Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

PEBB Continuation Coverage Election Notice

READ NOW

You are receiving this booklet because your Public Employees Benefits Board (PEBB) coverage recently ended. This booklet explains how you and your dependents can continue your PEBB coverage. To continue PEBB coverage, you must follow the instructions provided and complete the enclosed form(s). **The PEBB Program must receive your election form(s) no later than 60 days from the date PEBB health plan coverage ended or from the postmark date on this booklet, whichever is later.**

To continue life insurance under portability or conversion, complete the form sent to you by Metropolitan Life Insurance Company (MetLife). **MetLife must receive your completed form no later than 60 days after your employer-paid coverage ends. See Appendix A for details.**

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* online at **www.hca.wa.gov/erb**, 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/ebsa/key-topics/health-and-other-employee-benefits** 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 Program
1-800-200-1004 (toll free)
360-725-0440 (Olympia area)
711 (TRS)
Monday through Friday, 8 a.m. to 4:30 p.m. *(Note: Other business activities may result in phones being unavailable during this time.)*

www.hca.wa.gov/erb

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

Street address
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Note: The Health Care Authority (HCA) is open between 8 a.m. and 5 p.m. Monday through Friday. Visitors are seen on a first-come, first-served basis. To make sure the last lobby visit ends by 5 p.m., the last visitor will be accepted at 4:30 p.m.

Notify the PEBB Program of address changes

To protect your rights and the rights of your dependents, you must keep the PEBB Program informed of address changes for yourself and each of your dependents by calling us at 1-800-200-1004 (TRS:711) (select menu option 5), 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 can 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**.

Table of Contents

Introduction

This booklet contains important information about your and your dependents' right to continue Public Employees Benefits Board (PEBB) 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 Health 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.

- To elect PEBB Continuation Coverage, the PEBB Program must receive your completed election form(s) (found in this booklet) **no later than 60 days** from the date PEBB health plan coverage ended or from the postmark date on this booklet, whichever is later.
- If you are not eligible for PEBB Continuation Coverage (Unpaid Leave) and wish to continue your life insurance under portability or conversion, complete the form sent to you by Metropolitan Life Insurance Company (MetLife). MetLife must receive your completed form **no later than 60 days** after your employer-paid coverage ends. See Appendix A for information on portability or conversion.

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 eligible dependents stop being eligible. If elected, PEBB Continuation Coverage (COBRA) or PEBB Continuation Coverage (Unpaid Leave) 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 premium payment and applicable premium surcharges with your election form(s). However, your first premium and applicable premium surcharge payment is due to HCA **no later than 45 days** after your 60-day election period ends.

You can find important premium payment information under "When and how do I make payments?" on page 11. If you do not make your premium and applicable premium surcharge payment by the deadline, you will lose your right to enroll in PEBB Continuation Coverage.

Federal law requires that most group health plans (including the PEBB Program) give employees and their dependents 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. However, the premiums are not the same.

Each person who elects PEBB Continuation Coverage will have the same rights as other PEBB enrollees, including PEBB Program 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 dependents, if eligible, to continue PEBB coverage.

- PEBB Continuation Coverage (COBRA)—**a temporary extension of PEBB health plan coverage** available to PEBB members defined as qualified beneficiaries under federal Consolidated Omnibus Budget Reconciliation Act (COBRA) rules, and for state-registered domestic partners and their children, based on RCW 26.60.015 and PEBB policy resolution that extends PEBB coverage for dependents not otherwise eligible for COBRA. Coverage may be temporarily extended only if the PEBB member experiences a qualifying event. For eligibility information and forms, see Appendix A.
- PEBB Continuation Coverage (Unpaid leave)—**a temporary extension of PEBB insurance coverage** for unpaid employees who lose eligibility for the employer contribution toward insurance coverage due to specific types of leave. For eligibility information and forms, see Appendix B.

Premiums for the options above are on pages 14–16. To enroll, see "How do I elect PEBB 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 PEBB Continuation Coverage?

Qualified beneficiaries (employees, spouses, or dependent children) under federal COBRA continuation coverage, or state-registered domestic partners and their dependent children who are not qualified beneficiaries under federal COBRA rules, are entitled to elect PEBB Continuation Coverage (COBRA) if they lost PEBB health plan coverage due to a qualifying event (see page 6). For more information on who qualifies for PEBB Continuation Coverage (COBRA), see Appendix A.

Each individual (employee or dependent) who lost their PEBB employer-based group health plan due to a qualifying event has an independent election right to PEBB Continuation Coverage (COBRA). For example:

- The employee's eligible 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, some, 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 (Unpaid Leave) for themselves and eligible dependents. If an employee does not elect this coverage, their dependents do not have independent election rights to PEBB Continuation Coverage (Unpaid Leave).

How do I elect elect PEBB Continuation Coverage?

To elect PEBB Continuation Coverage, the PEBB Program must receive your completed form(s) **no later than 60 days** from the date PEBB health plan coverage ended or from the postmark date on this notice, whichever is later.

Oral communications (in person or by telephone) and electronic communications (fax or email) are

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not acceptable methods of making an election and will not preserve your continuation coverage rights.

If the PEBB Program does not receive your completed form(s) by the required 60-day 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
PO Box 42684
Olympia, WA 98504-2684

Or bring to (8 a.m. to 4:30 p.m. Monday–Friday):
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 PEBB Continuation Coverage?

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

You should carefully compare your other coverage options with 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 PEBB Continuation Coverage because the new coverage may impose a new deductible.

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 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 PEBB Continuation Coverage. Being offered 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 qualifying "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 without a qualifying event 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.** Washington State residents can visit **www.wahbexchange.org**.

Can I switch between PEBB Continuation Coverage and the Marketplace?

If you sign up for PEBB Continuation Coverage, you can switch to a Marketplace plan during the Marketplace's open enrollment period. You can also end PEBB Continuation Coverage early and switch to a Marketplace plan if you have a qualifying event that triggers a "special enrollment period" (such as marriage or birth of a child). Be careful—if you terminate PEBB Continuation Coverage without a qualifying event, you'll have to wait to enroll in Marketplace coverage until the next Marketplace open enrollment period. You could end up without health plan coverage and may be charged high

out-of-pocket costs if you receive health care services. To find out when the Marketplace open enrollment period is, visit **www.wahbexchange.org** (in Washington State) or **www.healthcare.gov** (all other states).

When your 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 PEBB Continuation Coverage, you cannot switch to PEBB Continuation Coverage under any circumstance.

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 elects 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 your PEBB Continuation Coverage ends.

What factors should I consider when choosing coverage options?

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

- **Premiums**. Your previous health plan can charge up to 102 percent of total health plan premiums under COBRA rules. The PEBB Program charges 100 percent of the total health plan premiums for PEBB Continuation Coverage (COBRA) and PEBB Continuation Coverage (Unpaid Leave), 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 prescription medications, a change in your health coverage may affect your prescription drug costs—and in some cases, your medication may not be covered by another plan. Check if your current medications are covered by the health plan you are considering.
- **Severance payments**. Under federal COBRA rules, 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 PEBB Continuation Coverage (COBRA) payments for a period of time. In this scenario, contact the U.S. Department of Labor at 1-866-444-3272 (TTY: 1-877-889-5627) to discuss your options.

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What if I'm thinking of retiring?

PEBB retiree insurance coverage is available to employees and their survivors who meet eligibility and enrollment requirements as described in Washington Administrative Code (WAC):

- Retiring employees, including employees determined eligible for a disability retirement, and elected or full-time appointed officials leaving public office, as described in WAC 182-12-133, 182-12-171, 182-12-180, 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, elected and full-time appointed officials, and retirees, as described in WAC 182-12-180 and 182-12-265.

To find out if you are eligible for PEBB retiree insurance coverage:

- Visit **www.hca.wa.gov/pebb-retirees**, or
- Call the PEBB Program at 1-800-200-1004 (TRS: 711) and select option 5 to request a *Retiree Enrollment Guide*.

To enroll in or defer enrollment in PEBB retiree insurance coverage, the PEBB Program must receive your election form(s) **no later than 60 days** after your employer-paid, COBRA, or PEBB Continuation Coverage ends, or **no later than 60 days** after the date you leave office if you are an elected or full-time appointed official as described in WAC 182-12-180(1).

- **Where you live**. Some health 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 health plan has a service or coverage area, or other similar limitations.
- **Other cost-sharing**. In addition to monthly premiums or contributions for health plan coverage, you probably pay out-of-pocket costs, such as copays, deductibles, coinsurance, or other fees when you receive health care services. Check what the cost-sharing requirements are for your health plan options. For example, one health plan option may have lower monthly premiums, but a higher deductible and higher copayments.

What if I decline PEBB Continuation Coverage?

If you reject or decline PEBB Continuation Coverage **before** the due date, you may change your mind as long as the PEBB Program receives your completed election form(s) **no later than 60 days** from the postmark date on this booklet, or from the date your PEBB health plan coverage ended, whichever is later.

How long can I remain on PEBB Continuation Coverage?

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

PEBB Continuation Coverage provides temporary health plan coverage and, in some instances, life and long-term disability insurance. Maximum coverage periods vary based on your qualifying event, and are described below in this section. In some situations, coverage can end before the maximum coverage period (see page 10).

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

PEBB Continuation Coverage (COBRA) can generally last up to 18 months if you meet other requirements explained in this booklet. Additional coverage may be available under PEBB Continuation Coverage (Unpaid Leave) 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 less than 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 PEBB Continuation Coverage (COBRA) for up to 18 months; 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 PEBB Continuation Coverage (COBRA), the employee loses their right to coverage under federal COBRA rules. However, the employee may:

- Continue health plan coverage for the remainder of the 18 month coverage period under PEBB Program rules; 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 continuation coverage for up to 36 months 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 PEBB Continuation Coverage (COBRA), the dependents may continue coverage 28 more months after the continuation coverage enrollment date. (The 36 months allowed under PEBB Continuation Coverage (COBRA), minus the eight months the employee was

entitled to Medicare before their termination of employment or reduction in hours, 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 **no more than 18 months before** the 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 (Unpaid Leave) generally can last for a maximum of 29 months as described in WAC 182-12-133:

- 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 defined in WAC 182-12-109.

The employee may continue any combination of:

- 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 PEBB Continuation Coverage (Unpaid Leave) as described above, but who has not used the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining difference in months allowed under PEBB Continuation Coverage (COBRA) for a maximum of 18–36 months depending on the qualifying event. However, life and long-term disability insurance cannot be continued under PEBB Continuation Coverage (COBRA).

(b) For a faculty employee who is between periods of eligibility, PEBB Continuation Coverage (Unpaid Leave) generally can last for a maximum of 12 months as described in WAC 182-12-142. The faculty employee may continue any combination of:

- Medical
- Dental
- Life insurance

Faculty who are no longer eligible for PEBB Continuation Coverage (Unpaid Leave) as described above, who have not used the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining months allowed under PEBB Continuation Coverage (COBRA). However, life insurance cannot be continued under PEBB Continuation Coverage (COBRA).

(c) For a seasonal employee who is between periods of eligibility, PEBB Continuation Coverage (Unpaid Leave) generally can last for a maximum of 12 months as described in WAC 182-12-142. Seasonal employees may continue any combination of:

- Medical
- Dental
- Life insurance

Seasonal employees who are no longer eligible for PEBB Continuation Coverage (Unpaid Leave) as described above, who have not used the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining months allowed under PEBB Continuation Coverage (COBRA). However, life insurance cannot be continued under PEBB Continuation Coverage (COBRA).

(d) If an employee reverts from an eligible position for reasons other than a layoff and is not eligible for the employer contribution toward insurance coverage, PEBB Continuation Coverage (Unpaid Leave) 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 any combination of:

- Medical
- Dental
- Life insurance

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An employee who reverts for reasons other than a layoff and who is no longer eligible for PEBB Continuation Coverage (Unpaid Leave) as described above, but who has not used the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining months allowed under PEBB Continuation Coverage (COBRA). However, life insurance cannot be continued under PEBB Continuation Coverage (COBRA).

(e) For an employee awaiting hearing of a dismissal action, PEBB Continuation Coverage (Unpaid Leave) generally can last until the dismissal is upheld or overturned for up to 29 months as described in WAC 182-12-148. An employee awaiting hearing of a dismissal action may continue any combination of:

- Medical
- Dental
- Life insurance

If the dismissal is upheld and the employee is no longer eligible for PEBB Continuation Coverage (Unpaid Leave), 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.

Employees whose dismissal is upheld and are no longer eligible as described above, and who have not used the maximum number of months allowed under federal COBRA rules, may continue medical, dental, or both for the remaining difference in months allowed under PEBB Continuation Coverage (COBRA). However, life insurance cannot be continued under PEBB Continuation Coverage (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 insurance coverage is lost due to the death of the employee, the employee's divorce, the employee's termination of a state-registered domestic partnership, or the dependent child losing eligibility (as described in WAC 182-12-260), PEBB Continuation Coverage (COBRA) coverage can last up to 36 months.

(b) 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 coverage if you meet both the procedural and eligibility requirements as outlined in WAC 182-12-250.

(c) If you are a surviving spouse, state-registered domestic partner, or dependent child of any employee or retiree, you may be eligible to enroll in PEBB retiree insurance coverage if you meet the procedural and eligibility requirements in WAC 182-12-180 and 182-12-265.

(5) When PEBB Continuation Coverage (COBRA) may be extended

You may be able to extend the maximum 18-month period of PEBB Continuation Coverage (COBRA) if you or a qualified dependent becomes disabled or a second qualifying event occurs. You must notify the PEBB Program of a disability or a second qualifying event to extend the continuation coverage period during the required timeframe. 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 during the first 60 days of PEBB Continuation Coverage (COBRA) 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 *2019 PEBB Continuation Coverage (COBRA) Election/Change* 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 their 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 before the end of the initial 18 months of PEBB Continuation Coverage (COBRA) 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 before the end of the initial 18 months of PEBB Continuation Coverage (COBRA), there will be no disability extension of PEBB Continuation Coverage (COBRA).

The right to the disability extension may be terminated if the Social Security Administration determines that the disabled qualified beneficiary is no longer disabled. You or your qualified beneficiaries have 30 days after the Social Security Administration's determination to notify the PEBB Program when a qualified beneficiary is no longer disabled.

(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), they 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 coverage due to termination of employer group participation with PEBB health plan 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 Program rules.

Note: The second qualifying event extension is not available when an employee becomes entitled to Medicare after their termination of employment or reduction of hours. However, the employee and covered dependents may remain enrolled in PEBB Continuation Coverage (COBRA) for the duration of the 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

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**State-registered domestic partners and their children who lost coverage due to a qualifying event are allowed to extend the period of continuation coverage in the same situations as a spouse or child who is a qualified beneficiary.*

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 Program rules as a result of the second qualifying event.
- The date the PEBB Program provides the qualified beneficiary with a Summary Plan Document (also called a Certificate of Coverage or benefits booklet) either in print or online at **www.hca.wa.gov/erb**, informing the beneficiary of their responsibility and the procedures to notify the PEBB Program.
- The date the PEBB Program mails a *PEBB Continuation Coverage Election Notice* to the qualified beneficiary, informing the beneficiary of their responsibility and the procedures to notify the PEBB Program.

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 (Unpaid Leave) counts toward your maximum PEBB Continuation Coverage (COBRA) coverage period**

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

Can PEBB Continuation Coverage be terminated before the end of the maximum coverage period?

Yes. PEBB Continuation Coverage can be terminated before the end of the maximum coverage period for the reasons listed below.

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

PEBB Continuation Coverage will terminate automatically before the end of the maximum period if:

(a) Any required premium and applicable premium surcharge 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).

PEBB Continuation Coverage may also end for the same reasons coverage could end for any other PEBB enrollee (such as fraud).

Once your coverage ends, you are not eligible to reenroll in PEBB Continuation Coverage.

(2) Medicare entitlement or other group health plan coverage

PEBB Continuation Coverage (COBRA) will terminate automatically under federal COBRA rules if you become entitled to Medicare **after** you enroll. However, you may continue your health coverage through PEBB Continuation Coverage (COBRA) for the remainder of your coverage period under PEBB Program rules.

If you elect PEBB Continuation Coverage (COBRA), your coverage will also terminate early if you enroll in other group health plan coverage.

After electing PEBB Continuation Coverage (COBRA), you must notify the PEBB Program in writing **no later than 60 days** after you or a qualified dependent becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan 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 PEBB Continuation Coverage (COBRA) may do so even if they have other group health plan coverage or are entitled to Medicare benefits before the date on which PEBB Continuation Coverage (COBRA) 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 sends you notice of the determination. PEBB Continuation Coverage (COBRA) for all qualified beneficiaries will end on the last day of the month that the Social Security Administration's determination was sent, or as allowed by law.

(4) Request to cancel coverage

If an enrollee would like to terminate coverage before the end of the maximum coverage period, they may submit a written request to:

Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

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

How much does PEBB Continuation Coverage cost?

See monthly premiums for PEBB Continuation Coverage on pages 14–16. Generally, you are required to pay the entire cost of PEBB Continuation Coverage, similar to the total cost paid by both the employer and employee.

You will also be charged 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 pages 17–18.

When and how do I make payments?

First premium payment for PEBB Continuation Coverage

Your first premium payment and applicable premium surcharge is due to the Health Care Authority (HCA) **no later than 45 days** after your election period ends. Your election period ends no later than 60 days from the date PEBB health plan coverage ended or the postmark date on this booklet, whichever is later.

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

You must make sure the amount of your first premium payment is correct. To confirm the amount due, call 1-800-200-1004 (TRS: 711) and select option 4 to speak with PEBB Accounting. **We will not enroll you until you elect to continue your PEBB coverage and make the first premium payment including applicable premium surcharges.**

(continued)

How to make premium and applicable premium surcharge payments

You must mail or bring your **first** premium payment to the Health Care Authority (HCA).

Mail to (for first payments only):
Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Or bring to (8 a.m. to 4:30 p.m. Monday–Friday):
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Make checks payable to **Health Care Authority**.

After HCA receives your first premium payment and any applicable premium surcharges, you must pay all continuation coverage premiums and applicable premium surcharges as they become due. Here are your premium payment options:

- **A personal check or money order**
  You may also pay in cash at the HCA office only. Bring payments to the street address listed above or mail to:

  Health Care Authority
  PEBB Program
  PO Box 34270
  Seattle, WA 98124-1270

- **Automatic bank account withdrawals**
  Fill out the *Electronic Debit Service Agreement* form and submit it to HCA. The form is available at **www.hca.wa.gov/erb** under *Forms & publications*. Approval takes six to eight weeks, so you must continue to pay the total due each month until you receive a letter from HCA with your electronic debit start date.

For premium payment questions, call 1-800-200-1004 (TRS: 711) and select option 4 to speak with PEBB Accounting.

When premium payments are considered made

We consider your premium and applicable premium surcharge payment made on the date it was mailed or hand delivered to HCA at one of the addresses above, or through electronic debit service. Premium payment is not considered made if your check is returned due to insufficient funds or for any other reason.

Due dates for monthly continuation coverage and applicable premium surcharge payments

After you elect continuation coverage and make your first premium and applicable premium surcharge payment, premium and applicable premium surcharge payments are due on the 1st of the month in which PEBB insurance coverage is effective. lf you make a premium 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 payment will be delinquent and your account may be terminated depending on the amount owed.

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

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

Grace period for monthly premium payments

You will be allowed a 30-day grace period from the date that your monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or premium surcharge. **If your monthly premium or applicable premium surcharge remains unpaid for 60 days from the original due date, your coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid in full.**

Monthly premiums and applicable premium surcharges for continuing PEBB medical must be made to HCA, as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance coverage must be made to MetLife. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

Monthly premiums and applicable premium surcharges are considered delinquent (unpaid) if:

- HCA doesn't receive payment for your monthly premium or applicable premium surcharge and it remains unpaid for 30 days after the original due date; or
- HCA receives an underpayment that is more than an insignificant shortfall (as defined in WAC 182-08-015), and the monthly premium or applicable premium surcharge remains underpaid for 30 days after the original due date.

If paying the unpaid premium balance creates a hardship for you (and HCA agrees), you may request that HCA set up a payment plan.

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

- The oldest month owed: The insurance coverage premium will be paid first, and then any applicable premium surcharges.
- The next oldest month owed: The insurance coverage premium will be paid first, and then any applicable premium surcharges.

If you fail to pay premiums and applicable premium surcharges within the required deadline, coverage will be terminated the last day of the month for which the monthly premium and applicable premium surcharges were paid.

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

Once your continuation coverage is terminated, you cannot reenroll.

2019 PEBB Continuation Coverage Monthly Premiums

1. To qualify for the Medicare premium, at least one covered member on your account must be enrolled in both Medicare Part A and Part B. (Medicare premiums are not available to PEBB Continuation Coverage [Unpaid Leave] members.)
2. Medicare members enrolled in a Kaiser Permanente Washington Medicare Advantage plan or Kaiser Permanente Northwest Senior Advantage plan 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.

Non-Medicare medical plan premiums

For members not eligible for Medicare (or enrolled in Part A only)	Subscriber only	Subscriber and spouse*	Subscriber and child(ren)	Subscriber, spouse*, and child(ren)
Kaiser Permanente NW Classic**	$710.65	$1,415.33	$1,239.16	$1,943.84
Kaiser Permanente NW CDHP**	$604.16	$1,196.38	$1,062.91	$1,596.81
Kaiser Permanente WA Classic	$733.39	$1,460.80	$1,278.95	$2,006.37
Kaiser Permanente WA CDHP	$600.44	$1,189.46	$1,056.79	$1,587.47
Kaiser Permanente WA SoundChoice	$603.21	$1,200.44	$1,051.13	$1,648.37
Kaiser Permanente WA Value	$656.25	$1,306.54	$1,143.96	$1,794.25
UMP Classic	$674.85	$1,343.72	$1,176.50	$1,845.38
UMP CDHP	$600.54	$1,189.65	$1,056.96	$1,587.74
UMP Plus-PSHVN	$618.07	$1,230.18	$1,077.15	$1,689.25
UMP Plus-UW Medicine ACN	$618.07	$1,230.18	$1,077.15	$1,689.25

Medicare medical plan premiums

For members enrolled in Medicare Part A and Part B	Subscriber only	Subscriber and spouse*		Subscriber and child(ren)		Subscriber, spouse*, and child(ren)		
	1 Medicare eligible	*1 Medicare eligible*	*2 Medicare eligible*	*1 Medicare eligible*	*2 Medicare eligible*	*1 Medicare eligible*	*2 Medicare eligible*	*3 Medicare eligible*
Kaiser Permanente NW Senior Advantage**	$333.64	$1,038.32‡‡	$661.31	$862.15‡‡	$661.31	$1,566.83‡‡	$1,189.82‡‡	$988.98
Kaiser Permanente WA Classic	N/A	$1,057.27	N/A‡	$875.41	N/A‡	$1,602.83	$1,199.29	N/A‡
Kaiser Permanente WA Medicare Plan	$329.85	N/A‡	$653.73	N/A‡	$653.73	N/A‡	N/A‡	$977.61
Kaiser Permanente WA SoundChoice	N/A	$927.09	N/A‡	$777.78	N/A‡	$1,375.01	$1,101.66	N/A‡
Kaiser Permanente WA Value	N/A	$980.13	N/A‡	$817.56	N/A‡	$1,467.84	$1,141.44	N/A‡
UMP Classic	$481.09	$1,149.96	$956.20	$982.74	$956.20	$1,651.62	$1,457.86	$1,431.32

*Or state-registered domestic partner

**Kaiser Foundation Health Plan of the Northwest, with plans offered in Clark and Cowlitz counties in Washington and select counties in Oregon.

‡ If a Kaiser Permanente WA member is enrolled in Medicare Part A and Part B and other enrolled members are not eligible for Medicare, the non-Medicare members must enroll in Kaiser Permanente WA Classic, SoundChoice, or Value plan. The subscriber will pay a combined Medicare and non-Medicare premium.

‡‡If a Kaiser Permanente NW member is enrolled in Medicare Part A and Part B and other enrolled members are not eligible for Medicare, the non-Medicare members will be enrolled in Kaiser Permanente NW Classic**. The subscriber will pay the combined Medicare and non-Medicare premium shown for Kaiser Permanente NW Senior Advantage.

(continued)

Medicare Supplement Plan F premiums (administered by Premera Blue Cross)

Available only for PEBB Continuation Coverage (COBRA) members and not subscribers enrolled in PEBB Continuation Coverage (Unpaid Leave)

	Subscriber only	Subscriber and spouse*			Subscriber and child(ren)	Subscriber, spouse*, and child(ren)		
	1 Medicare eligible	*1 Medicare eligible***	*2 Medicare eligible: 1 retired, 1 disabled*	*2 Medicare eligible*	*1 Medicare eligible*	*1 Medicare eligible***	*2 Medicare eligible: 1 retired, 1 disabled***	*2 Medicare eligible***
Plan F Age 65 or older, eligible by age	$212.38	$887.23	$573.41	$424.76	$720.01	$1,388.88	$1,081.04	$932.39
Plan F Under age 65, eligible by disability	$361.03	$1,035.88	$573.41	$722.06	$868.66	$1,537.53	$1,081.04	$1,229.69

* Or state-registered domestic partner

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

Monthly premium surcharges (for non-Medicare subscribers only)

The following surcharges may apply to subscribers not enrolled in Medicare Part A and Part B in addition to the monthly medical premium. **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 dependent (ages 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 coverage, and the spouse or state-registered domestic partner elected not to enroll in another 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 *2019 Premium Surcharge Help Sheet* at **www.hca.wa.gov/erb**.

Dental plan premiums with medical plan	DeltaCare, administered by Delta Dental of Washington	Uniform Dental Plan, administered by Delta Dental of Washington	Willamette Dental of Washington, Inc.
Subscriber only	$39.53	$45.87	$44.45
Subscriber and spouse*	$79.06	$91.74	$88.90
Subscriber and child(ren)	$79.06	$91.74	$88.90
Subscriber, spouse*, and child(ren)	$118.59	$137.61	$133.35

Dental plan premiums Dental only	DeltaCare, administered by Delta Dental of Washington	Uniform Dental Plan, administered by Delta Dental of Washington	Willamette Dental of Washington, Inc.
Subscriber only	$45.50	$51.84	$50.42
Subscriber and spouse*	$85.03	$97.71	$94.87
Subscriber and child(ren)	$85.03	$97.71	$94.87
Subscriber, spouse*, and child(ren)	$124.56	$143.58	$139.32

*Or state-registered domestic partner

HCA is committed to providing equal access to our services. If you need accommodation, or require documents in another format or language, please call 1-800-200-1004 (TRS: 711).

Premium Surcharges

These premium surcharges apply to PEBB subscribers who:

- Are enrolled in a PEBB medical plan;

AND

- Do not have Medicare Part A and Part B as their primary coverage.

Tobacco use premium surcharge

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

- You attest that you or a dependent age 13 or older enrolled on your PEBB medical has used a tobacco product in the past two months (whether your enrolled dependent lives with you or not);

OR

- You did not attest to the tobacco use premium surcharge **no later than 60 days** from the date your PEBB health plan coverage ended or from the postmark date on this booklet, whichever is later.

To determine whether the tobacco use premium surcharge applies to your account, use the *2019 Premium Surcharge Help Sheet* (found on page 51) and respond by completing and submitting the *2019 PEBB Continuation Coverage (COBRA) Election/Change* form or the *2019 PEBB Continuation Coverage (Unpaid Leave) Election/ Change* form. The PEBB Program must receive the form by the required deadline.

To report a change

If you or your enrolled dependents' tobacco use changes (or you or your dependents have enrolled in or accessed the tobacco cessation resources mentioned in the *2019 Premium Surcharge Help Sheet*), you may report the change by:

- Going to *My Account* at **www.hca.wa.gov/my-account** to change your attestation;

OR

- Completing and submitting a *2019 Premium Surcharge Change Form* (found at **www.hca.wa.gov/erb** under *Forms & publications*) to the PEBB Program.

If you submit a change that results in incurring the premium surcharge, the change is effective the first day 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 day 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, or if you enroll in Medicare Part A and Part B as your primary coverage, this surcharge does not apply to you.

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

- You have a spouse or state-registered domestic partner enrolled on your PEBB medical, and your spouse or state-registered domestic partner has elected not to enroll in another 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, and you did not attest to the spouse or state-registered domestic partner coverage premium surcharge **no later than 60 days** from the date your PEBB health plan coverage ended or from the postmark date on this booklet, whichever is later.

If you enroll a spouse or state-registered domestic partner on your PEBB medical plan, use the *2019 Premium Surcharge Help Sheet* (found on page 51) to determine whether the spouse or state-registered domestic partner coverage premium surcharge applies to your account. Then respond by completing the *2019 PEBB Continuation Coverage*

(COBRA) Election/Change form or *2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. The PEBB Program must receive the form by the required deadline.

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

- Incurring the surcharge;
- Not incurring the surcharge because your spouse's or state-registered domestic partner's share of the medical premium through their employer-based group medical is not comparable to UMP Classic's premium; or
- Not incurring the surcharge because the benefits provided by your spouse's or state-registered domestic partner's employer-based group medical are not comparable to UMP Classic.

You must update your attestation by either submitting the required *Premium Surcharge Change Form* or logging in to *My Account* at **www.hca.wa.gov/my-account** and following the instructions. If your attestation is not received within the PEBB Program annual open enrollment timeframe, you will be charged the monthly $50 premium surcharge (in addition to your monthly premiums) for the full plan year. **You will then only be able to change your attestation if your spouse or state-registered domestic partner's employer-based group medical 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 you 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 *2019 PEBB Continuation Coverage (COBRA) Election/Change* form or *2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change* 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 *2019 PEBB Continuation Coverage (COBRA) Election/Change* form or *2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form.

To change your current attestation (without adding or removing your spouse or state-registered domestic partner from PEBB medical), complete and submit a *2019 Premium Surcharge Change Form* (found at **www.hca.wa.gov/erb** under *Forms & publications*) to the PEBB Program. You must also submit proof of the qualifying event with your completed form **no later than 60 days after** the qualifying event.

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

For more information on the premium surcharges, visit **www.hca.wa.gov/erb**.

SmartHealth

SmartHealth is Washington State's voluntary wellness program designed to help you improve your health by participating in fun and engaging SmartHealth activities. The secure website offers tips and tools through fun activities that improve nutrition, sleep, exercise, and more. As you progress on your wellness journey, you can qualify for the SmartHealth wellness incentives.

Who is eligible to participate?

All subscribers, except those enrolled in both Medicare Part A and Part B as their primary coverage, are eligible to participate and qualify for the financial wellness incentives. Spouses or state-registered domestic partners enrolled in PEBB medical may also participate in SmartHealth through the SmartHealth website; however, only subscribers can qualify for the financial wellness incentives and other SmartHealth promotions.

What are the financial wellness incentives?

Eligible non-Medicare subscribers who participate in SmartHealth activities can qualify for two financial wellness incentives:

1. A $25 Amazon.com gift card*.
2. Either a $125 reduction in the subscriber's 2020 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 2020).

How do I qualify for the financial wellness incentives?

To qualify for the $25 Amazon.com gift card,* the subscriber must:

- Not be enrolled in Medicare Part A and Part B; **and**
- Complete the SmartHealth Well-being Assessment and claim the $25 Amazon.com gift card* by **December 31, 2019**.

To qualify for the $125 financial wellness incentives, the subscriber must:

- Not be enrolled in Medicare Part A and Part B;
- Complete the SmartHealth Well-being Assessment; **and**
- Earn 2,000 total points within the deadline requirement.

To qualify for the incentive in 2020, the subscriber must still be enrolled in a PEBB medical plan in 2020.

If a subscriber qualifies for the $125 wellness incentive in 2019, and enrolls in Medicare Part A and Part B while enrolled in a PEBB medical plan after January 1, 2020, they will still receive the incentive in 2020.

How do I get started?

Follow these simple steps to earn points to qualify for the financial wellness incentives:

1. Go to **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 financial wellness incentives). After completing the Well-being Assessment, you earn the $25 gift card wellness incentive.

   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. Complete other activities on SmartHealth's website to earn 2,000 total points by the applicable deadline to qualify for the $125 wellness incentive.

**The $25 Amazon.com gift card is a taxable benefit.*

Deadline requirements

When is the deadline to meet the requirements for the $25 gift card wellness incentive?

The deadline to earn and claim the $25 Amazon.com gift card wellness incentive is **December 31, 2019**.

When is the deadline to meet the requirements for the $125 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, 2019**.
- If your PEBB medical effective date is in July or August, your deadline is **120 days** from your medical effective date. **Example:** *Sam is new to state employment and Sam's PEBB medical effective date is July 1, 2019. Sam's deadline to complete the SmartHealth activities and earn the financial wellness incentive is October 29, 2019.*
- If your PEBB medical effective date is in September through December, your deadline is **December 31, 2019**.

Nondiscrimination Notice and Language Access Services

The PEBB Program and its contracted health plans comply with applicable federal civil rights laws and do not discriminate (exclude people or treat them differently) on the basis of race, color, national origin, age, disability, or sex.

The PEBB Program also complies with applicable state civil rights laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained guide dog or service animal by a person with a disability.

The PEBB Program provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe this organization has failed to provide language access services or discriminated in another way…	**You can file a grievance with:**
PEBB Program *You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HCA Compliance Officer is available to help you.*	Health Care Authority Division of Legal Services, Attn: HCA Compliance Officer PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) | Fax 360-507-9234 **compliance@hca.wa.gov**
PEBB MEDICAL PLANS	
Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest Attn: Member Relations – Kaiser Civil Rights Coordinator 500 NE Multnomah, Suite 100 Portland, OR 97232 1-800-813-2000 or 503-813-2000 (TRS: 711)
Kaiser Foundation Health Plan of Washington	Kaiser Foundation Health Plan of Washington Civil Rights Coordinator Quality GNE-D1E-07 PO Box 9812 Renton, WA 98057 1-888-901-4636 or 206-630-4636 (TRS: 711) | Fax 206-901-6205 **kp.org/wa/feedback**
Washington State Rx Services (for discrimination concerns about prescription-drug benefits for Uniform Medical Plan [UMP])	Washington State Rx Services Attn: Appeals Unit PO Box 40168 Portland, OR 97204-0168 1-888-361-1611 (TDD/TTY: 711) | Fax 1-866-923-0412 **compliance@modahealth.com**
Premera Blue Cross (for discrimination concerns about Medicare Supplement Plan F and the Center of Excellence Program for UMP Classic and UMP CDHP members)	Premera Blue Cross Attn: Civil Rights Coordinator - Complaints and Appeals PO Box 91102 Seattle, WA 98111 1-855-332-4535 (TTY: 1-800-842-5357) | Fax 425-918-5592 **AppealsDepartmentInquiries@Premera.com**

If you believe this organization has failed to provide language access services or discriminated in another way…	You can file a grievance with:
Regence BlueShield (for discrimination concerns about UMP Classic, UMP Consumer-Directed Health Plan [CDHP], and UMP Plus)	Regence BlueShield Civil Rights Coordinator MS: CS B32B, PO Box 1271 Portland, OR 97207-1271 1-888-344-6347 (TRS: 711) **CS@regence.com**
Regence BlueShield (for discrimination concerns about UMP Classic for Medicare members)	Regence BlueShield Civil Rights Coordinator MS: B32AG, PO Box 1827 Medford, OR 97501 1-866-749-0355 (TRS: 711) | Fax 1-888-309-8784 **medicareappeals@regence.com**
PEBB DENTAL PLANS	
Delta Dental (for discrimination concerns about DeltaCare and the Uniform Dental Plan)	Delta Dental Attn: Isaac Lenox, Compliance/Privacy Officer PO Box 75983 Seattle, WA 98175 1-800-554-1907 (TTY: 1-800-833-6384) | Fax 206-729-5512 **Compliance@DeltaDentalWA.com**
Willamette Dental *HCA will process discrimination complaints pertaining to Willamette Dental Group.*	Health Care Authority Division of Legal Services, Attn: HCA Compliance Officer PO Box 42704 Olympia, WA 98504-2704 1-855-682-0787 (TRS: 711) | Fax 360-507-9234 **compliance@hca.wa.gov**

You can also file a civil rights complaint with:

U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TDD: 1-800-537-7697)
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf (to submit complaints

[English] Language assistance services, including interpreters and translation of printed materials, are available free of charge. Employees: Contact your employer's personnel, payroll, or benefits office directly. Retirees, COBRA, and Continuation Coverage members only: Contact the PEBB Program at 1-800-200-1004. (TRS: 711).

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በነጻ ይገኛል። ተቀጣሪዎች፡ የቀጣሪዎትን ሰራተኛ፣ የደሞዝ ወይም ጥቅማ-ጥቅም ክፍያ ጽ/ቤትን በቀጥታ ያነጋግሩ። ጡረታ የወጡ፣ COBRA እና ቀጣይነት ያለው ሽፋን አባላት ብቻ፡ የPEBB ፕሮግራምን በ1-800-200-1004. (TRS: 711) ያነጋግሩ።

[Arabic] خدمات المساعدة في اللغات، بما في ذلك المترجمين الفوريين وترجمة المواد المطبوعة، متوفرة مجاناً. للموظفين: اتصل بمكتب شؤون العاملين بالشركة، أو مكتب المرتبات أو الاستحقاقات مباشرة. للمتقاعدين، وأعضاء COBRA وأعضاء التغطية المستمرة فقط: اتصل ببرنامج PEBB على الرقم 1-800-200-1004 . (TRS: 711).

[Burmese]
ဘာသာပြန်ဆိုသူများနှင့် ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်းအပါ
ခြင်းအပါအဝင် ဘာသာစကားအထောက်အကူဝန်ဆောင်မှုများကို အခမဲ့ရနိုင်ပါသည်။
ပါသည်။ အလုပ်သမားများ-
သင့်အလုပ်ရှင်၏ကိုယ်ရေးအရာရှိ၊ လစာ သို့မဟုတ် အကျိုးခံစားခွင့်ဆိုင်ရာ ရုံးသို့ တို
တိုက်ရိုက်ဆက်သွယ်ပါ။ ပင်စင်ယူသူများ၊ COBRA
နှင့် ဆက်လက်ပြီးအကျုံးဝင်သည့် အဖွဲ့ဝင်များသာလျှင်- PEBB ပရိုဂရမ်သို့
1-800-200-1004. (TRS: 711) ကိုဖုန်းခေါ်ဆိုပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្ទាល់មាត់ និង
ការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ និយោជិក ៖
សូមទាក់ទងការិយាល័យបុគ្គលិកនិយោជករបស់អ្នក ការិយាល័យប្រាក់ខែ
ការិយាល័យអត្ថប្រយោជន៍ដោយផ្ទាល់។ អ្នកចូលនិវត្តន៍, COBRA, និងសមាជិក
Continuation Coverage ប៉ុណ្ណោះ ៖ សូមទាក់ទងកម្មវិធី PEBB តាមលេខ
1-800-200-1004. (TRS: 711)។

[Chinese] 免费提供语言协助服务，包括口译员和印制资料翻译。雇员：直接联系雇主的私人、工资或福利办公室。仅限退休人员、COBRA 和持续承保成员：联系 PEBB 计划处，电话为 1-800-200-1004 (TRS: 711)。

[Korean] 통역 서비스와 인쇄 자료 번역을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 직원: 고용주의 인사, 급여 또는 수당을 관리하는 사무소에 직접 문의하십시오. 퇴직자, COBRA 및 Continuation Coverage 회원만 해당: 1-800-200-1004, TRS: 711 로 PEBB 프로그램에 문의하십시오.

[Laotian] ການບໍຣິການດ້ານພາສາ, ລວມທັ້ງນາຍແປພາສາ ແລະ ການ ແປເອກສານຕີພິມ, ມີໄວ້ໃຫ້ຟຣີໂດຍບໍ່ຄິດຄ່າ. ພະນັກງານ: ຕິດຕໍ່ ຫາຜະແນກຫະບຽນພິລອອງນາຍຈ້າງ, ຜະແນກບັນຊີເງິນເດືອນ, ຫລື ຫ້ອງການສະວັດດີການໂດຍກົງໂລດ. ຜູ້ອອກບໍານຽ, COBRA, ແລະ ການຄຸ້ມກັນຫຼີກຳເນີນຕໍ່ໄປສຳລັບສະມາຊິກເທົ່ານັ້ນ: ຕິດຕໍ່ຫາໂຄງການ PEBB ໄດ້ທີ່ເລກ 1-800-200-1004 (TRS: 711).

[Oromo] Tajajilwwan gargaarsa afaanii, turjumaanaafi i waantota maxxanfaman kan hiikan bilisaan jiru. Hojjetoota: Kallattiidhaan peeroolii personeelii ykn waajira faayidaawwanii hojjechiisaa kee qunnami. COBRA fimiseensota Haguuggii Itti fufinsaa qofa: Sagantaa PEBB 1-800-200-1004 (TRS: 711) irratti qunnamuu dandeessu.

[Persian] خدمات کمک زبانی، از جمله مترجم شفاهی و ترجمه اسناد و مدارک (مطالب) چاپی، بصورت رایگان ارائه خواهد شد. قابل توجه کارگران: با بخش پرسنل کارفرمای خود لیست حقوق، یا اداره‌ی رفاه مستقیماً تماس بگیرید. بازنشستگان، COBRA، و اعضایی که دارای طرح ادامه پوشش بیمه هستند فقط با برنامه PEBB با شماره 1-800-200-1004 (TRS: 711) تماس بگیرند.

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅੰਨੁਵਾਦ ਸਮੇਤ—ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। ਮੁਲਾਜ਼ਮ: ਆਪਣੇ ਰੁਜ਼ਗਾਰਦਾਤਾ ਦੇ ਮੁਲਾਜ਼ਮ, ਪੇਅਰੋਲ, ਜਾਂ ਲਾਭਾਂ ਵਾਲੇ ਦਫ਼ਤਰ ਨਾਲ ਸਿੱਧਾ ਸੰਪਰਕ ਕਰਨ। ਸੇਵਾ-ਮੁਕਤ ਮੁਲਾਜ਼ਮ, COBRA (ਕੋਬਰਾ), ਅਤੇ ਸਿਰਫ਼ ਕੰਟੀਨਿਊਏਸ਼ਨ ਕਵਰੇਜ ਮੈਂਬਰ: 1-800-200-1004. (TRS: 711)ਉੱਤੇ PEBB ਪ੍ਰੋਗਰਾਮ ਨਾਲ ਸੰਪਰਕ ਕਰਨ।

[Romanian] Serviciile de asistenţă lingvistică, inclusiv cele de interpretariat şi de traducere a materialelor imprimate, sunt disponibile gratuit. Angajaţi: Contactaţi biroul pentru personal, salarii sau beneficii al angajatorului dvs. în mod direct. Numai pentru pensionari, membri COBRA sau Continuation Coverage: Contactaţi Programul PEBB la 1-800-200-1004. (TRS: 711).

[Russian] Языковая поддержка, в том числе услуги переводчиков и перевод печатных материалов, доступна бесплатно. Наемные работники: обратитесь непосредственно в отдел кадров, бухгалтерию или социальный отдел вашего работодателя. Только пенсионеры, пользователи COBRA или программ продленного страхового покрытия: обратитесь в программу PEBB отдел по телефону 1-800-200-1004. (TRS: 711).

[Somali] Adeego caawimaad luuqada ah, ay ku jirto turjubaano afka ah iyo turjumid lagu sameeyo waraaqaha la daabaco, ayaa lagu helayaa lacag la'aan. Shaqaalaha: La xiriir shaqaalaha qofka aad u shaqaysid, liiska mushaarka shaqaalaha, ama si toos ah xafiiska dheefaha. Dadka hawlgabka ah, COBRA, iyo kaliya xubnaha Sii wadista Ceymiska: Kalaxiriir Barnaamijka PEBB lambarkan 1-800-200-1004. (TRS: 711).

[Spanish] Hay servicios de asistencia con idiomas, incluyendo intérpretes y traducción de materiales impresos, disponibles sin costo. Empleados: Comuníquense directamente con la oficina de personal, nómina o beneficios de su empleador. Sólo para jubilados y miembros de COBRA y cobertura continua: Comuníquese con el Programa PEBB al 1-800-200-1004. (TRS: 711).

[Swahili] Huduma za msaada wa lugha, ikiwa ni pamoja na wakalimani na tafsiri ya nyaraka zilizochapishwa, zinapatikana bure bila ya malipo. Wafanyakazi: wasiliana moja kwa moja na ofisi ya utumishi ya mwajiri wako, ofisi ya malipo, au ya mafao. Wastaafu, wanachama wa COBRA na wenye bima ya kuendelea tu: Wasiliana na Programu ya PEBB kwa nambari 1-800-200-1004. (TRS: 711).

[Tagalog] Mga serbisyong tulong sa wika, kabilang ang mga tagapagsalin at pagsasalin ng nakalimbag na mga kagamitan, ay magagamit ng walang bayad. Mga empleyado: Makipag-ugnay nang direkta sa mga tauhan, payroll, o tanggapan ng mga benepisyo ng iyong employer. Mga Pensyonado, COBRA, at mga kasapi ng Continuation Coverage lamang: Makipag-ugnay sa Program ng PEBB sa 1-800-200-1004. (TRS: 711).

[Tigrigna] ተርጎምትን ናይ ዝተፅሓፉ ማተርያላት ትርጉምን ሓዊሱ ናይ ቋንቋ ሓገዝ ግልጋሎት፤ ብዘይ ምንም ክፍሊት ይርከቡ። ሰራሕተኛታት፡ ንናይ መስርሒ ዉልቃዊ ዝርዝር ደሞዝ ወይ ቤት ጽሕፈት ጥቕምታት ብቐጥታ ርኸቡ። ጡረተኛታት፣ COBRA፣ ኣባላት መቐጸልታ ሽፋን ጥራሕ፡ ንመደብ PEBB ብ1-800-200-1004 ርኸብ (TRS: 711)።

[Ukrainian] Мовна підтримка, у тому числі послуги перекладачів та переклад друкованих матеріалів, доступна безкоштовно. Наймані робітники: зверніться безпосередньо до відділу кадрів, бухгалтерії або соціального відділу вашого роботодавця. Лише пенсіонери, користувачі COBRA або програм продовженого страхового покриття: зверніться у програму PEBB за телефоном 1-800-200-1004. (TRS: 711).

[Vietnamese] Các dịch vụ trợ giúp ngôn ngữ, bao gồm thông dịch viên và bản dịch tài liệu in, hiện có miễn phí. Người lao động: Liên hệ trực tiếp với phòng nhân sự, tiền lương, hoặc phúc lợi của sở làm quý vị. Chỉ những người hồi hưu, các thành viên COBRA, và thành viên chương trình Bảo Hiểm Tiếp Tục: Liên hệ với Chương Trình PEBB theo số 1-800-200-1004. (TRS: 711).

Appendix A:
PEBB Continuation Coverage (COBRA)

Complete the 2019 PEBB Continuation Coverage (COBRA) Election/Change 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 below the number of hours required to be eligible for the employer contribution toward health plan coverage.

Note: See pages 6–8 for a list of events that may qualify you for PEBB Continuation Coverage (Unpaid Leave), which may allow a longer coverage period and different benefits.

Spouse:

- Your spouse (the employee or retiree) died. **Note:** You may qualify for PEBB Continuation Coverage (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 and your spouse (the employee or retiree) divorced.

State-registered domestic partner:

- Your state-registered domestic partner (the employee or retiree) died. **Note:** You may qualify for PEBB Continuation Coverage (COBRA) 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 or retiree) terminated.

Dependent child:

- Your parent (the employee or retiree) died. **Note:** You may qualify for PEBB Continuation Coverage (COBRA) 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 health plan coverage as a dependent child ended (see WAC 182-12-260(3)).

State-registered domestic partner's child:

- Your parent's state-registered domestic partner (the employee or retiree) dies, and you don't qualify for PEBB retiree insurance coverage as a surviving dependent.
- Your parent's state-registered domestic partner's (the employee's) hours of employment are reduced.
- Your parent's state-registered domestic partner's (the employee's) employment ends for any reason other than gross misconduct.
- Your eligibility for PEBB health plan coverage as a dependent child ended (see WAC 182-12-260(3)).

Retiree:

- You are a retiree and your employer group ends participation in PEBB health plan coverage.
- You are a retiree and the Department of Retirement Systems has determined that you are no longer disabled, so your pension has stopped.

Read the following information carefully before completing the form(s).

Medical and dental benefits

You may elect to continue only the coverage that you were enrolled in on the day before the qualifying event (medical, dental, or both) by self-paying the premiums. Unless you make a separate election and elect to enroll separately, eligible dependents you elect to cover will be enrolled in the same plan you elect. To enroll, complete the enclosed *2019 PEBB Continuation Coverage (COBRA) Election/Change* form and submit it to the PEBB Program at the address shown at the end of the form.

If the PEBB Program does not receive your completed form no later than 60 days from the date your PEBB health plan coverage ended or from the postmark date on this booklet (whichever is later), PEBB coverage will end on the last day of the month you and your dependent(s) stopped 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.

Note: If you are enrolled in a PEBB Medical Flexible Spending Arrangement (FSA) and your employment ends, you may be eligible to continue making contributions to your Medical FSA through Navia Benefit Solutions until the end of the plan year by electing PEBB Continuation Coverage (COBRA).

If you are eligible for this option, Navia Benefit Solutions will mail a COBRA election notice to you. Your election must be received by Navia Benefit Solutions **no later than 60 days** from the date your health plan coverage ends or from the postmark date on Navia's COBRA election notice, whichever is later. You can find more information in the *2019 PEBB Medical Flexible Spending Arrangement Enrollment Guide* at **pebb.naviabenefits.com**. You may also contact Navia Benefit Solutions at 1-800-669-3539 or **customerservice@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 MetLife terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability.

Portability is also available on coverage you've selected for your spouse or state-registered domestic partner and dependent child(ren).

Generally, there is no minimum time that you must be covered by the plan before you can take advantage of the portability feature. For specific details, please see your MetLife certificate of coverage, available at **www.hca.wa.gov/erb** under *Forms & publications*. MetLife will send portability information to you, which will include instructions on how to continue coverage.

Conversion coverage

Generally, you can convert your group term life insurance to an individual whole life insurance policy if your coverage terminates due to loss of eligibility for employer-sponsored coverage. Conversion is available on all group life insurance coverages. Conversion is not available on accidental death and dismemberment (AD&D) coverage. MetLife will send conversion information to you, which will include instructions on how to continue coverage.

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

2019 PEBB Continuation Coverage (COBRA) Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* packet sent to you, whichever is later.
- Your first premium payment and applicable premium surcharges (if any) are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends as described above. Premiums and applicable premium surcharges are due back to the date your other coverage ended.
- List eligible dependents you wish to cover or remove from coverage. This form replaces all *PEBB Continuation Coverage (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.

All forms and documents are available at **www.hca.wa.gov/erb** or by calling 1-800-200-1004 (TRS: 711).

Employee or retiree information only	Employee or retiree name	
	Employee or retiree Social Security number	Date PEBB health plan coverage ended (mm/dd/yyyy)

Section 1: Subscriber Information

Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

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

County of residence	Date of birth (mm/dd/yyyy)	Home phone number ( )	Alternative phone number ( )

❑ **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 PEBB health plan 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. Your election to continue enrollment must be received by Navia Benefit Solutions **no later than 60 days** from the date your PEBB health plan coverage ended or from the postmark date on the election notice sent by Navia, whichever is later.

❑ **Terminate coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only

If terminating coverage, include reason _____ Terminate date _____

If I terminate my coverage, I understand that I am forfeiting all further rights to enroll in PEBB benefits terminated 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 Medicare Part(s) A and/or B?

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.
Write your full name and the last four digits of your Social Security number on the copy.

2019 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 1: Subscriber Information *(continued)*

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you are not enrolled in Medicare Part A and Part B, and you or a dependent (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 2019 Premium Surcharge Help Sheet *at* **www.hca.wa.gov/erb** *for instructions on how to respond. If you check YES below or leave this section blank, you will be charged the monthly $25 premium 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 enrolled in or accessed the tobacco cessation resources noted in the *2019 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. Dependents 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 dependent 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 dependent eligibility is available at* **www.hca.wa.gov/erb.**

Relationship to subscriber ❑ Spouse: date of marriage_____ ❑ State-registered domestic partner: date registered _____	Date of birth (mm/dd/yyyy)

Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

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
❑ **Terminate coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only

If terminating coverage, include reason _____ Termination 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 your 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 your spouse's or state-registered domestic partner's Medicare card with this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

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 $25 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 enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

2019 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

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 is enrolling in PEBB medical coverage and has elected not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan Classic. See the 2019 Premium Surcharge Help Sheet *and the* 2019 Spousal Plan Calculator *at* **www.hca.wa.gov/erb**. *To change your attestation, use the* 2019 Premium Surcharge Change Form. **If you check YES below or leave this section blank, you will be charged the monthly $50 premium surcharge.**

Does the spouse or state-registered domestic partner coverage premium 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 *2019 Premium Surcharge Help Sheet* and completed the *2019 Spousal Plan Calculator* online.

❑ NO, I am not subject to the $50 premium surcharge. I used the *2019 Premium Surcharge Help Sheet* and, if needed, completed the *2019 Spousal Plan Calculator* online.

Which questions, if any, on the *2019 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

❑ I am completing and submitting the printed *2019 Spousal Plan Calculator* for the PEBB Program to determine.

Section 3: Dependent Information (such as child as defined by WAC 182-12-260(3))

Use additional forms for more dependents.

List eligible dependents you wish to cover or remove from coverage. Dependents 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.*

A	Last name	First name	Middle initial	Sex ❑M ❑F	Social Security number

Relationship to subscriber	❑ Child ❑ Stepchild *(not legally adopted)* ❑ Extended dependent *(attach copy of court order)*	❑ Disabled *(check only if age 26 or older)*	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

❑ **Terminate coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only

If terminating coverage, include reason _____ Termination 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 your dependent's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part(s) A and/or B? **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 dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

Does the tobacco use premium surcharge apply to this dependent? *(Response required for dependents ages 13 or older enrolling in medical coverage.)* Check one:

❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The $25 premium surcharge does not apply.

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

❑ NO, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

2019 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 3: Dependent Information *(continued)*

B

Last name	First name	Middle initial	Sex ❑M ❑F	Social Security number

Relationship to subscriber			Date of birth (mm/dd/yyyy)
	❑ Child ❑ Stepchild *(not legally adopted)* ❑ Extended dependent *(attach copy of court order)*	❑ Disabled *(check only if age 26 or older)*	

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
❑ **Terminate coverage:** *(select one)* ❑ Medical and dental ❑ Medical only ❑ Dental only

If terminating coverage, include reason _____ Termination 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 your dependent's Social Security Disability Award letter.
You and your enrolled dependents may be eligible for additional months of coverage.

Enrolled in Medicare Part(s) A and/or B? **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 dependent's Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

Does the tobacco use premium surcharge apply to this dependent? *(Response required for dependents ages 13 or older enrolling in medical coverage.)* Check one:

❑ The subscriber listed in Section 1 is enrolled in Medicare Part A and Part B. The $25 premium surcharge does not apply.
❑ YES, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.
❑ NO, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 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 ❑ Terminate medical coverage ❑ Terminate 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 dependent is no longer eligible**. Coverage will be terminated the last day of the month of loss of eligibility. If applicable, provide former dependent's new address below.

Dependent's new address: _____

Additional changes you can make during annual open enrollment (November 1–30)

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

Subscriber's last name	First name	Middle initial	Social Security number

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 occurs. 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.

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.

Give date of event _____

Check the box next to the corresponding event(s) below.

Add dependent(s), change medical plan, and/or change dental plan:

- ❑ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ❑ 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/erb**.
- ❑ 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.
- ❑ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.
- ❑ Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.
- ❑ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Add dependent(s):

- ❑ 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.
- ❑ Subscriber's dependent moves from outside the United States to live within the United States or moving from inside the United States to live outside the United States.

Change medical plan and/or change dental plan:

- ❑ Subscriber or dependent has a change in residence that affects health plan availability.
- ❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- ❑ Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their 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 insurance coverage under another account? ❑ Yes ❑ No

2019 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 5: Medical Plan Selection *Check appropriate box(es).*

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

Kaiser Foundation Health Plan of the Northwest[1]
- ❑ Kaiser Permanente NW Classic[2]
- ❑ Kaiser Permanente NW Consumer-Directed Health Plan [2,3]
- ❑ Kaiser Permanente NW Senior Advantage[4]

Kaiser Foundation Health Plan of Washington[1]
- ❑ Kaiser Permanente WA Classic
- ❑ Kaiser Permanente WA Consumer-Directed Health Plan[3]
- ❑ Kaiser Permanente WA Medicare Plan[4,5]
- ❑ Kaiser Permanente WA SoundChoice[6,9]
- ❑ Kaiser Permanente WA Value[6]

- ❑ **Medicare Supplement Plan F, administered by Premera Blue Cross[7]**

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan[3]
- ❑ UMP Plus–Puget Sound High Value Network[1,3,8]
- ❑ UMP Plus–UW Medicine Accountable Care Network [1,3]

[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 Washington and select counties in Oregon.

[3] These plans are available only to members not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must terminate your dependent's PEBB insurance coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation coverage options.

[4] 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/erb for medical plans available by county.)

[5] If you cover members not enrolled in Medicare Part A and Part B, also select Kaiser Permanente WA Classic, SoundChoice, or Value for these members.

[6] This plan is available only if at least one covered member is not enrolled in Medicare Part A and Part B. Members enrolled in Medicare Part A and Part B will be enrolled in Kaiser Permanente WA's Medicare Plan.

[7] 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.

[8] This plan does not have network primary care providers for adults in Thurston County.

[9] Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

Section 6: Dental Plan Selection *Check only one.*

Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans, not your dentist, for benefits information.

Preferred Provider Organization (PPO)	❑ **Uniform Dental Plan** (Group #3000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time.
Managed-Care Plans (limited network)	❑ **DeltaCare** (Group #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, 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) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

2019 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

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

If I send payment, this does not mean that I will be automatically enrolled in PEBB coverage. The PEBB Program will verify eligibility for me and my dependents. 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 *PEBB Continuation Coverage (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/erb**.

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 PO Box 42684 Olympia, WA 98504-2684	Washington State Health Care Authority PO Box 42691 Olympia, WA 98504-2691	Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

Note: Do not send forms to the addresses below. They are only for your reference.

2019 PEBB Program Medical Contractors

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

Kaiser Foundation Health Plan of Washington
601 Union Street, Suite 3100, Seattle, WA 98101
In 2018: 1-888-901-4636 In 2019: 1-866-648-1928
or TTY 1-800-833-6388

Premera Blue Cross
PO 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 TRS 711

2019 PEBB Program Dental Contractors

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

Uniform Dental Plan
administered by Delta Dental of Washington
400 Fairview Ave. N, Suite 800, Seattle, WA 98109-5371
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 an accommodation, or require documents in another format or language, please call 1-800-200-1004 (TRS: 711).

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

C

2019 Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read and sign page 2 of this form.

Section 1: Retiree information

Medical effective date (mm/dd/yyyy)				
Social Security number	Last name (as it appears on Medicare card)	First name	Middle initial	Sex ❑ M ❑ F
Permanent residential address (required)	Apt./unit number	City	State	ZIP Code
Mailing address (if different than above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	❑ Married (mm/dd/yyyy)	❑ State-registered domestic partnership/legal union (mm/dd/yyyy)	Home phone number (with area code)

Retiree Medicare claim number from Medicare card	**Entitled to Part A (hospital)** ❑ Yes ❑ No If yes, effective date _____
	Entitled to Part B (medical) ❑ Yes ❑ No If yes, effective date _____

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

Social Security number	Last name (as it appears on Medicare card)	First name	Middle initial
Permanent residential or mailing address		Date of birth	Sex ❑ M ❑ F
City		State	ZIP Code + 4

Spouse or state-registered domestic partner's Medicare claim number from Medicare card	**Entitled to Part A (hospital)** ❑ Yes ❑ No If yes, effective date _____
	Entitled to Part B (medical) ❑ Yes ❑ No If yes, effective date _____

Section 3: Plan choice

Kaiser Foundation Health Plan of the Northwest

❑ Kaiser Permanente NW Senior Advantage

Kaiser Foundation Health Plan of Washington

❑ Kaiser Permanente WA Medicare Advantage

Name of **retiree's** contracting primary care provider (refer to plan's provider directory)	Current patient? ❑ Yes ❑ No
Name of **spouse's or state-registered domestic partner's** contracting primary care provider (refer to plan's provider directory)	Current patient? ❑ Yes ❑ No

(continued)

Please return this form by mail to:

Washington State Health Care Authority

PO Box 42684

Olympia, WA 98504-2684 **or fax to:** 360-725-0771

Section 4: Medical information	Retiree	Spouse or state-registered domestic partner
1. Do you currently have end-stage renal disease (kidney disease)?	❑ Yes ❑ No	❑ Yes ❑ No
2. Do you have any health insurance other than Medicare?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, through which carrier?	What type of policy?	
Do you intend to discontinue this policy?	❑ Yes ❑ No	❑ Yes ❑ No
Note: Your answers to questions 3 and 4 below will **not** affect your eligibility to enroll in a Medicare Advantage plan.		
3. Do you live in an institution?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, name of institution:	Date of admission:	
Address:	Phone number:	
4. Are you currently receiving Medicaid?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, Medicaid number:		

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 dependents and I may also lose PEBB 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. 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 benefits.

I have read and understand this form, including the Statement of Understanding (on the next page). I know that I must refer to my plan's certificate of coverage for rules I must follow to receive coverage under this Medicare Advantage contract.

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

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.)

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/erb.**

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

Signature of retiree	Date	Signature of spouse or state-registered domestic partner (if enrolling)	Date

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where they reside) on this application means that I have read and understand the contents of the application. If signed by an authorized representative (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.

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

Signature of authorized representative	Date

Name	Relationship to retiree
Address	**Phone**

HCA is committed to providing equal access to our services.
If you need accommodation, please call 1-800-200-1004 (TRS: 711).

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the first page 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 from 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 services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

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

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

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

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

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

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

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

*I understand that my enrollment in the Medicare Advantage plan I have selected is effective the day PEBB insurance begins, or the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during the PEBB Program's annual open enrollment (November 1-30), 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 of enrollment. 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 written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

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

Please contact the plans listed below 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.

Note: Do not send forms to the addresses below. They are only for your reference.

2019 PEBB MEDICAL CONTRACTORS

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-877-221-8221 or TRS: 711

Kaiser Foundation Health Plan of Washington
601 Union St., Suite 3100, Seattle, WA 98101-1374
In 2018: 1-888-901-4636 • In 2019: 1-866-648-1928
or TTY: 1-800-833-6388

Appendix B:
PEBB Continuation Coverage (Unpaid Leave)

Complete the *2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form if you are an employee who will lose your PEBB employer-based coverage because of one of the following events:

- 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 who is between periods of eligibility.

* You may also be entitled to continue long-term disability coverage. See page 41 for information on continuing long-term disability (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 only the 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 PEBB medical and or PEBB dental plan that you elect. If you do not elect PEBB Continuation Coverage (Unpaid Leave), your dependent(s) may not enroll independently because they do not have independent election rights to PEBB Continuation Coverage (Unpaid Leave).

To enroll, complete the enclosed *2019 PEBB Continuation Coverage (Unpaid Leave) Election/ Change* form and submit it to the PEBB Program at the address shown at the end of the form.

If the PEBB Program does not receive your completed form no later than 60 days from the date your PEBB health plan coverage ended or from the postmark date on this booklet (whichever is later), PEBB coverage will end on the last day of the month you and your dependent(s) stopped 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.

Note: If you are enrolled in a PEBB Medical Flexible Arrangement (FSA) and your employer-based coverage ends, you may be eligible to continue making contributions to your Medical FSA through Navia Benefit Solutions until the end of the plan year by electing PEBB Continuation Coverage (Unpaid Leave).

If you are eligible for this option, your election must be received by Navia Benefit Solutions **no later than 60 days** from the date your health plan coverage ends or from the postmark date on this booklet, whichever is later. You can find more information in Navia Benefits Solutions' *2019 PEBB Medical Flexible Spending Arrangement Enrollment Guide* at **pebb.naviabenefits.com.** You may also contact Navia Benefit Solutions at 1-800-669-3539 or **customerservice@naviabenefits.com.**

Life insurance benefits

You may choose to continue all or part of your life insurance coverage while on PEBB Continuation Coverage (Unpaid Leave). lf you choose to continue any part of your optional life insurance coverage, you must also continue the $35,000 Basic Life Insurance and $5,000 Basic Accidental Death & Dismemberment (AD&D) Insurance at a cost of $3.95 per month.

If you do not continue your life insurance coverage and wish to reenroll when you return to work, you may need to submit evidence of insurability (Statement of Health) depending on the coverage elected. 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 coverage continued 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 coverage to a maximum of 29 months after your active duty began.

lf you do not choose to continue your life insurance coverage under one of the following options, all life insurance coverage, including Basic Life Insurance and Basic AD&D Insurance coverage paid by your employer, will end at the end of the month in which you begin active duty.

There are two options for extending life insurance coverage:

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 Insurance and Basic AD&D Insurance will be continued. You are responsible for paying the premium for any optional life and AD&D coverage.
2. You can self-pay your life insurance coverage by completing the *2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change* form. You must make your premium payments directly to MetLife.

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 (Statement of Health). If you return to full-time employment status after the end of 29 months, and choose to enroll in life insurance coverage, you may be required to provide a Statement of Health.

Reinstating life insurance when you return to work

When you return to work, you have the following options for your employer-sponsored and optional coverage:

- If you choose to self-pay optional coverage during PEBB Continuation Coverage (Unpaid Leave), your employee coverage will be reinstated when you return to work without a Statement of Health.
- If you choose not to pay for optional coverage during PEBB Continuation Coverage (Unpaid Leave), complete the *MetLife Enrollment/Change Form*. Your enrollment may require a Statement of Health depending on the coverage you elect.

Long-term disability insurance coverage

You may self-pay basic and optional long-term disability (LTD) insurance 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.

Continuing LTD insurance coverage while on USERRA or educational leave

If you choose to continue LTD insurance coverage, you must pay the $2.10 monthly premium. If you are eligible to continue optional LTD insurance coverage under PEBB Continuation Coverage (Unpaid Leave) but choose not to elect it, you must provide evidence of insurability (Statement of Health) when you regain eligibility as described in WAC 182-08-197(3)(a)(iii).

Reinstatement requirements

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

(continued)

USERRA or educational leave only			All other types of leave
You discontinued LTD insurance coverage during PEBB Continuation Coverage (Unpaid Leave)	**You self-paid for LTD insurance coverage during PEBB Continuation Coverage (Unpaid Leave) and you return to active work immediately following your leave period**	**You self-paid for LTD insurance coverage during PEBB Continuation Coverage (Unpaid Leave) but did not return to active work immediately following your leave period**	**You were not eligible to continue LTD insurance coverage during PEBB Continuation Coverage (Unpaid Leave)**
To apply for optional LTD insurance coverage, your employer must receive your completed *Long Term Disability Enrollment/ Change Form* and The 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 will not become effective until approved by The Standard Insurance Company.	**If you become eligible for the employer contribution immediately following your leave during the first 29 months, your LTD insurance coverage 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 (Unpaid Leave). **If you wish to increase your waiting period for optional LTD insurance coverage—**your employer 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 insurance coverage—your employer must receive your completed *Long Term Disability Enrollment/Change Form* and The 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 The Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance coverage you had during PEBB Continuation Coverage (Unpaid Leave).	**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 coverage the first day of the month you regain eligibility for the employer contribution as a new subscriber. Your employer must receive your completed *Long Term Disability Enrollment/Change Form* **no later than 31 days** after 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 insurance coverage—**your employer 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 insurance coverage—**your employer must receive your completed *Long Term Disability Enrollment/Change Form* and The 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 The Standard Insurance Company. Otherwise, you will continue to be enrolled in the same level of basic and optional LTD insurance coverage you had during PEBB Continuation Coverage (Unpaid Leave).	Your basic and optional LTD insurance coverage is reinstated the first day of the month you regain eligibility for the employer contribution, to the same level of coverage you were enrolled in before PEBB Continuation Coverage (Unpaid Leave). You do not have to complete and submit any forms.

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change

- **Type or print clearly in dark ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- We must receive this form **no later than 60 days** from the date your employer-sponsored coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* packet sent to you, whichever is later.
- Your first premium payment and applicable premium surcharges (if any) are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends as described above. Premiums and applicable premium surcharges are due back to the date your other coverage ended.
- List eligible dependents you wish to cover or remove from coverage. This form replaces all PEBB *Continuation Coverage (Unpaid Leave) 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/erb** or by calling 1-800-200-1004 (TRS: 711).

Qualifying Event for PEBB Continuation Coverage (Unpaid Leave) *Check only one.*

- ❑ Applying for disability retirement
- ❑ Layoff
- ❑ USERRA (military) leave
  Date called to duty in the uniformed services _____
- ❑ Reversion employee (for reasons other than a layoff)
- ❑ 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

Date employer coverage ended

Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address / Apt./unit number	City	State	ZIP Code
Mailing address (if different from above) / Apt./unit number	**City**	**State**	**ZIP Code**

County of residence	Date of birth (mm/dd/yyyy)	Home phone number ( )	Alternative phone number ( )

❑ **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 at 1-800-669-3539 **no later than 60 days** after the mailing date on the *PEBB Continuation Coverage Election Notice* booklet.

❑ **Terminate coverage:**
❑ Medical and dental ❑ Medical only ❑ Dental only
❑ Long-term disability insurance (only if on educational or military leave)

To terminate life insurance, contact MetLife at 1-866-548-7139.

Include reason _____ Termination date _____

If I terminate my coverage, I understand that I am forfeiting all further rights to enroll in PEBB benefits terminated above unless I regain eligibility.

Subscriber's last name	First name	Middle initial	Social Security number

Section 1: Subscriber Information *(continued)*

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25-per-account surcharge in addition to your monthly premium if you or a dependent (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 2019 Premium Surcharge Help Sheet at **www.hca.wa.gov/erb** *for instructions on how to respond.* ***If you check YES below or leave this section blank, you will be charged the monthly $25 premium 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 enrolled in or accessed the tobacco cessation resources noted in the *2019 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. Dependents 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 dependent 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 dependent eligibility is available at* **www.hca.wa.gov/erb**.

Relationship to subscriber ❑ Spouse: date of marriage_____ ❑ State-registered domestic partner: date registered _____				Date of birth (mm/dd/yyyy)
Social Security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

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	To terminate life insurance, contact MetLife at 1-866-548-7139.
❑ **Add coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	
❑ **Terminate coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	

If terminating coverage, include reason _____ Termination 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.

Tobacco Use Premium Surcharge—if enrolling in medical coverage

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

❑ 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 enrolled in or accessed the tobacco cessation resources noted in the *2019 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 monthly premium if your spouse or state-registered domestic partner is enrolling in PEBB medical coverage and has elected not to enroll in another employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the 2019 Premium Surcharge Help Sheet *and the* 2019 Spousal Plan Calculator *at* **www.hca.wa.gov/erb**. *To change your attestation, use the* 2019 Premium Surcharge Change Form. ***If you check YES below or leave this section blank, you will be charged the monthly $50 premium surcharge.***

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

❑ YES, I am subject to the $50 premium surcharge. I used the *2019 Premium Surcharge Help Sheet* and completed the *2019 Spousal Plan Calculator* online.

❑ NO, I am not subject to the $50 premium surcharge. I used the *2019 Premium Surcharge Help Sheet* and, if needed, completed the *2019 Spousal Plan Calculator* online.

Which questions, if any, on the *2019 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

❑ I am completing and submitting the printed *2019 Spousal Plan Calculator* for the PEBB Program to determine.

(continued)

2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 3: Dependent Information (such as child as defined in WAC 182-12-260 (3))

Use additional forms for more dependents.

List eligible dependents you wish to cover or remove from coverage. Dependents 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.*

A

Last name	First name	Middle initial	Sex ❑M ❑F	Social Security number

Relationship to subscriber			Date of birth (mm/dd/yyyy)
	❑ Child ❑ Stepchild *(not legally adopted)* ❑ Extended dependent *(attach copy of court order)*	❑ Disabled *(check only if age 26 or older)*	

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	To terminate life insurance, contact MetLife at 1-866-548-7139.
❑ **Add coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	
❑ **Terminate coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	

If terminating coverage, include reason _____ Termination date _____

Does the tobacco use premium surcharge apply to this dependent? *(Response required for dependents ages 13 or older enrolling in medical coverage.)* Check only one:

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

❑ NO, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 Premium Surcharge Help Sheet*.

B

Last name	First name	Middle initial	Sex ❑M ❑F	Social Security number

Relationship to subscriber			Date of birth (mm/dd/yyyy)
	❑ Child ❑ Stepchild *(not legally adopted)* ❑ Extended dependent *(attach copy of court order)*	❑ Disabled *(check only if age 26 or older)*	

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	To terminate life insurance, contact MetLife at 1-866-548-7139.
❑ **Add coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	
❑ **Terminate coverage:** *(select one)*	❑ Medical and dental	❑ Medical only	❑ Dental only	

If terminating coverage, include reason _____ Termination date _____

Does the tobacco use premium surcharge apply to this dependent? *(Response required for dependents ages 13 or older enrolling in medical coverage.)* Check only one:

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

❑ NO, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months, or has enrolled in or accessed the tobacco cessation resources noted in the *2019 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 ❑ Terminate medical coverage ❑ Terminate dental coverage

To terminate life insurance, contact MetLife at 1-866-548-7139.

❑ 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 dependent is no longer eligible.** Coverage will be terminated 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 (November 1–30)

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

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

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 occurs.** 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.

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.

Give date of event _____

Check the box next to the corresponding event(s) below.

Add dependent(s), change medical plan, and/or change dental plan:

- ❑ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
- ❑ 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/erb**.
- ❑ 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.
- ❑ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.
- ❑ Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan.
- ❑ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ❑ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Add dependent(s):

- ❑ 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.
- ❑ Subscriber's dependent moves from outside the United States to live within the United States or moving from inside the United States to live outside the United States.

Change medical plan and/or change dental plan:

- ❑ Subscriber or dependent has a change in residence that affects health plan availability.
- ❑ Subscriber or dependent becomes entitled to or loses eligibility for Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan.
- ❑ Subscriber or dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- ❑ Subscriber or dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their 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 insurance coverage under another account? ❑ Yes ❑ No

(continued)

2019 PEBB Continuation Coverage (Unpaid Leave) Election/Change

Subscriber's last name	First name	Middle initial	Social Security number

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 the Northwest[1]
- ❑ Kaiser Permanente NW Classic[2]
- ❑ Kaiser Permanente NW Consumer-Directed Health Plan[2]

Kaiser Foundation Health Plan of Washington[1]
- ❑ Kaiser Permanente WA Classic
- ❑ Kaiser Permanente WA Consumer-Directed Health Plan
- ❑ Kaiser Permanente WA SoundChoice[4]
- ❑ Kaiser Permanente WA Value

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan
- ❑ UMP Plus–Puget Sound High Value Network[1,3]
- ❑ UMP Plus–UW Medicine Accountable Care Network[1]

[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 Washington and select counties in Oregon.

[3] This plan does not have network primary care providers for adults in Thurston County.

[4] Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

Section 6: Dental Plan Selection *Check only one.*

Before you select a dental plan, be sure your provider(s) participate with that plan. Contact the plans, not your dentist, for benefits information.

Preferred Provider Organization (PPO)

- ❑ **Uniform Dental Plan** (Group #3000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time.

Managed-Care Plans (limited network)

- ❑ **DeltaCare** (Group #3100), administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, 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) You will select and receive care from a primary care dental provider in the Willamette Dental Group Plan. Before you enroll, call 1-855-433-6825 to verify your provider is in the Willamette Dental Group network.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

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 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 PEBB Continuation Coverage (Unpaid Leave). (If you wish to decrease your life and/or AD&D insurance amounts while on PEBB Continuation Coverage (Unpaid Leave), please contact MetLife directly at 1-866-548-7139.)

❑ NO, I do not wish to continue the life and AD&D insurance I had as an 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 MetLife must receive my completed *MetLife Enrollment/Change* form through **http://mybenefits.metlife.com/wapebb 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)*

❑ 90-Day ❑ 180-Day ❑ 300-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 that 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 that 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)*

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 9: 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 dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of PEBB 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 dependents. 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 *PEBB Continuation Coverage (Unpaid Leave) 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/erb**.

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 PO Box 42684 Olympia, WA 98504-2684	Washington State Health Care Authority PO Box 42691 Olympia, WA 98504-2691	Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

Note: Do not send forms to the addresses below. They are only for your reference.

2019 PEBB Program Medical Contractors

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

Kaiser Foundation Health Plan of Washington
(formerly Group Health Cooperative)
601 Union Street, Suite 3100, Seattle, WA 98101
In 2018: 1-888-901-4636 • **In 2019:** 1-866-648-1928
or TTY 1-800-833-6388

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

2019 PEBB Program Life Insurance Contractor

Metropolitan Life Insurance Company (MetLife)
PO Box 14406, Lexington, KY 40512-4406
1-866-548-7139

2019 PEBB Program Dental Contractors

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

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

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

2019 PEBB Program Long-Term Disability Insurance Contractor

The Standard Insurance Company
411 108th Ave. NE, Suite 400, Bellevue, WA 98004
1-800-368-2860

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Do not submit this help sheet with your 2019 enrollment form or *2019 Premium Surcharge Change Form*.

2019 Premium Surcharge Help Sheet

- Use the information below to attest on your 2019 enrollment form or the *2019 Premium Surcharge Change Form* whether the premium surcharges apply.
- The surcharges do not apply to subscribers and any dependents enrolled in PEBB dental coverage only.
- The surcharges do not apply to retirees or continuation coverage subscribers enrolled in Medicare Part A and Part B.
- The tobacco use premium surcharge does not apply to any enrolled dependents 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 dependents ages 18 and older who use tobacco products are enrolled in the free tobacco cessation program through your PEBB medical plan, or if enrolled dependents ages 13–17 who use tobacco products accessed information and resources aimed at teens at **https://teen.smokefree.gov**. Enrolled dependents ages 12 and younger are automatically defaulted to NO (non-tobacco users); this means you do not have to attest for dependents ages 12 and younger. You do not need to attest when the dependent turns age 13 unless the dependent 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 dependent age 13 and older starts using tobacco products.
- **All** enrolled dependent 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/my-account** or submit a *2019 Premium Surcharge Change Form*. (**Note:** University of Washington employees must use Workday.) Changes that result in a premium surcharge will begin the first day of the month following the status change (the date you or your dependent(s) started 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 or you will be enrolling them on your 2019 PEBB medical plan, you must:

1. Answer **YES** or **NO** to the following Questions 2-6.
   AND
2. Check the corresponding box(es) on your 2019 enrollment/form or *2019 Premium Surcharge Change Form*.

	Questions	YES	NO
1	Are you covering your spouse or state-registered domestic partner in a Public Employees Benefits Board (PEBB) medical plan under your account in 2019?	✓	
2	Will your spouse or state-registered domestic partner be eligible for medical coverage through their employer in 2019? (If your spouse or state-registered domestic partner will not be employed in 2019, answer NO.)		
3	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 2019?		
4	Has your spouse or state-registered domestic partner elected not to enroll in their employer's medical in 2019?		
5	Will the coverage offered by your spouse's or state-registered domestic partner's employer in 2019 NOT be through the PEBB Program or TRICARE? • Answer YES if your spouse's or state-registered domestic partner's employer **does not** offer PEBB coverage or a TRICARE plan. • Answer NO if your spouse's or state-registered domestic partner's employer **does** offer PEBB coverage or a TRICARE plan.		
6	Will your spouse's or state-registered domestic partner's share of the medical premium through their employer be less than $111.16 per month in 2019?		

▶ **If you answered NO to ANY of these questions, check NO on your 2019 enrollment form or *2019 Premium Surcharge Change Form,* and show which question you answered No to. You will not have to pay the surcharge.**

▶ **If you answered YES to ALL of these questions, you must complete steps 1 and 2 below to find out whether you must pay the surcharge.**

1. Your spouse or state-registered domestic partner should ask their employer for a *2019 Summary of Benefits and Coverage (SBC)* for **all** medical plans that:
   - Serve the county of residence for your spouse or state-registered domestic partner.
   - Have a monthly premium of less than $111.16 per month for the employee.
2. Use the *2019 Summary of Benefits and Coverage (SBC)* information to answer the questions in the *2019 Spousal Plan Calculator* online tool at **www.hca.wa.gov/erb**. Or, you can download a paper version of the *2019 Spousal Plan Calculator* from the website and submit it with your 2019 enrollment form or your *2019 Premium Surcharge Change Form*.

If you don't have access to the Internet, you may request a paper version of the *2019 Spousal Plan Calculator* from your employer (if an employee). All other subscribers may call the PEBB Program at 1-800-200-1004 to request a paper copy.

If using the online *2019 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 state-registered domestic partner coverage surcharge apply to you?" Enter this response on your 2019 enrollment form or *2019 Premium Surcharge Change Form*.

If using a paper version of the *2019 Spousal Plan Calculator*:

- Provide all the information requested by the form.
- Check "Employer or PEBB Program to determine" on the 2019 enrollment form or *2019 Premium Surcharge Change Form*.
- Include a copy of the *2019 Spousal Plan Calculator* (not this help sheet) when you submit your form.
- Your employer (for employees) or the PEBB Program (for all others subscribers) will determine whether your spouse's or state-registered domestic partner's employer-based group medical is comparable to UMP Classic, and if the premium surcharge will apply.

Washington State
Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD
PO Box 42684
Olympia, WA 98504
HCA 50-801 (4/19)

READ NOW

The PEBB Program must receive your election form(s) no later than 60 days from the date PEBB health plan coverage ended or from the postmark date on this booklet, whichever is later. To continue life insurance, MetLife must receive your completed application no later than 60 days after your employer-paid coverage ends.