You are receiving this booklet because your Public Employees Benefits Board (PEBB) health coverage recently ended. This booklet explains how you and your dependents can continue your PEBB health coverage.

To continue PEBB health coverage, you must complete the enclosed form(s) and follow the instructions. **You have 60 days after the mailing date on this booklet to elect to continue your PEBB health coverage and submit your form(s) to the PEBB Program. To continue life insurance, MetLife must receive your completed application no later than 31 days (or 60 days, if you are retiring) after your employer-paid coverage ends.**
For more information

This notice does not fully describe your rights for continuation coverage. You can find more information in the PEBB Initial Notice of COBRA and Continuation Coverage Rights on the PEBB website at www.hca.wa.gov/public-employee-benefits, or from the PEBB Program. Contact the PEBB Program for questions about eligibility.

Federal resources

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/agencies/esa or call 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov.

PEBB contact information

If you have questions about your rights to continuation coverage or PEBB eligibility, contact:

PEBB Benefits Services
1-800-200-1004 (toll free)
360-725-0440 (Olympia area)
Monday through Friday, 8 a.m. to 5 p.m.

www.hca.wa.gov/public-employee-benefits

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

Street address
(for hand deliveries):
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Notify the PEBB Program of address changes

To protect your rights and the rights of your family, you must keep the PEBB Program informed of address changes for each of your family members by calling us at 1-800-200-1004, or notifying us in writing. You should also keep a copy of any notices you send to the PEBB Program for your records.

Where to find PEBB laws and rules

You may find the Public Employees Benefits Board’s laws in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-08, 182-12, and 182-16 of the Washington Administrative Code (WAC). These are available at www.leg.wa.gov.

To obtain this document in another format (such as Braille or audio), call 1-800-200-1004. TTY users may call this number through the Washington Relay service by dialing 711.
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This booklet contains important information about your and your family members’ right to continue PEBB health coverage, as well as other health coverage options that may be available to you, including:

- In Washington State: Washington Health Benefit Exchange  
  www.wahbexchange.org or 1-855-923-4633 (TTY 1-855-627-9604)

- Outside Washington State: Health Insurance Marketplace  
  www.healthcare.gov or 1-800-318-2596 (TTY 1-855-889-4325)

You may be able to get coverage through the Washington Health Benefit Exchange or Insurance Marketplace that costs less than PEBB Continuation Coverage.

We use “you” in this notice to refer to each person who will lose PEBB coverage.

Please read the information in this notice very carefully before making a decision. If you choose to elect PEBB Continuation Coverage, you must complete the enclosed form(s) and submit them to the PEBB Program following the instructions in this booklet. You have:

- 60 days after the mailing date on this notice to elect continuation coverage.
- 31 days (or 60 days, if you are retiring) after employer-paid coverage ends to continue life insurance through portability or conversion coverage.

If you do not elect to continue coverage within these timelines, your PEBB coverage will end on the last day of the month you and your family member(s) stop being eligible. If elected, continuation coverage begins the first day of the month after the date your other coverage ended.

To help process your enrollment faster, you should send your first payment with your election form. However, you have up to 45 days after the date the PEBB Program receives your election form to submit your first payment. Important information about payment for continuation coverage is included in this booklet (see “When and how do I make payments?” on page 11). If you do not make your premium payment by the deadline, you forfeit your right to enroll in PEBB Continuation Coverage.

Federal law requires that most group health plans (including the Public Employees Benefits Board [PEBB] Program) give employees and their families the opportunity to continue their health coverage when they lose coverage under an employer’s plan.

PEBB Continuation Coverage provides the same medical and dental benefits, choice of health plans, and cost-sharing (including annual deductibles, copays, and coinsurance) available to other PEBB enrollees who aren’t enrolled in continuation coverage.

Each person who elects PEBB Continuation Coverage will have the same rights as other PEBB enrollees, including annual open enrollment and special open enrollment rights.
How to Continue PEBB Coverage

What continuation coverage options are available?
The PEBB Program offers one or more ways for you and your family members, if eligible, to continue PEBB health plan coverage.

- **Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage**—A temporary extension of PEBB health plan coverage available to PEBB members defined as qualified beneficiaries under federal rules. For eligibility information and forms, see Appendix A.

- **PEBB Continuation Coverage**—A temporary extension of PEBB health plan coverage as an alternative for PEBB members who are not qualified beneficiaries under COBRA coverage and for those individuals in specific situations. For eligibility information and forms, see Appendix A (COBRA and PEBB Continuation Coverage) or Appendix B (PEBB Continuation Coverage [Leave Without Pay]).

Premiums for these options above are on pages 13–15. To enroll, see “How do I elect continuation coverage?” on this page.

The PEBB Program also offers **PEBB retiree insurance coverage**—A continuation of PEBB health plan coverage available to employees and survivors who meet retiree eligibility and enrollment requirements. See “What if I’m thinking of retiring?” on page 5.

Who can elect continuation coverage?
A “qualified beneficiary” (employee, spouse, or dependent child) who lost PEBB health plan coverage due to a qualifying event (see page 6) is entitled to elect COBRA coverage. State-registered domestic partners and their children who lost PEBB health plan coverage due to the same types of events are entitled to elect PEBB Continuation Coverage. For more information on who qualifies for COBRA coverage or PEBB Continuation Coverage, see Appendix A.

Each individual who loses their PEBB employer-based group health plan due to one of these events has an independent election right to COBRA coverage or PEBB Continuation Coverage. For example:

- The employee’s spouse or state-registered domestic partner may elect continuation coverage, even if the employee does not.
- The employee or their eligible spouse or state-registered domestic partner may elect continuation coverage for one, several, or all eligible dependent children. Certain newborns, newly adopted children, and children identified under a court order or National Medical Support Notice may also be eligible for continuation coverage.
- The employee or their eligible spouse or state-registered domestic partner may elect continuation coverage on behalf of their eligible children.

An employee who lost their PEBB employer-based group health plan due to the types of events listed in Appendix B may elect PEBB Continuation Coverage (LWOP) for themselves and eligible dependents. If an employee does not elect PEBB Continuation Coverage, their family members do not have independent election rights to PEBB Continuation Coverage (LWOP).

How do I elect continuation coverage?
To elect continuation coverage, send the completed form(s) in Appendix A or B of this booklet no later than 60 days after the mailing date on this notice.

Oral communications (in person or by telephone) and electronic communications (fax or email) are not acceptable methods of election and will not preserve your continuation coverage rights.

If you do not submit completed form(s) by the required deadline, your PEBB coverage will end on the last day of the month following the date of the qualifying event.
Mail to (if no payment enclosed):
PEBB Program
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Or bring to:
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

If sending payment with your form(s), see “When and how do I make payments?” on page 11 for information on where to submit your form(s) with payment.

Are there other coverage options besides COBRA or PEBB Continuation Coverage?

Yes. Instead of enrolling in COBRA or PEBB Continuation Coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as through a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less.

You should compare your other coverage options with COBRA or PEBB Continuation Coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose your employer-based group health plan, it’s important that you choose carefully between COBRA or PEBB Continuation Coverage and other coverage options.

What is the Health Insurance Marketplace?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing (your out-of-pocket costs for deductibles, coinsurance, and copays). You can see what your premium, deductibles, and out-of-pocket costs will be before you enroll. Through the Marketplace, you’ll also learn if you qualify for free or low-cost coverage from Medicaid (called Apple Health in Washington state) or the Children’s Health Insurance Program (CHIP). You can access the Marketplace for your state at www.healthcare.gov. (Washington State residents can access it at www.wahbexchange.org.)

Coverage through the Health Insurance Marketplace may cost less than COBRA or PEBB Continuation Coverage. Being offered COBRA or PEBB Continuation Coverage won’t limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You have 60 days from the time you lose your employer-based group health plan to enroll in the Marketplace (because losing your employer-based group health plan is a “special enrollment” event). After 60 days, your special enrollment period ends and you may not be able to enroll; take action right away. In addition, anyone can enroll in Marketplace coverage during its “open enrollment” period.

To find out more about enrolling in the Marketplace, such as when their next open enrollment period is and what you need to know about qualifying events and special enrollment periods, visit www.healthcare.gov.

Can I switch between COBRA coverage and the Marketplace?

If you sign up for COBRA or PEBB Continuation Coverage, you can switch to a Marketplace plan during the Marketplace’s open enrollment period. You can also end COBRA or PEBB Continuation Coverage early and switch to a Marketplace plan if you have another qualifying event that triggers a “special enrollment period” (such as marriage or birth of a child). Be careful, though—if you terminate COBRA or PEBB Continuation Coverage coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next Marketplace open enrollment period. You could end up without any health plan coverage and have to pay out-of-pocket costs in the interim.
Once your COBRA or PEBB Continuation Coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if the Marketplace open enrollment period has ended.

If you sign up for Marketplace coverage instead of COBRA or PEBB Continuation Coverage, you cannot switch to COBRA or PEBB Continuation Coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan) if you request enrollment no later than 30 days after your PEBB coverage ends because of a qualifying event.

If you or your dependent chooses to elect COBRA or PEBB Continuation Coverage, you will have another opportunity to enroll in the other group health plan under special enrollment rights no later than 30 days after losing your COBRA or PEBB Continuation Coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums.** Your previous plan can charge up to 102 percent of total plan premiums for COBRA coverage. The PEBB Program charges 100 percent of the total plan premiums for COBRA and PEBB Continuation Coverage, as well as applicable tobacco use and spouse or state-registered domestic partner coverage premium surcharges. Other options, like coverage under a spouse’s plan or through the Marketplace, may be less expensive.

- **Provider networks.** If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check if your current health care providers participate in a health plan you’re considering.

- **Drug formularies.** If you’re currently taking medications, a change in your health coverage may affect your medication costs—and in some cases, your medication may not be covered by another plan. You may want to check if your current medications are listed in drug formularies for other health coverage.

- **Severance payments.** If you lose your job and receive a severance package from your former employer, your former employer may offer to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the U.S. Department of Labor at 1-866-444-3272 to discuss your options.

- **Service areas.** Some plans limit their benefits to specific service or coverage areas. If you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- **Other cost-sharing.** In addition to premiums or contributions for health plan coverage, you probably pay copays, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check what the cost-sharing requirements are for other health care options. For example, one option may have lower monthly premiums, but a higher deductible and higher copayments.

What if I’m thinking of retiring?

PEBB retiree insurance is available to employees and their survivors who meet eligibility and enrollment requirements as described in WAC.

- Retiring employees, including employees applying for a disability retirement, as described in WAC 182-12-133, 182-12-171, and 182-12-211.

- Surviving dependents of emergency service personnel killed in the line of duty, as described in WAC 182-12-250.

- Surviving dependents of employees and retirees, as described in WAC 182-12-265.

If you are eligible for PEBB retiree insurance coverage, you can find information:


- By calling the PEBB Program at 1-800-200-1004 to request a Retiree Enrollment Guide.

The PEBB Program must receive your form requesting to enroll in or defer enrollment in PEBB retiree insurance coverage, no later than 60 days after your employer-paid or COBRA or PEBB Continuation Coverage ends.
What if I decline COBRA or PEBB Continuation Coverage?

If you reject or decline continuation coverage before the due date, you may change your mind as long as you mail or hand-deliver a completed form at the address on the form no later than 60 days from the date of this notice.

How long can I remain on continuation coverage?

Your “qualifying event” is the event that caused you to lose PEBB employer-based coverage. Your maximum coverage period is determined by your qualifying event.

COBRA and PEBB Continuation Coverage provide temporary health plan coverage. Maximum coverage periods are described below in this section. Coverage can end earlier, as described under “Can continuation coverage be terminated before the end of the maximum coverage period?” on page 10.

(1) When the qualifying event is a termination of employment or reduction in hours

Continuation coverage can generally last up to 18 months if you meet other requirements explained in this booklet. Additional coverage may be available under LWOP as described in number (3) of this section. Coverage may be extended due to disability or a second qualifying event as described in number (5) of this section.

(2) When the covered employee becomes entitled to Medicare within 18 months before their termination of employment or reduction in hours, it affects both the employee and their dependents

Employees

When the covered employee becomes entitled to Medicare less than 18 months before their termination of employment or reduction in hours, the employee may:

• Elect COBRA coverage, or
• Enroll in PEBB retiree insurance coverage, if the employee is an eligible retiree as defined in WAC 182-12-171.

When the covered employee becomes entitled to Medicare after enrolling in COBRA coverage, the employee loses their right to COBRA coverage. However, the employee may:

• Continue health plan coverage for the remainder of the COBRA coverage period through PEBB Continuation Coverage OR
• Enroll in PEBB retiree insurance coverage, if the employee is an eligible retiree as defined in WAC 182-12-171.

Dependents

When the covered employee becomes entitled to Medicare less than 18 months before their termination of employment or reduction in hours, the employee’s spouse or state-registered domestic partner and dependent children become entitled to PEBB Continuation Coverage for up to 36 months measured from the date of the employee’s Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before their termination of employment or reduction in hours, and the employee’s covered dependents elect COBRA or PEBB Continuation Coverage, the dependents may continue coverage 28 more months after the COBRA enrollment date. (The 36 months allowed under PEBB Continuation Coverage, minus the eight months the employee was entitled to Medicare before retiring, equals 28 months left.)

This special Medicare extending rule for a spouse and dependent child is available only if the covered employee becomes entitled to Medicare 18 months or less before termination of employment or reduction of hours.

(3) When an employee is on approved leave or when employment ends due to a layoff

(a) For the following events, PEBB Continuation Coverage (LWOP) generally can last for a maximum of 29 months as described in WAC 182-12-133(1):

• The employee is on authorized leave without pay.
• The employee is on approved educational leave.
• The employee is receiving time-loss benefits under workers’ compensation.
• The employee is called to active duty in the uniformed services, as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA).
• The employee is applying for disability retirement.
• The employee’s employment ends due to layoff as described in WAC 182-12-109.

The employee may continue:
• Medical
• Dental
• Life insurance
• Long-term disability insurance (only if employee is on USERRA or educational leave)

An employee who is no longer eligible for coverage as described above, but who has not used up the maximum number of months allowed under COBRA, may continue medical, dental, or both for the remaining difference in months allowed under COBRA. However, life and long-term disability insurance cannot be continued under COBRA.

(b) For a faculty employee who is between periods of eligibility, PEBB Continuation Coverage (LWOP) generally can last for a maximum of 12 months as described in WAC 182-12-142. The faculty employee may continue:
• Medical
• Dental
• Life insurance

Faculty who are no longer eligible for coverage as described above, who have not used up the maximum number of months allowed under COBRA, may continue medical, dental, or both for the remaining difference in months allowed under COBRA. However, life and long-term disability insurance cannot be continued under COBRA.

(c) For a seasonal employee who is between periods of eligibility, PEBB Continuation Coverage (LWOP) generally can last for a maximum of 12 months as described in WAC 182-12-142. Seasonal employees may continue:
• Medical
• Dental
• Life insurance

Seasonal employees who are no longer eligible for coverage as described above, who have not used up the maximum number of months allowed under COBRA, may continue medical, dental, or both for the remaining difference in months allowed under COBRA. However, life and long-term disability insurance cannot be continued under COBRA.

(d) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward insurance coverage, PEBB Continuation Coverage (LWOP) generally can last for a maximum of 18 months as described in WAC 182-12-141. An employee who reverts for reasons other than a layoff may continue:
• Medical
• Dental
• Life insurance

An employee who reverts for reasons other than a layoff and who is no longer eligible for coverage as described above, but who has not used up the maximum number of months allowed under COBRA, may continue medical, dental, or both for the remaining difference in months allowed under COBRA. However, life and long-term disability insurance cannot be continued under COBRA.

(e) For an employee awaiting hearing of a dismissal action, PEBB Continuation Coverage (LWOP) generally can last until the dismissal is upheld or overturned for up to 29 months as described in WAC 182-12-148. If the dismissal is upheld and the employee is no longer eligible for PEBB Continuation Coverage (LWOP), all insurance coverage will end at the end of the month in which the decision is entered or the date to which the premiums have been paid, whichever is later. An employee awaiting hearing of a dismissal action may continue:
• Medical
• Dental
• Life insurance

(continued)
Employees whose dismissal is upheld and are no longer eligible as described above, and who have not used up the maximum number of months allowed under COBRA, may continue medical, dental, or both for the remaining difference in months allowed under COBRA. However, life and long-term disability insurance cannot be continued under COBRA.

(4) **When the qualifying event is death, divorce, termination of a state-registered domestic partnership, or child’s loss of eligibility**

(a) When PEBB coverage is lost due to the death of the employee, the covered employee’s divorce, or the dependent child losing eligibility (as described in WAC 182-12-260), COBRA coverage can last up to 36 months.

(b) When PEBB coverage is lost due to the death of the employee, the covered employee’s termination of a state-registered domestic partnership, or a dependent child of a state-registered domestic partnership is no longer eligible (as described in WAC 182-12-260), PEBB Continuation Coverage can last up to 36 months.

(c) If you are a surviving spouse, state-registered domestic partner, or dependent child of an emergency service worker who was killed in the line of duty, you may be eligible to enroll in PEBB retiree insurance if you meet both the procedural and eligibility requirements as outlined in WAC 182-12-250.

(5) **When COBRA coverage and PEBB Continuation Coverage may be extended**

You may be able to extend the maximum 18-month period of COBRA or PEBB Continuation Coverage if you or a qualified dependent becomes disabled or a second qualifying event occurs. You must notify the PEBB Program no later than 60 days after a disability or a second qualifying event to extend the continuation coverage period. If you fail to provide the notice within the timeframe allowed, you will lose the right to extend continuation coverage.

(a) **Disability**

If the Social Security Administration determines that any qualified beneficiary is disabled, you and all of the qualified beneficiaries in your family may be entitled to receive up to 11 months of additional continuation coverage (for a total of 29 months). This extension is available only to those individuals who are receiving continuation coverage because of the covered employee’s termination of employment or reduction of hours.

The disability must have started before the 61st day after the covered employee’s termination of employment or reduction in hours and must last at least until the end of the 18-month continuation coverage period. The disability extension is available only if you notify the PEBB Program in writing and submit a 2017 COBRA Election/Change (Continuation of Coverage) form and a copy of the disability award letter from the Social Security Administration no later than 60 days after the last of the following events:

- The date of the covered employee’s termination of employment or reduction of hours.
- The date the qualified beneficiary loses (or would lose) coverage under PEBB rules as a result of the covered employee’s termination of employment or reduction of hours.
- The date the PEBB Program mails a PEBB Continuation Coverage Election Notice to the qualified beneficiary, informing the beneficiary of his or her responsibility and the procedures to notify the PEBB Program.
- The date of the Social Security Administration's disability determination.

You must also provide this notice within 18 months after the covered employee’s termination of employment or reduction of hours to be entitled to a disability extension. If the notice procedures in this booklet are not followed or if the notice is not submitted to the PEBB Program during the 60-day notice period and within 18 months after
the covered employee’s termination of employment or reduction of hours, there will be no disability extension of COBRA coverage or PEBB Continuation Coverage.

(b) **Second qualifying event extension of coverage**

If your qualified beneficiary experiences a second qualifying event while receiving 18 months of continuation coverage (or 29 months, if the second event occurs during a disability extension), he or she may be entitled to receive up to an additional 18 months of continuation coverage, for a maximum of 36 months of continuation coverage.

To qualify for a second qualifying event extension of coverage, the second event must:

- Occur during the initial continuation coverage period resulting from termination of employment, reduction of hours, or the retiree’s loss of PEBB retiree insurance due to termination of employer group participation with PEBB health coverage; **AND**
- Cause a qualified beneficiary to lose coverage under PEBB Program rules if the first qualifying event had not occurred. This includes:
  - The employee’s or retiree’s death.
  - Divorce.
  - Termination of a state-registered domestic partnership.
  - The dependent child’s loss of eligibility for coverage under PEBB rules.

Note: The second qualifying event extension is not available when an employee becomes entitled to Medicare after his or her termination of employment or reduction of hours. However, the employee and covered dependents may remain enrolled in COBRA for the duration of the COBRA coverage period.

Eligible dependents must have been covered under the plan on the day before the first qualifying event. Newborns or adopted children added after the first qualifying event are also eligible for the second qualifying event extension.

To request a second qualifying event extension, you or your qualified beneficiary must notify the PEBB Program in writing and provide notice of a second qualifying event within the required deadline noted below.

This notice of a second qualifying event must be submitted **no later than 60 days** after the later of:

- The date of the second qualifying event.
- The date the qualified beneficiary would lose coverage under PEBB rules as a result of the second qualifying event.

It must include:

- The second qualifying event and the date it happened.
- The names and addresses of all qualified beneficiaries who are receiving continuation coverage.
- Proof of the second qualifying event.

(c) **When PEBB Continuation Coverage (LWOP) counts toward your maximum COBRA coverage period**

If you are eligible for and elect to continue coverage under PEBB Continuation Coverage (LWOP), the maximum number of months allowed under COBRA coverage are included in the maximum number of months allowed under PEBB Continuation Coverage (LWOP). For example, if you are eligible for 29 months of PEBB Continuation Coverage (LWOP) PEBB rules, and eligible for 18 months of COBRA coverage because of your qualifying event, the first 18 months of PEBB Continuation Coverage (LWOP) will satisfy the 18-month COBRA coverage period. Likewise, if you are eligible for 12 months of PEBB Continuation Coverage (LWOP) and eligible for 18 months of COBRA coverage because of your qualifying event, you may switch to COBRA coverage for six months after the 12 months of PEBB Continuation Coverage (LWOP), for a total of 18 months of medical and/or dental continuation coverage.

(continued)
Can continuation coverage be terminated before the end of the maximum coverage period?

(1) **Automatic termination before the end of the maximum coverage period**

Continuation coverage will automatically be terminated before the end of the maximum period if:

(a) Any required premium (including applicable surcharges) is not paid on time.

(b) The employer stops providing any group health plan for its employees (this is particularly important for people eligible through an employer group such as a political subdivision).

Continuation coverage may also end for any reason coverage would end for any other PEBB enrollee (such as fraud).

Once your coverage ends, you are not eligible to reenroll in COBRA.

(2) **Medicare entitlement or other group health coverage**

COBRA coverage will end automatically if you become entitled to Medicare after you enroll. However, you may continue your health coverage for the remainder of your COBRA coverage period through PEBB Continuation Coverage.

If you elect COBRA or PEBB Continuation Coverage, your coverage will also end early if you enroll in other group health coverage.

You must notify the PEBB Program in writing **no later than 60 days** after electing COBRA or PEBB Continuation Coverage, if you or a qualified dependent becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health coverage.

There are limitations on plans imposing pre-existing exclusions, and such exclusions are prohibited under the Affordable Care Act.

**Note:** Qualified beneficiaries who are entitled to elect COBRA or PEBB Continuation Coverage may do so even if they have other group coverage or are entitled to Medicare benefits before the date on which COBRA or PEBB Continuation Coverage is elected.

(3) **A qualified beneficiary stops being disabled**

If the Social Security Administration determines that a qualified beneficiary is no longer disabled, you must notify the PEBB Program in writing **no later than 30 days** after the Social Security Administration's determination. COBRA or PEBB Continuation Coverage for all qualified beneficiaries will end on the last day of the month that the Social Security Administration's determination was made, or as allowed by law.

(4) **Request to cancel coverage**

If a member would like to terminate coverage before the end of the maximum coverage period, he or she may submit a written request to:

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

Coverage will end on the last day of the month in which the PEBB Program receives your written notice. If your written notice is received on the first day of the month, coverage will end on the last day of the previous month.

How much does continuation coverage cost?

Generally, you are required to pay the entire cost of continuation coverage, similar to the total cost paid by both the employer and employee. See monthly premiums for COBRA or PEBB Continuation Coverage on pages 13–15.

You will also pay the tobacco use premium surcharge and/or spouse or state-registered domestic partner coverage premium surcharge in addition to your medical plan premium if they apply to you. For more information, see “Premium Surcharges” on page 16.
When and how do I make payments?

(1) First payment for continuation coverage

You should send your first payment with the election form. However, you have up to 45 days after the date the PEBB Program receives your election form to submit your first payment.

Your first payment must cover the cost of continuation coverage from the time your PEBB coverage ends through the end of the previous month as well as any applicable premium surcharges. For example: Sue’s employment ends on September 15, and she loses coverage on September 30. Sue elects COBRA coverage on November 15. If her first payment is made in November, it must cover the premium (and any applicable premium surcharges) for October. If her first payment is made in December, it must cover premiums (and any applicable premium surcharges) for October and November, and is due no later than December 30, the 45th day after the date of her COBRA coverage election.

You must make sure the amount of your first payment is correct. You may contact the PEBB Program at 1-800-200-1004 to confirm the amount due.

We will not enroll you until you elect to continue your PEBB coverage and make the first payment.

(2) How to make premium (and applicable premium surcharge) payments

You must mail or bring your first payment to:

Mail to:
Health Care Authority
P.O. Box 42691
Olympia, WA 98504-2691

Or bring to:
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Make checks payable to the Health Care Authority.

After the Health Care Authority receives your first payment, you must pay all continuation coverage premiums (and any applicable premium surcharges) timely by check or electronic funds transfer. You may also pay in cash at the Health Care Authority’s office. Hand deliver subsequent payments to the street address provided, or mail subsequent payments for continuation coverage to:

Mailing address
PEBB Program
Health Care Authority
P.O. Box 34270
Seattle, WA 98124-1270

To request electronic funds transfer, contact the PEBB Program at 1-800-200-1004.

(3) When payments are considered made

We consider your payment made on the date it was mailed or hand delivered to the Health Care Authority at one of the addresses above or received via electronic funds transfer (see the Electronic Debit Service Agreement form at www.hca.wa.gov/public-employee-benefits). Payment will not be considered made if your check is returned due to insufficient funds or for any other reason.

(4) Monthly payments for continuation coverage (and applicable premium surcharges)

After you make your first premium payment to elect continuation coverage, subsequent payments are due on the 15th day of the month for that month’s coverage. If you make a monthly payment on or before the 15th day of the current month, your PEBB coverage will continue for that month. If your monthly premium or applicable premium surcharge remains unpaid for 30 days, your premium will be delinquent.

The monthly premium may change at the beginning of each calendar year. We will notify you before the beginning of each calendar year of changes to premiums and benefits.

Depending on your payment method, you may or may not receive a bill for your continuation coverage premium (and any applicable premium surcharges) as a reminder of your responsibility to pay your premiums on time. You must pay your monthly premiums (and any applicable premium surcharges) on time, even if we do not send a bill to you.

(continued)
(5) **Grace periods for monthly premium payments**

You will be allowed a 30-day grace period from the date that your premium and any applicable premium surcharge become delinquent to make each monthly payment. **If payment is not made within 60 days, coverage will be terminated retroactively to the last day of the month in which the premium and any applicable premium surcharge was paid.**

All payments received by the PEBB Program will be applied to the oldest month where a premium or applicable premium surcharge is unpaid or underpaid in the following order:

- The oldest month owed, first insurance coverage premium and then any applicable premium surcharge; and
- The next oldest month owed, first insurance coverage premium and then any applicable premium surcharge.

Premium payments (and any applicable premium surcharges) are due the 15th of each month. There is a 30-day grace period from the due date. If you fail to pay premiums and applicable premium surcharges as required, coverage will be terminated the last day of the month for which the premium and any applicable surcharges were made.

If your coverage is terminated, you will be financially responsible for all medical and/or dental claims incurred after the effective date of the termination.

Once you are terminated from COBRA or PEBB Continuation Coverage, you cannot reenroll.
2017 PEBB COBRA, Leave Without Pay, and Continuation Coverage Monthly Rates

Effective January 1, 2017 (See “Monthly Premium Surcharges” on back)

Special Requirements

1. To qualify for the Medicare rate, at least one covered family member must be enrolled in both Medicare Part A and Part B. (Medicare rates are not available to PEBB Continuation Coverage (Leave Without Pay) members.)

2. Medicare-enrolled subscribers in Kaiser Foundation Health Plan of Washington's (formerly Group Health) Medicare Advantage plan or Kaiser Foundation Health Plan of the Northwest Senior Advantage must complete and sign the Medicare Advantage Plan Election Form (form C) to enroll in one of these plans.

For more information on these requirements, contact your health plan's customer service department.

<table>
<thead>
<tr>
<th>Medical plans</th>
<th>Members not eligible for Medicare (or enrolled in Part A only)</th>
<th>Subscriber only</th>
<th>Subscriber and spouse*</th>
<th>Subscriber and child(ren)</th>
<th>Full family</th>
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<td>(formerly Group Health)</td>
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<td>Classic</td>
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<td>(formerly Group Health)</td>
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<tr>
<td>CDHP</td>
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<td>(formerly Group Health)</td>
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<td>SoundChoice</td>
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<td></td>
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<td>(formerly Group Health)</td>
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<td>Value</td>
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<td>Classic**</td>
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</tr>
<tr>
<td>Kaiser Permanente NW</td>
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<td>CDHP**</td>
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*or state-registered domestic partner
**Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.
(continued)
Members enrolled in Medicare Part A and Part B:

<table>
<thead>
<tr>
<th></th>
<th>Subscriber only</th>
<th>Subscriber and spouse*</th>
<th>Subscriber and child(ren)</th>
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<tbody>
<tr>
<td></td>
<td>1 Medicare</td>
<td>1 Medicare</td>
<td>2 Medicare</td>
<td>1 Medicare</td>
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<td>eligible</td>
<td>eligible</td>
<td>eligible</td>
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<td>Medicare Plan</td>
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<tr>
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<td>$1,075.93</td>
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<tr>
<td>SoundChoice</td>
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<td></td>
<td>N/A†</td>
</tr>
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<td>$970.01†</td>
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<td>$1,114.83†</td>
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<td>Value</td>
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<tr>
<td>UMP Classic</td>
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<td></td>
<td></td>
<td>$1,274.95</td>
</tr>
</tbody>
</table>

*or state-registered domestic partner
**Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.
† If a Kaiser Permanente WA (formerly Group Health) subscriber is enrolled in Medicare Part A and Part B and covers a family member who is not eligible for Medicare, the family member must enroll in Kaiser Permanente WA (formerly Group Health) Classic, SoundChoice, or Value plan and the subscriber will pay a combined Medicare and non-Medicare rate.
‡‡If a Kaiser Permanente NW subscriber is enrolled in Medicare Part A and Part B and covers a family member who is not eligible for Medicare, the family member will be enrolled in Kaiser Permanente NW Classic**. The subscriber will pay the combined Medicare and non-Medicare rate shown for Kaiser Permanente NW Senior Advantage.
## Medicare Supplement Plan F (Group), administered by Premera Blue Cross

<table>
<thead>
<tr>
<th></th>
<th>Subscriber only</th>
<th>Subscriber and spouse*</th>
<th>Subscriber and child(ren)</th>
<th>Full family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Medicare eligible</strong></td>
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<td>$566.29</td>
<td>$1,035.21</td>
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<td>$1,297.59</td>
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<td><strong>2 Medicare eligible</strong>, 1 retired, 1 disabled**</td>
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<td><strong>Plan F</strong></td>
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<td></td>
</tr>
<tr>
<td>Age 65 or older, eligible by age</td>
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<tr>
<td>Plan F</td>
<td>$356.55</td>
<td>$980.20</td>
<td>$566.29</td>
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<tr>
<td>Under age 65, eligible by disability</td>
<td></td>
<td></td>
<td>$713.10</td>
<td>$1,182.02</td>
</tr>
</tbody>
</table>

**or state-registered domestic partner**

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

## Monthly premium surcharges

You will pay the following surcharges in addition to your medical plan premium if they apply to you. These surcharges do not apply to COBRA and PEBB Continuation Coverage subscribers enrolled in Medicare Part A and Part B.

- A monthly $25-per-account surcharge will apply if the subscriber or any family member (age 13 and older) enrolled in PEBB medical uses tobacco products.
- A monthly $50 surcharge will apply if a subscriber enrolls a spouse or state-registered domestic partner in PEBB medical and the spouse or state-registered domestic partner has chosen not to enroll in employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic.

For more guidance on whether these surcharges apply to you, see the [2017 Premium Surcharge Help Sheet](www.hca.wa.gov/public-employee-benefits).

## Dental plans

### With medical plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>DeltaCare, administered by Delta Dental of Washington</th>
<th>Uniform Dental Plan, administered by Delta Dental of Washington</th>
<th>Willamette Dental of Washington, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber only</td>
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<td>$45.07</td>
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<td>Subscriber &amp; spouse*</td>
<td>$79.06</td>
<td>$90.14</td>
<td>$84.74</td>
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<tr>
<td>Subscriber &amp; child(ren)</td>
<td>$79.06</td>
<td>$90.14</td>
<td>$84.74</td>
</tr>
<tr>
<td>Full family</td>
<td>$118.59</td>
<td>$135.21</td>
<td>$127.11</td>
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</tbody>
</table>

### Dental only

<table>
<thead>
<tr>
<th>Plan</th>
<th>DeltaCare, administered by Delta Dental of Washington</th>
<th>Uniform Dental Plan, administered by Delta Dental of Washington</th>
<th>Willamette Dental of Washington, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber only</td>
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<td>Subscriber &amp; child(ren)</td>
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<td>$94.86</td>
<td>$89.46</td>
</tr>
<tr>
<td>Full family</td>
<td>$123.31</td>
<td>$139.93</td>
<td>$131.83</td>
</tr>
</tbody>
</table>

**or state-registered domestic partner**

HCA is committed to providing equal access to our services.
If you need accommodation, please call 1-800-200-1004 or 711 for relay services.
These premium surcharges apply to PEBB benefits-eligible subscribers who:

• Are enrolled in a PEBB medical plan.

  AND

• Do not have Medicare Part A and Part B as their primary coverage (excluding PEBB Continuation Coverage [Leave Without Pay] subscribers).

### Tobacco use premium surcharge

You will pay a monthly $25-per-account surcharge in addition to your medical plan premium if:

• You or any family member age 13 or older enrolled on your PEBB medical coverage has used a tobacco product in the past two months (whether your enrolled family member lives with you or not).

  OR

• You do not respond whether the tobacco use surcharge applies no later than 60 days after the mailing date on this booklet.

To determine whether the tobacco use surcharge applies to your account, use the 2017 Premium Surcharge Help Sheet (found on page 49) and respond by completing and submitting the 2017 COBRA Election/Change (Continuation of Coverage) form or the 2017 Continuation Coverage Election/Change (for Leave Without Pay) form to the address on the form by the required deadline.

### To report a change

If you or your enrolled family members’ tobacco use changes (or you or your family members have used the tobacco cessation resources mentioned in the 2017 Premium Surcharge Help Sheet), you may report the change by:

• Going to My Account at www.hca.wa.gov/public-employee-benefits to change your attestation.

  OR

• Completing and submitting a 2017 Premium Surcharge Change Form (found at www.hca.wa.gov/public-employee-benefits) to the PEBB Program.

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

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

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

Note: If you do not enroll a spouse or state-registered domestic partner on your PEBB medical plan, this surcharge does not apply to you.

You will pay a monthly $50 surcharge in addition to your medical plan premium if:

• You have a spouse or state-registered domestic partner enrolled on your PEBB medical coverage, and your spouse or state-registered domestic partner has elected not to enroll in other employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic. (This is regardless of whether you enroll in UMP Classic.)

  OR

• You have a spouse or state-registered domestic partner enrolled on your PEBB medical coverage, and you do not respond on the form whether the spouse or state-registered domestic partner coverage surcharge applies no later than 60 days after the mailing date on this booklet.

If you enroll a spouse or state-registered domestic partner on your PEBB medical plan, use the 2017 Premium Surcharge Help Sheet (found on page 49) to determine whether the spouse or state-registered domestic partner coverage surcharge applies to your account. Then respond by completing and submitting the 2017 COBRA Election/Change (Continuation of Coverage) form.
or 2017 Continuation Coverage (for Leave Without Pay) Election/Change form by the above required deadline.

During the PEBB Program’s annual open enrollment (November 1-30), you must attest if you enroll a spouse or state-registered domestic partner on your PEBB medical and you are:

- Paying the surcharge.
- Not incurring the surcharge because the spouse’s or state-registered domestic partner’s share of medical premium through his or her employer-based group medical was not comparable to UMP Classic premiums.
- Not paying the surcharge because the benefits provided by the spouse’s or state-registered domestic partner’s employer-based group medical were not comparable to UMP Classic.

A subscriber must update their attestation by either submitting the required Premium Surcharge Change Form or logging in to My Account at www.hca.wa.gov/public-employee-benefits and following the instructions. If your attestation is not received within the open enrollment timeframe, you will pay the monthly $50 premium surcharge (in addition to your monthly premiums) for the full plan year. You will only be able to change your attestation if your spouse or state-registered domestic partner’s status changes during the year and you submit proof of the event.

To report a change

Outside of the PEBB Program’s annual open enrollment, the following events allow a subscriber to make a new attestation or add or remove the spouse/state-registered domestic partner coverage premium surcharge:

- When there is an event that creates a special open enrollment to add a spouse or state-registered domestic partner to your PEBB medical, such as marriage or state-registered domestic partnership. (A full list of events that allow you to add a spouse or state-registered domestic partner is available on the 2017 COBRA Election/Change (Continuation of Coverage) form or 2017 Continuation Coverage Election/Change (for Leave Without Pay) form.
- When you regain eligibility for the employer contribution for PEBB benefits, if there is no break in PEBB medical.
- When there is a change in your spouse’s or state-registered domestic partner’s employer-based group medical.

If adding or removing a spouse or state-registered domestic partner from your PEBB medical, you must report the change by completing a 2017 COBRA Election/Change (Continuation of Coverage) form or 2017 Continuation Coverage Election/Change (for Leave Without Pay) form.

To change your current attestation (without adding or removing your spouse or state-registered domestic partner from PEBB medical), complete and submit a 2017 Premium Surcharge Change Form (found at www.hca.wa.gov/public-employee-benefits) to the PEBB Program. You must also submit proof of the qualifying event with your completed form.

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

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

For more information on the premium surcharges, visit www.hca.wa.gov/public-employee-benefits.
SmartHealth Wellness Program

SmartHealth is the state’s voluntary wellness program designed to help you take steps to improve your health by participating in fun and engaging SmartHealth Activities. As you progress on your wellness journey, you can qualify for the SmartHealth financial wellness incentive.

What is the financial wellness incentive?
Subscribers who qualify for the 2017 financial wellness incentive can receive:

- A $125 reduction in the subscriber’s 2018 PEBB medical deductible,
  
  OR

- A one-time deposit of $125 into the subscriber’s health savings account (if enrolled in a PEBB consumer-directed health plan in 2018).

Who is eligible to participate?
Subscribers and their spouses or state-registered domestic partners enrolled in PEBB medical coverage can participate in SmartHealth through the SmartHealth website; however, only subscribers can qualify for the $125 financial wellness incentive and SmartHealth promotions.

To qualify for the financial wellness incentive, the subscriber must:

- Not be enrolled in both Medicare Part A and Part B,

- Complete the SmartHealth Well-being Assessment, and

- Earn 2,000 total points within the deadline requirement.

To receive the incentive in 2018, the subscriber must still be enrolled in a PEBB medical plan during 2018.

If a subscriber qualifies for the incentive in 2017, and enrolls in Medicare Part A and Part B while enrolled in a PEBB medical plan in 2018, he or she will still receive the SmartHealth incentive in 2018.

How do I get started?
Follow these simple steps to earn points to qualify for the $125 wellness incentive:

1. Go to [www.smarthealth.hca.wa.gov](http://www.smarthealth.hca.wa.gov) and select Get started to walk through the activation process.

2. Take the SmartHealth Well-being Assessment (required to qualify for the wellness incentive). You do not earn SmartHealth points for completing your PEBB medical plan’s health assessment.

   Note: If you don’t have internet access, call SmartHealth Customer Service toll-free at 1-855-750-8866 (Monday through Friday, 7 a.m. to 7 p.m. Pacific Time) to complete the Well-being Assessment by phone.

3. After completing the Well-being Assessment, complete other Activities on SmartHealth’s website to earn 2,000 total points to qualify for the $125 wellness incentive.

Deadline requirements

When is the deadline to meet the requirements for the wellness incentive?

- If you are continuing enrollment in PEBB medical or are a new subscriber with a PEBB medical effective date in January through June, your deadline to qualify for the financial incentive is September 30, 2017.

- If your PEBB medical effective date is in July or August, your deadline is 120 days from your medical effective date.

  Example: Julie is new to state employment and her PEBB medical effective date is July 1, 2017. Julie’s deadline to complete her SmartHealth Activities and earn her financial wellness incentive is October 29, 2017.

- If your PEBB medical effective date is in September through December, your deadline is December 31, 2017.
Appendix A: COBRA and PEBB Continuation Coverage

Complete the 2017 COBRA Election/Change (Continuation of Coverage) form if the qualifying event is one of the following:

**Employee:**
- Your employment ended for any reason other than gross misconduct.
- Your hours of employment were reduced.

*Note:* See pages 6-7 for a list of events that may qualify you for PEBB Continuation Coverage under Leave Without Pay (LWOP), which may allow a longer coverage period and different benefits.

**Spouse:**
- Your spouse (the employee or retiree) died. *Note:* You may qualify for COBRA or PEBB retiree insurance coverage.
- Your spouse’s (the employee’s) hours of employment were reduced.
- Your spouse’s (the employee’s) employment ended for any reason other than gross misconduct.
- You divorced your spouse.

**State-registered domestic partner:**
- Your state-registered domestic partner (the employee or retiree) died. *Note:* You may qualify for PEBB Continuation Coverage or PEBB retiree insurance coverage.
- Your state-registered domestic partner’s (the employee’s) hours of employment were reduced.
- Your state-registered domestic partner’s (the employee’s) employment ended for any reason other than gross misconduct.
- Your state-registered domestic partnership (with the employee) terminated.

**Dependent child:**
- Your parent (the employee or retiree) died. *Note:* You may qualify for COBRA or PEBB Continuation Coverage, or PEBB retiree insurance coverage.
- Your parent’s (the employee’s) hours of employment were reduced.
- Your parent’s (the employee’s) employment ended for any reason other than gross misconduct.
- Your eligibility for PEBB coverage as a dependent child ended (see WAC 182-12-260(3)).

**Retiree:**
- You are a retiree and your employer group terminated plan participation.
- You are a retiree and the Department of Retirement Systems has determined that you are no longer disabled, so your pension has stopped.
Medical and dental benefits
You may elect to continue coverage you were enrolled in on the day before the qualifying event occurred (medical coverage only, dental coverage only, or both medical and dental coverage) by self-paying the premiums. Unless you make separate elections, eligible dependents you elect to cover will be enrolled in the same plans you elect. To enroll, complete the enclosed 2017 COBRA Election/Change (Continuation of Coverage) form and submit it to the PEBB Program at the address shown at the end of the form.

If you do not submit the completed form within 60 days after the mailing date on this booklet, PEBB coverage will end on the last day of the month you and your family member(s) stop being eligible for your original PEBB coverage.

After your enrollment begins, you can change health plans during the PEBB Program's annual open enrollment or after a qualifying event creates a special open enrollment.

Note: If you are enrolled in a PEBB Medical Flexible Spending Arrangement (FSA) and your employment ends, you can elect to continue your Medical FSA through Navia Benefit Solutions until the end of the plan year in which the qualifying event occurred if you are eligible to continue participation through COBRA. You must contact Navia Benefit Solutions at 1-800-669-3539 or customerservice@naviabenefits.com no later than 60 days after the mailing date on this booklet. You can find more information in Navia Benefits Solutions’ 2017 PEBB Medical Flexible Spending Arrangement Enrollment Guide at http://pebb.naviabenefits.com.

Life insurance benefits
You may elect to continue life insurance one of two ways:

Portability coverage
If you become ineligible for PEBB Program coverage for any reason, and your Basic, Optional, and Dependent Term Life Insurance under this plan terminates, you will have an opportunity to continue group term coverage (“portability”) under a different policy, subject to plan design and state availability. Premiums will be based on the experience of the group enrolled in portability coverage and MetLife will bill you directly. Premiums may be higher than your current premiums. To take advantage of this feature, you must have coverage of at least $10,000.

Portability is also available on coverage you’ve selected for your spouse or state-registered domestic partner and dependent child(ren). The maximum amount of coverage for your spouse or state-registered domestic partner is $250,000; the maximum amount of coverage for your dependent child is $25,000. Increases, decreases, and maximums are subject to state availability.

Generally, there is no minimum time that you must be covered by the plan before you can take advantage of the portability feature. Please see your certificate for specific details. MetLife will send portability information to you which will include instructions on how to continue coverage.

Conversion coverage
You can generally convert your group term life insurance to an individual whole life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or eligibility for employer-sponsored coverage ends. Conversion is available on all group life insurance coverages. Please note that conversion is not available on AD&D coverage. MetLife will send conversion information to you which will include instructions on how to continue coverage.
2017 COBRA Election/Change (Continuation of Coverage)

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form no later than 60 days after the date your employer-sponsored coverage ends or from the postmark on the PEBB Continuation Coverage Election Notice packet sent to you, whichever is later.
- We must receive your first payment before we can enroll you. Premiums and applicable surcharges are due back to the date your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all COBRA Election/Change forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form(s).

All forms and documents are available at www.hca.wa.gov/public-employee-benefits or by calling 1-800-200-1004 or 711 for relay services.

### Employee or retiree information only

<table>
<thead>
<tr>
<th>Employee or retiree name</th>
<th>Date employer coverage ended (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

### Section 1: Subscriber Information

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex</th>
<th>[ ] M  [ ] F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td>Apt./unit number</td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Mailing address (if different from above)</td>
<td>Apt./unit number</td>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>County of residence</td>
<td>Date of birth (mm/dd/yyyy)</td>
<td>Daytime phone number</td>
<td>Home phone number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] Continue coverage: (select one)  [ ] Medical and dental  [ ] Medical only  [ ] Dental only
  You may elect to continue coverage you were enrolled in on the day your employer-sponsored coverage ended. If you have life insurance and wish to port or convert contact MetLife at 1-866-548-7139.
  If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions at 1-800-660-3539 no later than 60 days after the date they provide you with the notice of your continuation right.

- [ ] Cancel coverage: (select one)  [ ] Medical and dental  [ ] Medical only  [ ] Dental only
  Reason_________________________________ Cancel date_____________________
  I understand that I am forfeiting all further rights to enroll in PEBB Program benefits cancelled above unless I regain eligibility.

| Are you covered by another group medical plan? | Yes  No  If yes, effective date__________ |
| Are you covered by another group dental plan? | Yes  No  If yes, effective date__________ |
| Are you disabled under Title II (OASDI) of the Social Security Act? | Yes  No  If yes, effective date__________ |
| Are you disabled under Title XVI (SSI) of the Social Security Act? | Yes  No  If yes, effective date__________ |

If yes, you must send a copy of your Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

| Enrolled in Part(s) A and/or B of Medicare? | Part A (hospital) | Yes  No  If yes, effective date__________ |
|                                            | Part B (medical)  | Yes  No  If yes, effective date__________ |

If yes, proof is required. Attach a copy of your Medicare card to this form.

(continued)
Section 1: Subscriber Information (continued)

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B, and you or a family member (age 13 or older) enrolled on your PEBB medical coverage 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. See the 2017 Premium Surcharge Help Sheet at www.hca.wa.gov/public-employee-benefits for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.

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

☐ 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 used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. If adding a state-registered domestic partner, you must provide proof of eligibility within PEBB enrollment timelines, or the state-registered domestic partner will not be enrolled. A list of documents we will accept to verify eligibility is available at www.hca.wa.gov/public-employee-benefits

Relationship to subscriber

☐ Spouse: date of marriage ___________________  ☐ State-registered domestic partner: date registered ___________________

Social Security number

Last name First name Middle initial Date of birth (mm/dd/yyyy) Sex ☐ M ☐ F

Street address Apt./unit number City State ZIP Code

☐ Continue coverage: (select one) ☐ Medical and dental ☐ Medical only ☐ Dental only
☐ Add coverage: (select one) ☐ Medical and dental ☐ Medical only ☐ Dental only
☐ Cancel coverage: (select one) ☐ Medical and dental ☐ Medical only ☐ Dental only

Reason ___________________ Cancel date ___________________

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

Covered by another group medical plan? ☐ Yes ☐ No If yes, effective date_____________________

Covered by another group dental plan? ☐ Yes ☐ No If yes, effective date_____________________

Disabled under Title II (OASDI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date_____________________

Disabled under Title XVI (SSI) of the Social Security Act? ☐ Yes ☐ No If yes, effective date_____________________

If yes, you must send a copy of the spouse’s or state-registered domestic partner’s Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ☐ Yes ☐ No If yes, effective date_____________________
Part B (medical) ☐ Yes ☐ No If yes, effective date_____________________

If yes, proof is required. Include a copy of the spouse’s or state-registered domestic partner’s Medicare card with this form.

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner? Check one:

☐ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
☐ YES, I am subject to the $25 premium surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months.
☐ NO, I am not subject to the $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.
## Section 2: Spouse or State-Registered Domestic Partner Information (continued)

### Spouse or State-Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if you are not enrolled in Medicare Part A and Part B, and your spouse or state-registered domestic partner has elected not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2017 Premium Surcharge Help Sheet and the 2017 Spousal Plan Calculator at [www.hca.wa.gov/public-employee-benefits](http://www.hca.wa.gov/public-employee-benefits). To change your attestation, use the 2017 Premium Surcharge Change Form. If you check YES below or leave this section blank, you will pay the monthly surcharge.

### Does the spouse or state-registered domestic partner coverage surcharge apply to you? Check one:

- [ ] The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- [ ] YES, I am subject to the $50 premium surcharge. I used the 2017 Premium Surcharge Help Sheet and completed the 2017 Spousal Plan Calculator online.
- [ ] NO, I am not subject to the $50 premium surcharge. I used the 2017 Premium Surcharge Help Sheet and, if needed, completed the 2017 Spousal Plan Calculator online.

### Which questions, if any, on the 2017 Premium Surcharge Help Sheet did you check NO? Check all that apply. Question 1 is not applicable. [ ] Question 2 [ ] Question 3 [ ] Question 4 [ ] Question 5 [ ] Question 6

- [ ] PEBB Program to determine. I am completing and submitting the printed 2017 Spousal Plan Calculator from [www.hca.wa.gov](http://www.hca.wa.gov).

## Section 3: Family Member Information (such as child) Use additional forms for more members.

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. Attach a completed Extended Dependent Certification form if enrolling an extended dependent. If enrolling a dependent with a disability age 26 or older, submit a completed Certification of Dependent With a Disability form and return as instructed on the form.

<table>
<thead>
<tr>
<th>Relationship to subscriber</th>
<th>Check only if age 26 or older.</th>
<th>Sex</th>
<th>Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended dependent validated by court order?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Date of birth (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address (only if different from subscriber)</td>
<td>Apt./unit number</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

- [ ] Continue coverage: (select one)
- [ ] Add coverage: (select one)
- [ ] Cancel coverage: (select one)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Cancel date</th>
</tr>
</thead>
</table>

- [ ] Covered by another group medical plan? [ ] Yes [ ] No If yes, effective date ________________
- [ ] Covered by another group dental plan? [ ] Yes [ ] No If yes, effective date ________________
- [ ] Disabled under Title II (OASDI) of the Social Security Act? [ ] Yes [ ] No If yes, effective date ________________
- [ ] Disabled under Title XVI (SSI) of the Social Security Act? [ ] Yes [ ] No If yes, effective date ________________

If you check YES below or leave this section blank, you must send a copy of the family member’s Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

<table>
<thead>
<tr>
<th>Enrolled in Part(s) A and/or B of Medicare?</th>
<th>Part A (hospital)</th>
<th>Part B (medical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check only if age 26 or older.</td>
<td>[ ] Yes [ ] No If yes, effective date ________________</td>
<td>[ ] Yes [ ] No If yes, effective date ________________</td>
</tr>
</tbody>
</table>

If yes, proof is required. Attach a copy of the family member’s Medicare card to this form.

## Tobacco Use Premium Surcharge

### Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 or older.) Check one:

- [ ] The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.
- [ ] YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.
- [ ] NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.
Section 3: Family Member Information (continued)

B Relationship to subscriber

Check only if age 26 or older.

Disabled? □ Yes □ No

Sex □ M □ F

Social Security number

Extended dependent validated by court order? □ Yes □ No

Last name First name Middle initial Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number City State ZIP Code

□ Continue coverage: (select one) □ Medical and dental □ Medical only □ Dental only

□ Add coverage: (select one) □ Medical and dental □ Medical only □ Dental only

□ Cancel coverage: (select one) □ Medical and dental □ Medical only □ Dental only

Reason ___________________________ Cancel date ___________________________

Covered by another group medical plan? □ Yes □ No If yes, effective date ________________

Covered by another group dental plan? □ Yes □ No If yes, effective date ________________

Disabled under Title II (OASDI) of the Social Security Act? □ Yes □ No If yes, effective date ________________

Disabled under Title XVI (SSI) of the Social Security Act? □ Yes □ No If yes, effective date ________________

If yes, you must send a copy of the family member’s Social Security Disability Award letter. You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Part(s) A and/or B of Medicare?

Part A (hospital) □ Yes □ No If yes, effective date ________________

Part B (medical) □ Yes □ No If yes, effective date ________________

If yes, proof is required. Attach a copy of the family member’s Medicare card to this form if we don’t already have a copy.

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 or older.) Check one:

□ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

□ YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.

□ NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

Section 4: Changes to an Existing Account

Are you making changes to an existing account?

□ Yes If yes, what changes? (Check all that apply in the sections below.)

□ No If no, go to Section 5.

Changes you can make anytime Give date of event/change ___________________________

□ Name change □ Address change □ Cancel medical coverage □ Cancel dental coverage

□ Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of state-registered domestic partnership, death, or other loss of eligibility under PEBB Program rules), we must receive this form no later than 60 days after the last day of the month the dependent loses eligibility for health plan coverage. Coverage will be cancelled the last day of the month of loss of eligibility. If applicable, provide former dependent’s new address:

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested.

□ Add dependent(s) □ Change medical plan □ Change dental plan

(this section continued on next page)
Section 4: Changes to an Existing Account  
(continued)

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. The PEBB Program must receive this form and proof of the event no later than 60 days after the event. However, if adding a newborn or adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.

Check the box next to each change you are requesting and indicate the corresponding event(s). See the numbers beside each change to verify that your requested change may be allowed. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

- Add dependent(s) (allowable under events 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12)
- Change medical plan (allowable under events 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15)
- Change dental plan (allowable under events 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15)

Give date of event ________________________________

Check the box(es) next to the corresponding event(s). The event number below must be listed next to the change(s) you are requesting above.

- 1. Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- 4. 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.
- 5. Subscriber has a change in employment status that affects the subscriber’s or dependent’s eligibility for the employer contribution toward his or her employer-based group health plan.
- 6. Subscriber’s dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.
- 7. Subscriber or 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.
- 8. Subscriber’s dependent moves from outside the United States to live within the United States or moves from inside the United States to live outside the United States.
- 9. Subscriber or dependent has a change in residence that affects health plan availability.
- 10. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.
- 11. Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP).
- 12. Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- 13. Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- 14. Subscriber or dependent’s current health plan becomes unavailable because the subscriber or dependent is no longer eligible for a health savings account.
- 15. Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

Are you or any eligible dependents enrolled in PEBB Program coverage under another account? Yes ☐ No ☐
Section 5: Medical Plan Selection  Check appropriate box(es).

Kaiser Foundation Health Plan of Washington\(^6\)  (formerly Group Health Cooperative)
- [ ] Kaiser Permanente WA Classic  (formerly Group Health Classic)
- [ ] Kaiser Permanente WA Medicare Plan  (formerly Group Health Medicare Plan)\(^1,2\)
- [ ] Kaiser Permanente WA SoundChoice  (formerly Group Health SoundChoice)\(^5\)
- [ ] Kaiser Permanente WA Value  (formerly Group Health Value)

Kaiser Foundation Health Plan of Washington Options Inc.\(^6\)  (formerly Group Health Options Inc.)
- [ ] Kaiser Permanente WA Consumer-Directed Health Plan  (formerly Group Health Consumer-Directed Health Plan)\(^3\)

Kaiser Foundation Health Plan of the Northwest\(^6\)
- [ ] Kaiser Permanente NW Classic\(^7\)
- [ ] Kaiser Permanente NW Consumer-Directed Health Plan\(^3,7\)
- [ ] Kaiser Permanente NW Senior Advantage\(^1\)
- [ ] Medicare Supplement Plan F, administered by Premera Blue Cross\(^4\)

Uniform Medical Plan, administered by Regence BlueShield
- [ ] UMP Classic
- [ ] UMP Consumer-Directed Health Plan\(^3\)
- [ ] UMP Plus—Puget Sound High Value Network\(^3,6\)
- [ ] UMP Plus—UW Medicine Accountable Care Network\(^3,6\)

1 These Medicare Advantage plans are available in certain counties to Medicare members. Also complete and attach the Medicare Advantage Plan Election Form (form C) if you live in a county where Medicare Advantage is available. (See www.hca.wa.gov/public-employee-benefits for medical plans available by county.)
2 If you cover dependents not enrolled in Medicare Part A and Part B, also select Kaiser Permanente WA Classic, SoundChoice, or Value for these dependents.
3 These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent’s PEBB Program coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.
4 Also complete and return the Group Medicare Supplement Enrollment Application (form B) to enroll in Medicare Supplement Plan F. The PEBB Program does not offer the high-deductible Plan F.
5 This plan is available only if at least one covered family member is not enrolled in Medicare Part A and Part B. Family members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA’s (formerly Group Health) Medicare Plan.
6 These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program no later than 60 days after you move.
7 Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR area.

Section 6: Dental Plan Selection  Check only one.

Before you select a dental plan, be sure your provider(s) participate with that plan.

Preferred Provider Organization
You can choose any dental provider and change providers at anytime.
- [ ] Uniform Dental Plan (Group #3000), administered by Delta Dental of Washington

Managed-Care Plans
You must choose a provider from the dental plan network. Before you select a managed-care plan, be sure to call the dental plan to verify your provider is in their network.
- [ ] DeltaCare (Group #3100), administered by Delta Dental of Washington
  Call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.
- [ ] Willamette Dental of Washington, Inc. (Group WAB2)
  Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.
Section 7: Signature Required

I have received and read the PEBB Continuation Coverage Election Notice, including any appendices. By signing 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 plan(s). My family members and I may also lose PEBB Program 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 may include imprisonment, fines, and denial of PEBB Program insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. 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 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.

This form replaces all COBRA Election/Change forms previously submitted to the PEBB Program.

HCA’s Privacy Notice:
We will keep your information private as allowed by law.
To see our Privacy Notice, go to www.hca.wa.gov/public-employee-benefits.

Subscriber’s signature __________________________________________  Date ____________________

Please sign and date this form.

Mail to:  If payment is enclosed, make it payable to Health Care Authority and mail to:  Or hand-deliver to:
Washington State Health Care Authority  Washington State Health Care Authority  Washington State Health Care Authority
P.O. Box 42684  P.O. Box 42691  626 8th Ave. SE
Olympia, WA 98504-2684  Olympia, WA 98504-2695  Olympia, WA 98501

2017 PEBB Program Medical Contractors
Kaiser Foundation Health Plan of Washington
(formerly Group Health Cooperative)
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc.
(formerly Group Health Options Inc.)
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 711

Premera Blue Cross
P.O. Box 327
Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Ave., Suite 235, Seattle, WA 98101
1-888-849-3681 or TTY 711

2017 PEBB Program Dental Contractors
DeltaCare, administered by Delta Dental of Washington
9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan
administered by Delta Dental of Washington
9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-537-3406

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

HCA is committed to providing equal access to our services. If you need accommodation, please call 1-800-200-1004 or 711 for relay services.
# 2017 Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read and sign the back of this form.

## Section 1: Retiree information

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Last name (as appears on Medicare card)</th>
<th>First name</th>
<th>Middle initial</th>
<th>Medical effective date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent residential address (required)</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code + 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing address (if different than above)</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code + 4</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>County of residence</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Married (mm/dd/yyyy)</th>
<th>Home phone number (including area code)</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Retiree Medicare claim number</th>
<th>Entitled to Part A (hospital)</th>
<th>Yes</th>
<th>No</th>
<th>If yes, effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Entitled to Part B (medical)</th>
<th>Yes</th>
<th>No</th>
<th>If yes, effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

## Section 2: Spouse or state-registered domestic partner information (if applying)

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Last name (as appears on Medicare card)</th>
<th>First name</th>
<th>Middle initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Permanent residential or mailing address</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Sex</th>
<th>Home phone number (including area code)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code + 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse or state-registered domestic partner’s Medicare claim number from Medicare card</th>
<th>Entitled to Part A (hospital)</th>
<th>Yes</th>
<th>No</th>
<th>If yes, effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Entitled to Part B (medical)</th>
<th>Yes</th>
<th>No</th>
<th>If yes, effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## Section 3: Plan choice

I wish to enroll in:

- Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative)
  - Kaiser Permanente WA Medicare Advantage PEBB Retire (HMO)
  - Kaiser Permanente NW Senior Advantage (HMO)

I wish to cancel my current medical coverage: Yes | No

Name of RETIREE’S contracting primary care provider (PCP) (refer to plan’s provider directory) | Current patient? Yes | No

Name of SPOUSE’S or STATE-REGISTERED DOMESTIC PARTNER’S contracting primary care provider (PCP) (refer to plan’s provider directory) | Current patient? Yes | No
### Section 4: Medical information

<table>
<thead>
<tr>
<th>Retiree</th>
<th>Spouse or State-Registered Domestic Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you currently have end-stage renal disease (kidney disease)?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Do you have any health insurance other than Medicare?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, through which company?</td>
<td>What type of policy?</td>
</tr>
<tr>
<td>3. Do you live in an institution?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, name of institution</td>
<td>Date of admission</td>
</tr>
<tr>
<td>Address</td>
<td>Phone number</td>
</tr>
<tr>
<td>4. Are you currently receiving Medicaid?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, Medicaid number</td>
<td></td>
</tr>
</tbody>
</table>

### Signature and authorization

By signing 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 law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB Program benefits as of the last day of the month we qualified. 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 knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB Program benefits.

We have read and understand this form, including the Statement of Understanding below. We know that we must refer to our plan’s certificate of coverage for rules we must follow to receive coverage under this Medicare Advantage contract.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS to better serve you.

**This form cannot be signed more than 90 days before the effective date of this coverage.** (*See Statement of Understanding on the next page for Medicare Advantage Plan coverage effective date.)

I understand that my enrollment and my dependents’ enrollment are subject to my adherence to all applicable deadlines and PEBB rules and policies. Failure to comply with applicable deadlines and PEBB rules and policies may result in my benefits selection being rejected or defaulted.

**HCA’s Privacy Notice:** We will keep your information private as allowed by law.


<table>
<thead>
<tr>
<th>Signature of applicant</th>
<th>Date</th>
<th>Signature of spouse or state-registered domestic partner (if enrolling)</th>
<th>Date</th>
</tr>
</thead>
</table>

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where he or she resides) on this application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from the Medicare Advantage plan or by Medicare.

<table>
<thead>
<tr>
<th>Signature of individual who assisted the applicant and/or spouse or state-registered domestic partner in completing this form</th>
<th>Date</th>
</tr>
</thead>
</table>

If you are the authorized representative, you must sign above and provide the following information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to applicant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>
Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, 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 of my Medicare Advantage plan 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 under unusual and extraordinary circumstances, provided 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, which 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 the 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 of or coordination of benefits or the 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 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, and may not be the same as my date of retirement. If I submit this form during the PEBB Program’s annual open enrollment, then 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. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers. Note: Until you have received this written notification, 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 that (s)he may begin using the plan services as of the effective date.

Please contact the plans listed on the previous page if you need information in another language or format.

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

GROUP CUSTOMER INFORMATION  (To be Completed by the Recordkeeper)

<table>
<thead>
<tr>
<th>Name of Group Customer/Employer</th>
<th>Group Customer #</th>
<th>Report #</th>
<th>Sub Code</th>
<th>Branch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington State Health Care Authority</td>
<td>164995</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YOUR ENROLLMENT INFORMATION  (To be Completed by the Employee)

<table>
<thead>
<tr>
<th>Name (First, Middle, Last)</th>
<th>Social Security #</th>
<th>Male</th>
<th>Female</th>
<th>Address (Street, City, State, Zip Code)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Phone #</th>
<th>Email Address</th>
<th>New Enrollment</th>
<th>Change in Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington State Health Care Authority</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

► If you are enrolling during the initial enrollment period, you must complete a Statement of Health form:
  • If you are enrolling for more than $500,000 of Optional Life Insurance
  • If you are enrolling for more than $100,000 of Dependent Spouse/Domestic Partner Life Insurance

► If you are enrolling after the initial enrollment period, you must also complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

- **Basic Life**
  - Enter a multiple of $10,000 up to a maximum of $1,000,000. $________

- **Optional Life**
  - Enter a multiple of $5,000 up to a maximum of $200,000. $________

- **Dependent Spouse/Domestic Partner**
  - Enter a multiple of $5,000 up to a maximum of $20,000. $________

Accidental Death & Dismemberment (AD&D) Insurance

- **Basic AD&D**
  - Enter a multiple of $10,000 up to a maximum of $250,000. $________

- **Optional AD&D**
  - Enter a multiple of $5,000 up to a maximum of $25,000. $________

- **Dependent Spouse/Domestic Partner**
  - Enter a multiple of $5,000 up to a maximum of $25,000. $________

<table>
<thead>
<tr>
<th>Term Life Insurance</th>
<th>Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Basic Life</td>
<td>☑ Basic AD&amp;D</td>
<td></td>
</tr>
<tr>
<td>☑ Optional Life</td>
<td>☑ Optional AD&amp;D</td>
<td></td>
</tr>
<tr>
<td>☑ Dependent Spouse/Domestic Partner</td>
<td>☑ Dependent Spouse/Domestic Partner AD&amp;D</td>
<td></td>
</tr>
<tr>
<td>☑ Dependent Child Life</td>
<td>☑ Dependent Child AD&amp;D</td>
<td></td>
</tr>
</tbody>
</table>

1. Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

2. Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

3. Amounts will be subject to state limits, if applicable.

GEF02-1 ADM
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; and GEF02-1 ADM applies to residents of Connecticut, North Dakota and Utah)

SUBMISSION INSTRUCTIONS
After completion, make a copy for your records and return the original to MetLife Recordkeeping Center, P.O. Box 14406, Lexington, KY 40512-4406. Fax (859) 825-6719 Email: Southfield_RES@metlife.com.
Smoking Status Information

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 2 months?  

<table>
<thead>
<tr>
<th>Employee</th>
<th>Spouse/Domestic Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
</tr>
</tbody>
</table>

If you are changing smoking status

Status is changing from:  □ Smoker to Non-Smoker  □ Non-Smoker to Smoker  Change is for:  □ Employee  □ Spouse/Domestic Partner

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

<table>
<thead>
<tr>
<th>Name of your Spouse/Domestic Partner (First, Middle, Last)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>□ Male</th>
<th>□ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name(s) of your Child(ren) (First, Middle, Last)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>□ Male</th>
<th>□ Female</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; and

GEF02-1
ADM applies to residents of Connecticut, North Dakota and Utah)

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person knowing and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; and

GEF09-1
FW applies to residents of Connecticut, North Dakota and Utah)
BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)  Social Security #  Date of Birth (Mo./Day/Yr.)  Relationship  Share %
Address (Street, City, State, Zip)  Phone #

Full Name (First, Middle, Last)  Social Security #  Date of Birth (Mo./Day/Yr.)  Relationship  Share %
Address (Street, City, State, Zip)  Phone #

Full Name (First, Middle, Last)  Social Security #  Date of Birth (Mo./Day/Yr.)  Relationship  Share %
Address (Street, City, State, Zip)  Phone #

Payment will be made in equal shares or all to the survivor unless otherwise indicated.  TOTAL: 100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)  Social Security #  Date of Birth (Mo./Day/Yr.)  Relationship  Share %
Address (Street, City, State, Zip)  Phone #

Full Name (First, Middle, Last)  Social Security #  Date of Birth (Mo./Day/Yr.)  Relationship  Share %
Address (Street, City, State, Zip)  Phone #

Payment will be made in equal shares or all to the survivor unless otherwise indicated.  TOTAL: 100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:
1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician’s care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee  Print Name  Date Signed (MM/DD/YYYY)

GEF09-1 DEC
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; and GEF09-1 DEC applies to residents of Connecticut, North Dakota and Utah)
Appendix B:
PEBB Continuation Coverage (Leave Without Pay)

Complete this 2017 Continuation Coverage (Leave Without Pay) form if you are an employee who will lose your PEBB employer-based coverage because of one of the following events:

Employee:

- You are on authorized leave without pay from your agency.
- Your employment ends due to a layoff.
- You reverted to a position that is not eligible for the employer contribution toward insurance coverage.
- You are appealing a dismissal action.
- You are receiving time-loss benefits under workers’ compensation.
- You are applying for disability retirement.
- You are called to active duty in the uniformed services, as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA).*
- You are on approved educational leave.*
- You are a faculty member who is between periods of eligibility.
- You are a seasonal employee during an off season.

*You may also be entitled to continue long-term disability coverage. See pages 39-40 for information on continuing LTD coverage while on USERRA or approved educational leave.
Read the following information carefully before completing the form(s).

**Medical and dental benefits**
You may elect to continue coverage you were enrolled in on the day before the qualifying event (medical, dental, or both) by self-paying the premiums. Your enrolled eligible dependents will be enrolled in the same plans that you elect. If you do not elect PEBB Continuation Coverage (LWOP), your family members may not enroll independently as they do not have independent election rights to PEBB Continuation Coverage (LWOP). To enroll, complete the enclosed 2017 Continuation Coverage Election/Change (for Leave Without Pay) form and submit it to the PEBB Program at the address shown at the end of the form.

If you do not submit the completed form within 60 days after the mailing date on this booklet, PEBB coverage will end on the last day of the month you and your family member(s) stop being eligible for your original PEBB coverage.

After your enrollment begins, you can change health plans during the PEBB Program's annual open enrollment (November 1-30) or after a qualifying event creates a special open enrollment.

**Life insurance benefits**
You may choose to continue all or part of your life insurance coverage while on PEBB Continuation Coverage (LWOP). If you choose to continue any part of your optional life coverage, you must also continue the $35,000 Basic Life and Accidental Death & Dismemberment (AD&D) Insurance at a cost of $3.89 per month.

If you do not continue your life insurance or if you continue coverage and self-pay for a reduced amount of optional life insurance, you must submit a Statement of Health and reapply to enroll or increase your optional life insurance. All enrollment forms must be submitted to MetLife for processing.

**Please note the following:**

**If you wish to continue spouse/state-registered domestic partner coverage**
The amount of Optional Spouse/State-Registered Domestic Partner Life Insurance continued during PEBB Continuation Coverage (LWOP) cannot exceed 50 percent of the Employee Optional Life Insurance coverage in force.

**If you continue coverage while on active military duty**
If you are called to active military duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may extend life insurance to a maximum of 29 months after your active duty began. You cannot continue Optional AD&D Insurance. If you do not choose to continue your life insurance under one of the following options, all life insurance, including Basic Life and AD&D Insurance paid by your employer, will end at the end of the month in which you begin active duty. There are two options for extending insurance benefits:

1. You can use agency-approved annual or military leave to maintain a minimum of eight hours' pay status each month. Employer-sponsored Basic Life and AD&D Insurance will be continued. You are responsible for paying the premium for any optional life insurance. Optional AD&D Insurance coverage cannot be continued.
Read the following information carefully before completing the form(s).

2. You can self-pay your life insurance coverage by completing the MetLife Enrollment/Change Form. If you return to full-time employment status before the end of the 29 months in which you began active duty, you may reinstate your original coverage without evidence of insurability. If you return to full-time employment status after the end of 29 months, you may be required to provide a Statement of Health for any optional life insurance. Any increase to the amount of life insurance you had in place when you were called to active duty will require a Statement of Health.

Reinstating life insurance when you return to work
When you return to work, you will need to complete and submit the appropriate form within 31 days in both situations to reinstate your employer-sponsored and optional coverage:

- If you choose to self-pay optional coverage during LWOP, complete the MetLife Enrollment/Change Form. Your employee coverage will be reinstated when you return to work without evidence of insurability.
- If you choose not to pay for optional coverage or if you reduced your coverage during LWOP, complete the MetLife Enrollment/Change Form.

Long-term disability insurance benefits
You may self-pay basic and optional long-term disability (LTD) coverage when you are on approved educational leave or called to active duty in the uniformed services as defined under USERRA. Your personnel, payroll, or benefits office has a definition of educational leave.

If you continue LTD coverage while on USERRA or educational leave
If you choose to continue LTD coverage, you must pay the $2.10 monthly premium. If you are eligible to continue optional LTD insurance under PEBB Continuation Coverage (LWOP) but choose not to elect it, you must provide evidence of insurability when you regain eligibility as described in WAC 182-12-133 and 182-08-197(6)(c).

Reinstatement requirements
Reinstating your LTD coverage when you return to work from LWOP will differ based on whether you continued LTD coverage during LWOP. The chart on the next page describes the requirements for each circumstance.

(continued)
<table>
<thead>
<tr>
<th>USERRA or educational leave only</th>
<th>All other types of leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>You discontinued LTD coverage during PEBB Continuation Coverage (LWOP)</td>
<td>You were not eligible to continue LTD coverage during PEBB Continuation Coverage (LWOP)</td>
</tr>
<tr>
<td><strong>You self-paid for LTD coverage during PEBB Continuation Coverage (LWOP) and you return to active work immediately following your leave period</strong></td>
<td></td>
</tr>
<tr>
<td>If you do not immediately return to work after your approved leave period and your insurance ends—You are eligible to reinstate your basic and optional LTD insurance the first day of the month you regain eligibility for the employer contribution as a new subscriber. Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days of becoming eligible for benefits. After 31 days of becoming eligible for benefits, follow these steps for requesting changes to your waiting period: If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution. If you wish to decrease your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form and Standard Insurance Company must receive your completed Long Term Disability Evidence of Insurability Form after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance you had during PEBB Continuation Coverage (LWOP).</td>
<td></td>
</tr>
<tr>
<td>If you do not immediately return to work after your approved leave period and your insurance ends—you are eligible to reinstate your basic and optional LTD insurance the first day of the month you regain eligibility for the employer contribution. Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days of becoming eligible for benefits. After 31 days of becoming eligible for benefits, follow these steps for requesting changes to your waiting period: If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution. If you wish to decrease your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form and Standard Insurance Company must receive your completed Long Term Disability Evidence of Insurability Form after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance you had during PEBB Continuation Coverage (LWOP).</td>
<td></td>
</tr>
<tr>
<td><strong>You self-paid for LTD coverage during PEBB Continuation Coverage (LWOP) but did not return to active work immediately following your leave period</strong></td>
<td></td>
</tr>
<tr>
<td>To apply for optional LTD insurance, your employing agency must receive your completed Long Term Disability Enrollment/Change Form and Standard Insurance Company must receive your completed Long Term Disability Evidence of Insurability Form no later than 31 days after you regain eligibility for the employer contribution. Your insurance would not become effective until approved by Standard Insurance Company.</td>
<td></td>
</tr>
<tr>
<td>If you become eligible for the employer contribution immediately following your leave during the first 29 months, your LTD insurance does not end. You do not have to complete and submit any forms to continue the amount of coverage you had during PEBB Continuation Coverage (LWOP). If you wish to increase your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form no later than 31 days after you regain eligibility for the employer contribution. If you wish to decrease your waiting period for optional LTD coverage—Your employing agency must receive your completed Long Term Disability Enrollment/Change Form and Standard Insurance Company must receive your completed Long Term Disability Evidence of Insurability Form after you regain eligibility for the employer contribution. The decreased waiting period would not become effective until approved by Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance you had during PEBB Continuation Coverage (LWOP).</td>
<td></td>
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</tbody>
</table>
2017 Continuation Coverage
Election/Change (for Leave Without Pay)

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form no later than 60 days after the date your employer-sponsored coverage ends or from the postmark on the PEBB Program Continuation Coverage Election Notice packet sent to you, whichever is later.
- We must receive your first payment before we can enroll you. Premiums and applicable surcharges are due back to when your other coverage ended.
- List eligible family members you wish to cover or remove from coverage. This form replaces all Continuation Coverage Election/Change forms previously submitted.
- If adding a dependent with a disability age 26 or older, or an extended dependent, you must also include the required dependent certification form.

All forms and documents are available at www.hca.wa.gov/public-employee-benefits or by calling 1-800-200-1004 or 711 for relay services.

Qualifying Event for Leave Without Pay Coverage  Check only one.

- Applying for disability retirement
- Layoff
- USERRA (military) leave
- Reversion employee
- Approved Leave Without Pay (LWOP)
- Workers’ compensation
- Approved educational leave
- Faculty between periods of eligibility
- Seasonal employee off-season
- Employee appealing a dismissal action

Section 1: Subscriber Information

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Sex</th>
<th>Date employer coverage ended</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street address</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing address (if different from above)</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County of residence</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Daytime phone number</th>
<th>Home phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Continue coverage:
- (select all that apply)
  - Medical and dental
  - Medical only
  - Dental only
  - Life insurance
  - Long-term disability insurance (only if on educational or military leave)

If you are enrolled in a Medical Flexible Spending Arrangement and would like to continue it, contact Navia Benefit Solutions.

Cancel coverage:
- (select all that apply)
  - Medical and dental
  - Medical only
  - Dental only
  - To cancel life insurance, contact MetLife at 1-866-548-7139.
  - Long-term disability insurance (only if on educational or military leave)

Reason ________________________________  Cancel date _______________________

I understand that I am forfeiting all further rights to enroll in PEBB Program benefits cancelled above unless I regain eligibility.

Visit our website at www.hca.wa.gov/public-employee-benefits (continued)
2017 Continuation Coverage Election/Change

Section 1: Subscriber Information (continued)

Tobacco Use Premium Surcharge
The PEBB Program requires a monthly $25-per-account surcharge in addition to your premium if you or a family member (age 13 or older) enrolled on your PEBB medical coverage 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. See the 2017 Premium Surcharge Help Sheet at www.hca.wa.gov/public-employee-benefits for instructions on how to respond. If you check YES below or leave this section blank, you will pay the surcharge.

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

☐ 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 used tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

Section 2: Spouse or State-Registered Domestic Partner Information
List an eligible spouse or state-registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. If adding a state-registered domestic partner you must provide proof of eligibility within PEBB Program enrollment timelines, or the state-registered domestic partner will not be enrolled. A list of documents we will accept to verify eligibility is available at www.hca.wa.gov/public-employee-benefits.

Relationship to subscriber
☐ Spouse: date of marriage ___________________  ☐ State-registered domestic partner: date registered _______________

Social Security number

<table>
<thead>
<tr>
<th>Street address (only if different from subscriber)</th>
<th>Apt./unit number</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
<th>Date of birth (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

☐ Continue coverage: (select one)  ☐ Medical and dental  ☐ Medical only  ☐ Dental only  To cancel life insurance, contact MetLife at 1-866-548-7139.

☐ Add coverage: (select one)  ☐ Medical and dental  ☐ Medical only  ☐ Dental only

☐ Cancel coverage: (select one)  ☐ Medical and dental  ☐ Medical only  ☐ Dental only

Reason ____________________________________________________________________  Cancel date ____________

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

Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner?
Read each option and check only one:

☐ I previously attested to my spouse’s or state-registered domestic partner’s tobacco use and my attestation has not changed.

☐ YES, I am subject to the $25 surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months.

☐ NO, I am not subject to the $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or has used tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

Spouse or State-Registered Domestic Partner Coverage Premium Surcharge
The PEBB Program requires a monthly $50 surcharge in addition to your premium if your spouse or state-registered domestic partner has elected not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2017 Premium Surcharge Help Sheet and the 2017 Spousal Plan Calculator at www.hca.wa.gov/public-employee-benefits. To change your attestation, use the 2017 Premium Surcharge Change Form. If you check YES below or leave this section blank, you will pay the monthly surcharge.

Does the spouse or state-registered domestic partner coverage surcharge apply to you? Check one:

☐ YES, I am subject to the $50 premium surcharge. I used the 2017 Premium Surcharge Help Sheet and completed the 2017 Spousal Plan Calculator online.

☐ NO, I am not subject to the $50 premium surcharge. I used the 2017 Premium Surcharge Help Sheet and, if needed, completed the 2017 Spousal Plan Calculator online.

Which questions, if any, on the 2017 Premium Surcharge Help Sheet did you check NO? Check all that apply. (Question 1 is not applicable.)  ☐ Question 2  ☐ Question 3  ☐ Question 4  ☐ Question 5  ☐ Question 6

2017 Continuation Coverage Election/Change

Section 3: Family Member Information (such as child) Use additional forms for more members.
List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. Attach a completed Extended Dependent Certification form if enrolling an extended dependent. If enrolling a dependent with a disability age 26 or older, submit a completed Certification of Dependent with a Disability form and return as instructed on the form.

<table>
<thead>
<tr>
<th>Relationship to subscriber</th>
<th>Check only if age 26 or older.</th>
<th>Sex</th>
<th>Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Extended dependent validated by court order? Yes No

Last name First name Middle initial Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number City State ZIP Code

Continue coverage: (select one) Add coverage: (select one) Cancel coverage: (select one)

Medical and dental Medical and dental Medical and dental

Medical only Medical only Medical only

Dental only Dental only Dental only

To cancel life insurance, contact MetLife

Reason Cancel date

Does the tobacco use premium surcharge apply to this family member? (Response required for family members ages 13 or older.) Check only one:

YES, I am subject to the $25 premium surcharge. This family member has used tobacco products in the past two months.

NO, I am not subject to the $25 premium surcharge. This family member has not used tobacco products in the past two months, or has used the tobacco cessation resources noted in the 2017 Premium Surcharge Help Sheet.

Section 4: Changes to an Existing Account

Are you making changes to an existing account? Yes No If yes, what changes? (Check all that apply in the sections below.)

Changes you can make anytime

<table>
<thead>
<tr>
<th>Name change</th>
<th>Address change</th>
<th>Cancel medical coverage</th>
<th>Cancel dental coverage</th>
</tr>
</thead>
</table>

Remove dependent(s) from coverage. In most cases, when removing a dependent from coverage, the change will occur prospectively. If removing due to loss of eligibility (divorce, dissolution of state-registered domestic partnership, death, or other loss of eligibility under PEBB Program rules), we must receive this form no later than 60 days after the last day of the month the dependent loses eligibility for health plan coverage. Coverage will be cancelled the last day of the month of loss of eligibility. If applicable, provide former dependent’s new address:

Additional changes you can make during annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested. Add dependent(s) Change medical plan Change dental plan
Section 4: Changes to an Existing Account (continued)

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of annual open enrollment when an event creates a special open enrollment. The PEBB Program must receive this form and proof of the event no later than 60 days after the event. However, if adding a newborn or adopted child increases your premium, this form must be received no later than 12 months after the birth or adoption.

Check the box next to each change you are requesting, and indicate the corresponding event(s) below. See the numbers beside each change to verify that your requested change may be allowed. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

- Add dependent(s) (allowable under events 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12)
- Change medical plan (allowable under events 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15)
- Change dental plan (allowable under events 1, 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15)

Give date of event _____________________________

Check the box(es) next to the corresponding event(s). The event number below must be listed next to the change(s) you are requesting above.

1. Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
2. Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete an Extended Dependent Certification form available at www.hca.wa.gov/public-employee-benefits.
4. 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.
5. Subscriber has a change in employment status that affects the subscriber’s eligibility for their employer contribution toward his or her employer-based group health plan.
6. Subscriber’s dependent has a change in his or her own employment status that affects his or her eligibility for the employer contribution under his or her employer-based group health plan.
7. Subscriber or 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.
8. Subscriber’s dependent moves from outside the United States to live within the United States or moves from inside the United States to live outside the United States.
9. Subscriber or dependent has a change in residence that affects health plan availability.
10. A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible child of the subscriber.
11. Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP).
12. Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
13. Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
14. Subscriber or dependent’s current health plan becomes unavailable because the subscriber or dependent is no longer eligible for a health savings account.
15. Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

Are you or any eligible dependents enrolled in PEBB Program coverage under another account?  □ Yes  □ No

(continued)
### 2017 Continuation Coverage Election/Change

<table>
<thead>
<tr>
<th>Subscriber's last name</th>
<th>First name</th>
<th>Middle initial</th>
<th>Social Security number</th>
</tr>
</thead>
</table>

### Section 5: Medical Plan Selection

**Check only one.**

Contact the plans for benefits information; their contact information is located at the end of this form.

**Kaiser Foundation Health Plan of Washington**

- [ ] Kaiser Permanente WA Classic (formerly Group Health Classic)
- [ ] Kaiser Permanente WA SoundChoice (formerly Group Health SoundChoice)
- [ ] Kaiser Permanente WA Value (formerly Group Health Value)

**Kaiser Foundation Health Plan of Washington Options, Inc.**

- [ ] Kaiser Permanente WA Consumer-Directed Health Plan (formerly Group Health Consumer-Directed Health Plan)

**Kaiser Foundation Health Plan of the Northwest**

- [ ] Kaiser Permanente NW Classic
- [ ] Kaiser Permanente NW Consumer-Directed Health Plan

**Uniform Medical Plan, administered by Regence BlueShield**

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

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1 These plans have a specific service area. If you move out of the service area, you may need to change your plan. You must notify the PEBB Program no later than 60 days after you move.

2 Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in WA, and the Portland, OR, area.

### Section 6: Dental Plan Selection

**Check only one.**

Before you select a dental plan, be sure your provider(s) participate with that plan.

**Preferred Provider Organization**

You can choose any dental provider and change providers at anytime.

- [ ] Uniform Dental Plan (Group #3000), administered by Delta Dental of Washington

**Managed-Care Plans**

You must choose a provider from the dental plan network. Before you select a managed-care plan, be sure to call the dental plan to verify your provider is in their network.

- [ ] DeltaCare (Group #3100), administered by Delta Dental of Washington
  
  Call DeltaCare at 1-800-650-1583 to verify your provider accepts the specific plan network and plan group.

- [ ] Willamette Dental of Washington, Inc. (Group WA82)
  
  Call Willamette Dental of Washington at 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.
Section 7: Life and Accidental Death & Dismemberment (AD&D) Insurance

- YES, I wish to continue the life and AD&D insurance I had as an active employee. I understand I will need to pay MetLife for Basic Life Insurance and Basic AD&D Insurance in addition to any optional life and AD&D insurance I have while on Leave Without Pay. If you wish to decrease your life and/or AD&D insurance amounts while on Leave Without Pay, please use the MetLife Enrollment/Change Form and return it to MetLife.

- NO, I do not wish to continue the life and AD&D insurance I had as an active employee. I understand I must reapply for optional life insurance and submit evidence of insurability to MetLife when I return to work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work.

Section 8: Long-Term Disability

This section applies only to employees on approved educational leave or called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Current Enrollment With Agency

- Basic coverage ($2.10/month)
- Optional coverage (select a waiting period)
  - 30-Day
  - 90-Day
  - 180-Day
  - 300-Day
  - 60-Day
  - 120-Day
  - 240-Day
  - 360-Day

Desired Enrollment While Self-Paying

- I wish to maintain the same coverage I had as an active employee. __________ (initials)

- I wish to maintain the same Basic Long-Term Disability Insurance I had as an active employee, and increase the Optional Long-Term Disability Insurance waiting period. I understand I must reapply for the lower waiting period under Optional Long-Term Disability and submit evidence of insurability to the carrier for approval when I return to work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work. __________ (initials)

- I do not wish to maintain the long-term disability coverage I had as an active employee. I understand I must reapply for the lower waiting period under Optional Long-Term Disability and submit evidence of insurability to the carrier for approval when I return to work. I understand that the required enrollment forms must be received by my employing agency no later than 31 days from the date I return to work. __________ (initials)
I have received and read the PEBB Continuation Coverage Election Notice, including any appendices. By signing 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 plan(s). My family members and I may also lose PEBB Program 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 providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of PEBB Program insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If I 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 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.

This form replaces all Continuation Coverage Election/Change forms I have previously submitted to the PEBB Program.

HCA’s Privacy Notice:
We will keep your information private as allowed by law.
To see our Privacy Notice, go to www.hca.wa.gov/public-employee-benefits.

Subscriber’s signature ___________________________ Date ______________

Mail to:
Washington State Health Care Authority  
P.O. Box 42684  
Olympia, WA 98504-2684

If payment is enclosed, make it payable to Health Care Authority and mail to:  
Washington State Health Care Authority  
P.O. Box 42691  
Olympia, WA 98504-2695

Or hand-deliver to:  
Washington State Health Care Authority  
626 8th Ave. SE  
Olympia, WA 98501

2017 PEBB Program Medical Contractors
Kaiser Foundation Health Plan of Washington  
(formerly Group Health Cooperative)  
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233  
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of Washington Options, Inc.  
(formerly Group Health Options Inc.)  
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233  
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest  
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099  
1-800-813-2000 or TTY 711

Uniform Medical Plan, administered by Regence BlueShield  
1800 Ninth Ave., Suite 235, Seattle, WA 98101  
1-888-849-3681 or TTY 711

2017 PEBB Program Life Insurance Contractor
Metropolitan Life Insurance Company (MetLife)  
P.O. Box 14406, Lexington, KY 40512-4406  
1-866-548-7139

2017 PEBB Program Dental Contractors
DeltaCare, administered by Delta Dental of Washington  
9706 Fourth Ave. NE, Seattle, WA 98115-2157  
1-800-650-1583

Uniform Dental Plan  
administered by Delta Dental of Washington  
9706 Fourth Ave. NE, Seattle, WA 98115-2157  
1-800-537-3406

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

2017 PEBB Program Long-Term Disability Insurance Contractor
Standard Insurance Company  
411 108th Ave. NE, Suite 400, Bellevue, WA 98004  
1-800-368-2860

HCA is committed to providing equal access to our services. If you need accommodation, please call 1-800-200-1004 or 711 for relay services.
2017 Premium Surcharge Help Sheet

- Use the information below to attest on your 2017 enrollment form or the 2017 Premium Surcharge Change Form whether the premium surcharges apply.
- The surcharges do not apply to subscribers and any family members enrolled in PEBB dental coverage only.
- The surcharges do not apply to retirees, COBRA, or continuation coverage subscribers enrolled in Medicare Part A and Part B.
- The tobacco use surcharge does not apply to any enrolled family members ages 12 and younger.

Tobacco use premium surcharge

What are “tobacco products”?
Tobacco products means 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.
- Tobacco cessation aids approved by the FDA, such as:
  1. Over-the-counter nicotine replacement products.
     - All over-the-counter tobacco cessation products for adults ages 18 and older.
     - All over-the-counter tobacco cessation products for children under age 18 if recommended by a doctor.
   Examples of over-the-counter nicotine replacement products include:
   - Skin patches—generic (nicotine film), private label, or brand-name (Habitrol or Nicoderm).
   - Chewing gum (also called nicotine gum)—generic (nicotine polacrilex or Thrive), private label, or brand-name (Nicorette).
   - Lozenges—generic (nicotine polacrilex), private label, or brand-name (Nicorette or Commit).
  2. Prescription nicotine replacement products.
     - Nasal spray or oral inhaler—brand name (Nicotrol)
     - Products not containing nicotine, such as pills—generic (buproprion hydrochloride) or brand name (Chantix or Zyban).

What is “tobacco use”?
Tobacco use is defined as any use of tobacco products within the past two months. It does not include the religious or ceremonial use of tobacco.

The surcharge will not apply if you and all enrolled family members ages 18 and older who use tobacco products are enrolled in your PEBB medical plan’s tobacco cessation program, or if enrolled family members ages 13–17 who use tobacco products access information and resources at www.teen.smokefree.gov. Enrolled family members ages 12 and younger are automatically defaulted to NO (non-tobacco users); this means you do not have to attest for family members ages 12 and younger. You do not need to attest when the family member turns age 13 unless the family member uses, or begins using, tobacco products.

Does this mean tobacco use within the past two months from today?
Tobacco products used within the two months before the date you complete this form count as “tobacco use.”

What if tobacco use changes?
You must change your attestation when:
- Any enrolled family member age 13 and older starts using tobacco products.
- All enrolled family members ages 13 and older have stopped using tobacco products for two months, or have used the tobacco cessation resources noted above.

You can change your attestation online using My Account at www.hca.wa.gov/public-employee-benefits or submit a 2017 Premium Surcharge Change Form. Changes that result in a premium surcharge will begin the first day of the month following the status change (the date the family member(s) started or stopped using tobacco products). If that day is the first of the month, the change to the surcharge begins on that day. Changes that result in removing a premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

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

Will the spouse or state-registered domestic partner coverage premium surcharge apply to me?
If you don’t have a spouse or state-registered domestic partner enrolled on your PEBB medical plan, you don’t need to complete this questionnaire—this surcharge doesn’t apply to you. If you have a spouse or state-registered domestic partner enrolled on your 2017 PEBB medical plan, you must:
1. Answer YES or NO to the following Questions 2-6.

2. Check the corresponding box(es) on your 2017 enrollment/change form or 2017 Premium Surcharge Change Form.

<table>
<thead>
<tr>
<th>Questions</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you covering your spouse or state-registered domestic partner in Public Employees Benefits Board (PEBB) medical under your account in 2017?</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Will your spouse or state-registered domestic partner be eligible for medical coverage through his or her employer in 2017? (If your spouse or state-registered domestic partner will not be employed in 2017, answer NO.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will your spouse’s or state-registered domestic partner’s employer offer at least one medical plan that serves your spouse’s or state-registered domestic partner’s county of residence in 2017?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your spouse or state-registered domestic partner elected not to enroll in his or her employer’s medical in 2017?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will the coverage offered by your spouse’s or state-registered domestic partner’s employer in 2017 NOT be through the PEBB Program or TRICARE?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Answer YES if your spouse’s or state-registered domestic partner’s employer does not offer PEBB coverage or TRICARE.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Answer NO if your spouse’s or state-registered domestic partner’s employer does offer PEBB coverage or TRICARE.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will your spouse’s or state-registered domestic partner’s share of the medical premium through his or her employer be less than $98.81 per month in 2017?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered NO to ANY of these questions, you will not have to pay the surcharge if you check NO on your 2017 enrollment form or 2017 Premium Surcharge Change Form.

If you answered YES to ALL of these questions, you must do 1 and 2 below to find out whether you must pay the surcharge.
1. Your spouse or state-registered domestic partner should ask his or her employer for a 2017 Summary of Benefits and Coverage (SBC) for all medical plans that:
   • Serve the county of residence for your spouse or registered domestic partner.
   • Have a monthly premium of less than $98.81 per month for the employee.
   Or, you can download a paper version of the 2017 Spousal Plan Calculator from the website and submit it with your 2017 enrollment form or your 2017

If you don’t have access to the Internet, you may request a paper 2017 Spousal Plan Calculator from your employer (if an employee). Retirees, COBRA, and continuation coverage subscribers may call the PEBB Program at 1-800-200-1004 to request a paper copy.

If using the online 2017 Spousal Plan Calculator:
• Provide all the information requested by the form.
• Click the Calculate button.
• You will be provided with the YES or NO response to the question “Does the spouse or registered domestic partner coverage surcharge apply to you?” Enter this response on your 2017 enrollment form or 2017 Premium Surcharge Change Form.

If using a paper 2017 Spousal Plan Calculator:
• Provide all the information requested by the form.
• Check “Employer or PEBB Program to determine.”
• Include a copy of the 2017 Spousal Plan Calculator (not this Help Sheet) when you submit your 2017 enrollment form or 2017 Premium Surcharge Change Form.
• Your employer or the PEBB Program will determine whether your spouse’s or state-registered domestic partner’s employer-based group medical is
You have 60 days after the mailing date on this booklet to elect to continue your PEBB health coverage.

To continue life insurance, MetLife must receive your completed application no later than 31 days (or 60 days, if you are retiring) after your employer-paid coverage ends.