2024 PEBB Continuation Coverage (Employer Group Ended Participation) Election/Change

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Use this form if you are a retired public or school employee of an employer group and you lost eligibility for PEBB retiree insurance coverage due to your employer group ending participation in Public Employee Benefits Board (PEBB) or School Employee Benefits Board (SEBB) insurance coverage. We must receive this form no later than your election period, which is **60 days** after your employer group ended their participation.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after the election period ends. We will not enroll you until we receive your first payment. If HCA does not receive your first payment during this 45-day timeframe, you will not be enrolled and you will lose your rights for PEBB Continuation Coverage (Employer Group Ended Participation). Premiums and applicable premium surcharges are due from the date your employer group ended their participation.

This form replaces all *PEBB Continuation Coverage (Employer Group Ended Participation) Election/Change* forms previously submitted. Complete the entire form, including the dependent section for any children you want to cover.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in dark ink and use all capital lettering in the spaces provided. Example J O H N

All forms and documents are available on HCA's website at **hca.wa.gov/pebb-continuation** under *Forms & publications* or by calling 1-800-200-1004 (TRS: 711).

⚠ Remember to read and sign Section 7.

1 Subscriber

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

[1] *This field is required for health care services.*

[2] *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

⚠ You must report a new address to the PEBB Program **no later than 60 days** after you move. You can report it using this form, or send a written request by mail or secure message (see page XX), or call 1-800-200-1004 (TRS: 711).

Date employer group ended participation

Are you or any eligible dependents already enrolled in PEBB insurance coverage under another account?

☐ Yes ☐ No

Enroll in coverage	**Add coverage**	**Terminate coverage**
Select all that apply.	Select all that apply.	Select all that apply.
☐ Medical ☐ Dental	☐ Medical ☐ Dental	☐ Medical ☐ Dental

Termination date:

If terminating coverage, include reason

Are you enrolled in Medicare Part A or Part B?

⚠ If you were previously enrolled in PEBB retiree term life insurance and you wish to convert it, call MetLife at 1-866-548-7139

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective date shown on your Medicare card

Part B (medical)

☐ Yes ☐ No If Yes, enter effective date shown on your Medicare card

Medicare number:

If Yes, proof is required. Attach a copy of your entire Medicare benefit verification letter or a copy of your Medicare card to this form. Write your last name and the last four digits of your Social Security number on the copy.

☐ I am in the process of enrolling in Medicare Part A and Part B. I will submit proof after I receive my Medicare benefit verification letter or Medicare card.

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Subscriber's last name | Social Security number

These premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage.

The PEBB Program requires a $25-per-account tobacco use premium surcharge, in addition to your monthly medical premium, if you or a dependent age 13 or older enrolled on your PEBB medical plan uses a tobacco product. 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 and prescription nicotine replacement products.

If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the PEBB Program Administrative Policy 91-1 at **hca.wa.gov/pebb-rules**.

The premium surcharge will not apply if you and any enrolled dependents who use tobacco products meet these requirements: Age 18 and older – enrolled in the free tobacco cessation program through your SEBB medical plan (visit HCA's website at **hca.wa.gov/tobacco-free-sebb**). Age 13 to 17 – accessed resources for teens at **teen.smokefree.gov**).

To change your attestation, use the *PEBB Premium Surcharge Attestation Change form.*

Does the tobacco use premium surcharge apply to you? Check one:

- ☐ No, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- ☐ Yes, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months.
- ☐ No, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted above.

Subscriber's last name | Social Security number

2 Spouse or state-registered domestic partner (SRDP)

List an eligible spouse or SRDP you wish to cover or remove from coverage. State-registered domestic partner is defined in WAC 182-12-109. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law.

Your spouse or SRDP cannot be enrolled in two PEBB medical or dental accounts at the same time.

If enrolling an SRDP, also submit a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP due to a special open enrollment event if they are not a tax dependent.

You must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-continuation**.

Relationship to subscriber

- Spouse: date of marriage
- SRDP: date registered

Social Security number | Date of birth | Sex assigned at birth[1] Male Female

Last name | Gender identity[2] Male Female X

First name | Middle initial | Suffix

Street address (if different from subscriber)

Address line 2 | City | State

ZIP/Postal code | County

Enroll in coverage (Select all that apply.)

Medical Dental

Add coverage (Select all that apply.)

Medical Dental

Terminate coverage (Select all that apply.)

Medical Dental Termination date

If terminating coverage, include reason

⚠ If removing a spouse due to divorce, attach a copy of the divorce decree. If removing an SRDP due to dissolution, attach a copy of the dissolution of state-registered domestic partnership.

[1] This field is required for health care services.

[2] Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

Subscriber's last name

Social Security number

Is this person enrolled in Medicare Part A or B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card

Medicare number

If Yes, proof is required. Attach a copy of their Medicare card to this form. Write your full name and last four digits of your Social Security number on the copy.

☐ They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their Medicare benefit verification letter or Medicare card.

⚠ Premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge, in addition to your monthly premium.

Does the tobacco use premium surcharge apply to you? Check one:

☐ No, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ Yes, I am subject to the $25 premium surcharge. This person has used tobacco products in the past two months.

☐ No, I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources noted on page 3.

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Subscriber's last name | Social Security number

Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage.

The PEBB Program requires a $50 premium surcharge, in addition to your monthly medical premium, if you enroll your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic.

Answer these questions:	**Yes**	**No**
1. Are you covering your spouse or SRDP in a PEBB medical plan under your account in 2024?	✓	■
2. Will they be eligible for medical coverage through their employer in 2024? (If they will not be employed in 2024, answer No.)		
3. Will their employer offer at least one medical plan that serves their county of residence in 2024?		
4. Have they chosen not to enroll in their employer's medical (including SEBB) coverage in 2024?		
5. Will the coverage offered by their employer in 2024 not be through the PEBB Program or a TRICARE plan? Answer Yes if their employer does not offer PEBB coverage or a TRICARE plan. Answer No if their employer offers PEBB coverage or a TRICARE plan.		
6. Will their share of the medical premium through their employer be less than $117.81 per month in 2024?		

If you answered No to any of these questions, check No below. You will not be charged the surcharge.
If you answered Yes to all of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:

a. Serve their county of residence.

b. Have a monthly premium of less than $117.81 per month for the employee.

2. Use the SBC information to answer the questions in the *PEBB Spousal Plan Calculator* online tool (address at bottom of page). You will get a Yes or No response from the calculator. Enter this response below.

⚠ If you check Yes or leave this section blank, you will be charged the $50 monthly premium surcharge.

Does the spouse or SRDP coverage premium surcharge apply to you? Check one:

☐ No, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ Yes, I am subject to the $50 premium surcharge. I completed the *PEBB Spousal Plan Calculator* online.

☐ No, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator* online.

☐ The PEBB Program to help determine if the premium surcharge applies. I am submitting a printed PEBB Spousal Plan Calculator. The PEBB Program will use this to help determine whether my spouse's or SRDP's employer-based group medical is comparable to UMP Classic and whether I am subject to this premium surcharge.

⚠ The *PEBB Spousal Plan Calculator* is available at **hca.wa.gov/pebb-continuation** under ***Surcharges.*** To change your previous attestation, use Benefits 24/7 or the *PEBB Premium Surcharge Attestation Change Form.*

Subscriber's last name

Social Security number

3 Dependents

List eligible dependents you wish to cover or remove from coverage. Enrolled children must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday (regardless of marital status, student status, or eligibility for coverage under another plan) and children age 26 or older with a disability.

Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time.

You must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-continuation**.

If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, also attach a ***PEBB Declaration of Tax Status*** to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP's child due to a special open enrollment event if they are not a tax dependent.

If enrolling an extended dependent, also attach a *PEBB Extended Dependent Certification* and a valid court order showing legal custody or guardianship.

If enrolling a child with a disability age 26 or older, submit a *PEBB Certification of a Child with a Disability.*

Relationship to subscriber

⚠ If adding more than one dependent child, copy pages 7 and 8 and attach them to this form.

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability age 26 or older

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

[1] *This field is required for health care services.*

[2] *Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit* **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Enroll in coverage

Select all that apply.

☐ Medical ☐ Dental

Add coverage

Select all that apply.

☐ Medical ☐ Dental

Terminate coverage

Select all that apply.

☐ Medical ☐ Dental

Termination date

If terminating coverage, include reason

Is this person enrolled in Medicare Part A or B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on your Medicare card

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on your Medicare card

Medicare number

If Yes, proof is required. Attach a copy of their Medicare card to this form. Write your full name and last four digits of your Social Security number on the copy.

Tobacco use premium surcharge

Response required for dependents age 13 or older enrolling in medical coverage. See page 3 for instructions on how to respond.

⚠ If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the tobacco use premium surcharge apply to you? Check one:

☐ No, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ Yes, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months. (If this is a change to a previous attestation, submit the *PEBB Premium Surcharge Attestation Change Form*.)

☐ No, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources noted on page 3.

Subscriber's last name

Social Security number

4 Changes to an existing account

Are you making changes to an existing account?

☐ Yes If Yes, check all changes that apply in the sections below.

Date of event/change:

☐ No If No, go to Section 5.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for you or your enrolled dependents

✔ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child), the PEBB Program must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility. Coverage will be terminated the last day of the month of loss of eligibility.

If applicable, provide your former dependent's new address.

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Changes you can make during annual open enrollment

All changes become effective January 1 of the following year. Check the box next to the changes requested.

☐ Add dependents

☐ Remove dependents

☐ Add or change medical plan

☐ Add or change dental plan

Subscriber's last name | Social Security number

Changes you can make if an event creates a special open enrollment (SOE)

The PEBB Program only allows changes outside of annual open enrollment when an event creates an SOE. The change must be allowed under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with an SOE event for the subscriber, the subscriber's dependents, or both. To disenroll from a Medicare Advantage plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c).

The PEBB Program must receive this form and proof of the event **no later than 60 days** after the event occurs.

To enroll a newborn or child whom you (the subscriber) have adopted or have assumed legal responsibility for support ahead of adoption, notify the PEBB Program by submitting the required forms as soon as possible. Doing so will ensure timely payment of claims. If adding the child increases the premium, we must receive the required forms **no later than 60 days** after the date of the birth or adoption, or the date the legal responsibility is assumed ahead of adoption.

In most cases, the enrollment or change will be effective the first day of the month after the date of the event or the date we receive the form, whichever is later. Exceptions apply for new enrollment in a PEBB Medicare Supplement plan or a Medicare Advantage plan.

Note: A health plan change is not allowed when adding a state-registered domestic partner or their child if they are not a tax dependent.

Check the box next to the applicable special open enrollment events below.

The following events allow a subscriber to add dependents or change medical or dental plans.

- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *PEBB Extended Dependent Certification* and *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes, available at **hca.wa.gov/pebb-continuation**.
- ☐ Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- ☐ Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan.
- ☐ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ☐ Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- ☐ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for support in anticipation of adoption. If enrolling a state-registered domestic partner or their child, you must also submit a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

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Subscriber's last name

Social Security number

The following events allow a subscriber to enroll dependents.

- Subscriber or dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent moves from another country to the United States, or from the United States to another country, and the move resulted in the dependent losing their health insurance.
- Subscriber's dependent loses eligibility for Medicare.

The following events allow a subscriber to change medical or dental plans.

- Subscriber or dependent has a change in residence that affects health plan availability. **Note:** If the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or the dependent's new residence, the subscriber may select a new dental plan.
- Subscriber or dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).
- Subscriber or dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).

The following event allows a subscriber to change medical plans.

- Subscriber or dependent enrolls in Medicare or loses eligibility under Medicare or enrolls or terminates enrollment in a Medicare Advantage Prescription Drug plan or a Medicare Part D plan.

5 Medical plan selection

Choose one medical plan. Contact the plans with questions about benefits and providers. Their contact information is on page 17.

Kaiser Foundation Health Plan of the Northwest[1,2] (Kaiser Permanente NW)

- ☐ Kaiser Permanente NW Classic[2]
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[2,5]
- ☐ Kaiser Permanente NW Senior Advantage (MA)[2]

Kaiser Foundation Health Plan of Washington[1] (Kaiser Permanente WA)

- ☐ Kaiser Permanente WA Classic[6]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA Medicare Plan[3,4]
- ☐ Kaiser Permanente WA SoundChoice[6]
- ☐ Kaiser Permanente WA Value[6]

Premera Blue Cross

- ☐ Medicare Supplement Plan G[7]

Uniform Medical Plan (UMP), administered by Regence BlueShield and Washington State Rx Services

- ☐ UMP Classic
- ☐ UMP Select[5]
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus–Puget Sound High Value Network[1,5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[1,5]

UnitedHealthcare Medicare Advantage Prescription Drug

- ☐ UnitedHealthcare PEBB Balance[8] (MAPD)
- ☐ UnitedHealthcare PEBB Complete[8] (MAPD)

1. These plans have specific service areas. If you move out of the service area and your plan is no longer available, you must select a new plan. If you do not, the PEBB Program will enroll you in a plan. You must notify the PEBB Program of your new address and submit any plan change request **no later than 60 days** after you move.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. These Medicare plans are available only in certain counties. You will be enrolled in either KPWA Original Medicare or KPWA Medicare Advantage (MA), depending on the county you live in. See ***Medical plans available by county*** at **hca.wa.gov/pebb-continuation**.
4. If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.
5. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.
6. Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.
7. Also submit Form B to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.
8. These plans are only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.

6 Dental plan selection

Choose one dental plan. Before you enroll, make sure the provider you want to use accepts the specific plan and group you choose. Plan contact information is on page 17.

Preferred Provider Organization (PPO)

☐ **Uniform Dental Plan** (Group #03000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time.

Managed-Care Plans (limited network)

☐ **DeltaCare** (Group #03100), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network.

☐ **Willamette Dental Group of Washington** (Group WA82), administered by Willamette Dental of Washington, Inc. You will select and receive care from a primary care dental provider in the Willamette Dental Group network.

Subscriber's last name

Social Security number

7 Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans. My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible.

To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of PEBB insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB health plan coverage. The PEBB Program will verify eligibility for my dependents and me. If we do not qualify, I will receive a refund.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge, in addition to my monthly medical premium.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

If I am electing to enroll in a Kaiser Medicare Advantage (MA) or UnitedHealthcare Medicare Advantage Prescription Drug (MAPD) plan, I certify that I have read and understand the Statement of Understanding in Section 8. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage contract. I understand that enrollment in a Kaiser MA or UnitedHealthcare MAPD plan may not be retroactive. If I elect to enroll in a Kaiser MA plan, and the required forms are received by the PEBB Program after the date PEBB health plan coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser plan during the gap month(s) prior to when Kaiser MA coverage begins. If I elect to enroll in a UnitedHealthcare MAPD plan, and the required forms are received by the PEBB Program after the date PEBB health plan coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare MAPD plan begins. **This form cannot be signed more than 90 days before the effective date of this coverage.** (See Statement of Understanding in Section 8 for coverage effective date.)

I understand that my enrollment and my dependents' enrollment are subject to me abiding by all applicable deadlines and PEBB Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my benefits selection being rejected. This form replaces all *PEBB Continuation Coverage (Employer Group Ended Participation) Election/Change* forms previously submitted to the PEBB Program.

Sign, date, and keep a copy for your records.

Subscriber's signature

Date

Spouse or SRDP signature (only required for MA or MAPD plan)

Date

Dependent signature (only required for MA or MAPD plan)

Date

Form return

Submit form and documentation using one of the methods below.

Mail to:

Washington State Health Care Authority
PO Box 42684
Olympia, WA 98504-2684

Fax to:

360-725-0771

If payment is enclosed, make it payable to Health Care Authority and mail to:

Washington State Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Secure message:

Send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

8 Medicare Advantage and Medicare Advantage Prescription Drug plan enrollment only

This section applies only to subscribers enrolling in a Medicare Advantage (MA) or Medicare Advantage Prescription Drug (MAPD) plan. We offer four MA or MAPD plans: Kaiser Permanente of the Northwest Senior Advantage, Kaiser Permanente of Washington Medicare Advantage Plan, UnitedHealthcare PEBB Balance, and UnitedHealthcare PEBB Complete. If you or your dependent are not enrolling in one of these plans, skip this section and continue to page 16.

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected in Section 5 of this form, as long as this form is signed prior to the effective date, all medical services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my Medicare Advantage plan when required will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage plan will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including — but not limited to — physicians, hospitals, insurance companies, and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision or coordination of benefits or to professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective the day PEBB insurance begins, or the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later. If I submit this form during the PEBB Program's annual open enrollment (November 1–30), my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date of enrollment. I understand that when my coverage begins I must get all of my medical (and prescription drug, if applicable) benefits from the plan. Note: Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so they may begin using the plan services as of the effective date of enrollment.

Please contact the plans if you need information in another language or format.

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and UnitedHealthcare are Medicare Advantage plans and have contracts with the federal government. Enrollment depends on contract renewal.

2024 PEBB Continuation Coverage (Employer Group Ended Participation) Election/Change

Subscriber's last name

Social Security number

Medicare Advantage plan enrollment supplemental demographic information

Providing this demographic information is **optional** and will not affect your enrollment in a Medicare Advantage plan.

Preferred language other than English

- Spanish
- Other (please indicate):
- No selected preference

Preferred accessible format

- Braille
- Large print
- Audio CD
- No selected preference

Subscriber

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Spouse or SRDP

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Dependent

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Subscriber's last name

Social Security number

PEBB Program contractors

⚠ Do not send forms to the addresses below. This information is only for your reference.

Medical

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2023
503-813-2800 (TRS: 711)

Kaiser Foundation Health Plan of Washington
1300 SW 27th St.
Renton, WA 98057
1-866-648-1928
TTY: 1-800-833-6388

Premera Blue Cross
PO Box 327, MS 295
Seattle, WA 98111
425-918-4000 (TRS: 711)

Uniform Medical Plan, administered by Regence BlueShield (for medical benefits questions)
PO Box 1106
Lewiston, ID 83501-1106
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

UnitedHealthcare
185 Asylum Ave.
Hartford, CT 06103
1-855-873-3268

Dental

DeltaCare, administered by Delta Dental of Washington
400 Fairview Ave. N, Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan, administered by Delta Dental of Washington
400 Fairview Ave. N, Suite 800
Seattle, WA 98109-5371
1-800-537-3406
TTY: 1-800-833-6384

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-433-6825 (TRS: 711)

HCA complies with all applicable federal and Washington State civil rights lawas and is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-200-1004 (TRS: 711) or visit **hca.wa.gov/about-hca/nondiscrimination-statement**.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, go to the HCA website at **hca.wa.gov/pebb-continuation**.