Section 4 of the form.

(Continued)

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:
 - Life insurance
 - AD&D insurance
 - Long-term disability insurance
 - Medical FSA
 - Limited Purpose FSA
 - DCAP
- 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
- Premium payment plan

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:

- Eligibility for or enrollment in:
 - Medical coverage
 - Dental coverage
- Premium payment plan

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 *PEBB Employee Request for Review/Notice of Appeal* form (available on the PEBB appeals webpage at hca.wa.gov/pebb-appeals) 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
- Life insurance premium payments

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

Enrollment form links

Below are links to the forms that are found in the printed version of this guide.

[2022 PEBB Employee Enrollment/change form \(50-400\)](#)

[2022 PEBB Employee Enrollment/change for Medical Only Groups form \(52-0030\)](#)

[2022 PEBB Premium Surcharge Attestation Help Sheet 950-0226\)](#)

[2022 Standard Insurance Employee Long-Term Disability Insurance Enrollment/Change form](#)

Update your mailing address

Keep your address up to date so we can send you important account information that can't be emailed, including eligibility or payment deadlines. This also ensures that the health plans you are enrolled in send information to the right address. Learn how to update your address by visiting the HCA website at hca.wa.gov/employee-retiree-benefits/contact-us.

