Your PEBB benefits for

2025

Employee Enrollment Guide

HCA | Health Care Authority
Public Employees Benefits Board

HCA 50-0100 (11/24)

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
- Checking if your wellness incentive was applied to your deductible

Contact your payroll or benefits office for help with:

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

Experiencing a mental health or substance use crisis?

These resources are available for all people in Washington regardless of your income or whether you have insurance or not.

- **For a life-threatening emergency:** Call 911.
- **For 24-hour suicide prevention or a mental health crisis:** Call or text 988.
- **For substance use, problem gambling, or mental health support:** Call the Washington Recovery Help Line at 1-866-789-1511 or the mental health crisis line in your area.

Medical plans

Kaiser Foundation Health Plan of the Northwest (Kaiser Permanente NW) Classic, CDHP
kp.org/wapebb
1-800-813-2000 (TRS: 711)

Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA) Classic, CDHP, SoundChoice, Value
kp.org/wa/pebb
1-866-648-1928 (TRS: 711)

Uniform Medical Plan (UMP) Classic, Select, CDHP—Administered by Regence BlueShield and ArrayRx
Medical services (Regence BlueShield):
ump.regence.com/pebb
1-888-849-3681 (TRS: 711)
Prescription drugs (ArrayRx):
ump.regence.com/pebb/bene its/prescriptions
1-888-361-1611 (TRS: 711)

UMP Plus–Puget Sound High Value Network
Administered by Regence BlueShield and ArrayRx
Medical services (Regence BlueShield):
pugetsoundhighvaluenetwork.org
1-855-776-9503 (TRS: 711)
Prescription drugs (ArrayRx):
ump.regence.com/pebb/bene its/prescriptions
1-888-361-1611 (TRS: 711)

UMP Plus–UW Medicine Accountable Care Network—Administered by Regence BlueShield and ArrayRx
Medical services (Regence BlueShield):
pebb.uwmedicine.org
1-888-402-4237 (TRS: 711)
Prescription drugs (ArrayRx):
ump.regence.com/pebb/bene its/prescriptions
1-888-361-1611 (TRS: 711)

Dental plans

DeltaCare
Administered by Delta Dental of Washington
deltadentalwa.com/pebb
1-800-650-1583
1-800-833-6384

Uniform Dental Plan
Administered by Delta Dental of Washington
deltadentalwa.com/pebb
1-800-537-3406
1-800-833-6384

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

Vision plans

Davis Vision by MetLife
Underwritten by Metropolitan Life Insurance Company
metlife.com/wshca
1-888-496-4275
1-800-523-2847

EyeMed Vision Care
Underwritten by Fidelity Security Life Insurance Company
member.eyemedvisioncare.com/wahca/en
1-800-699-0993
1-844-230-6498

MetLife Vision Plan
Underwritten by Metropolitan Life Insurance Company
metlife.com/wshca
1-866-548-7139
1-800-428-4833

Auto and home insurance

Liberty Mutual Insurance Company
libertymutual.com/pebbsae
1-800-706-5525

Flexible spending arrangement (FSA) and Dependent Care Assistance Program (DCAP)

Navia Benefit Solutions
pebb.naviabenefits.com
1-800-669-3539

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

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

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

Metropolitan Life Insurance Company (MetLife)
Enrollment and management:
mybenefits.metlife.com/wapebb
Info, docs, and more:
metlife.com/wshca
1-866-548-7139 (TRS: 711)

Long-term disability (LTD) insurance

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

Voluntary wellness program

SmartHealth
Log in and complete activities:
smarthealth.hca.wa.gov
Eligibility and deadlines:
hca.wa.gov/pebb-smarthealth
1-800-947-9541

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.

Contents

The *PEBB Employee Enrollment Guide* provides you with the information you need to sign up for, use, or change your PEBB benefits.

If there are updates or corrections to this document, you can find the latest version on HCA's website at **hca.wa.gov/erb** under *Forms & Publications*.

1. Learn about your benefits

All employers offer these benefits

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

2. Choose your health plans

This guide has resources to help you make your health coverage selections, including the following:

- Medical plans available by county
- Premiums
- PEBB medical benefits at-a-glance
- PEBB dental benefits at-a-glance
- PEBB vision benefits at-a-glance

3. Enroll yourself and your dependents

Log in to our online enrollment system, Benefits 24/7, at **benefits247.hca.wa.gov**. It works on your computer or mobile device and is the easiest way to enroll.

Note: Pierce County, Washington State University, and University of Washington employees use Workday to manage their PEBB benefits.

Use Benefits 24/7 to enroll in medical, dental, and vision coverage.

Do you plan to enroll a spouse, state-registered domestic partner, or children on your health plan? You can enroll your dependents in the same health plans that you choose for yourself. You can use Benefits 24/7 to enroll dependents and upload verification documents to prove they are eligible.

You will have access to Benefits 24/7 once your employer has entered your information into the system. If you're using paper forms, submit them to your payroll or benefits office.

Either way you enroll, the enrollment must be completed (or the forms and documents must be received) **no later than 31 days** after you become eligible for PEBB benefits.

4. 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.

Learn more

Refer to other sections of this guide for more details. You can also find information on the HCA website at **hca.wa.gov/pebb-employee**.

How to use Benefits 24/7

Employees can use Benefits 24/7, our online enrollment system, on a computer or mobile device to enroll in and manage changes to their benefits.

Note: Pierce County, Washington State University, and University of Washington employees use Workday to manage their PEBB benefits.

⚠ If you need help accessing Benefits 24/7, contact your payroll or benefits office.

What can I do in Benefits 24/7?

- Choose your medical, dental, and vision plans
- Waive enrollment in PEBB medical coverage
- Enroll your eligible dependents in PEBB benefits
- Upload documents to prove dependent eligibility
- Access vendor websites to enroll in supplemental (employee-paid) life and supplemental accidental death and dismemberment (AD&D) insurance, a flexible spending arrangement (FSA) or Limited Purpose FSA, and the Dependent Care Assistance Program (DCAP)
- Reduce or decline coverage in employee-paid long-term disability (LTD) insurance
- Attest to premium surcharges
- Request a change due to a special open enrollment
- Apply for PEBB Continuation Coverage (COBRA or Unpaid Leave)
- Apply for PEBB retiree insurance coverage

Good to know!

What's your browser?

Google Chrome is the preferred browser for Benefits 24/7, but Edge, Firefox, and Safari will also work. For more information, check out the *Help with Benefits 24/7* webpage at **benefits247.hca.wa.gov**.

How do I set up an account?

You will need to create a login for Benefits 24/7 using SecureAccess Washington (SAW). SAW is the state's secure single-sign-on portal and will keep your sensitive information secure.

If you already have a SAW account, you do not need to create another one.

1. **Visit benefits247.hca.wa.gov** and click the green *Log in to Benefits 24/7* button. You'll be directed to the SAW website.
2. **Click** *Sign up* to create a SAW account. (If you already have a SAW account, enter your username and password and skip to step 5.) Enter your name, email address (we recommend using your personal email address), a username, and password. Save your username and password in a safe place so you don't forget them the next time you log in.
3. **Check the box** to indicate you're not a robot, click *Submit*, and follow the link to activate your account.
4. **Check your email** for a message from SAW. Click on the confirmation link, close the *Account Activated!* browser window that opens, and return to your original window. Follow the instructions on the screen to finish creating your account.
5. **You'll be directed back** to Benefits 24/7 automatically. Enter your last name, date of birth, and last four digits of your Social Security number. Click *Verify my information*.
6. **Select your security questions and answers.** Like your username and password, be sure to save these in a safe place where you can find them for future use. You'll be directed to the Benefits 24/7 dashboard.

When can I access Benefits 24/7?

After your employer enters your eligibility information into Benefits 24/7, you can log in and enroll in benefits within your 31-day eligibility period. Come back anytime to check your coverage or request special open enrollment changes.

How do I enroll with Benefits 24/7?

Once you log in to Benefits 24/7, the step-by-step tool at the top of the page will guide you through the enrollment process. The steps are:

1. **Add your dependents.** Enter your dependents' information, select the benefits you want to enroll them in, and attest to premium surcharges. If you are not adding dependents, skip to step 3.

2. **Verify your dependents.** You must provide proof of your dependents' eligibility.

   Upload documents from your computer or mobile device to verify your dependents' eligibility. Your documents must be verified and approved before your dependents are enrolled under your coverage. Acceptable documents (such as a birth certificate, marriage certificate, or recent tax return) and file types (PDF, JPEG, JPG, or PNG) are listed in Benefits 24/7. Be sure to keep the documents you submit.

   If you are unable to upload documents online, you can submit paper documents to your payroll or benefits office.

   Your dependents will not be enrolled until the documents are approved.

3. **Select your plans.** Select your plans in Benefits 24/7 by checking the box next to the medical, vision, and dental plans you want for yourself and any dependents you want to enroll. Your dependents will be enrolled in the same plans as you.

   You can waive PEBB medical coverage, but not other benefits, if:

   - You have other employer-based group medical coverage, a TRICARE plan, or Medicare; or
   - You have School Employees Benefits Board (SEBB) medical, vision, and dental coverage.

   You cannot enroll in both PEBB and SEBB health plans.

4. **Attest to the premium surcharges.** Determine whether you'll be charged the monthly $25-per-account tobacco use premium surcharge and the monthly $50 spouse or state-registered domestic partner coverage premium surcharge.

5. **Choose your supplemental benefits.** You can reduce or decline employee-paid LTD insurance. Learn about your life and AD&D insurance options, flexible spending arrangements, the Dependent Care Assistance Program, and health savings accounts, as well as SmartHealth, our voluntary wellness program at **hca.wa.gov/pebb-employee**.

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. Go to Benefits 24/7 at **benefits247.hca.wa.gov** to sign up.

Exception: 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 and notify you (see Washington Administrative Code [WAC] 182-12-114 and 182-12-131). 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., 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.

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 (1)(c) for details.

Good to know!

Stacking hours for employees and seasonal 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) or (2)(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 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 institution of higher education. 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; see WAC 182-12-114 (3)(b).

You may continue any combination of medical, dental, or vision, 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 *PEBB Continuation Coverage Election Notice* we send, 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. A "season" means any recurring, annual period of work at a specific time of year that lasts 3 to 11 consecutive months.

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.

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, dental, or vision 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 *PEBB Continuation Coverage Election Notice* we send, 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, dental, or vision 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 19 for options available to you.

Eligibility in both PEBB and SEBB

If you are eligible for enrollment in both the PEBB and School Employees Benefits Board (SEBB) Programs, you and your eligible dependents are each limited to a single enrollment in medical, dental, and vision plans in the SEBB Program **or** in the PEBB Program. If you or your dependents are enrolled in both the PEBB and SEBB Programs and 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).

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 17.

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. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children through the last day of the month in which they turn age 26, regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below.

How are children defined?

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

- Your 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.
- Children of any age with a developmental or physical disability.

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 them 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.

If you have already enrolled a child with a disability and are changing to a health plan administered by a different insurance carrier (for example Kaiser Permanente or Uniform Medical Plan), you will need to submit a new *PEBB Certification of a Child with a Disability* to your new health plan, even if they were previously certified.

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 at least two years. After that, we will periodically review their eligibility, but not more than once a year. These verifications may require updated information from you and your child's doctor. 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 age 26 or older 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 using Benefits 24/7 (or in a written letter) when your child with a disability age 26 or older 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 at the same time you enroll 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 by the PEBB Program. You can upload your documents for verification in Benefits 24/7 or provide them directly to your payroll or benefits office.

Documents to enroll a spouse

Provide a copy of (choose one):

- The most recent year's federal tax return filed jointly that lists the spouse (black out financial information)
- The most recent year's federal tax returns for you and your spouse if filed separately (black out financial information)
- A marriage certificate[1] and evidence that the marriage is still valid[2] (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 petition for dissolution, petition for legal separation, or petition to invalidate (annul) your marriage. Must be filed within the last six months.
- Defense Enrollment Eligibility Reporting System (DEERS) registration
- Valid J-1 or J-2 visa issued by the U.S. government

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

Provide a copy of (choose one):

- A certificate/card of state-registered domestic partnership or legal union[1] and evidence that the partnership is still valid[2] (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 petition to invalidate (annul) state-registered domestic partnership. Must be filed within the last six months.

If enrolling a state-registered domestic partner, attach a completed *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

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**.

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 the spouse or partner in PEBB health plan coverage.

1 If within six months of marriage or partnership, only the certificate/card is required.

2 Separate utility bills with the same address showing your or your spouse's/partner's names on it as evidence the marriage/partnership is still valid.

- 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 14 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 make the change in Benefits 24/7 and upload the NMSN (or submit the appropriate enrollment/change form and include a copy of the NMSN to your payroll or benefits office).

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

The following options are allowed:

- The child will be enrolled under the subscriber's PEBB health plan coverage as directed by the NMSN.
- If you have previously waived PEBB medical coverage, you will be enrolled in medical coverage as directed by the NMSN in order to enroll the child.
- The subscriber's selected health plan will be changed if directed by the NMSN.
- If the child is already enrolled under another PEBB subscriber, the child will be removed from the other health plan coverage and enrolled as directed by the NMSN. If the 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. Remove the dependent from your account in Benefits 24/7 (or submit your completed enrollment/change form to your payroll or benefits office). The change must be submitted in Benefits 24/7 (or received by the payroll or benefits office) **within 60 days** of the last day of the month the dependent no longer meets PEBB eligibility criteria. If a dependent child with a disability age 26 or older 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 change 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, dental, or vision coverage under one of the continuation coverage options described in WAC 182-12-270.
- 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.

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" for more information.

How to enroll

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. You may have the option to waive your enrollment. See "Waiving enrollment" on page 19.

How do I enroll?

The easiest way to enroll yourself and your dependents is with our online enrollment system, Benefits 24/7, at **benefits247.hca.wa.gov**. See "How to use Benefits 24/7" on page 6.

Exception: Pierce County, Washington State University, and University of Washington employees must enroll through Workday.

If you cannot access the internet to enroll, use the *PEBB Employee Enrollment/Change* form or the *PEBB Employee Enrollment/Change for Medical Only Groups* form, available from your payroll or benefits office.

You must enroll and provide dependent verification documents if requesting to enroll eligible dependents **no later than 31 days** after you become eligible for PEBB benefits. A list of documents we will accept as proof of dependent verification is on page 12.

If you do not enroll or the documents are not received in time, you will be automatically enrolled as a single subscriber and your dependents will not be enrolled. 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.

Automatic enrollments

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.

Consider supplemental insurance options

You may also want to:

- Reduce or decline employee-paid LTD insurance coverage. You can do this at any time.
- Enroll in supplemental life and supplemental AD&D at **mybenefits.metlife.com/wapebb**. If you miss the deadline to enroll in supplemental life insurance coverage or request coverage over the guaranteed issue coverage amount, evidence of insurability will be required to enroll. Please note that future increases in life insurance coverage amounts will require evidence of insurability. Evidence of insurability is not required for supplemental AD&D insurance.
- Enroll in a flexible spending arrangement (FSA), Limited Purpose FSA, or the Dependent Care Assistance Program (DCAP) (available to state agency and higher-education employees only). Visit the Navia website at **pebb.naviabenefits.com**.

  Exception: Washington State University and University of Washington employees must enroll through Workday.
- For auto/home insurance, see page 71 of this guide, visit Liberty Mutual's website at **libertymutual.com/pebbsae** 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 using Benefits 24/7 (or submitting the appropriate enrollment/change form to your payroll or benefits office), also submit the following applicable forms.

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 developmental or physical disability occurred before age 26 and they are incapable of self-sustaining employment and chiefly dependent on you for support and maintenance and meet the program criteria described in WAC 182-12-260.

PEBB Extended Dependent Certification

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

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

Good to know!

Find your form

Enrollment forms are available from your payroll or benefits office. Downloadable forms are available on the HCA website at **hca.wa.gov/pebb-employee** under *Forms & publications*.

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 enrollment within PEBB Program timelines. You may waive enrollment in PEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. If you waive enrollment in PEBB medical, you will be enrolled in PEBB dental and vision if your employer offers them.

You must indicate your intent to enroll or waive enrollment using Benefits 24/7 (or by submitting an enrollment/change form to your payroll or benefits office). See "Waiving enrollment" on page 19 for instructions and timelines.

Exception: You may waive enrollment in PEBB medical to enroll in School Employees Benefits Board (SEBB) medical only if you are enrolled in SEBB dental and vision. By doing so, you also waive enrollment in PEBB dental and vision.

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. If your employer offers these benefits, you will also be automatically enrolled as a single subscriber in Uniform Dental Plan, MetLife Vision, basic life insurance, basic AD&D insurance, and employer-paid LTD insurance.
- You will also be automatically enrolled in employee-paid LTD insurance (if your employer offers it).
- You will be charged a monthly premium for your medical coverage and a tobacco use premium surcharge. You can change your tobacco use attestation anytime.
- 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.
- 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 in the SEBB Program **or** the 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 in two PEBB accounts?

No. Medical, dental, and vision 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 can 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 and vision coverage. You must enroll in PEBB dental, vision, 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.
- Enroll in PEBB medical, as well as PEBB dental, vision, 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 as a dependent from the other medical, dental, and vision coverages.

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

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

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).

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

Waiving PEBB employee medical or removing your Medicare-eligible dependent

You may choose to waive your enrollment in PEBB employee medical and have Original Medicare Parts A and B as your primary medical coverage. However, you will remain enrolled in PEBB dental, vision, 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 employee-paid LTD insurance (if your employer offers this), unless you decline it. See "Waiving enrollment" on page 19.

You may also choose to remove a dependent who enrolls in Medicare Part A and Part B as a special open enrollment event.

If you waive PEBB employee 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.

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 defer enrollment in Medicare Part B and enroll in Part B later, after employment ends, without a late enrollment penalty. 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 active employees and their dependents provide creditable prescription drug coverage, which means it is as good as or better than Medicare Part D coverage. You cannot be enrolled in both a commercial Medicare Part D plan and a PEBB medical plan that includes creditable drug coverage.

When you enroll in Medicare Part A or Part B, you can keep your PEBB employee insurance coverage and not pay a Medicare Part D late enrollment penalty if you later decide to enroll in a Medicare Part D plan. 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 months after your PEBB medical ends, you may have to wait for the next Medicare Open Enrollment Period to enroll in 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. You will have to pay this premium penalty for as long as you have a Medicare Part D plan.

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.

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. For more information to help you prepare for retirement, visit **hca.wa.gov/prepare-to-retire**.

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.

Can I waive enrollment?

If you are eligible for 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 Original Medicare. Specific situations allow you to waive your enrollment in PEBB dental and vision.

If you waive enrollment in medical

- You must still enroll in PEBB dental, vision, 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 enrolled in employee-paid LTD insurance, if your employer offers it, unless you decline it.
- You cannot enroll your eligible dependents in PEBB medical, but you can enroll them in PEBB dental and/or vision, if your employer offers them.
- 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, supplemental AD&D insurance, a flexible spending arrangement (FSA), Limited Purpose FSA, and the Dependent Care Assistance Program (DCAP), if your employer offers them.

How do I waive medical?

To waive PEBB medical, use Benefits 24/7 (or submit the appropriate enrollment/change form to your payroll or benefits office). The form must be received **no later than 31 days** after you become eligible for PEBB benefits. You can also waive medical during annual open enrollment or due to a qualifying special open enrollment event.

You may waive 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 and vision. 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 these 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, vision, 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. Your spouse, state-registered domestic partner, or parent must use Benefits 24/7 (or submit the appropriate enrollment/change form to their payroll or benefits office) to remove you from their dental and vision to prevent two enrollments in PEBB health plan coverage.
- Enroll in PEBB health plan coverage under your own account using Benefits 24/7 (or submit the appropriate enrollment/change form to your payroll or benefits office) so that the change is made (or the form is received) **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 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 medical 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.

Good to know!

Special open enrollment

See "Changes you can make with a special open enrollment" on page 53. When a special open enrollment event occurs, coverage will begin as noted in the table that begins on that page.

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

If you are eligible 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. If your employer offers these benefits, you will also be automatically enrolled as a single subscriber in Uniform Dental Plan, MetLife Vision insurance, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and employer-paid long-term disability (LTD) insurance.

You will also be automatically enrolled in employee-paid LTD insurance, if your employer offers it, for which you pay a premium, unless you decline the coverage.

You will be charged a monthly premium for your medical coverage, as well as a tobacco use premium surcharge.

You can change your tobacco use attestation anytime using Benefits 24/7 at **benefits247.hca.wa.gov** (or by submitting a *PEBB Premium Surcharge Attestation Change* form to your payroll or benefits office).

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 certain PEBB benefits and enroll in SEBB?

Yes, in certain circumstances.

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. In doing so, you waive your enrollment in PEBB dental and vision.

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

You cannot waive your enrollment in employee PEBB medical to stay enrolled in PEBB retiree insurance coverage, even if you are enrolled in Medicare. The PEBB Program will automatically defer PEBB retiree insurance coverage if you become eligible for the employer contribution toward PEBB benefits as an employee.

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 and vision coverage (if your employer offers them) 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 basic 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. You will also pay a monthly premium for any supplemental and employee-paid insurance you buy. Your monthly premiums cannot be prorated for any reason, including when a member dies before the end of the month. See page 34 for premiums.

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 23 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, dental, and vision plans you choose. See the medical, dental, and vision benefits at-a-glance on pages 35 through 47 to compare plans side-by-side.

Supplemental and employee-paid insurance

If your employer offers these benefits, you can buy supplemental life insurance 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 employee-paid LTD coverage, you will have to provide evidence of insurability and be approved by the insurer. See "Life and AD&D insurance" on page 60 and "Long-term disability insurance" on page 64.

How much will my monthly medical premiums be?

For state agency and higher-education employees

See the "2025 PEBB employee monthly premiums" on page 34. There are no employee premiums for dental or vision coverage.

For other employees

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

For state agency and higher-education employees

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.

Exception: If you enroll a dependent who does not qualify as a tax 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. Submit the *PEBB Declaration of Tax Status* in Benefits 24/7 at **benefits247.hca.wa.gov** (or through your payroll or benefits office) if you enroll a dependent who does not qualify as a tax dependent.

For other employees

Ask your payroll or benefits office if they offer a pretax deduction benefit under their own Section 125 plan.

Good to know!

Additional benefits you may like

The flexible spending arrangement (FSA), Limited Purpose FSA, and Dependent Care Assistance Program (DCAP) are benefits that may suit your financial needs. See "FSAs and DCAP" on page 67.

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 tax laws and their 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 by submitting 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**.

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 yourself or all enrolled dependents age 13 or older, or if you attest that 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 to the spouse or state-registered domestic partner coverage premium surcharge or if you attest that the surcharge applies to you.

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. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use.

Tobacco products are any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. Tobacco products do not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids, such as over-the counter nicotine replacement products recommended by a doctor and prescription nicotine replacement products.

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

You must attest when you enroll using Benefits 24/7 (or by submitting the appropriate enrollment/change form to your payroll or benefits office). If submitting a paper form, request the form from your payroll or benefits office. **Exception**: 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:

- You or 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 (Pierce County, Washington State University, and University of Washington employees must use Workday):

- Go to Benefits 24/7 at **benefits247.hca.wa.gov** to change your attestation.
- 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!

Ready to kick tobacco?

Your medical plan can help you live tobacco free! You and your enrolled dependents 18 and older can sign up for a tobacco cessation program through your medical plan. Visit our *Living tobacco free* webpage at **hca.wa.gov/tobacco-free** to learn how to get started.

For enrolled dependents 17 and under, contact your medical plan for programs they offer. Additional resources are available at **teen.smokefree.gov**.

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 Benefits 24/7 (or the appropriate enrollment/change form) to find out if this premium surcharge applies to you. Then, attest in Benefits 24/7 (or submit the appropriate enrollment/change form to your payroll or benefits office) to respond to this surcharge. **Exception**: Pierce County, Washington State University, and University of Washington employees 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 you attest that the surcharge applies to you, 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, use Benefits 24/7 at **benefits247.hca.wa.gov** (or 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**. You must provide proof of the qualifying event. **Exception**: 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 day 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 day of the month, then the change begins that day.

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 at-a-glance

You'll find benefits at-a-glance 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 plan features. See "PEBB medical benefits at-a-glance" on page 35, "Dental benefits at-a-glance" on page 43, and "Vision benefits at-a-glance" on page 45.

Benefits booklets

The health plans provide benefits booklets, also called certificates of coverage (COCs) or evidence of coverage (EOCs), with detailed information about plan benefits and what is and is not covered. You can find the benefits booklets for all PEBB health plans on the *Medical plans 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 a 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 at-a-glance or the plans' benefits booklets.

Supplemental life and AD&D insurance

In addition to your employer-paid life and accidental death and dismemberment (AD&D) insurance, you can buy more coverage for yourself and your family, if your employer offers it. See "Life and AD&D insurance" on page 60.

Employee-paid LTD insurance

If you are eligible for employer-paid long-term disability (LTD) insurance, you will also be automatically enrolled in employee-paid LTD insurance, although you can reduce or decline the coverage. See "Long-term disability insurance" on page 64.

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, dental, and vision plans, as well as life insurance, accidental death and dismemberment (AD&D) insurance, long-term disability insurance, 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 42 and "Selecting a vision plan" on page 44.

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 or have an upcoming surgery, have a chronic condition (such as diabetes, heart disease, depression, or cancer), or are taking a high-cost medication. For example, you will want to make sure your providers are in network for the plan you want to enroll in. You may need to choose different providers that are in-network with your plan, or risk paying higher costs. If you cover dependents, they must enroll in the same medical, dental, and vision plans, so you should consider their care needs and providers as well. You will also need to make sure the plan is available where you live.

Things to consider when choosing a medical plan

Eligibility

Not everyone qualifies to enroll in a consumer-directed health plan (CDHP) with a health savings account (HSA). See "CDHPs with an HSA" on page 29.

Availability

To enroll in a Kaiser Permanente plan, you must live in one of the counties where it is offered. Uniform Medical Plan (UMP) plans are available in all Washington counties and nationwide, except for the UMP Plus plans, which require that you live in one of the counties where they are offered. See "PEBB employee medical plans available by county" on page 33. 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 must change your plan. You must report your new address and request to change your medical plan to your payroll or benefits office **no later than 60 days** after you move. If you do not, you will be enrolled in a PEBB medical plan designated by the HCA director or designee.

Good to know!

Only one account

PEBB medical, dental, and vision coverage is limited to a single enrollment per individual. See "Can I enroll on two PEBB accounts?" on page 16.

What types of plans are available?

The PEBB Program offers several types of medical plans, explained below.

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 below 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.

- Kaiser Permanente Northwest[1] Classic
- Kaiser Permanente Washington Classic
- Kaiser Permanente Washington SoundChoice
- Kaiser Permanente Washington Value

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

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.

- UMP Classic, administered by Regence BlueShield and ArrayRx
- UMP Select, administered by Regence BlueShield and ArrayRx
- **UMP Plus–Puget Sound High Value Network**, administered by Regence BlueShield and ArrayRx (not available to members enrolled in Medicare)
- **UMP Plus–UW Medicine Accountable Care Network**, administered by Regence BlueShield and ArrayRx (not available to members enrolled in Medicare)

Consumer-directed health plans (CDHPs)

A CDHP lets you use a tax-free health savings account (HSA) to help pay for out-of-pocket medical expenses, has 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 Flexible Spending Arrangement (FSA), which allows you to set aside pretax money to pay for dental and vision expenses. See "CDHPs with an HSA" on page 29. The following PEBB medical plans are CDHPs:

- Kaiser Permanente Northwest CDHP
- Kaiser Permanente Washington CDHP
- UMP CDHP, administered by Regence BlueShield and ArrayRx

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 25.

What medical plan differences should I 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 PEBB plan provider* webpage at **hca.wa.gov/pebb-employee**.

Your current care

If you are currently receiving care, are on a treatment plan, have an upcoming surgery, or are taking prescription medications, some things you will want to consider for you and your dependents are:

- Whether you can continue to receive care with your current provider(s) or facilities as in network;
- If your current prescription drugs are in the plans' formulary and under which prescription drug tier;
- How to transfer your care or treatment smoothly to another plan; and
- If you are ok with paying different cost-shares, for example, the deductible or out-of-pocket maximum levels and coinsurance or copays.

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 use treatment

On their websites, carriers must provide additional information to consumers on their ability to ensure timely access to mental health and substance use care. See "Behavioral health coverage" on page 31.

Coordination with your other benefits

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

If you are also covered by another health plan, call the medical plans directly to ask how they will coordinate benefits. This is especially important for those also enrolled in Apple Health.

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. See "PEBB medical benefits at-a-glance" on page 35.

Deductibles

A deductible is a fixed dollar amount you must pay each calendar year for covered health care expenses before the plan starts paying for covered services. Medical plans may also have a separate annual deductible for prescription drugs. The deductible does not apply to covered preventive care services when you see a network provider. 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 amount, 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 the allowed amount for most in-network covered services 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 benefit booklet for details.

Referral procedures

When you enroll in a medical plan, you may choose your primary care provider. 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. Although some medical plans may not require a referral from your primary care provider to see a specialist, the specialist may require you to have one prior to seeing them for services.

Paperwork

In general, PEBB medical plans don't require you to file claims. However, if you have a UMP plan, you may need to file a claim if you receive services from an out-of-network provider. Or if you have a Kaiser Permanente plan, you may need to file a claim if you receive services out of area, including out of country. Urgent or emergency care may also require you to submit claims. 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 a higher deductible and 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**.

If you have an HSA, you can also enroll in a Limited Purpose Flexible Spending Arrangement (FSA) and the Dependent Care Assistance Program (DCAP). See "FSAs and DCAP" on page 67.

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.
- You are enrolled in Apple Health (Medicaid).
- You are enrolled in another comprehensive health plan.
- You, your spouse, or your state-registered domestic partner (SRDP) 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 by submitting a *Limited HRA Coverage Election* form to your VEBA plan.
- You have a TRICARE plan.
- You are enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).
- You are claimed as a dependent on someone else's tax return.
- You are enrolled in an FSA. This also applies if your spouse or SRDP has an FSA, even if you are not covering them on your health plan with a CDHP. This does not apply to a Limited Purpose FSA.

Other exclusions apply. To confirm whether you qualify, check *The Complete HSA Guidebook* on the HealthEquity website at **healthequity.com/pebb** under *Documents*, read *IRS Publication 969 — Health Savings Accounts and Other Tax-Favored Health Plans* on the IRS website at **irs.gov**, contact your tax advisor, or call HealthEquity 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 2025; or
- $116.67 each month for a subscriber with one or more enrolled dependents, up to $1,400.04 annually for 2025.

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 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 2025, the limit is $4,300 (for subscriber only) and $8,550 (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 over 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?

No. If you enroll in Medicare Part A or Part B and are enrolled in a CDHP with an HSA, you should change medical plans. If you do not change medical plans, you will be responsible for any tax penalties that result from contributions to your HSA while you are enrolled in Medicare Part A or Part B.

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.

What is behavioral health?

Behavioral health is a term that covers the full range of mental and emotional well-being, including:

- Managing day-to-day challenges
- Treating chronic and emergency mental health (such as anxiety, depression, eating disorders, or post-traumatic stress)
- Managing substance use (problems with drug, tobacco, and alcohol use)
- Navigating problem gambling disorders

Your behavioral health affects your physical health. If you or someone you know needs access to behavioral health services, you can use this guide to research each plan's network adequacy and timely access to services for substance use, mental health, and recovery care.

Ensuring timely access to 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 plan's provider directory. Carriers are required by law to include a notation on the provider directory when a mental health or substance use provider is closed to new patients. If you need more information, check the plan's website or call the plan's customer service number.

Wait times for an appointment may vary depending on whether you are seeking emergent, urgent, or routine care. When considering your plan enrollment, you can check the provider directory to see if your provider is in a plan's network, and what in-network emergent and urgent behavioral health care providers are in your area. Make sure to specify how quickly you need care when scheduling appointments.

All carriers must prominently post information on their websites about how to access mental health and substance abuse treatment services, including the number of days within which a member must have access to covered mental health and substance use treatment. You can access links to this information from HCA's *Behavioral health services by plan* webpage at **hca.wa.gov/bh-pebb**. For more information, see RCW 48.43.765 (Brennen's Law) on the Washington State Legislature's website at **leg.wa.gov**.

If you are having trouble receiving services

The first step is to contact the plans using the information at the beginning of this guide. If you continue to have trouble, you can file a complaint with the Office of the Insurance Commissioner (OIC) to report issues scheduling an appointment or accessing timely behavioral health services. To file a complaint, visit the OIC website at **insurance.wa.gov/file-complaint-or-check-your-complaint-status** or call 1-800-562-6900. To see the number of mental health care access complaints in Washington State, view the latest annual mental health access report on the OIC website at **insurance.wa.gov/legislative-and-commissioner-reports**.

Good to know!

Naloxone, also known by the brand name, Narcan, is a fast-acting medication that can reverse the effects of opioids and stop an overdose. You can get naloxone for free. Visit **StopOverdose.org** to find a location near you, or request naloxone to be mailed to you by the People's Harm Reduction Alliance at **phra.org/naloxone**. Naloxone is also available for purchase from many pharmacies in Washington and is covered by your PEBB insurance, subject to cost-sharing.

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' benefits booklets, which are on the *Medical plans and benefits* webpage at **hca.wa.gov/pebb-employee**. Also see the *Behavioral health services by plan* webpage at **hca.wa.gov/bh-pebb**.

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 "2025 PEBB medical benefits at-a-glance" beginning on page 35 includes a high-level summary of coverage by plan.

Crisis information

If you or someone you know is experiencing a mental health or substance-use crisis:

For immediate help

Call **911** for a life-threatening emergency or **988** for a mental health emergency.

For immediate help with a mental health crisis or thoughts of suicide

Call the National Suicide Prevention Lifeline at 1-800-273-8255 (TTY: 1-800-799-4889) or call, text, or chat 988. The line is free, confidential, and available every day. You can also dial 988 if you are worried about someone you know who may need crisis support.

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.

Support beyond the crisis

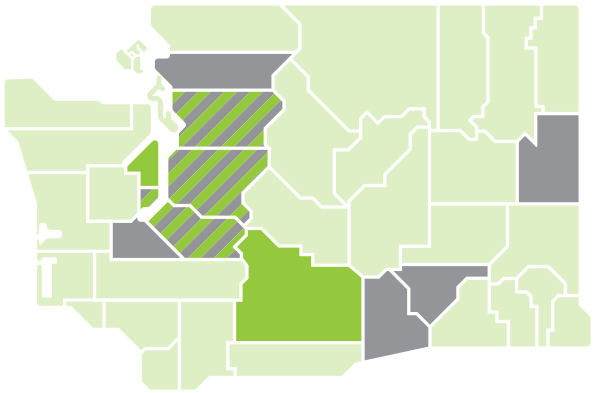
Supporting someone you know through a behavioral health crisis or experiencing one yourself is often not only about the crisis, but also about longer term needs for support. Resources for the immediate crisis are included in this section, but if you need additional resources or support, consider exploring:

- Resources available through your employer, such as employee assistance programs (if your employer offers this type of program). If you're unsure what's available, ask your payroll or benefits office.
- Extended leave resources, such as the Washington State Paid Family Medical Leave Act (PFMLA).
- Resources such as Crisis Connections, **crisisconnections.org**. The *Get Help* section includes many resources, including the Washington Warm Line, which supports people living with emotional and mental health challenges, **crisisconnections.org/wa-warm-line**.
- Resources available through your medical plans, such as counseling, apps to support mental health, and other programs. See the *Behavioral health services by plan* webpage at **hca.wa.gov/bh-pebb**.

2025 PEBB employee 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 plans 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.

Uniform Medical Plan (UMP)



UMP Classic, UMP Select, and UMP CDHP

Available in all Washington, Idaho, and Oregon counties

UMP Plus–Puget Sound High Value Network

- Kitsap
- Yakima

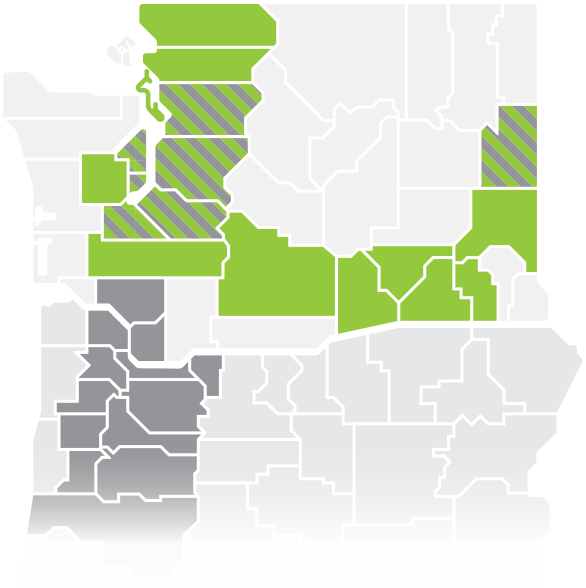
UMP Plus–UW Medicine Accountable Care Network

- Benton
- Franklin
- Skagit
- Spokane
- Thurston

Both **UMP Plus–Puget Sound High Value Network** and **UMP Plus–UW Medicine Accountable Care Network**

- King
- Pierce
- Snohomish

Kaiser Permanente WA (KPWA) and Kaiser Permanente NW (KPNW)



KPWA Classic, KPWA CDHP, and KPWA Value

- Benton
- Columbia
- Franklin
- Island
- Lewis
- Mason
- Skagit
- Walla Walla
- Whatcom
- Whitman
- Yakima

KPWA Classic, KPWA CDHP, KPWA Value, and KPWA SoundChoice

- King
- Kitsap
- Pierce
- Snohomish
- Spokane
- Thurston

KPNW Classic and KPNW CDHP

–Washington

- Clark
- Cowlitz

–Oregon

- Clackamas
- Columbia
- Lane
- Marion
- Multnomah
- Polk
- Washington
- Yamhill
- Benton County ZIP codes: 97330, 97331, 97333, 97339, 97370
- Hood River County ZIP code: 97014
- Linn County ZIP codes: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389

2025 PEBB employee monthly premiums

The amounts below are the monthly costs for PEBB medical coverage. There are no employee premiums for dental, vision, basic life insurance, basic accidental death and dismemberment insurance, and employer-paid long-term disability insurance. These benefits are paid for by your employer.

Note: Employees who work for a city, county, port, tribal government, water district, hospital, etc., need to contact their payroll or benefits office to get their monthly premiums.

The term "spouse" is interchangeable with "state-registered domestic partner".

Effective January 1, 2025	Managed Care Plans						Preferred Provider Organization (PPO) Plans			
	Kaiser Permanente NW		Kaiser Permanente WA				Uniform Medical Plan			
	Classic	CDHP	Classic	CDHP	SoundChoice	Value	Classic	CDHP	Select	UMP Plus
Subscriber only	$189.00	$37.00	$128.00	$25.00	$73.00	$119.00	$133.00	$46.00	$83.00	$158.00
Subscriber & spouse	$378.00	$74.00	$256.00	$50.00	$146.00	$238.00	$266.00	$92.00	$166.00	$316.00
Subscriber & children	$331.00	$65.00	$224.00	$44.00	$128.00	$208.00	$233.00	$81.00	$145.00	$277.00
Subscriber, spouse, & children	$520.00	$102.00	$352.00	$69.00	$201.00	$327.00	$366.00	$127.00	$228.00	$435.00

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

Uniform Medical Plan (UMP) is administered by Regence Blue Shield and ArrayRx (formerly Washington State Rx Services).

Medical premium surcharges

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

- A monthly $25-per-account premium surcharge will apply if you or any dependent (age 13 or 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 UMP Classic.

Visit HCA's website at **hca.wa.gov/pebb-employee** under *Surcharges* for more information.

2025 PEBB medical benefits at-a-glance

Use the following charts to view the deductibles, out-of-pocket Benefits and visit limits listed as per year are based onlimits, per-visit out-of-pocket costs, and prescription drug costs for PEBB medical plans.

You must pay your annual deductible before most coinsurance (%) applies, unless noted that the deductible is waived. The deductible does not apply to most copays ($), unless enrolled in a consumer-directed health plan (CDHP). You must pay the deductible first for most covered services before copays or coinsurance apply to a CDHP.

Some costs are separate for single subscribers and families. These costs are shown in order as individual/family.

Benefits and visit limits listed as per year are based on calendar years (January 1 through December 31).

Call the plans directly for specific benefit information, including preauthorization requirements and exclusions.

If anything in these charts conflicts with the plan's benefits booklet (also called evidence of coverage or certificate of coverage), the benefits booklet takes precedence and prevails.

Note: Some benefits include symbols to represent additional information that is described on the next page.

Continued on next page →

What you pay ↘	Managed Care and Health Management Organization (HMO) Plans					
	Kaiser Permanente NW		Kaiser Permanente WA			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Annual costs (individual/family)						
Medical deductible	$300 / $900	$1,650 / $3,300	$175 / $525	$125 / $375	$250 / $750	$1,650 / $3,300
Medical out-of-pocket limit	$2,500 / $5,000	$5,100 / $10,200	$2,000 / $4,000		$3,000 / $6,000	$5,100 / $10,200
Prescription drug deductible	None	Combined with medical deductible	$100 / $300 (does not apply to Value or Tier 1 drugs)			Combined with medical deductible
Prescription drug out- of-pocket limit	Combined with medical limit		$2,000 / $8,000			Combined with medical limit
Emergency services						
Ambulance	15%		20%*			10%
Emergency room			$250	$75 + 15%	$300	
Hearing services						
Hearing aids (per ear)	Any amount over $3,000 every 36 months*	Any amount over $3,000 every 36 months	Any amount over $3,000 every 36 months*			Any amount over $3,000 every 36 months
Routine annual hearing exam	$35*	$30	$15 ($30#)	$20* (15%#)	$30 ($50#)	10%

Uniform Medical Plan is administered by Regence BlueShield and ArrayRx, formerly known as Washington State Rx Services.

Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.

Some benefits include symbols to represent additional information as described below:

*	Deductible is waived
#	Specialist copay/coinsurance
†	Applies to Tier 2 drugs only, except covered insulins
‡	See additional terms and conditions in the plan's benefits booklet
⁂	$0 for ages 17 and under
▲	Out-of-pocket limit not to exceed $7,000

What you pay ↘	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan			
	Classic	Plus	Select	CDHP
Annual costs (individual/family)				
Medical deductible	$250 / $750	$125 / $375	$750 / $2,250	$1,650 / $3,300
Medical out-of-pocket limit	$2,000 / $4,000		$3,500 / $7,000	$4,200 / $8,400▲
Prescription drug deductible	$100† / $300†	None	$250† / $750†	Combined with medical deductible
Prescription drug out- of-pocket limit	$2,000 / $4,000			Combined with medical out-of-pocket limit
Emergency services				
Ambulance	20%			
Emergency room	$75 + 15%		$75 + 20%	15%
Hearing services				
Hearing aids (per ear)	Any amount over $3,000 every 3 years‡*			Any amount over $3,000 every 3 years‡
Routine annual hearing exam	$0			15%

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact the following. Employees: Your payroll or benefits office. Retirees and continuation coverage members: Call us at 1-800-200-1004 (TRS: 711)

What you pay ↘	Managed Care and Health Management Organization (HMO) Plans					
	Kaiser Permanente NW		Kaiser Permanente WA			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Hopital care						
Inpatient	15%		$150 / day up to $750/ per admission	$500 /per admission	$250 /day up to $1,250/ per admission	10%
Outpatient			$150	15%	$200	
Office visits						
Behavioral health	$25*	$20	$15	$20*	$30	10%
Preventive care*	$0		$0*			
Primary care	$25*	$20	$15	$20*	$30	10%
Specialist	$35*	$30	$30	15%	$50	
Telemedicine / virtual care	$0*	$0	$10* ($0* virtual care)			
Urgent care	$45*	$40	$15 ($30#)	15%	$30 ($50#)	10%
Therapies (cost/visits per year)						
Acupuncture	$35*/12 (no limit with referral)	$30/12 (no limit with referral)	$15/24	$20*/24	$30/24	10%/24
Chiropractic (spinal manipulations)			$15 ($30#)/24	$20* (15%#)/24	$30 ($50#)/24	10%/24
Massage	$25*/12	$25/12	$30/24‡	15%/24‡	$50/24‡	10%/24‡
Physical, occupational, speech, and neurodevelopmental therapy (NDT)	$35*/60	$30/60	$30/60 (no limit NDT)	15%/60 (no limit NDT)	$50/60 (no limit NDT)	10%/60 (no limit NDT)

What you pay ↘	Preferred Provider Organization (PPO) Plan			
	Uniform Medical Plan			
	Classic	Plus	Select	CDHP
Hospital care				
Inpatient	$200 /day up to $600/ 15% professional services ‡		$200 /day up to $600/ 20% professional services ‡	15%
Outpatient	15%		20%	
Office visits				
Preventive care*	$0			
Primary care	15%	$0	20%	15%
Specialist	15%	15%	20%	15%
Telemedicine / virtual care	Varies‡			
Urgent care	15%		20%	15%
Therapies (cost/visits per year)				
Acupuncture Chiropractic (spinal manipulations) Massage	$15/24			
Physical, occupational, speech, and neurodevelopmental therapy	15%/60		20%/60	15%/60

Behavioral health benefits

When accessing behavioral health services such as substance use disorder treatment, mental health counseling, etc. use the charts below to find out what you pay for behavioral health services. Most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.

What you pay ↘	Managed Care and Health Management Organization (HMO) Plans					
	Kaiser Permanente NW		Kaiser Permanente WA			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Inpatient treatment						
Hospital facility– Mental health Hospital facility- Substance use Detoxification Residential treatment facility	15%		$150 /day up to 750 admission	$500 / admission	$250 /day up to $1,250/ admission	10%
Outpatient treatment						
Hospital– Mental health Hospital - Substance use	Not covered‡		$150	15%	$200	10%
Partial hospitalization (or day treatment program) Intensive outpatient Withdrawal management/ detoxification	$25*/ per office visit or per day.**	$20/ per office visit or per day.**				
Office visits for accessing outpatient mental health and substance use services						
Mental health Substance use	$25*	$20	$15	$20*	$30	10%
Primar/Specialist	$35*	$30				
Urgent care – mental health & substance use disorder crisis services	$45*	$40	$15 ($30#)	$20* (15%#)	$30 ($50#)	
Telemedicine / virtual care	$0*	$0	$10* ($0 virtual care)			
Therapies						
Occupational and Neurodevelopmental (NDT)	$35/60	$30/60	$30/60 (no limit NDT)	15%/60 (no limit NDT)	$50/60 (no limit NDT)	10%/60 (no limit NDT)

What you pay ↘	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan			
	Classic	Plus	Select	CDHP
Inpatient treatment				
Hospital – Mental health Hospital – Substance use Withdrawal management/ detoxification Residential treatment facility	$200 /day up to $600‡			15%
Outpatient treatment				
Hospital – Mental health Hospital – Substance use Partial hospitalization (or day treatment program) Withdrawal management/ detoxification Intensive outpatient	15%		20%	15%
Office visits for accessing outpatient mental health and substance use services				
Mental health Substance use Primary / Specialist Urgent care – mental health & substance use disorder crisis services Telemedicine / Telehealth/ virtual care	15%	15%‡ (0% and deductible waived for primary care provider)	20%	15%
Therapies				
Occupational and Neurodevelopmental	15%	15%	20%	15%

Prescription drug benefits

Amounts below 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. All plans cover legally required preventive prescription drugs at 100 percent of the allowed amount with no deductible.

Drug tiers	Kaiser Permanente NW			
	Retail (up to 30-day supply)		Mail-order (up to 90-day supply)	
	Classic	CDHP	Classic	CDHP
Generic	$15*	$15	$30*	$30
Preferred brand-name	$40*	$40	$80*	$80
Non-preferred brand-name	$75*	$75	$150*	$150
Specialty	50% up to $150*	50% up to $150	50% up to $150 for a 30-day supply	

Drug tiers	Kaiser Permanente WA							
	Retail (up to 30-day supply)				Mail-order (up to 90-day supply)			
	Classic	SoundChoice	Value	CDHP	Classic	SoundChoice	Value	CDHP
Value	$5*			N / A	$10*			N / A
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	Not covered	$150		Not covered	Not covered			
Non-preferred specialty		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			15%; 5% up to $10 ‡	5% up to $30			15%; 5% up to $30 ‡
Tier 1 (Primarily low-cost generic)	10% up to $25			15%; 10% up to $25 ‡	10% up to $75			15%; 10% up to $75 ‡
Tier 2 (Preferred brand- name, high-cost generic, and specialty drugs)	30% up to $75; 30% up to $35 ‡			15%; 30% up to $35 ‡	30% up to $225; 30% up to $105 ‡			15%; 30% up to $105 ‡

Selecting a dental plan

If you are eligible for PEBB Program benefits and your employer offers this coverage, 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 as a single subscriber in Uniform Dental Plan.

There are three PEBB Program dental plans to choose from — two managed-care plans and one preferred-provider plan.

Check 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. This is especially important because DeltaCare and Uniform Dental Plan are both administered by Delta Dental of Washington. 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 it pays 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 are in network with this PPO.

When you see a network preferred provider, your out-of-pocket expenses are generally lower than if you chose a premier provider or 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.

The UDP network is Delta Dental PPO (Group 3000).

Dental plan options

Make sure you confirm with the dental plan that the dental provider you want is in the plan's network.

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

2025 PEBB dental benefits at-a-glance

Use the following charts to see what you pay for dental services. Before you select a dental plan or provider, compare the plans to find out what is covered, which providers are in-network, and your costs for care. If anything in these charts conflicts with the plan's certificate of coverage (COC), the COC takes precedence and prevails. For information on specific benefits and exclusions, and coordination of benefits with other coverage, refer to the COC or contact the plan directly.

DeltaCare and Willamette Dental Group (underwritten by Willamette Dental of Washington, Inc.) are managed-care plans. You must select and receive care from a primary care dental provider in that plan's network.

Uniform Dental Plan is a preferred-provider organization (PPO) plan. You can choose any dental provider and change providers at any time. The plan deductible does not apply to orthodontia, preventive care, and services for children under age 15. You must meet the deductible before the plan pays for all other services covered under this plan.

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

Selecting a vision plan

If you are eligible for PEBB Program benefits and your employer offers this coverage, vision 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 vision plan. If you do not select a vision plan, you will be automatically enrolled in MetLife Vision as a single subscriber. See "Vision benefits at-a-glance" starting on the next page or the plans' certificates of coverage for details.

Before you select a vision plan, check with the plan (not the provider) to see if the vision provider you want is in the plan's network. You can call the vision plan's customer service number (listed in the beginning of this guide) or use the vision plan network's online directory.

Vision plan options

There are three PEBB Program vision plans to choose from.

- Davis Vision by MetLife, underwritten by Metropolitan Life Insurance Company
- EyeMed, underwritten by Fidelity Security Life Insurance Company
- MetLife Vision, underwritten by Metropolitan Life Insurance Company

2025 PEBB vision benefits at-a-glance

Use these charts to compare vision benefits by plan. If anything in these charts conflicts with the vision plan's benefits booklet (also called evidence of coverage or certificate of coverage) the benefits booklet takes precedence and prevails. For information on specific benefits and exclusions, refer to the plan's benefits booklet or contact the plan directly.

For Davis Vision by MetLife and MetLife Vision, lens enhancements are not available out-of-network.

For EyeMed, out-of-network lens enhancement reimbursement is available. Check with your provider for details.

*EyeMed members may use both their $200 contact lens allowance and $200 frame allowance during the same visit. Your provider will offer a 20% discount on lenses for your frames.

Benefits for adults 19+

⚠ The amounts listed below show what you pay for in-network services. **The amounts in parentheses show the most the plan would reimburse you for out-of-network services.**

	Davis Vision by MetLife	EyeMed	MetLife Vision
Vision care services			
Routine eye exam (once per year starting January 1)	$0 ($40)	$0 ($84)	$0 ($45)
Frames (renews every January 1 of odd years)	$0 up to $200, then 80% of balance ($0); $0 at Visionworks or for any of the Davis Vision Frame Collection ($50)	$0 up to $200, then 80% of balance ($100)	$0 up to $200, then 80% of balance; or $0 up to $110 allowance at Costco, Walmart, or Sam's Club ($70)
Lenses (renews every January 1 of odd years)	$0 (single $40; bifocal $60; trifocal $80; lenticular $100)	$0 (single $25; bifocal $40; trifocal $55; lenticular $55)	$0 (single $30; bifocal $50; trifocal $65; lenticular $100)
Progressive lenses (renews every January 1 of odd years)	$50 to $175 ($60)	$55 to $175 ($55)	$0 to $175 ($50)
Lens enhancements			
Anti-reflective coating	$35 to $85 ($0)	$45 to $85 ($5)	$41 to $85 ($0)
Scratch-resistant	$0 ($0)	$0 ($5)	$17 to $33 ($0)
Polycarbonate	$30 ($0)	$40 ($0)	$35 ($0)
Photochromic/transitions	$65 ($0)	$75 ($0)	$75 ($0)
Polarized	$75 ($0)	80% of retail price ($0)	80% of retail price ($0)
Tinting	$0 ($0)	$15 ($0)	$17 to $44 ($0)
UV treatment	$12 ($0)	$15 ($0)	$0 ($0)
Contact lenses (instead of glasses)			

Benefits for adults 19+ (continued)

	Davis Vision by MetLife	EyeMed	MetLife Vision
Conventional	$0 up to $200, then 85% of balance; or 4 boxes from Collection lenses without copay ($105)	$0 up to $200, then 85% of balance ($200)*	$0 up to $200, then 100% of balance ($105)
Disposable	$0 up to $200, then 85% of balance; or 8 boxes from Collection lenses without copay ($105)	$0 up to $200, then 100% of balance ($200)*	$0 up to $200, then 100% of balance ($105)
Medically necessary	$0 ($225)	$0 ($300)*	$0 ($210)
Fitting fee	Conventional lenses: covered in full Specialty lenses: $0 up to $60, then 85% of balance ($0)	Standard fit and follow-up: Up to $55 Premium: 10% off retail ($0)	$60 ($0)
Additional member savings			
Additional prescription glasses	You pay 70% on complete pairs: some limitations apply ($0)	You pay 60% on complete pairs ($0)	You pay 80% on complete pairs: some limitations apply ($0)
LASIK surgery	You pay 50% to 60% of national average price of traditional LASIK ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)

Benefits for children under 19

⚠ The amounts listed below show what you pay for in-network services. **The amounts in parentheses show the most the plan would reimburse you for out-of-network services.**

	Davis Vision by MetLife	EyeMed	MetLife Vision
Vision care services (once per year starting January 1)			
Routine eye exam	$0 ($40)	$0 ($90)	$0 ($45)
Frames	$0 up to $200, then 80% of balance or $0 at Visionworks or for any of the Davis Vision Frame Collection ($50)	$0 up to $200, then 80% of balance ($100)	$0 up to $200, then 80% of balance or $0 up to $110 allowance at Costco, Walmart, or Sam's Club ($70)
Lenses	$0 (single $40; bifocal $60; trifocal $80; lenticular $100)	$0 (single $25; bifocal $35; trifocal $53; lenticular $53)	$0 (single $30; bifocal $50; trifocal $65; lenticular $100)
Progressive lenses	$50 to $175 ($60)	$0 to $175 ($40)	$0 to $175 ($50)
Lens enhancements			
Anti-reflective coating (depends on level of coating)	$35 to $85 ($0)	$45 to $85 ($5)	$41 to $85 ($0)
Scratch-resistant	$0 ($0)	$0 ($8)	$0 ($0)
Polycarbonate	$0 ($0)	$0 ($20)	$0 ($0)
Photochromic/transitions	$0 ($0)	$75 ($0)	$75 ($0)
Polarized	$75 ($0)	$0 ($0)	$0 ($0)
Tinting	$0 ($0)	$15 ($0)	$17 to $44 ($0)
UV treatment	$0 ($0)	$15 ($0)	$0 ($0)
Contact lenses (instead of glasses)			

Benefits for children under 19 (continued)

	Davis Vision by MetLife	EyeMed	MetLife Vision
Conventional	$0 up to $300, then 85% of balance or 4 boxes from Collection lenses without copay ($105)	Any amount over $300 (50% of charge up to $300)*	Any amount over $300 ($105)
Disposable	$0 up to $300, then 85% of balance or 8 boxes from Collection lenses without copay ($105)		
Medically necessary	$0 ($225)		$0 ($210)
Fitting fee	Conventional: covered in full Specialty Lens: $0 up to $60 then $85% of balance ($0)	Standard: $0 Premium: $0 copay, 10% discount then balance over $65 ($65)	Covered in full ($0)
Additional member savings			
Additional prescription glasses	You pay 70% on complete pairs: some limitations apply ($0)	You pay 60% of complete pairs ($0)	You pay 80% on complete pairs: some limitations apply ($0)
LASIK surgery	You pay 50% to 60% of national average price of traditional LASIK ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)	You pay 85% of retail price or 95% of a promotional offer ($0)

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please contact the following: **Employees:** Your payroll or benefits office. **Retirees and PEBB Continuation Coverage members:** Call us at 1-800-200-1004 (TRS: 711).

After you enroll

What happens next?

Once you have enrolled in health coverage, you can download a copy of your Summary of Coverage Elections (a list of the plans you chose) in Benefits 24/7. This shows your selections regardless of whether your dependents are approved. After you're enrolled in coverage, your current coverage is displayed on the *Current Coverage* tile. You should receive a welcome packet or letter from your new health plans.

If you have questions that you can't find answers to on the HCA website at **hca.wa.gov/pebb-employee** or in this guide, contact your payroll or benefits office.

When do my benefits begin?

For newly eligible employees

Your medical, dental, and vision coverage, 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 decline this insurance) begin on the first day of the month after you become eligible. However, if you become eligible on the first working day of the month, PEBB benefits begin on that day. The same effective date will apply for enrollment in a flexible spending arrangement (FSA), Limited Purpose FSA, or the Dependent Care Assistance Program (DCAP) if you are eligible for these benefits and enroll in them. See the exception for faculty hired on a quarter-to-quarter or semester-to-semester basis.

For faculty hired on a quarter-to-quarter or semester-to-semester basis

Medical, dental, vision, 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 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. The same effective date will apply for enrollment in the FSA, Limited Purpose FSA, or DCAP if you are eligible for these benefits and enroll in them.

For all subscribers

Contact your payroll or benefits office with questions about eligibility and when your benefits begin. 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 your employer offers these benefits. If you are an employee who works for a city, county, port, tribal government, water district, hospital, etc., contact your payroll or benefits office for eligibility criteria because they could be different from the guidance provided here.

If you later request to enroll in or increase your employee-paid LTD insurance coverage, it is effective the day the evidence of insurability is approved by the insurer. A decrease in coverage takes effect the first day of the month following the date your employing agency receives the required form.

When do my benefits begin if I am regaining eligibility?

Faculty regaining eligibility

Medical, dental, and vision 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 regaining eligibility by 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.

Employees regaining eligibility

Your medical, dental, and vision 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.

All subscribers

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 return 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.

Note: When an employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Medical, dental, vision, basic life insurance, basic AD&D insurance, and employer-paid LTD insurance will begin the first day of the month in which they return from active duty.

Good to know!

ID cards

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

Uniform Dental Plan (UDP) does not mail ID cards, but you can download one from the UDP website at **deltadentalwa.com/pebb**.

When coverage begins

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. See "When do my benefits begin?" or "When do my benefits begin when I am regaining eligibility?".

If you enroll or make changes during annual open enrollment

January 1 of the following year.

If you get married or register a state-registered domestic partnership

The first of the month after the date of the event or the date you enroll your spouse or partner using Benefits 24/7 (or 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 for your dependent begins on that day. You can submit the proof of eligibility later, as long as it is within 60 days of the event date.

If you have a birth or 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, 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.

When an employee returns from active duty in the uniformed services

Their employer-paid PEBB benefits will begin the first day of the month they return from active duty.

Other events that create a special open enrollment

The first of the month after the date of the event or the date you make the change using Benefits 24/7 (or 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.

Some changes can be made anytime and some can be made only during annual open enrollment or when a life event makes you eligible for a special open enrollment.

Changes you can make anytime

The following changes can be made in Benefits 24/7 at **benefits247.hca.wa.gov** or by submitting the appropriate enrollment/change form to your payroll or benefits office unless otherwise noted.

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

- Change your name or address by notifying your payroll or benefits office. You cannot change this through Benefits 24/7.
- Remove dependents from coverage due to loss of eligibility (this is required). You must submit this change **within 60 days** of the last day of the month the dependent loses eligibility for PEBB health plan coverage. If submitting the paper form, it must be received by your payroll or benefits office by the deadline. You may also need to provide proof of the event before the dependent can be removed.
- Change your tobacco use premium surcharge attestation using Benefits 24/7 or by submitting the *PEBB Premium Surcharge Attestation Change* form found under *Forms & publications* at **hca.wa.gov/pebb-employee** to your payroll or benefits office.
- Life and accidental death and dismemberment (AD&D) insurance
  - Enroll in or change coverage amounts for supplemental (employee-paid) life and AD&D insurance using MetLife's *MyBenefits* portal at **mybenefits.metlife.com/wapebb**. Evidence of insurability may be required.
  - Cancel supplemental life and AD&D insurance using the *PEBB Cancellation of Supplemental Life and AD&D Insurance* form, available under *Forms & publications* at **hca.wa.gov/pebb-employee**.
  - Update beneficiary information for basic life and AD&D insurance using MetLife's *MyBenefits* portal.
- Long-term disability (LTD) insurance
  - Reduce or decline employee-paid LTD coverage using Benefits 24/7 or the *Long Term Disability Insurance Enrollment and Change* form, available on HCA's *Long-term disability* webpage at **hca.wa.gov/pebb-ltd**.
  - Enroll in or increase employee-paid LTD coverage using the *Long Term Disability Insurance Enrollment and Change* form. You will have to provide evidence of insurability.
- Health savings account (HSA)
  - Start, stop, or change your contribution to your 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**.
- Submit special open enrollment requests.
- Apply for, change, or cancel auto or home insurance coverage.

Changes you can make during open enrollment

These changes must be completed by the last day of annual open enrollment. Enrollment changes made during annual open enrollment will be effective January 1 of the following year. These can be completed using Benefits 24/7 at **benefits247.hca.wa.gov** or by submitting the appropriate enrollment/change form to your payroll or benefits office unless otherwise noted.

Exception: Pierce County, Washington State University, and University of Washington employees use Workday.

- Change your medical, dental, and vision plans
- Enroll or remove eligible dependents
- Upload documents
- Enroll in a medical plan if you previously waived PEBB medical
- Waive PEBB medical coverage if you are enrolled in other employer-based group medical insurance, a TRICARE plan, or Medicare. You may not waive enrollment in PEBB medical if you are enrolled PEBB retiree insurance coverage.
- Change your spouse or state-registered domestic partner coverage premium surcharge attestation using Benefits 24/7 or by submitting the *PEBB Premium Surcharge Attestation Change* form to your payroll or benefits office. At any time outside open enrollment, you can only report a change **within 60 days** of a change in your spouse's or partner's employer-based group medical insurance and you must provide proof of the event.

- Enroll in or opt out of participation under the premium payment plan. Submit the *PEBB Premium Payment Plan Election/Change* form to your payroll or benefits office.
- Enroll or reenroll in the flexible spending arrangement (FSA), Limited Purpose FSA, and Dependent Care Assistance Program (DCAP) on the Navia Benefit Solutions website at **pebb.naviabenefits.com**. If you cannot use the Navia website, your payroll or benefits office must receive *FSA and DCAP enrollment* form by the last day of open enrollment.

Good to know!

Reenroll each year in the FSA, Limited Purpose FSA, and DCAP

Your participation in the 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.

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 pages 53 through 55 may be allowed as a special open enrollment.

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) using Benefits 24/7 (or by submitting an appropriate enrollment/change form to your payroll or benefits office) and submitting other required documents or forms to your payroll or benefits office. The required forms and documents must be received **no later than 60 days** after the event. In many instances, the date your form or change is received affects the effective date of the change in enrollment. **Exception**: 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, use Benefits 24/7 (or submit the required forms to your payroll or benefits office) along with 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 change or your required form and proof of your dependent's eligibility and/or the event must be received **no later than 60 days** after the date of birth, adoption, or the date you assume legal obligation for support in anticipation of adoption.

Changes you can make with a special open enrollment

The icons indicate which changes may be available in your situation. Grayed-out icons indicate that the change is not permitted for that situation.

Add dependent | Remove dependent | Change PEBB medical, dental, or vision 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.

For a state-registered domestic partner or partner of a legal union, also submit a *PEBB Declaration of Tax Status*. An employee may not change their health plan if the state-registered domestic partner or their state-registered domestic partner's child is not a tax dependent.

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

An 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.

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

Waiving for this event is allowed only if the employee enrolls in medical under the new spouse's 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 is required 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 due to birth or adoption.

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

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 another employer-based group health plan based upon a change in employment status that affects eligibility for the employer contribution.

Employee's dependent has a change in employment status that affects their eligibility or their dependent's eligibility for their 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 26 C.F.R. 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 dependent's employer-based group health plan where they gained eligibility for the employer contribution.

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 creditable 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 during open enrollment under another 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 creditable 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 creditable coverage

Please note: If the employee has a change in residence and the employee's current medical plan is no longer available, the employee must select a new medical plan as described in WAC 182-08-196(3).

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 (Apple Health in Washington) or a state Children's Health Insurance Program (CHIP)

Submit these documents:

Enrollment or termination letter from Medicaid (Apple Health in Washington) 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 coverage 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 the employee enrolls in Medicare. If enrolling after waiving PEBB medical, only allowed if the employee 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

Please note: A dental or vision plan change is not allowed.

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

Submit these documents:

Cancellation letter from the high-deductible 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, dental and/or vision 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 98504-2684

Employee or a dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan

Submit these documents:

Certificate of creditable coverage; proof of enrollment or termination of coverage from a TRICARE plan

⚠ In addition, employees can make changes to supplemental life and supplemental AD&D insurance during a special open enrollment. See "Life and AD&D insurance" on page 60.

Learn more

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**.

When coverage ends

Your or your dependent's PEBB insurance coverage ends as described below. Your dependent's 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.

- 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.

Note: If your employing agency deducted your premium for PEBB insurance coverage after you were no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

What happens if I or my dependent loses 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 using Benefits 24/7 (or your payroll or benefits office must receive the appropriate 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.

There are three options administered by HCA that 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

How does PEBB Continuation Coverage work?

PEBB Continuation 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.

We 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 can also use Benefits 24/7.

You or your eligible dependents must apply for PEBB Continuation Coverage. The enrollment form or your enrollment through Benefits 24/7 must be received **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 you do not apply in Benefits 24/7 (or we do not receive the form) by the deadline, you will lose all rights to continue PEBB insurance coverage.

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 to COBRA 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, long-term disability (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 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 (TRS: 711). (This phone line is only for retiring employees and continuation coverage members. Employees should contact their payroll or benefits office with questions about the PEBB Program or account-related questions.) For more information to help you prepare for retirement, visit **hca.wa.gov/prepare-to-retire**.

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. Generally, you have **60 days** from the date your own employer-paid PEBB coverage, COBRA coverage, or continuation coverage ends for the PEBB Program to receive your application for retiree insurance coverage.

Note: If you choose to enroll in a Medicare Advantage Prescription Drug (MAPD) plan or the Uniform Medical Plan (UMP) Classic Medicare with Part D (PDP) plan, and the required forms are received after the date the PEBB retiree insurance coverage is to begin, you and your enrolled dependents will be enrolled in transitional coverage during the gap month(s) prior to when the MAPD or the UMP Classic Medicare with Part D (PDP) coverage begins.

Once you apply, PEBB Program staff will review your application 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, you must enroll and stay enrolled in Medicare Part A and Part B to enroll in or remain eligible for 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 PEBB" on page 17.

For general eligibility and enrollment questions regarding continuation coverage or retiree insurance coverage, you can also call the PEBB Program at 1-800-200-1004. This phone line is only for retiring employees and continuation coverage members. You can also send a secure message with HCA Support at **support.hca.wa.gov**. You must set up a secure login for this option. This helps protect your privacy and sensitive health information. Employees should contact their payroll or benefits office with questions about the PEBB Program or account-related questions.

What happens to my 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 federal Family and Medical Leave Act (FMLA), Washington's Paid Family and Medical Leave program, or military leave, you are no longer eligible to contribute to your 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. 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.

See the *PEBB FSA Enrollment Guide* or *PEBB Limited Purpose FSA Enrollment Guide* on the Navia member portal at **pebb.naviabenefits.com** for more

information about your FSA or Limited Purpose FSA, including when you are eligible to continue them under continuation coverage through Navia Benefit Solutions. 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 consumer-directed health plan (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 "Who to contact for help" at the front of this guide.

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 60 or contact MetLife at 1-866-548-7139.

If I die, are my surviving dependents eligible?

If you die, your dependents will not receive your 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.

What do I do if a dependent dies?

If your covered dependent dies, use Benefits 24/7 (or submit the appropriate enrollment/change form to your payroll or benefits office) to remove the deceased dependent from your coverage. The change or form must be received **no later than 60 days** after the death.

By submitting this change, 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. 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, dental, or vision 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 disagrees with a decision made by your employer or the PEBB Program, you or your dependent may file an appeal. You have **30 days** from the date of the decision to request an appeal with the PEBB Appeals Unit. You can find guidance on filing an appeal in Chapter 182-16 WAC and on the HCA website at **hca.wa.gov/pebb-appeals**.

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 institutions of higher education, as well as employer groups that offer PEBB medical, dental, and vision coverage. These benefits are not available to employees who are only offered medical benefits.

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.

Life and AD&D insurance are 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. The certificate of coverage can also be found on MetLife's website at **metlife.com/wshca**.

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 types 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 (the guaranteed issue amount) 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 spouses or state-registered domestic partners

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 (the guaranteed issue amount) 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 (the guaranteed issue amount) 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 you becoming eligible for PEBB benefits.

What does supplemental life insurance cost?

The following table shows the monthly cost per $1,000 of coverage, based on your (the employee's) age as of December 31, 2024, and tobacco use by the insured person.

Supplemental life insurance monthly rates

Age of employee	Monthly cost per $1,000	Tobacco user
Under 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:	x 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 registering a state-registered domestic partnership, birth, adoption, or when you have assumed a legal obligation for total or partial support in anticipation of adoption, or when a child becomes eligible as an extended dependent through legal custody or legal guardianship.

Once you have enrolled one child in dependent life insurance, each succeeding child you enroll will be covered for the same amount on the date that child becomes eligible as defined in MetLife's certificate of coverage. A newborn child must be at least 14 days old before supplemental dependent life insurance coverage is effective. If you apply for or change your employee, 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?") will require evidence of insurability only for amounts over the guaranteed issue amount. 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 anytime using MetLife's *MyBenefits* portal at **mybenefits.metlife.com/wapebb**. If you have any questions about enrollment or need a paper form, call MetLife at 1-866-548-7139.

How do I cancel (employee-paid) supplemental life insurance?

You can cancel your supplemental life insurance anytime by submitting the *PEBB Cancellation of Supplemental Life and AD&D Insurance* form to MetLife, or by calling MetLife directly at 1-866-548-7139. For dependents who are no longer eligible due to events such as divorce or a child turning age 26, notice should be provided as soon as possible to avoid overpayment of premiums and loss of eligibility for portability or conversion of coverage.

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. You should see *View your WA State Health Care Authority PEBB benefits* box.
2. Select the *Register* button.
3. Complete the registration form and verification process.
4. Select *Go to Accounts* in the registration confirmation pop-up.

If you have questions about enrollment or the MetLife website, or you need paper forms, 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 at **hca.wa.gov/pebb-employee**. You may also designate a beneficiary via phone by contacting MetLife customer service at 1-866-548-7139.

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, if you object to this coverage, you have two options:

- 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. Please contact the MetLife customer service team at 1-866-548-7139 following your separation of employment if you do not receive a portability and conversion application via mail. 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 enroll in 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, or 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. Please note that the maximum accelerated benefit for a spouse or state-registered domestic partner is 80 percent of the dependent life amount, not to exceed $400,000.

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	
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:	x 0.019
Monthly cost:	$ 0.19

When can I enroll in supplemental AD&D insurance?

You can enroll in supplemental AD&D anytime. Supplemental AD&D insurance never requires evidence of insurability.

How do I enroll in supplemental AD&D insurance?

Enroll online using MetLife's *MyBenefits* portal at **mybenefits.metlife.com/wapebb**. If you have questions about enrollment or need to request a form, call MetLife at 1-866-548-7139.

How do I cancel (employee-paid) supplemental AD&D insurance?

You can cancel your supplemental AD&D insurance at any time by submitting *the PEBB Cancellation of Supplemental Life and AD&D Insurance* form to MetLife, or by calling MetLife directly at 1-866-548-7139. For dependents who are no longer eligible due to events such as divorce or a child turning age 26, notice should be provided as soon as possible to avoid overpayment of premiums and loss of eligibility for portability or conversion of coverage.

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. If your employer offers it, the PEBB Program offers two kinds of LTD insurance:

- Employer-paid
- Employee-paid

Exceptions: Employee-paid LTD insurance is not available to port commissioners or seasonal employees who work a recurring, annual 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 forms, go to the *Long-term disability insurance* webpage on HCA's website at **hca.wa.gov/pebb-ltd** or contact your payroll or benefits office.

What is considered a disability?

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

After the first 24 months, disability as a result of sickness, injury, or pregnancy means being unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably able through education, training, or experience.

During this period, you are considered partially disabled if you are working but unable to earn more than 60 percent of your indexed predisability earnings in that occupation and in all other occupations for which you are reasonably suited.

What is 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.

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 the first $16,667 of your monthly predisability earnings, up to a monthly benefit maximum of $10,000.

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 based on either 60 percent or 50 percent (depending on the coverage level you choose) of your monthly predisability earnings, reduced by any deductible income. The minimum benefit is $100 a month or 10 percent of the LTD benefit before deductible income, whichever is greater. The maximum monthly benefit is $10,000 for the 60-percent coverage level, or $8,333 for the 50-percent coverage level.

What does employee-paid LTD insurance cost?

Your monthly employee-paid LTD premium is based on which employee retirement 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%
0.0053	0.0032	0.0042	0.0025

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	Higher-education employees retirement plans		TRS, PERS, and other retirement plans	
	60%	50%	60%	50%
$3,000	$15.90	$9.60	$12.60	$7.50
$4,000	$21.20	$12.80	$16.80	$10.00
$5,000	$26.50	$16.00	$21.00	$12.50
$6,000	$31.80	$19.20	$25.20	$15.00
$7,000	$37.10	$22.40	$29.40	$17.50
$8,000	$42.40	$25.60	$33.60	$20.00
$9,000	$47.70	$28.80	$37.80	$22.50
$10,000	$53.00	$32.00	$42.00	$25.00

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

You will be automatically enrolled in an employee-paid LTD plan during your initial 31-day enrollment period. You will not need to provide evidence of insurability. The coverage will start when your other PEBB benefits start. **Exception:** The starting date may be different for an employee regaining eligibility.

How do I change my employee-paid LTD insurance?

You can reduce or decline your employee-paid LTD coverage at any time using Benefits 24/7 or *the Long Term Disability Insurance Enrollment and Change* form, available on HCA's *Long-term disability insurance* webpage at **hca.wa.gov/pebb-ltd**. If you decline employee-paid LTD insurance **within the 31-day newly eligible period,** you are not required to pay premiums.

Use the *Long Term Disability Insurance Enrollment and Change* form to increase or enroll in LTD coverage. If you 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.

If you reduce or decline employee-paid LTD coverage **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. If you decline the employee-paid LTD insurance, premiums will be assessed until the coverage has ended.

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

Benefits start after the benefit waiting period, whichever 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
- The end of Washington's Paid Family and Medical Leave for which you receive benefits

Benefits continue during your disability up to the maximum benefit period.

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. Social Security normal retirement age is abbreviated as SSNRA.

Age	Maximum benefit period
Up to 61	To age 65 or to SSNRA 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 12-month pre-existing condition exclusion. Please read your certificate of coverage carefully to understand this benefit.

Questions?

- **For help with enrollment and premium payments,** contact your benefits or payroll office.
- **For help with plan details,** call Standard Insurance Company at 1-800-368-2860.

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

- Flexible spending arrangement (FSA)
- Limited Purpose FSA, for those enrolled in consumer-directed health plans (CDHPs)
- Dependent Care Assistance Program (DCAP)

All three are available to public employees eligible for PEBB benefits who work at state agencies, institutions of higher education, and community and technical colleges, as described in Washington Administrative Code (WAC) 182-12-116. You may enroll in the DCAP and either an FSA or Limited Purpose FSA.

These benefits are not available to employees of an employer group, such as a city, county, port, tribal government, water district, hospital, etc.

You must enroll in an FSA, Limited Purpose FSA, or DCAP each year you want to participate. Enrollment does not automatically continue from plan year to plan year. You may choose different amounts for each. See the *Life, home, auto, AD&D, LTD, FSA, & DCAP 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 an FSA?

Your 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, dental, or vision plan.

If you are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA), you **cannot** enroll in an FSA in the same plan year. If you do, you will only be enrolled in a CDHP with an HSA. You can be enrolled in a CDHP with an HSA and the Limited Purpose FSA.

What is a 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.

How does an FSA or Limited Purpose FSA work?

You can contribute as little as $120 or as much as $3,200 for plan year 2025 to an FSA or Limited Purpose FSA. To figure out how much you may want to contribute, estimate your out-of-pocket medical expenses for the calendar year and enroll in an 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 the benefit will work for you.

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

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, divorce, or death. Your change in election amount must be consistent with the qualifying event.

If you have not spent all the funds in your FSA or Limited Purpose FSA by December 31 and you are still employed and eligible for this benefit, you may be able to take advantage of the carryover feature.

You must submit all claims to Navia Benefit Solutions for reimbursement by March 31, 2026 for qualified services incurred during the 2025 plan year.

What is carryover?

Both the FSA and the Limited Purpose FSA allow you to carry over leftover funds. Carryover helps reduce the amount of money employees will forfeit by allowing them to keep it for future years. The IRS sets the maximum amount employees are allowed to carry over each year. For 2025, the maximum carryover amount will be at least $640. (Because of the timing

of the IRS updates to this limit, this carryover amount may increase slightly. It will not decrease.)
To qualify for carryover, you must either:

- Enroll in an FSA the following plan year to carry over any amount up to $640, or
- Have at least $120 remaining in your account to carry over any balance between $120 and $640 (you do not need to reenroll for this option).

Eligible funds will be rolled over in late January 2026. Any amount over $640 will be forfeited to the Health Care Authority, per IRS guidelines. (Because of the timing of the IRS updates to this limit, we cannot include all updates in this guide. This carryover amount may increase slightly. It will not decrease.)

$250 FSA contribution for represented employees

You may be eligible to receive a $250 FSA contribution through your collective bargaining agreement. You are likely to receive this contribution if you meet the following criteria:

- You are employed in a PEBB benefits-eligible position on January 1, 2025.
- You are a union-represented employee participating in PEBB Program benefits.
- Your union is part of the Health Care Coalition described in **RCW 41.80.020(3)**.
- Your rate of pay on November 1, 2024 is $60,000 or less for a full-time equivalent position.
- If you work part-time, you may still qualify for this contribution if your position would provide a salary of $60,000 or less as full-time. For example, if you earn $30,000 and work 20 hours per week, your full-time salary would be $60,000 and you would still qualify.
- You are not enrolled in a CDHP with an HSA.
- You met the other eligibility criteria as described in the Health Care Coalition Agreement, including PEBB Program eligibility requirements and eligible medical plan enrollment.

This money is an employer-paid benefit; it **will not come** out of your paycheck. Other eligibility criteria apply. If you have questions, contact your payroll or benefits office.

Note: If your spouse is enrolled in a CDHP with an HSA, you cannot use the FSA funds due to IRS rules. If you have questions about your eligibility to use these funds, contact your payroll or benefits office.

How to receive the contribution

- If you are eligible for this contribution, you will receive it automatically from your employer. If you do not enroll in an FSA for 2025, Navia Benefit Solutions will open an account in your name and send you a welcome letter and a debit card loaded with $250 (the debit card will be sent separately in an unmarked envelope for security purposes). Use the debit card for eligible health care expenses.
- If you enroll in an FSA for 2025, the $250 contribution will be added to your account with Navia Benefit Solutions in January 2025.

If you enroll in a CDHP with an HSA for 2025 and still have at least $120 of this benefit left over from the previous plan year, the leftover amount will be converted to a Limited Purpose FSA. This limitation is an IRS rule. You will also forfeit this benefit if you waive PEBB medical coverage for 2025, 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 a joint income tax return) or $2,500 annually (for each married person filing a separate income tax return). The minimum DCAP annual contribution is $120.

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, 2025. DCAP does not offer a carryover feature. Submit all claims for DCAP expenses to Navia Benefit Solutions for reimbursement by March 31, 2026. Money left in your account after that date will be forfeited to the Health Care Authority.

DCAP works like a bank account. Reimbursement cannot exceed the account balance at the time you submit your claim, and you will not receive reimbursement until after the service has been provided.

When can I enroll?

You can enroll in the 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

How do I enroll?

Before you enroll, make sure to review the following on the Navia member portal at **pebb.naviabenefits.com**:

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

During the PEBB Program's annual open enrollment, enroll in the FSA, Limited Purpose FSA, or DCAP on the Navia member portal or by downloading the *PEBB Open Enrollment* form at **pebb.naviabenefits.com**. Online enrollment is available only during the annual open enrollment period.

To enroll in these benefits when you are newly eligible for PEBB benefits, download and print the *Midyear Enrollment Form for 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. **Exception**: 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 an FSA in the same plan year. If you do, you will only be enrolled in a CDHP with an HSA. However, you can enroll in a CDHP with an HSA and a Limited Purpose FSA in the same plan year. You also cannot enroll in the FSA and the Limited Purpose FSA in the same plan year. If you are not enrolled in a CDHP with an HSA and you elect both an FSA and a Limited Purpose FSA, you will be enrolled in the FSA.

Call Navia Benefit Solutions at 1-800-669-3539 if you have questions.

When can I change my election?

You can enroll in or change your election in an FSA, Limited Purpose FSA, or DCAP 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. **Exception**: Washington State University and University of Washington employees must submit the change through Workday.

SmartHealth

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.

For full details about eligibility, the $125 wellness incentive, and additional support, see **hca.wa.gov/pebb-smarthealth**.

Who is eligible?

You and your spouse or state-registered domestic partner enrolled in PEBB medical coverage can use SmartHealth. Only you (the employee) can qualify for the SmartHealth wellness incentive. If you waive PEBB medical coverage, you can still access SmartHealth, but you cannot qualify for the SmartHealth wellness incentive.

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?

The $125 wellness incentive you qualify for in 2025 will be applied by the end of January 2026, if you are still eligible to participate in the PEBB wellness incentive program and are enrolled in PEBB medical coverage on January 1, 2026.

How do I qualify for the wellness incentive each year?

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

- Sign in to SmartHealth at **smarthealth.hca.wa.gov** or on the *Wellness At Your Side* app. If you need help logging in, visit **hca.wa.gov/accessing-smarthealth**.
- Complete the SmartHealth well-being assessment. It takes about 15 minutes and is worth 800 points.
- 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, 2025.
- If you are a new subscriber with a PEBB medical coverage effective date of January through September 2025, your deadline is November 30, 2025.
- If you are a new subscriber with a PEBB medical coverage effective date of October through December 2025, your deadline is December 31, 2025.

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 request to waive the requirement.

To request an alternative requirement, call SmartHealth Customer Service at 1-800-947-9541. 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 at 1-800-947-9541, Monday through Friday, 6 a.m. to 6 p.m. (Pacific) to learn how you can participate.

Who can I contact for more help?

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

- Call 1-800-947-9541, Monday through Friday, 6 a.m. to 6 p.m. (Pacific)
- Online at **smarthealth.hca.wa.gov/contact**.

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 *Life, home, auto, AD&D, LTD, FSA, & DCAP benefits* on the HCA website at **hca.wa.gov/pebb-employee** or on the Liberty Mutual website at **libertymutual.com/pebbsae**.
- 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.

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)

Washington

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

Oregon

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

It's important to 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 your health plans can send information to the right address.

Let your payroll or benefits office know of any address changes. (You can't update your mailing address in Benefits 24/7.)

HCA | **Health Care Authority**
Public Employees Benefits Board